

Student Name: Lexi Garza

# Outpatient Preparation Worksheet - OB Simulation

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

Patient initials: <b>S.R.</b>				Date of Admission:				
EDD: <b>12/8/XX</b>	Gest. Age <b>36 weeks</b>	G <b>1</b>	P	T	PT	AB	L	M
Blood Type / Rh: <b>O+</b>		Rubella Status: <b>immune</b>			GBS Status: <b>Negative</b>			
Complication with this or Previous Pregnancies: <b>Breech presentation (discussed external version *fearful of c/s)</b>								
Chronic Health Conditions: <b>Diabetes, HTN, Heart disease, at risk for CA (Breast)</b>								
Allergies: <b>NKDA</b>								
Current Medications: <b>PNV (nature made), Tylenol, Sudafed</b>								
Patient Reported Concern Requiring Outpatient Evaluation: <b>External version, fearful of c/s)</b>								
What <b>PRIORITY</b> assessment do you plan based on the patient's reported concern? <b>Fetal Assessment- FHR and movement Abd. Assessment- fetal position and fundal height</b>								

## Pharmacology

Review patient home medications and any drug(s) ordered for the outpatient.

Medications	Pharm. Class	Mechanism of Action in OWN WORDS	Common Side Effects	Assessments/Nursing Responsibilities
Prenatal Vitamins (nature made)	multivitamins	Support fetal growth and development while supplementing moms' vitamins and minerals.	Nausea, constipation, abd. Cramping, bloating, tarry-stools (iron)	<ol style="list-style-type: none"> <li>1. Take at bedtime to decrease nausea</li> <li>2. Stool softeners/dark colored stools</li> <li>3. Hydration (iron)</li> </ol>
Tylenol	Antipyretic/analgesic	Blocks pain signals to brain and lowers body temperature	Nausea, HA, loss of appetite, dark urine, LIVER Damage	<ol style="list-style-type: none"> <li>1. Avoid alcohol</li> <li>2. Monitor or liver toxicity (jaundice and RUQ abd. Pain)</li> <li>3. No more than 4000 mg/day</li> </ol>
Sudafed	Alpha-adrenergic agonist	Vasoconstriction to reduce swelling and congestion	Tachycardia, elevated BP, anxiety, HA, nausea	<ol style="list-style-type: none"> <li>1. Contraindicated for HTN or heart conditions</li> <li>2. Asking how long she's been taking can cause decreased</li> </ol>

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				blood flow to fetus.

## Pathophysiology

**Interpreting clinical data** - state the pathophysiology of the reported problem in your own words.

**Make sure to include both the maternal and fetal implications**

Medical/Obstetrical Problem	Pathophysiology of Medical/Obstetrical Problem
Breech Presentation	Fetus's buttocks/feet are presenting first.
Fetal/Newborn Implications	Pathophysiology of Fetal/Newborn Implications
Fetal- <b>birth trauma</b> (head entrapment, fractures), <b>Cord prolapse</b> (compression of the umbilical cord = hypoxia)  Maternal- <b>c/s risk, infection, hemorrhage</b>	Birth trauma- head can become trapped after body is delivered, this can cause compression on the umbilical cord. Umbilical cord compression/prolapse can cause hypoxia, which could lead to neurological damage.  C/S risk- incision which can lead to infection and hemorrhage. The risk for infection is increased due to prolonged labor or PROM (chorioamnionitis), and C/S (wound infection)

## Problem Recognition

Based on the patient's reported concern, answer each question in the table below.

Question	Most Likely Maternal Complication	Worst Possible Maternal Complication	Most Likely Fetal/Complication	Worst Possible Fetal/Complication
Identify the most likely and worst possible complications.	C/S	Uterine rupture	Cord prolapse/compression	Death
What assessments are needed to identify complications early?	External version successful/unsuccessful, fetal positioning, monitor maternal VS and FHR	Continuous FHR (<110) monitoring, frequent maternal pain assessments and VS	Monitor FHR for variable/late decels, vaginal exam	FHR, maternal VS, pain assessment, bleeding, fetal movement
What nursing interventions will the nurse implement if the complication develops?	After version is completed, if mother or babies HR do not return to normal call HCP immediately	Immediate intervention (call for help), monitor FHR, administer oxygen, IV bolus	Call for help, manually relieve pressure on the cord, knee-chest position, administer oxygen, IV bolus	Notify HCP immediately, stay with mom, offer support, document

## Nursing Management of Care

**Identify the nursing priority** after interpreting clinical data collected for this outpatient evaluation.

**List three priority nursing assessment/interventions specific to the patient concern.** Include a rational and expected outcome for each.

