



Avkin Simulations

Martha Patel



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SCENARIO RECORDKEEPING

Simulation Name:	Martha Patel		
Name & Title of Designer(s):		Reviewer:	
<ul style="list-style-type: none"> Megan Weldon, CHSE, Director of Education, Avkin Dr. Nina Williams DNP, MSN-NE, RN, Simulation Designer, Creative OB Solutions, LLC 		<ul style="list-style-type: none"> Kim Anderson, BPS, NRP, CHSE, CSM-Avkin 	
Date Designed: (Preparation)	11/30/2021	Level of Complexity or Participant Experience:	<input type="checkbox"/> Advanced Pre-licensure <input type="checkbox"/> Beginning Post Licensure <input type="checkbox"/> Intermediate Post Licensure <input type="checkbox"/> Advanced Post Licensure
Date Evidence Last Reviewed:	Date: 12/3/2021	Approval/Reviewed by Simulation Coordinator:	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: Name:
Updates/Revisions:	<input type="checkbox"/> Yes Date-	Topical Index IPE Sim Opportunity? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Women and Infant Health <input type="checkbox"/> Women's Health
Select QSEN Competencies Addressed:	<input checked="" type="checkbox"/> Patient-Centered Care <input checked="" type="checkbox"/> Teamwork & Collaboration <input type="checkbox"/> Evidence-Based Practice <input checked="" type="checkbox"/> Quality Improvement <input checked="" type="checkbox"/> Safety <input checked="" type="checkbox"/> Informatics	Select ACEN Competencies Addressed:	<input checked="" type="checkbox"/> Knowledge for Nursing Practice <input checked="" type="checkbox"/> Person-Centered Care <input checked="" type="checkbox"/> Population Health <input type="checkbox"/> Scholarship for the Nursing Discipline <input checked="" type="checkbox"/> Quality and Safety <input checked="" type="checkbox"/> Interprofessional Partnerships <input type="checkbox"/> Systems-Based Practice <input type="checkbox"/> Informatics and Healthcare Technologies <input checked="" type="checkbox"/> Professionalism <input type="checkbox"/> Personal, Professional, and Leadership Development
Expected Pre-brief Time (minutes): 5	Expected Simulation Time (minutes): 20	Expected Debrief Time (minutes): 40	Expected Total Time (minutes): 65

SIMULATION RESOURCES

[AACN -The Essentials: Core Competencies for Professional Nursing Education](#)

[ASPE Standards of Best Practice](#)

[Evaluating Healthcare Simulation – Freely available instruments developed to evaluate simulation-based education](#)

[Establishing a Safe Container for Learning in Simulation](#)

[INACSL Standards of Best Practice: Debriefing](#)

