ASSESSMENT OF SUBTLE CHANGES IN PATIENT STATUS: OB PATIENTS GOING BAD

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Recognizing when OB Patients Go Bad

• Failure to Rescue
• Officially defined as:
• Hospital deaths after adverse events.

• Identified by Institute of Medicine (IOM) as a key area for improvement in patient safety.
Categories of Failure to Rescue

- Timely response (prompt recognition of complications)
- Appropriate response (correct management and treatment)
Issues

- Caregivers fail to notice recognize/interpret or respond (treat) when a patient is in trouble
- (assessment)
- Studies show widespread problems in both of these areas.
  - Issues such as lack of vital signs measurement to timely action in response abnormal vital sighs (Taemzer. et.al 2011)
  - Better nurse to patient ratios associated with lower patient mortality
Assessment for subtle changes

- Early recognition and treatment
  - Pt usually show signs 6-8 hours before deterioration
  - Changes in Neuro and RR status (associated with high mortality rates)

- LOC/Neurological changes
  - Personality changes

Respiratory Status
  - Hyper/Hypocapnia

- Cardiovascular changes
  - Tachycardia
  - Bradycardia

- Urinary output
  - Oliguria
  - Polyuria
Recognition Subtle Signs

• OB patients with volume issue more likely to experience deterioration
  • Close monitoring warranted in this population
    Early warning signs
    RR: especially >27
    Low RR <6 associated with mortality
    Also urine output and serum sodium shown to be indicators of deterioration
Emergency Response

- RRT/OB RRT/CodeTeam
- Bring critical care resources to patients in a noncritical area (CCRN’s RRT)
- Alert when patient demonstrate early signs of deterioration /crisis
- Anyone can activate heath care team or family member
Criteria for RRT

- HR > 130 or < 40
- SBP < 90
- RR < 8 or > 30
- SPO2 < 90% with O2
- Acute mental status changes
- Difficulty speaking
- Threatened airway
- Nurse/staff member concern about patient
- Cyanosis is late late sign
- These may be late signs look for subtle signs in patient status.
Keep Patient Safe

- Priority Setting: establishing which patients are most at risk
- Assignments and Nursing skills must be compatible
  - (novice vs experts nursing experience)
- Knowing your patient
- Critical thinking
- Focused assessment
- Documentation
- Handovers
# Priority Setting

<table>
<thead>
<tr>
<th>What needs to be done immediately</th>
<th>Items critical to maintaining life</th>
</tr>
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<tbody>
<tr>
<td>Oxygenation</td>
<td>CPR skills</td>
</tr>
<tr>
<td>Circulation</td>
<td>Time urgency (Fetal/Maternal Resuscitation)</td>
</tr>
<tr>
<td>Determination of problem source</td>
<td>OR preparations</td>
</tr>
<tr>
<td>Communication and Team work</td>
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</table>

<table>
<thead>
<tr>
<th>What is most important to the patient?</th>
<th>Pain management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information</td>
<td>Family notification</td>
</tr>
<tr>
<td>Trust</td>
<td>Infant data</td>
</tr>
<tr>
<td>Support</td>
<td>Relief of sever anxiety</td>
</tr>
<tr>
<td>Relationship building</td>
<td></td>
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</table>
Critical Thinking

- What is happening
  - Be able to interpret abnormal findings
  - What do these finding mean
    What might be happening?
    What is the worst case scenario?
  Recognize when you need to get help
    Get help before it’s to late
    Know who’s in your bed!
Knowing Your Patients

- Knowing the patients directly
- Who’s in my bed (potential for problems)
  - 37y/o G9P8 189/112 P122 RR 26 T.101 SROM x 12 hours
  - 2/thick/high output 24cc c/o HA, blurry vision, epigastric pain

- Knowing the patient through the family
- Family recognize changes (Why is she so swollen?)
- Knowing that something is not as expected
- Know and understand illness trajectories
P’s are Problems

- PIH
- Previa’s
- Prolapse
- Prematurity
- Primigravada Breech
- Painless bleeding
- Platelet Problems
- Precipitous deliveries

(examples of P Problems)
All bleeding is considered an emergency until ruled out.
Slow trickles
Profuse bleeding
Note changes in vital signs
Decrease Blood Pressure
Increase Pulse rate
Decreasing output
Assessment of Subtle Change

• Signs of generalized vasospasm
• Increasing Blood Pressure
• LOC
• Blurred vision
• Epigastric
• Pain
PEARLS OF PIH