<b>Nursing Priority</b>	Fetal & Maternal well-being after procedure
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<b>Goal/Outcome</b>	Successful fetal version and discharged until ready for delivery	
<b>Priority Assessment/Intervention(s)</b>	<b>Rationale</b>	<b>Expected Outcome</b>
1. FHR	1. watch for any fetal distress (report immediately/ variable decels. Could indicate cord compression)	1. baby's FHR has no variable or late decels. and is stable
2. maternal VS	2. watch for tachycardia, resp. distress, and signs of infection (temp)	2. all VS WDL
3. monitor for complications	3. Vaginal bleeding (heavy bleeding), amniotic fluid (ROM), uterine rupture (severe abd. Pai)	3. small amount of vaginal bleeding is okay, no amniotic fluid is visible, and there should be no severe abd. Pain.

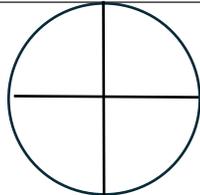
### Outpatient Evaluation Orders

1. Admit as Outpatient to the OB Triage assessment center
2. Vital signs on admission as needed
3. Fetal Heart Monitor obtain 20-30 minute strip to evaluate fetal status
4. Non-Reassuring Fetal Heart Rate Patterns implement Intrauterine resuscitation and notify provider
5. Monitor uterine activity to evaluate for labor status
6. Cervical exam if no active bleeding or history of placent previa to determine Labor or SROM (no nitrazine test prior to use of lubricant)
7. Notify provided of evaluation for admission or discharge orders

Physician Signature: **Baby Delivery, MD**  
0600

Date & Time: Today @

**This Section is to be completed in the Sim center- do not complete before!**

<p>Fetal Assessment:</p> <p>Position determined by Leopolds _____</p> <p>Place an <b>X</b> in the circle to document point or maximum impulse for FHR</p>	
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Time	Temp	B/P	P	R	Uterine Activity Freq / Dur. / Str.	Dil. / Efa. / PP / Stat cm / % / /	FHR /Var. /Acel. / Decl.	Pain	Comments

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<b>Additional Nurses Notes:</b>

**Procedure Notes:**

Circle Procedure Performed: **Amino** **BPP** **NST** **CST** **US** **Labor Eval**  
**SROM Eval.** **Version**

**Documentation for Invasive Procedure:**

V/S prior to procedure @ \_\_\_\_\_ T \_\_\_\_\_ B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ FHR \_\_\_\_\_

**Consent (if required) verified prior to procedure** **Yes** **No**

**Provider arrived** @ \_\_\_\_\_

**Timeout** @ \_\_\_\_\_ prior to procedure by \_\_\_\_\_ MD  
\_\_\_\_\_ RN

**Procedure started** @ \_\_\_\_\_

**Procedure performed by** \_\_\_\_\_ MD

**Ultrasound by provided confirm:**

1. **Amniotic pocket - Amniotic fluid** \_\_\_\_\_ ml obtained by provider specimen sent to lab @ \_\_\_\_\_
2. **Fetal position**
  - o **Position** \_\_\_\_\_ **verified prior to version** @ \_\_\_\_\_
  - o **Position** \_\_\_\_\_ **verified after version** @ \_\_\_\_\_

**Additional Notes is needed:**

**Procedure ended** @ \_\_\_\_\_  
\_\_\_\_\_ RN

**Nurses Signature:**

## Professional Communication - SBAR to Primary NURSE

Situation
<ul style="list-style-type: none"> <li>Name/age</li> <li>G P T PT AB L M EDB / / Est. Gest. Wks. :</li> <li>Reason for admission</li> </ul>
Background
<ul style="list-style-type: none"> <li>Primary problem/diagnosis</li> <li>Most important obstetrical history</li> <li>Most important past medical history</li> <li>Most important background data</li> </ul>
Assessment
<ul style="list-style-type: none"> <li>Most important clinical data:                             <ul style="list-style-type: none"> <li>Vital signs</li> <li>Assessment</li> <li>Diagnostics/lab values</li> </ul> </li> <li><i>Trend</i> of most important clinical data (stable - increasing/decreasing)</li> <li>Patient/Family birthing plan?</li> <li>How have you advanced the plan of care?</li> <li>Patient response</li> <li>Status (stable/unstable/worsening)</li> </ul>
Recommendation
<ul style="list-style-type: none"> <li>Suggestions for plan of care</li> </ul>

O2 therapy \_\_\_\_\_

IV site \_\_\_\_\_ IV Maintenance \_\_\_\_\_

Pain Score \_\_\_\_\_ Treatment \_\_\_\_\_

Medications Given \_\_\_\_\_

Fall Risk/Safety \_\_\_\_\_

Diet \_\_\_\_\_

Last Void \_\_\_\_\_ Last BM \_\_\_\_\_

Intake \_\_\_\_\_ Output: \_\_\_\_\_

**Notes:**