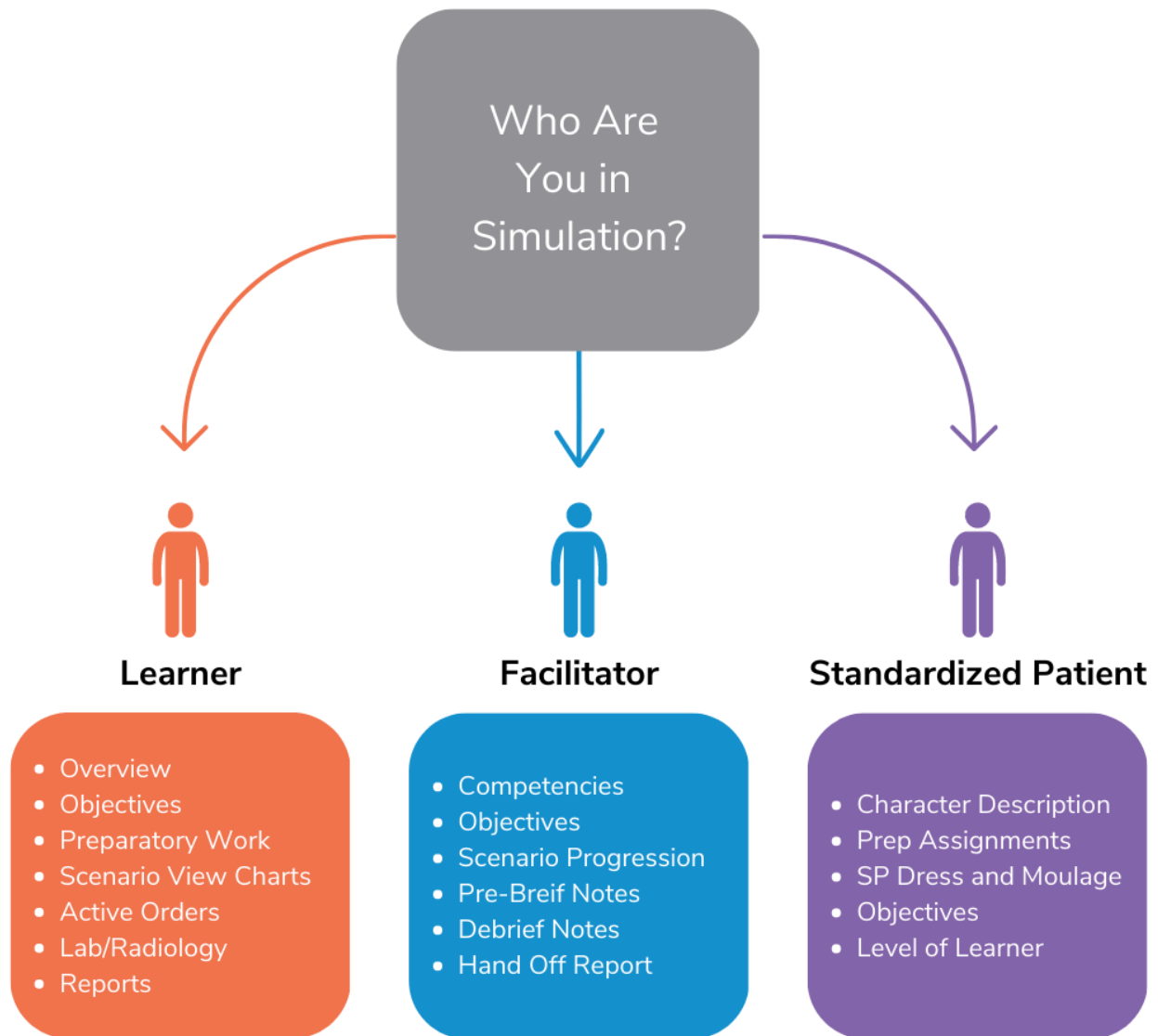
[NLN Simulation Innovation and Resource Center \(SIRC\) Tools and Tips](#)

[Society for Simulation in Healthcare – Healthcare Simulationist Code of Ethics](#)

[Society for Simulation in Healthcare- Healthcare Simulation Dictionary](#)

[The 3D Model of Debriefing: Defusing, Discovering and Deepening](#)

CONCEPT MAP



SECTION 1 LEARNER INFORMATION

SCENARIO OVERVIEW

Martha is a 24-year-old gravida 3 para 1 who enters the birthing unit at 41 weeks' gestation. She arrives with her husband. Her history reveals a previous vaginal delivery of a Macrosomic infant after a 16-hour labor period. She reports that she diagnosed with gestational diabetes in both pregnancies and that she has been taking her own capillary blood glucose (CBG) levels 3 times a day.

Her last CBG value was 5.6 mmol/L. External monitoring shows 2–3-minute contractions lasting 45–60 seconds. The fetal baseline is 140 variability is average with no deceleration. The initial vaginal exam indicates that the cervix is 50% effaced, 5–6 cm dilated with the vertex presenting at 0 station. Membranes are intact.

SIMULATION OBJECTIVES

1. Provide psychosocial support with the laboring woman and her family to build a caring and supportive relationship.
2. Assess maternal and fetal status with a systematic and comprehensive assessment to identify complications during childbirth appropriate to each stage and phases of labor.
3. Prepares for the delivery of the baby with appropriate prioritization in urgent situations to respond to maternal and fetal complications during childbirth.
4. Identifies complications with the condition of the infant to provide safe neonatal care.

