The Preeclampsia scenario focuses on a hospitalized pregnant female.

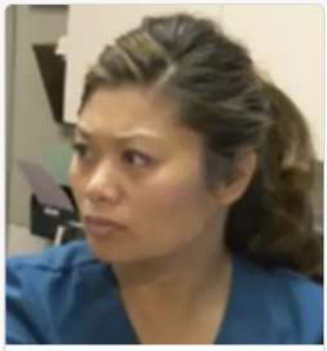
# ATI Simulation Real Life 3.0: RN Maternal Newborn Pre-eclampsia

**Primary characters you will meet in this scenario:**

Viewing 1 of 1

**Alex**
Registered Nurse, Emergency Department

**Morgan**
Registered Nurse



**Jenny**
Registered Nurse, Charge Nurse

**Katherine Klein**
Client

**Lisa**
Registered Nurse

**Nora**
Registered Nurse

**Dr. Hunt**
Provider

**Additional characters you may meet depending on the choices you make in this scenario:**

**Hannah**
Code Team Member

**Lacey**
Code Team Member

**Larry**
Code Team Member

Next

EMR

Nurse Alex is reviewing the EMRs in preparation to transfer Ms. Kline to the maternal newborn unit. Use the SBAR format to prepare a transfer report. (Type your response in the text box below and then click the submit button.)

**Compare the answer you submitted to the information below:**

SBAR:
S = Situation: 25 year-old female, gravida 1 para 0, at 27 weeks gestation. Came to the ED this morning at 0800.
B = Background: Reports sudden weight gain, and a new onset of nausea & vomiting, also blurred vision and headache. Says she had breakfast earlier this morning but that she vomited soon after eating.
A = Assessment: Vital Signs: T 37.0, P 92, R 22, BP 162/88, O2 sat 97%, urine protein 1 +, deep tendon reflexes 3+, reports right upper quadrant pain, nausea and vomiting and blurred vision with a headache.
R = Recommendation: transfer to maternal newborn unit.

✓

Ms. Kline, a 25-year-old lady, arrived at the Emergency Department (ED) this morning. She is 27 weeks pregnant (gestation). Her complaints include abrupt weight gain, headache, impaired vision, and new-onset nausea and vomiting. She is a first-time mother (G1, P0). Ms. Kline reported that she had eaten breakfast earlier in the day but then started throwing up. Vital signs upon assessment show a temperature of 37 degrees Celsius, a blood pressure of 162/88, a heart rate of 92, a respiratory rate of 22, and an oxygen saturation of 97%. She also has deep tendon reflexes at 3+, 1+ urine protein, and soreness in the right upper quadrant. She also experiences nausea, vomiting, headaches, and impaired vision. She is advised to be sent to the Maternal Newborn Unit for additional care.

EMR

Nurse Morgan completes an admission assessment for Ms. Klein. Based on the assessment, which of the following is the priority nursing intervention at this time?

The greatest risk to the client and fetus is injury from seizures and resulting hypoxemia. The priority intervention is to initiate seizure precautions.

Insert an indwelling urinary catheter.

Initiate seizure precautions.

Monitor Ms. Klein's I&O.

Apply antiembolism stockings.

EMR

Nurse Morgan prepares to call Dr. Hunt and give a report. Which of the following is the most important clinical data for Morgan to include in the SBAR report?

The elevated blood pressure is the priority clinical finding to include in the SBAR report. The greatest risk to the client and her fetus is impaired tissue perfusion to the placenta and vital organs secondary to arteriolar vasospasm.

- ✓ Elevated blood pressure
- Urine protein 1+
- Epigastric pain
- Absence of vaginal bleeding

EMR

Nurse Morgan is reviewing prescriptions from Dr. Hunt. For which of the following manifestations should she plan to monitor following administration of hydralazine (Apresoline)?

Following administration of hydralazine, the nurse should monitor for alterations in blood pressure and tachycardia.

✓

Polyuria

✓ Tachycardia

Dry mouth

Hyperglycemia