

# OB Simulation Patient Preparation Worksheet

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

Student Name: Avery Fira Admit Date: \_\_\_\_\_  
Patient initials: CW G 3 P 2 AB 0 L 1 M0 EDD: / / Gest. Age: 38 3/7 w  
Blood Type/Rh: o neg Rubella Status: immune GBS status: neg  
Obstetrical reason for admission: Induction/augmentation of labor at 38 3/7 weeks for history of gestational diabetes (insulin controlled), elevated blood pressure, and prior stillbirth.

Complication with this or previous pregnancies: Gestational diabetes (current pregnancy)

Elevated BP / history of preeclampsia (1st pregnancy)

Macrosomia (10 lb 8 oz infant, 1st pregnancy)

Stillbirth at 39 weeks (2nd pregnancy)

Chronic health conditions: Gestational diabetes requiring insulin

Maternal obesity (BMI 35 pre-pregnancy)

History of pregnancy-induced hypertension

History of postpartum depression

Allergies: Morphine

Priority Body System(s) to Assess: Maternal-fetal monitoring (uteroplacental perfusion, FHR, contractions)

**Cardiovascular** (BP, risk of preeclampsia)

**Endocrine/Metabolic** (blood glucose monitoring, insulin management)

**Psychological/Emotional** (history of IUFD, anxiety, depression risk)

## Pathophysiology

Interpreting clinical data collected, what is the primary/current medical/obstetrical problem?

State the pathophysiology of this problem in your *own* words.

**Complete the medical/obstetrical problem & fetal implications section for any pregnant patient.**

**Complete the medical/obstetrical problem ONLY for any postpartum patient.**

**Complete the newborn implications ONLY for any newborn infant.**

Medical/Obstetrical Problem	Pathophysiology of Medical/Obstetrical Problem
Gestational diabetes mellitus (insulin controlled) with elevated blood pressure at 38 3/7 weeks.	In pregnancy, placental hormones increase insulin resistance, which can cause high maternal blood sugars unless controlled with insulin. Elevated blood pressure occurs when abnormal placental blood flow triggers vessel spasms and organ stress, increasing risk for preeclampsia. Together, these

	conditions place both mother and fetus at high risk for complications, so careful monitoring and induction of labor are needed.
<b>Fetal/Newborn Implications</b>	<b>Pathophysiology of Fetal/Newborn Implications</b>

## Problem Recognition

To prevent a complication based on the primary medical problem, answer each question in the table below.

Question	Most Likely Maternal Complication	Worst Possible Maternal Complication	Most Likely Fetal/Newborn Complication	Worst Possible Fetal/Neonatal Complication
Identify the most likely and worst possible complications.	Uterine tachysystole from oxytocin; hypoglycemia from insulin therapy; progression to preeclampsia.	Eclampsia, HELLP syndrome, stroke, uterine rupture.	Fetal distress (late decelerations, decreased variability) from decreased uteroplacental perfusion; neonatal hypoglycemia (due to maternal insulin use)	Stillbirth, severe birth asphyxia, neonatal respiratory failure, long-term neurologic injury.
What interventions can prevent them from developing?	<b>Maternal:</b> Careful oxytocin titration, monitor VS & reflexes, control blood glucose with sliding scale insulin, maintain IV hydration.	- Reflexes, edema assessment	<b>Fetal:</b> Continuous EFM, position changes (left side), oxygen PRN, stop oxytocin if non-reassuring FHR	- FHR monitoring (variability, accels, decels)
What clinical data/assessments are needed to identify complications early?	- FHR monitoring (variability, accels, decels) - I&O for fluid overload	- Maternal VS (esp. BP), neuro symptoms (headache, vision, RUQ pain) - Reflexes, edema assessment	Blood glucose checks AC/HS & PRN	Continuous EFM, position changes (left side), oxygen PRN, stop oxytocin if non-reassuring FHR
What nursing interventions will the nurse implement if the anticipated complication develops?	Stop oxytocin, reposition to left side, IV fluid bolus, O <sub>2</sub> , notify provider, give terbutaline if ordered	Notify provider, anticipate magnesium sulfate, seizure precautions	Check BG, give juice/glucose tabs if awake; D50 IV if severe	Continue intrauterine resuscitation, prepare for possible urgent C-section

## Surgery or Invasive Procedures – *LEAVE BLANK if this does not apply to your patient*

Describe the procedure in your *own* words.

