IM6 OB Simulation Patient Preparation Worksheet

RECOGNIZE & ANALYZE CLUES

This section is to be completed prior to Sim Day 1:

Student Name: Anne Ghandour
Patient initials: SR Admit Date: ______
Diagnosis: G P AB L M
EDD: 12 / 08 / 23 Gest. Age: 36 wk
Blood Type/Rh: O positive Rubella Status: immune GBS status: negative
Obstetrical reason for admission: PROM & breech presentation
Complication with this or previous pregnancies: breech at 34wk
Chronic health conditions: No pertinent health hx
Allergies: NKDA
Priority Body System(s) to Assess: Leopold, cardiac, respiratory, FHR

Pathophysiology

Interpreting clinical data collected, what is the primary/current medical/obstetrical problem?
State the pathophysiology of this problem in your *own* words.

Medical/Obstetrical Problem	Pathophysiology of Medical/Obstetrical Problem
Breech Presentation	Abn amniotic fluid, abn shape/size of the uterus, placenta covers cervix, preterm, birth defects, multiples
Fetal/Newborn Implications	**Pathophysiology of Fetal/Newborn Implications**
PROM	The barrier is broken

Problem Recognition

To prevent a complication based on the primary medical problem, answer each question in the table below.

Question	Most Likely Maternal	Most Likely Fetal	Worst Possible Maternal	Worst Possible Fetal
Identify the most likely and worst possible complications.	genital injury / Damage	getting wedged = dislocated limbs/defects	hemorrhage	Prolapsed cord which can lead to death
What interventions can prevent them from developing?	getting an early C-section	The Dr can attempt to turn the baby & if it doesn't work, do a C-section	combo of medicine, massage the uterus/fundus, repair tears	cannot be prevented - surgery may be needed
What clinical data/assessments are needed to identify complications early?	vaginal birth: vaginal exam C-section: abd exam/incision	a full head to toe ROM/skin assessment	H&H, weigh saturated pads, check for excessive clots	FHR (<120bpm) vaginal exam sudden change in BP
What nursing interventions will the nurse implement if the anticipated complication develops?	changing saturated pads frequently & monitor for abn bleeding, provide ice & ensure comfort measures	hold the affected joint in place for early intervention	manual replacement & surgery	gently trying to lift cord] head

Surgery or Invasive Procedures -

Describe the procedure in your *own* words. ***If this applies to your patient. If not, leave blank.***

Procedure
C-section: delivering through an incision in the abdomen & uterus

Surgery / Procedures Problem Recognition ***If this applies to your patient complete. If not, leave blank.***

To prevent a complication based on the procedure, answer each question in the table below.

Question	Most Likely Maternal	Most Likely Fetal	Worst Possible Maternal	Worst Possible Fetal
Identify the most likely and worst possible complications.	infection	moist lungs (cough up mucus)	hemorrhage	Respiratory Distress
What interventions can prevent them from developing?	Prophylactic antibiotics & clean incision well	can't prevent - natural push squeezes fluid out	oxytocin right after delivery	can't be prevented - monitor
What clinical data/assessments are needed to identify complications early?	incision assessment WBC's	resp assessment - crackles in lungs & wet coughs	measure blood loss (>1000 mL) & excessive clots	x-ray, blood test listen for grunting lip cyanosis flaring, retractions
What nursing interventions will the nurse implement if the anticipated complication develops?	antibiotics	monitor regularly - they cough it up	blood transfusion give fluids & meds like pitocin	give oxygen give surfactant antibiotics

Pharmacology

Any new drugs ordered during scenario must be added to the sheet before student leaves the simulation center for the day.

Medications	Pharm. Class	Mechanism of Action in OWN WORDS	Common Side Effects	Assessments/nursing responsibilities
Terbutaline 0.25mg/mL SQ	Broncho-dilator	Relaxes & opens airway Slows heart down	• Tremor • dizziness • ↑HR • ↑BP • N/V • sweat • rash • Local pain	• check for ↑BP, ↑HR • edu about calling for help to get up
cefazoline 1g IV to OR	Antibiotic	Prophylactic for infection prevention	• N/V/D • Abd Pain • Rash • IV site reaction	• check for penicillin allergies • make sure pt doesn't have hx of seizure • check IV site for redness, swelling

STARTING POINT & PLAN OF ACTION - Nursing Management of Care

Severe, CHTN, eclampsia

1. After interpreting clinical data collected, identify the nursing priority goal for your shift and three priority interventions specific for your patient. For each intervention write the rationale and expected outcome.

Nursing Priority	Assess mom/baby - monitor for complications
Goal/Outcome	To not have any complications - healthy mom/baby

Priority Intervention(s)	Rationale	Expected Outcome
1. Leopold's assessment & FHR b4 surgery	1. monitor baby & make sure they are doing okay	1. baby will be breached & FHR will be WNL
2. administer prophylactic antibiotics	2. to try & prevent infection from c-section	2. NO infection
3. monitor for signs of hemorrhage like mom & resp distress for infant	3. we want to prevent complications & intervene if necessary	3. No hemorrhage or resp distress

EDUCATION PRIORITIES/DISCHARGE PLANNING

1. Identify three priority educational topics that should be included in a teaching plan to prevent complications and prepare this patient for discharge.