PRE-SIMULATION LEARNING ACTIVITIES/ ASSIGNMENTS

Learners will have basic knowledge of following prior to simulation:

- Pathophysiology, risk factors and treatment of gestational diabetes
- Pathophysiology, risk factors and treatment of shoulder dystocia
- Communication with the woman in labor and her family
- Asepsis technique of sterile procedures
- Principles of teamwork and collaboration
- Dimensions of family centered care

Learners will understand following skills prior to simulation:

- Neonatal respiratory assessment
- Thermoregulation assessment
- Neonatal safety consideration
- Collaborative interventions for complications during childbirth
- Safe administration of medication during childbirth
- SBAR communication within the inter-professional team

PATIENT HISTORY

Electronic Health Record				
Name: Martha Patel			Support/Family: Ishaan (Ish) Husband	
Age: 24	DOB: 06/24/xxxx	Gender: Fe	Height: TBD	Weight: TBD
Admit Diagnosis: Active Labor				
Presenting Complaint: Pain with Contractions History of Present Illness: Intrauterine pregnancy of 41 weeks gestation and gestational diabetes. Previous pregnancy delivered Macrosomic infant after 16-hour labor.				
HR: 102	BP: 132/88	RR: 20	O2 Sat: 98	
Temp: 98.4 F	BGL: 125 mg/dL		GCS: 15	
Assessment: Pain: 7/10 with contractions General Behavior/Communication: Speech normal with no signs of difficulty. Patient pleasant and corporative. Cardiovascular: Sinus Rhythm, 102 beats per minute Respiratory: No abnormalities present; lungs clear bilaterally GI: No abnormalities present; bowel sounds positive x4 quadrants GU: No abnormalities present; voiding without difficulties or complaints Extremities: No abnormalities present; mild generalized edema noted to lower extremities Skin: Pink; moist; no bruising or tears noted; no tattoos or piercing Neurological: Alert and oriented to time, place, and person Labs: CBC, CMP, Prenatal Labs (Results below) IVs: #1: Saline Lock: Right forearm; 20 gauge				
Allergies: Medications: None Food: None		Immunization Status: Has received both COVID vaccines (Pfizer) and annual flu vaccine.		
Primary Care Provider: Dr. Smith, family practice		Religion: Christian-Non-Denominational		
Past Medical History: Gestational Diabetic with previous pregnancy		Current Home Medications: Prenatal vitamins, Humalog with meals as corrective		

LAB RESULTS

TEST	RESULT	REFERENCE RANGE
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CHEMISTRY	<i>Yesterday</i>	<i>This AM</i>	
Albumin	3.1	3.1	3.4-5.4 g/dL
Alkaline phosphatase	111	115	20-140 iu/l
ALT	44	48	7-55 u/l
AST	30	24	8-48 u/l
BUN	10.4	10.3	10-20 mg/dl
Calcium	8.0	7.9	8.6-10.2 mg/dl
Chloride	102	101	98-107 mEq/l
CO ₂	44	42	35-45 mm hg
Creatinine	1.1	1.1	0.6-1.2 mg/dl
Glucose	120	125	70-99 fasting
Potassium	3.7	3.5	3.5-5.0 mEq/L
Sodium	142	144	135-145 mEq/L
Total Bilirubin	1.0	0.8	0.2-1.2 mg/dL
Total Protein	5.7	4.9	6.0-8.3 gm/dL
VDRL	Negative		Negative (nonreactive)
Group Beta Strep	Positive		Negative
HIV	Negative		Negative
Herpes	Negative		Negative

TEST	RESULT		REFERENCE RANGE
CBC	<i>Yesterday</i>	<i>This AM</i>	
RBC	3.9	3.9	4.5-5.9 M/ul
MCV	82	85	80-94 fl
MCH	25	27	27-31 pg
MCHC	34	33	32-36 g/dl
RDW	13	12	11.5-14.5 %
HEMOGLOBIN	13	12	12-15 g/dl
HEMATOCRIT	31	31	40-52 %
RETICULOCYTES	2	2	0.5-2.5 %
WBC	11	12	6-11 K/ul
DIFFERENTIAL %			
NEUTROPHILS	2.5	2.5	2.4-7.6 K/ul
SEGS	60	60	50-70 %
BANDS	0.2	0.2	1.5-2.6 %
EOSINOPHILS	0.0	0.1	0.0-6.0 %
BASOPHILS	0.0	0.0	0.0-0.2 %
LYMPHOCYTES	25	30	20-40%
MONOCYTES	0.0	0.1	0.0-15 %
PLATELETS	391	390	130-400 K/ul
PT	n/a		
aPTT	n/a		
INR	n/a		
BLOOD ALCOHOL	n/a		
TYPE AND SCREEN	O negative		

Current Active Orders:

- Admit:
 - Admit to labor room #2 in active labor
 - Notify NICU of labor
 - Consult with pediatrician prior to birth
- Medications:
 - Morphine 2-5 mg IV q 4h prn or Morphine 10mg IM q 4h prn in active labor (less than 8 cm dilation)
 - Oxytocin 18 mu loading dose then 3.6 mu over two hours upon delivery of the anterior shoulder.
 - Hemabate (Carboprost) 250 mcg IM x1 dose prn for bleeding
 - Lactated Ringers 125 mL/hr continuous during labor.
 - Humalog 1 unit per 15 grams of carbohydrates (BG-150/30)
 - Humulin R U-500
- Nursing:
 - VS every 30 minutes
 - Temperature Q4 while membranes are intact; Q2 hours once ruptured
 - Continuous fetal monitoring
 - NPO
 - Daily weights
 - Blood glucose checks every hour while in labor
- Labs:
 - Daily CMP and CBC
 - Type and Screen
- Consult:
 - Dietician for diabetes education

SECTION 2 FACILITATOR INFORMATION

LEVEL OF LEARNER

Intermediate Pre-licensure - Has had all necessary class work (didactic) and skills lab education for simulation presented. Learners are minimally in their first semester/ rotation of clinical experiences in the simulation topic.

Advanced Pre-licensure- - Has completed all class work (didactic) and skills lab education in curriculum. Learners have had at least 1 semester of clinical experiences in the simulation topic.

Beginning Post Licensure- Transitioning for academic to clinical practice, passed licensure exam, within first 3 months of professional practice/ residency.

Intermediate Post Licensure- 3 months to 1 year of professional practice/ residency.

Advanced Post Licensure- Has practiced specific discipline for at least 1 year

SIMULATION SET-UP/ AVKIN PRODUCTS/ NEEDED EQUIPMENT/ SUPPLIES/ PROPS

Include a numbered list of Avkin Products appropriate for simulation, all needed equipment, learner supplies, and presentation of the patient at the inception of the simulation.

Needed equipment	Disposable supplies	Presentation of the patient
LDR bed against right wall. patient monitor next to bed, wooden bedside cabinet next to bed	Goggles, gloves, gown	Laboring in hospital gown in bed
IV pump with mainline	1000mL Lactated Ringers w/ 20 units Pitocin	
Avbirth	OB Kit	
Fetal Heart monitor/Toco Monitor		
Radiant warmer, oxygen, suction, weight scale, neonatal resuscitative equipment	neonatal resuscitative equipment	

PATIENT NAME BAND & MEDICATION LABELS

<p>Humalog</p> <p>insulin lispro injection</p> <p>100 units/mL</p> <p>10mL vial</p> <p>Not for Human Use</p> <p>Simulation Only</p>	<p>Humulin R</p> <p>Regular insulin human injection</p> <p>100 units/mL</p> <p>10 mL vial</p> <p>Not for Human Use</p> <p>Simulation Only</p>
<p>Oxytocin (Pitocin)</p> <p>Add dose mg/mL</p> <p>Add how supplied 1mL vial</p> <p>Not for Human Use</p> <p>Simulation Only</p>	<p>Hemabate (Carboprost)</p> <p>250 mcg/mL</p> <p>Add how supplied 1mL vial</p> <p>Not for Human Use</p> <p>Simulation Only</p>
<p>Misoprostol (Cytotec)</p> <p>200 mg</p> <p>tablets</p> <p>Not for Human Use</p> <p>Simulation Only</p>	<p>Methylergonovine (Methergine)</p> <p>**REFRIGERATION REQUIRED**</p> <p>0.2 mg/mL</p> <p>Add how supplied 1mL vial</p> <p>Not for Human Use</p> <p>Simulation Only</p>
<p>Lactated Ringers</p> <p>1000mL</p> <p>Not for Human Use</p> <p>Simulation Only</p>	<p>0.9% Sodium Chloride</p> <p>1000 mL</p> <p>Not for Human Use</p> <p>Simulation Only</p>

Patel, Martha
06/24/xxxx Age: 24 MRN:

Hospitalized days: 1

SIMULATION OBJECTIVES

1. Provide psychosocial support with the laboring woman and her family to build a caring and supportive relationship.
2. Assess maternal and fetal status with a systematic and comprehensive assessment to identify complications during childbirth appropriate to each stage and phases of labor.
3. Prepares for the delivery of the baby with appropriate prioritization in urgent situations to respond to maternal and fetal complications during childbirth.
4. Identifies complications with the condition of the infant to provide safe neonatal care.