Procedure

## Surgery/Procedures Problem Recognition – *LEAVE BLANK if this does not apply*

To prevent a complication based on the procedure, answer each question in the table below.

Question	Most Likely Maternal Complication	Worst Possible Maternal Complication	Most Likely Fetal/ Newborn Complication	Worst Possible Fetal/ Neonatal Complication
Identify the most likely and worst possible complications.				
What interventions can prevent them from developing?				
What clinical data/assessments are needed to identify complications early?				
What nursing interventions will the nurse implement if the anticipated complication develops?				

## Pharmacology

New drugs ordered during scenario must be added before student leaves the simulation center for the day.

Medications	Pharm. Class	Mechanism of Action in OWN WORDS	Common Side Effects	Assessments/Nursing Responsibilities
PNV – Nature Made Prenatal Multi + DHA	Vitamin/mineral supplement with omega-3 fatty acid	Provides extra vitamins, minerals, iron, folic acid, and DHA needed for healthy fetal development and to prevent maternal deficiency.	Nausea, constipation, dark stools, fishy aftertaste (from DHA)	Take with food to reduce GI upset; encourage fluids/fiber for constipation; monitor Hgb/Hct for iron status.
Acetaminophen (Tylenol)	Non-opioid analgesic / antipyretic	Lowers fever by acting on brain's heat-regulating center; reduces pain by blocking pain signals in CNS	Nausea, liver toxicity if overdosed.	Assess pain/fever before and after giving; do not exceed 3,000 mg/day; avoid alcohol or other liver-toxic meds
Sudafed (Pseudoephedrine)	Decongestant / alpha-adrenergic agonist	Shrinks swollen nasal passages by tightening blood vessels in nose.	Increased BP, restlessness, insomnia, palpitations	Monitor BP/HR (esp. in pregnancy with HTN history); avoid near bedtime; use short-term only
Insulin Aspart	Rapid-	Helps move sugar from	Low blood sugar	Always check blood glucose

(NovoLog – sliding scale)	acting insulin	blood into body cells for energy; works quickly after injection.	(shakiness, sweating, confusion); injection site irritation.	before giving; hold if BG <70 and treat hypoglycemia; give within 15 min of meals; monitor for hypoglycemia during labor.
Meperidine (Demerol) 25 mg IVP q2h PRN	Opioid analgesic	Works on opioid receptors in the brain and spinal cord to block pain signals and change the way pain is felt	Sedation, dizziness, nausea, constipation, hypotension, respiratory depression, itching	Assess pain level before/after giving. Monitor RR, O <sub>2</sub> sat, and level of sedation. Monitor BP and HR. Keep naloxone available. Avoid within 4 hrs of delivery (risk for neonatal respiratory depression)
Promethazine (Phenergan) 12.5 mg IVP q4h PRN (diluted in 10 mL NS)	Antiemetic ; antihistamine (phenothiazine)	Blocks histamine and dopamine in the brain's vomiting center, helping reduce nausea and vomiting.	Drowsiness, dizziness, dry mouth, blurred vision, hypotension, tissue irritation if IV not diluted	Always <b>dilute in 10 mL NS</b> , give slowly IV. Monitor effectiveness for nausea. Assess LOC and fall risk (sedation). Monitor BP. Watch IV site closely—can cause severe tissue injury if infiltrated

## 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's possible complications (listed on page one)**. For each intervention write the rationale and expected outcome.

<b>Nursing Priority</b>	Promote maternal–fetal safety during induction of labor by preventing complications from gestational diabetes, hypertension, and oxytocin use.		
<b>Goal/ Outcome</b>	Mother will remain stable with normotensive BP and stable blood glucose; fetus will maintain reassuring FHR pattern throughout shift.		
<b>Priority Assessment/Intervention(s)</b>	<b>Rationale</b>	<b>Expected Outcome</b>	
1. Monitor maternal BP, reflexes, and assess for preeclampsia symptoms (headache, vision changes, RUQ pain)	1. Early detection of hypertension/preeclampsia prevents progression to severe complications such as eclampsia or stroke.	1. Maternal BP remains <140/90, no neurologic or hepatic complications.	
2. Perform blood glucose checks AC/HS/PRN and administer insulin per sliding scale.	2. Reduces maternal/fetal complications and prevents neonatal hypoglycemia after birth.	2. Maternal blood glucose remains within target range (70–120 mg/dL); neonate stable at delivery	
3. Continuously monitor FHR and contraction pattern while on oxytocin; stop infusion and initiate intrauterine resuscitation if tachysystole or late decelerations occur.	3. Oxytocin can cause uterine hyperstimulation, decreasing placental perfusion and leading to fetal distress	3. FHR remains reassuring with moderate variability and accelerations; no prolonged decelerations or fetal compromise	