Teaching About Illness Care	Rationale	How are you going to teach?
1. monitor for excessive bleeding & clots. also monitor for signs of infection	1. That could be a sign of hemorrhaging. infection can be serious if untreated	1. while changing pads, show her what to look for/do. check incision for redness, swelling, pus, pain
2. monitor baby's breathing & report fast/difficult breathing that is prolonged	2. This could mean respiratory distress syndrome	2. explain normal respirations for a NB (30-60 bpm), play sounds of grunting, retractions, etc
3. Take comfort measures after surgery	3. Mom does not want to overdo it & wants to wait for the okay from her dr during the follow up	3. explain that she shouldn't be lifting heavy things, no sex right after up to about 6 wks, easy on the driving, rest when the baby is sleeping, etc

Abnormal Relevant Lab Test	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
WBC	15.5	indicator of infection
Hgb	11.8	potential bleeding risk
Hct	35.4	potential bleeding risk
Metabolic Panel Labs		
Are there any Labs result that are concerning to the Nurse?		
WBC - infection		

This Section will be completed at Simulation Lab when you receive your patient's chart prior to the scenario. Do not complete before your scenario.

Current Priority Focused Nursing Assessment							
CV	Resp	Neuro	GI	GU	Skin	VS	Other
						FHR in 120's w/ accels & variables → decels from prolapsed cord	Leopold's: breech vag exam: Prolapsed cord

Time:		Focused OB Assessment					
VS	Contractions	Vaginal exam	Fetal Assessment	Labor Stage/phase	Pain Plan	Emotional	Other
100.2° 92 HR 19 RR 124/78 99% RA FHR 120's	Freq. Dur. Str.	Dil. Eff. Sta. Prest. BOW	FHR Var. Accel. Decel. TX.		comfort measures	reassure about c-section	education about c-section

Time:		Focused Postpartum Assessment					
VS	CV	Resp	Neuro	GI	GU/Fundal	Skin	Other
					Bladder Fundal loc Tone Lochia		

Time:		Focused Newborn Assessment					
VS	CV	Resp	Neuro	GI	GU	Skin	Other

EVALUATION of OUTCOMES – *to be completed AFTER scenario.*

1. Which findings have you collected that are most important and need to be noticed as clinically significant?

Most Important Maternal Assessment Findings	Clinical Significance
emotional distress - scared about c-section & baby	we needed to reassure her while acting fast for the emergency c-section
Most Important Fetal Assessment Findings	**Clinical Significance**
Fetus breeched w/a prolapsed cord	we needed to get her prepped for an emergency c-section

2. After implementing the plan of care, interpret clinical data at the end of your shift to determine if your patient's condition has improved, has not changed, or has declined.

Most Important Data	Patient Condition		
	Improved	No Change	Declined
FHR			x
Vaginal exam			x

3. Has the patient's *overall* status improved, declined, or remained unchanged during your shift? If the patient has not improved, what other interventions must be considered by the nurse?

Overall Status	Additional Interventions to Implement	Expected Outcome
declined - prolapsed cord & FHR having decels that needed to be addressed	Prep for C-section & get team into the room quickly	Successful C-section w/healthy baby

End of shift SBAR to oncoming nurse (the observers for your scenario)

Situation	This is Sarah Rogers, 23 y/o female. She came in for her scheduled C-section due to breeched presentation.
Background	She is a primigrava patient who does not want a C-section. She was given exercises to attempt to turn the baby around to occipital
Assessment	Upon Leopold's assessment, baby was still breeched. A vag exam was performed & we felt the prolapsed cord. We initiated IUR
Recommendation	After calling the doctor, we prepped Mrs. Rogers for an emergency C-section which she was just taken down for.

OB Sim Student Performance Checklist

INFECTION CONTROL	MET	UNMET	COMMENTS
1. Demonstrates appropriate hand hygiene.			
2. Demonstrates appropriate use of personal protective equipment.			
INITIAL ASSESSMENT			
1. Reviews EHR.			
2. Introduces self to patient and mother.			
3. Checks & verifies patient's identity band.			
4. Assess maternal vital signs.			
5. Assess & interpreter FHR pattern			
FOCUSED ASSESSMENT			
1. Conducts focused assessment of cardiac and respiratory systems.			
2. Conducts appropriate focused OB assessment according to patient needs: a. Cervical exam - (Dil., Eff., Sta.) b. DTR's Deep tendon reflexes - (0-3+) c. Gestation age - (Preterm, Term, Post Term) d. FHM pattern - (Var, Early, Late, Tachysystole) e. Pain - (0-10) f. Uterine contractions - (freq. dur, str)			
3. Recognizes and intervenes for abnormal assessment: a. FHR Pattern - IUR (LL, Bolus, O2, Oxytocin off) b. DTR's deep tendon reflexes c. Lab – treatment indicated. d. Labor pattern - (stages & phases) e. Pain – (Relax/BT, Med. Epi)			
COMMUNICATION			
1. Utilizes therapeutic communication with patient and family.			
2. Contacts provider and communicates findings in SBAR format.			
3. Reads back and orders and /or lab accurately documents.			
MEDICATION ADMINISTRATION			
1. Verifies presence of allergies.			
2. Verifies correct medication, dose, time, route, patient, documentation.			
3. Assesses IV site / lines prior to medication administration.			
4. Administers medications to the mother/ newborn using appropriate technique.			
PATIENT/FAMILY EDUCATION			
1. Initiates teaching with mother / family about interventions			
EVALUATION			
1. Evaluates patient's responses to interventions.			
DOCUMENTATION			
1. Documents assessments, interventions, and evaluation of patient responses.			