IM6 OB Simulation Patient Preparation Worksheet

RECOGNIZE & ANALYZE CLUES

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

Student Name: ____Thalia Cole_____

Patient initials: ____A.S._____ Admit Date: __11/14/XX_____

Diagnosis: G1 P1 AB L M_____
EDD: 12/21/XX_____ Gest. Age: ___28 weeks____
Blood Type/Rh: ___positive_____ Rubella Status: Immune__ GBS status: Unknown___
Obstetrical reason for admission: Preeclampsia (severe pregnancy induced hypertension) ___
Complication with this or previous pregnancies: ____severe hypertension_____
Chronic health conditions:___NA_____
Allergies: __NKDA_____
Priority Body System(s) to Assess: ___Cardiac & lung focus assessments, Fundus, liver, fetal heart rate, LOC

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
Severe Preeclampsia HELLP syndrome	• Begins after 20 weeks of pregnancy. A pregnancy complication of high blood pressure. Blood vessels not working properly. • (Hemolysis, Elevated liver enzymes, low platelets)
Fetal/Newborn Implications	**Pathophysiology of Fetal/Newborn Implications**
Risks of preeclampsia	• Lack of oxygen, nutrients and blood supply to fetus. • Emergency early birth risk, still born, fetal death. • Delay on growth development of all organs.

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.	Early delivery, c-section, seizures	Lack of oxygen, delay growth, weak lungs, decreased nutrients and blood flow	Death, impaired liver, seizures, brain damage, stroke	Still born, death, undeveloped organs
What interventions can prevent them from developing?	Decrease b/p with antihypertensive med, seizure precautions set up, suctioning set up, Magnesium sulfate med to prevent seizures,education on possible c-section due to risk of high b/p effecting the baby.	Turn mom to left side and provided fluids on going or bolus to help with increasing flow to fetus and o2 mask if needed for mom. Prepare for emergent c-section if	Emergent delivery, death, seizures, stroke, brain damage, unresponsive	In distress due to lack of oxygen, blood, and nutrient flow from the placenta.

		baby in distress.		
What clinical data/assessments are needed to identify complications early?	Monitoring vitals every 15 to 30 minutes, CBC and CMP blood draws, deep tendon reflexes, urine output, seizure precautions, large IV bore access.	Monitor fetal heart rate, kicks, position Fundus, cervical, Leopold assessments	N/A	N/A
What nursing interventions will the nurse implement if the anticipated complication develops?	Decrease b/p with antihypertensive med, seizure precautions set up, suctioning set up, Magnesium sulfate med to prevent seizures, education on possible c-section due to risk of high b/p effecting the baby, then prep mom for c-section and get consent forms signed.	IURs performed, educate whats going on and why.	N/A	N/A

Surgery or Invasive Procedures -

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

Procedure
C-section surgical procedure of the delivery of the baby through an incision made on the mother's abdomen and 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.	Bleeding out over the safe amount, death, infection, and uti, anesthesia complication, thromboembolism	Fetal distress, lungs issue from not getting the natural birth squeeze. Injury or trauma	Maternal coagulation defects	Prolapse umbilical cord
What interventions can prevent them from developing?	Sterile cath insertion, sterile draping, positioning of mom, NPO	Avoid coagulation meds before surgery	Check labs	Risk of delay on birth causing more distress on fetus
What clinical data/assessments are needed to identify complications early?	Consents forms signed, check allergies, anesthesiology clearance	Newborn assessments	Trauma, injury, incision injury risk to baby or mom	Too immature to survive, lung issues
What nursing interventions will the nurse implement if the anticipated complication develops?	Start IV antibiotic, surgical prep, blood transfusion consents sign and others.	Have NICU team ready and informed of situation	ICU team notified and ready	Too immature to survive, cold stress, infection, hypoglycemia

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
Magnesium Sulfate	sulfate	Prevent seizures, relaxes the deep tendon reflexes.	Confusion, dizziness, muscle weakness	Magnesium labs, reflexes, loc, urine output, excessive bleeding, cardiac and lung focus assessment
Calcium gluconate	Calcium salt	Helps manage hypermagnesemia (antidote)	Irregular heart rate, n/v, increased thirst	Magnesium labs, reflexes, loc, cardiac and lung focus assessment
Carboprost	prostaglandin	Treats postpartum uterine hemorrhage	Fast or slow HR, headache, SOB	Asses for n/v, and diarrhea. Check that the pt does not have asthma before given.
Methylergonovine	Ergot alkaloids	Treats postpartum uterine hemorrhage	Confusion, itching, dizziness, tingling feeling	Monitor vitals, uterine response. Asses for signs of ergotism such as cold or numb fingers, chest pain, ect.

Misoprostol	Synthetic prostaglandin E1 analog	Treats postpartum uterine hemorrhage	Uterotonic, diarrhea, abdominal pain	Check fetal hr, uterine activity, vitals
Oxytocin	Uterotonic agents	Helps with contractions in labor and control bleeding after labor.	N/V, anaphylaxis, more intense and frequent contractions	Contractions, monitor vitals, fetal heart rate, uterine activity

STARTING POINT & PLAN OF ACTION - Nursing Management of Care

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	Risk of seizures, fall risk due to post anesthesia, fundus and lochia monitoring for post hemorrhage
Goal/Outcome	Decrease b/p, normal range kept for magnesium, fundus firm, lochia light to scant

Priority Intervention(s)	Rationale	Expected Outcome
1.Monitor Mg levels Q4	1.theruputic range is (5-7)	1. kept within the therapeutic range
2.monitor vitals, LOC	2. Decrease blood pressure, monitor for hypotension	2. b/p within normal range and x4 orientated
3. monitor fundus and lochia (massage fundus)	3.post hemorrhage risk	3.light to scant goal

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.C-section care at home	1.Avoiding infection and healing to progress	1.No submerging incision site, light wash with towel on area with soap. Not lifting or sexual intercourse or other mod to heavy activities until incision is healed to prevent from opening or injury. Healthy protein diet and hydration. Report S/S of infection to PCP.
2. Monitor preeclampsia S/S	3. Does not go away after giving birth still at high risk of s/s continuing.	2.Monitoring b/p, HR, feeling SOB, fever and taking medications as prescribed to help. Report any s/s immediately and seek help to an urgent care or ER and state that you are in post-partum stage. Eat high protein foods due to protein loss in urine.
3.postpartum depression	3. High risk due to pregnancy c-section, teen age, and new parent role	3. Report or meet with therapist or PCP for s/s of depression or self harm or to baby.