• The most dangerous time is shift change.
• Restless, movement may indicate oxygen deprivation: O2 saturation of 100%
• Hgb of 5 Hct 15 means that each Hgb molecule is attached to a oxygen molecule 100%.
• If a Mag. Patient is to good, to quiet, no complaints, no needs, if she is not dead check her LOC, and Magnesium level.
• A Foley heights the sense of responsibility
• The eye to recovery is through the Kidneys.
What to Do during a Seizure

- Give magnesium sulfate IM
- Gather emergency equipment (O2, mask, yanker suction etc.)
- Position on left side (rescue breathing)
- Protect from injury but do not restrain
- Fetal Heart tones will be down. Recover the mother recover the baby

Observe the seizure, protect the patient
DON’T’ PUT ANYTHING IN HER MOUTH
Post-convulsion Management

- Prevent further convulsions
- Control blood pressure
- Prepare for delivery (if undelivered)
MAGNESIUM OVERDOSE

#1 CAUSE OF RESPIRATORY ARREST FROM MAGNESIUM IS TRANSPORTATION DISCONNECT IN ROUTE
Assessment of Subtle Changes

- Respiratory rate trends
- DTR changes
- Clonus
- Output trends
- Increased edema
Focuses Assessments

- Respiratory
- Cardiovascular (Tachycardia, bradycardia)
- Neurological (changes in LOC, to quite, excessive anxiety)
- Fetal assessment
- Listen to your patient
- Pay attention to clues
- Pay attention to details.
Interventions

- Activate RRT
- Apply CBA’s
- Provide lifesaving measure including CPR
  - O.R. D. E. R.
  - MATERNAL FETAL STAUS
- Position change
- Increase perfusion
- Oxygen supplement
- Decrease uterine activity
- Notify the Doctor
- Keep patient and family informed
O.R. D. E. R

- Oxygenate
- Restore Circulating Volume (large bore IV 16 gage 18 gage 2 sites)
- Drug
- Evaluate
- Remedy the problem
  - Tone Pitocin Methergine, Prostaglandin
  - Tear; Repair
  - Tissue: Remove
  - Thrombin: Labs, Platelets, FFP
Documentation

- Pay attention to trends
  - Respiratory Rate with Magnesium Sulfate
  - Decreasing urine output
  - Change in DTR’s
  - Blood pressure changes
  - Fetal heart rate baseline and variability
  - Level of consciousness changes

- Make sure documentation is up to date
  - If it was not documented it was not done
  - Late entries only when necessary
  - Don’t write on sheets and pillowcases
  - Use a standardized form
Handovers

• Notify providers
  • Get help before you are overwhelmed
  • USE SBAR
  • Provides a complete/concise information
  • Go with the patient
<table>
<thead>
<tr>
<th>Situation</th>
<th>Identify yourself, unit. Patient 2 identifiers. Room number, Why you are calling. Briefly state problem</th>
</tr>
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<tbody>
<tr>
<td>Background</td>
<td>Information related to situation Admission diagnosis and date, most recent vital signs, current meds. Allergies, IV fluids, test results, lab results and date and time done, comparison to previous results; other pertinent information Code Status</td>
</tr>
<tr>
<td>Assessment</td>
<td>What is your assessment or the situation? What are you calling about</td>
</tr>
<tr>
<td>Recommendation</td>
<td>What do you want to be done. TEST or medication order. Patient needs to be seen now. Order change</td>
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**CASE #1**

<p>| | |</p>
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<tbody>
<tr>
<td><strong>S</strong></td>
<td>Hi. Dr. Jones this is Olinda Johnson I am with Ms. Jackson in L&amp;D #6 the patient is having a continuous contraction with a resting tone of 40 mmHg per IUPC and palpable manually at a + 3 with recurrent late decelerations and minimal variability.</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Ms. Jackson admitted at 630 this morning is a 21y/o G4P3 previous C/Section x1 for TOL induction Negative medical history. Vital signs 110/74 P.88 RR 22 Temp 97.8 baseline FHTs baseline has changed from 130 moderate variability to 110 minimal variability with a prolong late deceleration lasting for 15 minutes the last 20 minutes. Pitocin was started at 730a and is now at 4mu/min for the last 30 minutes IV D5LR @125cc/hr. with Pitocin 20u/liter D5/LR @ 4mu/min being titrated 1mu/min q 30 minutes as tolerated due to the deceleration the Pitocin has been off 5 mins. H/H 11/37 Plats 160,000 T&amp;S on hold in blood bank. Patient is on her left side O2 is infusing at 10 liters and her spouse is at bedside providing support.</td>
</tr>
<tr>
<td><strong>A</strong></td>
<td>Ms. Jackson based on my palpation and support of 40 mgHg intensity of the IUPC is possibly having a uterine abruption,</td>
</tr>
<tr>
<td><strong>R</strong></td>
<td>Please come stat meet us in the OR, I have called anesthesia, request Dr. Crocker the on call staff come to the beside, notified the OR and requested the Blood bank set up 2 units of PRBC is there anything else you need me to do until you meet us in the OR. Patient is being prep as we speak.</td>
</tr>
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CASE #2