[Pre-briefing Information](#)- Scan QR code for detailed information



Introduction	Basic Assumptions	Fiction Contract	Confidentiality Statement
Review Objectives	Sim Flow	Answer Questions	SBAR Report

Facilitator SBAR Report:

Situation: Martha is a 24-year-old gravida 3 para 1 who enters the birthing unit at 41 weeks' gestation. She arrives with her sister. Her history reveals a previous vaginal delivery of a Macrosomic infant after a 16-hour labor period. She reports that she diagnosed with gestational diabetes in both pregnancies and that she has been taking her own capillary blood glucose (CBG) levels 3 times a day.

Her last CBG value was 5.6 mmol/L. External monitoring shows 2–3-minute contractions lasting 45-60 seconds. The fetal baseline is 140 variability is average with no deceleration. The initial vaginal exam indicates that the cervix is 50% effaced, 5-6 cm dilated with the vertex presenting at 0 station. Membranes are intact.

Background (Patient History): Previous vaginal delivery of a Macrosomic infant after long 16-hour labor. Martha has also experienced gestational diabetes with both pregnancies.

Assessment: Patient is awake, alert, and oriented x3. Current vital signs: HR 102, BP 132/88, RR 20, SpO2 98%, Temp 98.4. Lungs clear to auscultation. Gestational diabetes has been diet controlled with a prescription of Humalog N to maintain blood glucose levels between 90-140. Patient checks her glucose three times per day. Currently, patient is complaining of pain during contractions rating a 7 out of 10. She does request an epidural later in the labor process. Contractions are 2-3 minutes apart. Membranes are intact.

Recommendations and Active Orders: Continuous fetal monitoring and IV fluids of LR @ 125/hr. Will maintain under close observation during labor process.

EXPECTED SIMULATION FLOW

Scenario Progression		
Phase ID & Patient Presentation	SP interaction/ Cues	Expected Actions and Progression
Pre-brief (see notes) <i>0-5 minutes</i>	***SP should not be in the room if pre-brief is conducted in the patient room	Notes: Facilitator led: Fiction contract, confidentiality statement, appropriate information regarding videotaping, SBAR Report
		Note: Learners should not see SP prior to start of the simulation

