IM6 OB Simulation Patient Preparation Worksheet

Tocalytics - to stop

RECOGNIZE & ANALYZE CLUES

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

Student Name: Shallas Taylor
Patient initials: S.R Admit Date: ?
Diagnosis: G 1 P 0 AB0 L 0 M 0 → Hx of stillbirth so G2? + story?
EDD: 12/8/XX Gest. Age: 36 weeks
Blood Type/Rh: O+ Rubella Status: immune GBS status: Negative
Obstetrical reason for admission: PPROM
Complication with this or previous pregnancies: Breech
Chronic health conditions: None noted
Allergies: NKDA
Priority Body System(s) to Assess: Vaginal exam, position of baby

Pathophysiology

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

Keep in mind placental abrupt. → c/section → O2/fluid → signs of shock → dark red → uterine tender pers. abdom pain → rigid board

Medical/Obstetrical Problem	Pathophysiology of Medical/Obstetrical Problem
Infection related to PPROM	Cause unknown: ↑risk if patient has sh, vaginal bleeding cigarette smoking, Hx of stillbirth (preterm?) short cervix, weak structure,
Fetal/Newborn Implications	**Pathophysiology of Fetal/Newborn Implications**
Assess for cord compression or FHR abnormality	Gush of water can be enough to move the cord into a position to be compressed since it no longer has the fluid to cushion

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.	Premature labor → c/section (if breech)	Premature birth → cord compression	Chorioamnionitis (Death)	Infection Death RDS - if lungs aren't mature
What interventions can prevent them from developing?	Antibiotic therapy	early delivery	c/section	C-section
What clinical data/assessments are needed to identify complications early? vaginal exam	Vital sign monitoring WBC - lab → tetrazine	FHR Monitor	~	~
What nursing interventions will the nurse implement if the anticipated complication develops?	monitor VS and FHR, Admin Antibiotics, assess if baby is still breech prep for c/section	FHR monitoring vaginal assess → if cord is present place in trendelen burg use sterile glove to hold pressure off + prep for c-section	Admin Antibiotics, monitor VS, monitor closely after birth	FHR Monitoring Assess for distress Assess babys respirations

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 delivery of baby through incision made in lower abdomen

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	surgical injury	PPH	RDS
What interventions can prevent them from developing?	Prophalactic Antibiotic	MD takes time & not rush	Funaal rub	delayed delivery steroids
What clinical data/assessments are needed to identify complications early?	VS WBC	None VS-	Funaal- blood loss measured. assessments lochia assessed	Newborn Assessment
What nursing interventions will the nurse implement if the anticipated complication develops?	VS monitoring Antibiotic therapy	wound care	Admin oxytocic identify underlying cause notify MD massage uterus - Bimanul uterine compress	Oxygen support

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
Cefazolin	Antibiotic	Help body fight off infection and prevents infection	N/V/D	- Drug allergies - Assess for Allergic reaction
PNV- Nature made prenatal multi-DHA	Vitamin	Helps replish needed vitamins during preg. keeps mom & baby healthy	Nausea constipation changes in stool-urine	Folic acid importance, ensure compliance & teach importance
Tylenol	Anti pyretic & pain reliever	Helps bring temp down and relieves pain	Nausea, stomach pain, headache	- monitor amount No more than 3000mg
Sudafed	decongestant	relieves sinus pressure and congestantion	headach, dry mouth, Anxiety	- Avoid if planning to breastfeed - Assess reason 4 use

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	Monitor maternal vitals + FHR to detect early complications	
Goal/Outcome	safe delivery - Healthy baby	
Priority Intervention(s)	**Rationale**	**Expected Outcome**
1. Monitor vitals - Give tylenol, Antibiotic as ordered 2. Monitor FHR 3. Vaginal exam + Fetal position	1. ↑ could indicate infection and need for delivery 2. FHR abnormalities could indicate cord compression 3. Breech position + detect cord prolapse and birth prog.	1. ↓ risk of infection and ↓ temp to lessen chance of it affecting baby 2. Identify early signs of fetal instability ↑ better outcome for baby, directs plan of delivery 3. Better ability to adapt birthing plan if we know where baby stands

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. report SIS of infection ↑ in temp, N/V/D, malise redness, tenderness around surgery site or abdomen 2. Monitor bleeding 3. Post op surgical care 4. PPD screening	1. Temp already ↑, PPROM + if C/section required all ↑ risk of infection - prevent Sepsis 2. Due to ↑ risk of PPH important that pt reports ↑ bleeding 3. Infection prevention potential birth plan change could ↑ risk (Hx of stillbirth)	1. Due to these risk factor its important to monitor how your feeling + temp because your risk of infection is higher and we want to prevent. 2. If you notice that your bleeding increases, you pass LARGE clots, saturate a pad an hour for multiple hours notify provider - (12 hrs) 3. Do not submerge, Keep dry and clean No heavy lifting, Report Drainage, red smell 4. Have pt fill out risk form

Abnormal Relevant Lab Test	Current	Clinical Significance
Complete Blood Count (CBC) Labs		
WBC	15.5	indicates poss. infection
Metabolic Panel Labs		
Are there any Labs result that are concerning to the Nurse?		