

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
	-lung sounds -respiration				-cyanotic	-Temp is low -RR elevated	

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
-Temp is low		-lung sounds -respiration -cyanosis					

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
Respiratory Assessment	- respiratory distress, unable to maintain temp, cyanosis,

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
Temperature instability			✓
CBC - 29000			✓

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	<ul style="list-style-type: none"> -Baby transferred to NICU. -Administered antibiotic -Keep baby under radiant warmer. 	Baby will get better in NICU.

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

<p>Situation Female infant born today. 39 weeks. 8lbs 7oz. Apgar 8-9. Infant transferred to NICU. Inability to stabilize temperature following delivery.</p> <p>Full code NKDA</p>
<p>Background Mom was Group B Strep positive @ 36 weeks. Assessment at delivery infant was crying, pink, good muscle tone, with vigorous activity. Newborn needs 90%. Infant bonded well with mom/dad. Infant was unable to maintain temp. (97.2)</p>
<p>Assessment T: 96.6, P: 154, R: 58, BP: 70/50, 96%. now on blow by oxygen. Infant jittery, mottled, ↑ respirations & grunting heard. Cyanotic around mouth.</p>
<p>Recommendation Move to NICU, administer antibiotics, continue to warm infant under radiant warmer</p>