<p>Initial Assessment: HR: 102 BP: 138/88 RR: 20 T: 98.4 ECG: 5-10 minutes</p> <p>© 2022 Avkin, Inc.</p>	<p>SP Interaction/Ques</p> <ul style="list-style-type: none"> • Patient has contractions, grunting and moans with contractions. • fetal heart monitoring baseline remains 140-150 bpm. No decelerations. • Mild discomfort with vaginal exam- Dilation 7-8 cm. Artificial rupture of membranes (AROM) reveals clear fluid, and a fetal scalp electrode is placed for monitoring. • Pain medication is administered about an hour after admission and 	<p>Correct Action:</p> <ul style="list-style-type: none"> • Initial assessment, develop rapport with patient / support person • Positions FHM • Palpate the intensity of contractions. • Determines the stage and phase of labor by eliciting questions about the frequency and duration of the contractions. • Performs a vaginal examination to determine presentation, effacement, dilation, station. <p>Assess comfort and response to the contraction by considering non-pharmacological and pharmacological pain relief.</p> <p>Administers narcotic opioid analgesia as ordered.</p>	<p>Incorrect Action:</p> <ul style="list-style-type: none"> • Assure introduction to client and the family • Importance of identifying and responding to the appropriate stages and phases of labor • Listing the pharmacologic al and non-pharmacological methods of pain relief. <p>15</p>
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<p>Focused Assessment</p> <p>Second stage of labor begins, and she is diaphoretic and pushing with contractions. Her family member is present and offering her positive encouragement. They are offering her a cold face cloth and ice chips.</p> <p>TPR 99.0, 112, 24 BP 132/82 FHR 132 <i>10-15 minutes</i></p>	<p>SP Interaction/Questions</p> <ul style="list-style-type: none"> • Martha continues to grunt and moan with each contraction. Calls out for help and screams with fear that the “baby is coming” • She is ready to push, fetal baseline remains 150 and variable decelerations continue. Fetal descent is slow. Second stage is completed in approximately 2.5 hours. The presenting part finally reaches the perineum but there is no crowning. 	<p>Correct Action:</p> <ul style="list-style-type: none"> • Nurse performs a vaginal examination to determine presentation, effacement, dilation, and station. • Vital signs and fetal heart rate are taken • Calls obstetrician (or midwife) into the delivery • Calls for assistance of a secondary nurse to prepare for the birth of the baby (radiant warmer, oxygen, suction, weight scale, neonatal resuscitative equipment) • Identifies risk factors and the clinical manifestations of shoulder dystocia and recognizes the ALARMER response for shoulder dystocia 	<p>Incorrect Action:</p> <ul style="list-style-type: none"> • Have a clear understanding of performing a vaginal examination to determine presentation, effacement, dilation, and station. • Normal values for fetal heart rate. • Recognize the cardinal movements of labor (mechanism of labor) • ALARMER response to shoulder dystocia
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<p>Safety Assessment <i>Second stage of labor continues.</i> 15-20 minutes</p>	<p>SP Interaction/Ques</p> <ul style="list-style-type: none"> • The vaginal delivery is managed by the nurses and the obstetrician (or midwife). The vacuum extractor is required to deliver the head of the newborn. Shoulder dystocia is encountered, and the practitioner is unable to deliver the anterior shoulder with moderate downward traction on the fetal head. The nurse is asked to flex the mother's legs onto her abdomen (McRoberts's maneuver) and apply suprapubic pressure. A left medio-lateral episiotomy is performed, and the anterior shoulder is delivered following rotation to an oblique position. The posterior shoulder is then delivered without further difficulty. • Baby is delivered the. Estimated blood loss is 450 mL and there is trickling of blood 	<p>Correct Action:</p> <ul style="list-style-type: none"> • Vital signs and fetal heart rate are reassessed. • Nurse calls for assistance of a pediatrician and RT to prepare for the birth of the baby (radiant warmer, oxygen, suction, weight scale, neonatal resuscitative equipment). • Identifies the tight diameter between the fetal head and perineum, identifies the "turtle" sign as clinical manifestations of shoulder dystocia. • Performs McRoberts maneuvers as instructed by the physician for midwife and applies suprapubic pressure (Rubin's maneuver) with success to deliver the anterior should. • Administers oxytocin IV as per MD order. Informs Martha and her family throughout the birth process. • Identifies the need to take the baby to NICU for post resuscitative care. Explains the outcomes to Martha and her family allowing her time to hold her infant prior to the transfer. • Reassess Martha's vital signs and perineal bleeding and her fundus. 	<p>Incorrect Action:</p> <ul style="list-style-type: none"> • Clarification of roles • Identifying the strategies utilized within a collaborative team during an emergency childbirth • Review of neonatal resuscitation guidelines. • Review of APGAR scoring. • Review of maternal and neonatal complications of shoulder dystocia.
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	<p>with a gush on palpation of the fundus.</p> <ul style="list-style-type: none"> • Martha is asking questions about her baby's condition at the radiant warmer. • Fundus is boggy with trickling bright red blood. • The neonate is limp, flaccid, cyanotic and does not cry spontaneously at delivery. The baby's pulse is 100 beats per minute. He requires immediate resuscitation of oxygen with positive pressure ventilation, and he begins to breathe 40 breaths per minute. The nurse notices no spontaneous movement of his right arm. The is transferred to the NICU. 		
<p>Debriefing 20-40 minutes</p>	<ul style="list-style-type: none"> • SP preparing notes for debriefing • Co Debriefing With an SP 	<p>Debrief based on completion of objectives and opportunities in conjunction with INACSL SOBP.</p>	

1. **Introduction**
 - a. We're going to take the next 40 minutes to debrief the simulation activity.
 - b. We will discuss your thoughts/ feelings, analyze what learnings from previous simulations/ clinical experiences you integrated into this simulation, explore what went well and look at what you might do differently and why, discuss what your thoughts were at various points during the simulation in relation to the objectives, and talk about how you may apply what you've learned today to the clinical setting.
 - c. Please remember that anything shared here is to remain confidential to ensure psychological safety for everyone.
2. **Defuse/ De-role**
 - a. What learnings from previous simulations/ clinical experiences did you integrate into this simulation? Were they successful?
 - b. What do you think went well? Unpack more.
 - c. What you might do differently if you had a second chance? Why?
 - d. Anything in the simulation you felt as though you were not prepared to address with the patient?
3. **Discovery**
 - a. Obtain feedback from SP.
 - b. Ask SPs to resolve any undiscussed questions or concerns mentioned during defuse/ de-role.
 - c. Let's slowly analyze simulation and summarize the case (engage the SPs in dialogue when appropriate).
 - i. Assessment findings (subjective and objective)
 - ii. Level of concern for this patient?
 - iii. Review the objectives & ask for feedback regarding attainment
 - iv. How will they document their findings/ interaction?
 - d. Any concerns/ questions we have not discussed?
 - e. Consider a concept map
4. **Deepening**
 - a. What communication strategies or interventions are helpful going forward?
 - b. Share one key take-away.
 - c. Summarize the key learning points (focus on objectives and feedback).

