IM6 OB Simulation Patient Preparation Worksheet

RECOGNIZE & ANALYZE CLUES

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

Student Name: __Alexandra Redman_
Patient initials: ___A.S.__ Admit Date: not given
Diagnosis: G1 P1 AB0 L1 M0
EDD: 12/21/xx__ Gest. Age: ___28 weeks__
Blood Type/Rh: ___A+__ Rubella Status: ___immune_____ GBS status: unknown
Obstetrical reason for admission: _headache, nausea, abdominal pain, she was pregnant and didn't know
Complication with this or previous pregnancies: ____BP: 160/112, DTR 3+, clonus 2+_____
Chronic health conditions:_N/A__
Allergies: NKDA__
Priority Body System(s) to Assess: Blood pressure, abdomen d/t boggy fundus after C-section, risk for infection and hemorrhage

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
Preeclampsia → eclampsia	Vasoconstriction, leading to hypertension, proteinuria, oliguria, impaired liver function, which can lead to eclampsia and grand mal seizures
Fetal/Newborn Implications	**Pathophysiology of Fetal/Newborn Implications**
Preterm birth	Complications with the mother or the child can result in the need for the baby to be delivered before the EDD

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.	Preeclampsia → eclampsia	Preterm birth – lungs are not developed, not able to maintain internal temperature	Grand mal seizure d/t eclampsia	Death
What interventions can prevent them from developing?	Mag sulfate to prevent seizures, seizure precautions, monitor vitals, monitor I&O, lab values	Corticosteroids before delivery, or surfactant, blankets, clothing, skin-to-skin with mother or father, incubation We cannot prevent preterm birth in this situation	Mag sulfate to prevent seizures, seizure precautions, monitor vitals, I&O, lab values	Monitor vitals of baby, promote skin-to-skin as the nurse, ensure baby is warm, have NICU present during birth

What clinical data/assessments are needed to identify complications early?	Vitals, ALT and AST levels, I&O, assess for hyperreflexia or clonus, ask about any epigastric pain, vision changes, or N/V	APGAR score, vital signs	Vitals, ALT and AST levels, I&O, assess for hyperreflexia or clonus, ask about any epigastric pain, vision changes, or N/V	Vital signs, visible presentation of baby
What nursing interventions will the nurse implement if the anticipated complication develops?	Put seizure precautions into place, administer Magnesium Sulfate, check vitals frequently, check I&O frequently	Corticosteroids before delivery, or surfactant, blankets, clothing, skin-to-skin with mother or father, incubation	Seizure precautions: Airway management, place pt. on her side, have suction ready and available, side rails padded and up	Obtain crash cart, NICU team present

Surgery or Invasive Procedures -

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

Procedure
Cesarean section – Surgical incision located on the lower stomach – done in emergency situations to deliver baby

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	Laceration, bruising, transient tachypnea of the newborn, lung immaturity	Bleeding out	death
What interventions can prevent them from developing?	Aseptic technique, good hygiene, wound care, observation of the incision	Corticosteroids before delivery, NICU team at delivery	Monitor bleeding, monitor lab values, monitor vital signs Assess for blue lips, bluing under the fingernails, decreased urine output, excessive sweating, low bp, shallow breathing	Supplemental oxygen, corticosteroids before birth, NICU team at delivery
What clinical data/assessments are needed to identify complications early?	WBC lab values, ESR lab values, wound cultures, observe wound healing	O2 levels, APGAR score	Vital signs, CBC, H&H, platelets, visible blood loss	O2 levels, APGAR score
What nursing interventions will the nurse implement if the anticipated complication develops?	Antibiotics, wound care	Surfactant, supplemental oxygen	Massage fundus, large bore IV, administer oxytocin, alert physician, comfort measures	Supplemental oxygen, NICU team

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
Oxytocin	Oxytocic hormone	Stimulates uterine contractions	N/V, cardiac dysrhythmias,	Monitor FHR, observe for tachysystole,
Magnesium Sulfate	anticonvulsant	Prevent seizures during preeclampsia	Flushing, dry mouth, lethargy, headache, cardiac arrest	Monitor for S/S of mag toxicity: -Respiratory difficulty/depression -Chest pain -Mental confusion; Slurred speech -Depressed deep tendon reflexes (muscle tone) -Flushing,

				-Sweating -lethargy -Hypotension STOP THE MAG
Morphine	opiate	Decrease moderate to severe pain	Respiratory depression, constipation, drowsiness	Monitor vitals, reassess in 30 minutes, reassess pain, offer stool softener if pt. is constipated
Calcium Gluconate	Calcium salt	Antidote for magnesium sulfate toxicity	Constipation, nausea, dry mouth, increased thirst, decreased appetite	Monitor vitals (can cause hypotension), offer stool softener if pt. is constipated
Methylergonovine	Ergot alkaloid	Stimulates uterine muscles to increase contractions	nausea, vomiting, cramping, headache, severe hypertension, bradycardia, dysrhythmias, myocardial infarction	Check for any history of hypertension (contraindicated for hypertensive patient) monitor V/S, pain, headache, chest pain, shortness of breath, uterine contractions, vaginal bleeding
Carboprost	Synthetic prostaglandin	Stimulates uterine muscles to increase contractions	headache, nausea, vomiting, diarrhea, fever, tachycardia, hypertension, pulmonary edema	monitor V/S, vaginal bleeding and uterine tone check for any history of asthma, cardiac, renal & hepatic disease (contraindicated)

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	Prevent eclamptic grand mal seizure
Goal/Outcome	Pt. does not experience a grand mal seizure

Priority Intervention(s)	Rationale	Expected Outcome
1. Administer magnesium sulfate	1. magnesium sulfate is an anticonvulsant that can prevent grand mal seizures from happening	1. pt. does not experience grand mal seizure
2. Seizure precaution	2. if pt. does have a seizure, all precautions will be put into place to ensure pt. safety	2. even though pt. still experiences seizure, they will be safe while doing so
3. fall precaution	3. pt. needs to be put on fall precaution since there are a seizure risk	3. pt. does not fall

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. Watch incision site for signs of infection	1. If the patient can understand the signs and symptoms of infection, it can be caught and treated earlier.	1. Explain signs and symptoms of infection - Fever/flulike symptoms - Discharge or a foul smell

2. Avoid strenuous activity 3. report any signs and symptoms of bleeding	2. Any heavy lifting or increased activity can cause opening of the surgical site 3. increased bleeding can mean the patient is experiencing a postpartum hemorrhage	at site - Redness, swelling, inflammation, irregular pain at incision site 2. encourage no heavy lifting for 6 weeks, get a lot of rest, avoid stairs if possible 3. Call HCP if you notice you are bleeding through one sanitary pad in an hour

Abnormal Relevant Lab Test	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
WBC	13.5	Possible infection at incision site
Hgb	10.5	Possible PPH
Hct	31.5	Possible PPH
Metabolic Panel Labs		
ALT	42	Impaired liver function due to preeclampsia
AST	39	Impaired liver function due to preeclampsia
Are there any Labs result that are concerning to the Nurse?		
The H&H are concerning because it could mean the patient is experiencing a postpartum hemorrhage. The ALT and AST are also concerning because it shows there is impaired liver function which happens during preeclampsia and eclampsia which puts the patient at risk for Grand Mal seizures.		

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**

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
					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
Most Important Fetal Assessment Findings	**Clinical Significance**

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

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

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

Situation
Background
Assessment
Recommendation