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Abnormal Relevant Lab Test	Current	Clinical Significance
<b>Complete Blood Count (CBC) Labs</b>		
WBC	18.5 K/ $\mu$ L	Elevated (leukocytosis). In pregnancy/labor, WBC can be mildly elevated due to stress response, but >18 may also signal early infection (chorioamnionitis, endometritis). Requires monitoring with temp and fetal heart rate trends
<b>Metabolic Panel Labs</b>		
Glucose	148 mg/dL	Elevated — consistent with <b>gestational diabetes</b> . Requires continued blood glucose monitoring and insulin per sliding scale. Maternal hyperglycemia increases risk of neonatal hypoglycemia after birth
AST/ALT	55-65	Mildly elevated — may indicate <b>liver irritation</b> . Important to monitor because rising AST/ALT can signal <b>preeclampsia with severe features or HELLP syndrome</b> .
<b>Are there any Labs results that are concerning to the Nurse?</b>		
<p><b>Glucose 148 mg/dL</b> → Requires close monitoring and insulin management to avoid maternal hyperglycemia and neonatal hypoglycemia</p> <p><b>Elevated AST/ALT</b> → May signal early liver involvement in hypertensive disorder of pregnancy (preeclampsia/HELLP). Requires frequent BP checks, neuro assessment (HA, vision changes), and provider notification if worsening.</p>		

Current Priority Focused Nursing Assessment							
C V	Resp	Neuro	GI	GU	Skin	VS	Other
Monitor <b>BP closely</b> (risk for preeclampsia). Assess for edema, reflexes, and signs of HELLP (RUQ pain, epigastric tenderness). Monitor maternal HR for tachycardia with terbutaline or fluid overload	Assess rate, effort, O <sub>2</sub> sat. Watch for respiratory depression if opioids (meperidine/promethazine) are given. Monitor lungs for fluid overload from IV fluids/oxytocin.	Monitor for <b>headache, vision changes, hyperreflexia, clonus, seizures</b> (possible preeclampsia). LOC changes if hypoglycemia develops.	Assess for <b>RUQ or epigastric pain, nausea/vomiting</b> (can signal liver involvement in preeclampsia/HELLP). Monitor PO intake and nausea with labor meds.	Monitor urine output (renal perfusion, preeclampsia risk). Assess for proteinuria if ordered. Note frequency/urgency changes with labor	Observe IV site for infiltration/phlebitis (oxytocin/IV fluids). Check for pallor, diaphoresis with hypoglycemia.	Temp, HR, RR, BP, O <sub>2</sub> sat. <b>BP is highest priority</b> . Monitor q15–30 min while on oxytocin.	<b>Fetal Monitoring:</b> Continuous EFM for variability, accels, decels. - <b>Uterine Activity:</b> Contraction frequency, duration, intensity. - <b>Blood Glucose:</b> AC/HS/PRN with insulin coverage.



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

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 - Complete this section AFTER scenario.**

- Which findings have you collected that are most important and need to be noticed as clinically significant?

<b>Most Important Maternal Assessment Findings</b>	<b>Clinical Significance</b>
<b>Most Important Fetal Assessment Findings</b>	<b>Clinical Significance</b>

- 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

- 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

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## Professional Communication - SBAR to Primary NURSE

### Situation

- Name/age
- G P AB L EDB / / Est. Gest. Wks.:
- Reason for admission

### Background

- Primary problem/diagnosis
- Most important obstetrical history
- Most important past medical history
- Most important background data

### Assessment

- Most important clinical data:
  - Vital signs
  - Assessment
  - Diagnostics/lab values

*Trend* of most important clinical data (stable - increasing/decreasing)
- Patient/Family birthing plan?
- How have you advanced the plan of care?
- Patient response
- Status (stable/unstable/worsening)

### Recommendation

- Suggestions for plan of care

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

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

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

IV Drips \_\_\_\_\_

Anesthesia Local / Epidural / Spinal / General

Episiotomy \_\_\_\_\_ Treatment \_\_\_\_\_

Incision \_\_\_\_\_ Dressing \_\_\_\_\_

Fundus Location \_\_\_\_\_ Firm / Boggy \_\_\_\_\_

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

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

### Notes:

Diet \_\_\_\_\_

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

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