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<tr>
<th>S</th>
<th>Dr. Miles this is Brady RN in 2nd floor Recovery bed 9. I am with Ms. Jackson 21y/o S/P stat C/Section hysterectomy for an uterine abruption see arrived in RR 2 hours ago, who just expelled 800cc bright red blood Patients B/P is 70/43 consecutively</th>
</tr>
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<tr>
<td>B</td>
<td>Ms. Jackson is a post op stat C/hys that was undergoing a TOL</td>
</tr>
<tr>
<td>A</td>
<td>B/p is 70/43 Pulse 120’s RR 26 Temp 99.9 IV D5LR@125cc/hr Foley to bedside drainage with 35cc output last hour and a total of 70 since admitted to RR 2 hours ago. EKG to chest wall Sinus Tachycardia with occasional PVC’s. Pulse ox showing 02Saturation of 93% on NRM at 10 liters. H/H sent 15 minutes ago as order no result yet. H/H 11/33 prior to surgery. There is oozing at the incision site and oozing at the IV insertion site patient has petechia on arms and legs Patient is going into DIC</td>
</tr>
<tr>
<td>R</td>
<td>I need you to the bedside stat, I would like to request the 2units of PRBC and order more units( informed the lab to implement the MTP). I would like to initiate a bolus of fluid until you arrive to assess the patient. I have requested anesthesia return to bedside. Is there anything else you would like me to do till you arrive.</td>
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SBAR

- Take a few moments to decide what the real problem is. That becomes the Situation.” The person you are calling knows immediately why you are calling
- Provide pertinent back information—what has been going on with the patient that has now changed
- Say what you are concerned about. Assessment of what you think might be happening
- End with what you want to happen/what you need.
Components of the Rescue Process

• Careful surveillance
• Timely identification of complications
• Appropriate interventions
• Activation a team response
The OB Patient Going Bad

• 1. Failure to accurately assess maternal/fetal status
• 2. Appropriate treatment for nonreassuring status
• 3. Correct communication to physician/midwife
• 4. Underestimation of blood loss
• 5. Response to or initiate chain of command
  • K. Simpson 2009
THE KEY IS PREVENTION

• Primary Nurse Responsibility
• Early Identification
• Quick Response
• Evaluation of treatment regime
• On going assessment
• Clear lines of communication.

• You may not always know what wrong but be familiar with what right, and when its not right get help
EVALUATION OF RESPONSE TO THERAPY

VITAL SIGNS
MENTAL STATUS
URINARY OUTPUT
CAPILLARY REFILL
ASSESS AND REASSESSMENT
BLOOD TO LAB, HGB, BLOOD GAS ELECTROLYTES
REMEDY THE PROBLEM

FIX IT

ATONY: DRUGS
TEARS: REPAIR
TISSUE: REMOVE
THROMBIN: GIVE BLOOD PRODUCTS AND MONITOR

Category III Deliver
NEVER BE TO PROUD TO ASK FOR HELP.

QTIP RULE: QUIT TAKING IT PERSONAL. ITS NOT ABOUT YOU BUT THE PATIENT.

SAVE THE MOMA, YOU SAVE THE BABY

WHEN IN DOUBT TURN THE PIT OFF.

THE FETUS ONLY WAY TO COMMUNICATE WITH US FROM INUTERO IS VIA HIS/HER HEART BEAT READ IT CAREFULLY.
PEARLS. FOR COMMUNICATION

- Develop clear guidelines for fetal monitoring
- Education and terminology of MD’s Midwives and Nursing be on one accord.
- Clear chain of command policy and procedure
- Q TIP
- Established protocols
- PI Monitoring
- Joint Strip reviews (all medical staff included)
- Adoption of the NICDH guidelines.