Abnormal Relevant Lab Test	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
WBC- 13.5	high	Possible infection

Platelets- 100 HGB 10.5 and HCT 31.5	low	High blood pressure (preeclampsia)
ALT 42 AST 39	high	Preeclampsia damaging liver
Metabolic Panel Labs		
Mg 10.9	high	Mag sulfate med is causing the lab to be high and dangerous
Are there any Labs result that are concerning to the Nurse?		
Yes, Mg is dangerously high, WBC infection, Platelets thrombo. high risk, ALT, AST impaired liver indication		

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**
	Breath sounds with crackles and rhonchi bilateral, resp, shallow	Alert x 4	N/A	45ml/4 hours output	DTR 1+	97.6 temp 110 HR RR 12 O2 96% RA B/P 160/108	Fundus boggy at U/U and lochia is heavy

Time:		**Focused OB Assessment**					
VS	**Contractions**	**Vaginal exam**	**Fetal Assessment**	**Labor Stage/phase**	**Pain Plan**	**Emotional**	**Other**
	Freq. **Dur.** **Str.**	**Dil.** **Eff.** **Sta.** **Prest.** **BOW**	**FHR** **Var.** **Accel.** **Decel.** **TX.**				
Time:		**Focused Postpartum Assessment**					
VS	**CV**	**Resp**	**Neuro**	**GI**	**GU/Fundal**	**Skin**	**Other**
Heart reate high 110 **High blood pressure then b/p decreased hypotention occurred**	**110 hr**	**11 shallow breathing**	**LOC- unresponsive**		**Urine output** **45ml/4 hours** **Orange with blood color**	**Absent reflexes**	**Mg lab 10.9 high** **Bladder-** **U/U** **Fundal loc- boggy** **Tone** **Lochia- heavy**
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
Cardia, lungs focus assessments, deep tendon reflexes, LOC, Mg blood draw results, fundus assessment, lochia assessment	Currently on Mg sulfate drip, and oxytocin, and eclampsia precautions , post-partum high risk hemorrhage, fundus results, high b/p, HR readings , low urine output, lung sounds, shallow breathing
Most Important Fetal Assessment Findings	**Clinical Significance**
Delay fetal growth due to lack of 02, nutrients and blood from placenta and preemie birth.	c-section birth at 28 weeks premie infant

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
Mg levels at 10.9, labs need to be redone to check levels again after antidote			Yes
Unresponsive then back after given antidote	Yes, after antidote given		Yes
Hypotension vitals need to be rechecked			yes
Urine output decreased / need to be strict Is and Os			yes
Absent reflexes then some reflexes returned after antidote	Yes, mild		yes
Fundus boggy and lochia heavy, after given oxytocin will improve	Yes after given oxytocin		yes

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
The pt is in severe condition due to given a high dose of Mg sulfate that caused her to go unresponsive and no reflexes.	Pt will need to be sent to ICU care for constant monitoring on her labs and blood pressure and seizure precautions. Due to med error from night nurse the pt will be in ICU until labs on Mg have decreased and hemorrhage controlled and decreased.	Mg back to normal level, fundus firm and light to scant lochia, normal b/p nad HR

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

Situation A.S, 06/01/xx ,15 y/o ,room 1, DR. all wright, allergies:NKDA Code full

Pt came to ER due to severe pregnancy induced hypertension, not aware of being pregnant at 28 weeks. Had an emergent c-section and give birth to 2lb. 1oz male baby G1P1L1 magnesium sulfate was restated at post-delivery.

Background

Patient reports she had headache, nausea, and abdominal pain yesterday morning. She thought it was a stomach bug which was going around school. Late yesterday evening her mother brought her to the ED. Her B/P was 160/112, DTR 3 +, with 2 + clonus. Magnesium 4gms. loading dose was given, followed by a Magnesium 2 gm/hr. drip. The patient was delivered by C-Section due to her increasing blood pressures. Magnesium 2gm/hr. drip was restarted in the recovery room.

Current Vital Signs: T 97.6, HR 110, R 12, B/P 160/108, O2Sat 96% on RA,

Safety Concerns: Risk for seizure; Risk for falls post anesthesia.

Pertinent Assessment: Respirations shallow at a rate of 12, breath sounds with crackles and rhonchi bilateral, urine output 45 ml / 4 hours, DTR 1+; fundus boggy at u/u, lochia is heavy.

Upon entering room pt was unresponsive and absent reflexes and heavy lochia bleeding with boggy fundus. Mg sulfate was stopped due to med error on it and oxytocin increased to 80ml/hr corrected due to set on a lower amount med error by the night nurse. Calcium gluconate 4.65/10ml was given and pt was responsive again but confused and cannot remembered anything or what is going on. Due to the bleeding the pt was rushed to ICU unit for intensive care for post hemorrhage and high Mg levels.

Recommendation

Monitoring on vitals, Mg levels, fundus, and lochia. Emotional support is needed. Precautions for seizures and post-partum depression. Monitor for hypovolemic shock. High fall risk.