*Zigmont, J. J., Kappus, L. J., & Sudikoff, S. N. (2011, April). The 3D model of debriefing: defusing, discovering, and deepening. In *Seminars in perinatology* (Vol. 35, No. 2, pp. 52-58). WB Saunders.

PATIENT NAME BAND & MEDICATION LABELS

Last, First
XX/XX/XXXX Age: MRN:

Hospitalized days: 1

SECTION 3 STANDARDIZED PATIENT EDUCATOR INFORMATION

SIMULATION OBJECTIVES

Basic classwork (didactic) and skills lab education. No clinical experiences in the simulation topic necessary.

LEVEL OF LEARNER

Foundations Pre-licensure: Has basic class work (didactic) and skills lab education. No clinical experiences in the simulation topic.

Intermediate Pre-licensure - Has had all necessary class work (didactic) and skills lab education for simulation presented. Learners are minimally in their first semester/ rotation of clinical experiences in the simulation topic.

Advanced Pre-licensure- Has completed all class work (didactic) and skills lab education in curriculum. Learners have had at least 1 semester of clinical experiences in the simulation topic.

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Intermediate Post Licensure- 3 months to 1 year of professional practice/ residency.

Advanced Post Licensure- Has practiced specific discipline for at least

CHARACTER DESCRIPTION

Simulated Patient Name: Martha Patel

Simulated Husband Name: Ishaan Patel

Age: 24

Birth Date: 06/24/XXXX

Overall Emotional State: In extreme pain

Environment/setting/location of visit: Labor & Delivery

41 weeks' gestation

Background: Martha and Ishaan (Ish) have been married for four years. He goes by Ish and will introduce himself to the nurses that way. He moved to the US when he was 8 years old. He still has memories of being in India but very much considers himself an American. He became a citizen at 21. Ish very much assimilated to American culture but his parents are very traditional, he always feels like a bridge between his parents and the American culture. Ish and his parents are a part of tightknit India group in their area. About ten families that live in the areas are very close. Ish refers to the mothers of these other families as aunties, they are the closest thing he has to extended family in the US and they are very involved in what is going on in his life.

Ish never realized how important his culture was to him until he got closer to the due date and wanted to make sure his culture was represented with his son. Martha wants her child to know about her husband's culture but feels a hesitation about some of the requests. Ish requested to have his mother in the room but Martha pushed back because she was not comfortable having her in the room. Ish is also aware that his mother will want Martha to stay home for about a month. This is important to her for the babies and mother's health. This is something that Martha rolls her eyes at; she thinks it is completely unnecessary but Ish will be a bit persistent because he

knows it is important to his family. Ish might hint at this or talk to Martha about this during labor and they will have a bit of back and forth but not get into an argument over this.

Martha is not close to her mom. She has been an alcoholic Martha's entire life and she does not feel the need to have her in her life. This has been difficult for Martha because she does not feel like she has the normal support that women get in labor. She loves her mother in law but feels like she has different expectations since she comes from a different culture. Martha will really look to the nurses and midwife to know what is normal. Martha was diagnosed with gestational diabetes at 28 weeks. This was a big shock to Martha and really required her to change her diet. Martha has not been great at checking her sugars. Normally every other day she will remember to do it once or twice but has not been able to keep up with checking it. Since she was having uncontrolled sugars and the baby was growing rapidly, they planned an induction, but her water broke a few days ahead of time. Martha is concerned about risks with the baby and will have a lot of questions. Martha does not want an epidural and wants to try to labor as naturally as possible.

Health: Martha was diagnosed with gestational diabetes at 28 weeks. She has had a difficult time managing her sugars and did not regularly check them. She was around 130-160 when she would check after eating but did not do much to adjust. The baby was starting to grow very quickly, and they planned to induce her, but her water broke before then. She is been in active labor for a few hours now and is in a lot of pain.

Family: Martha's family is not in her life. Her mom is an alcoholic and Martha decided a few years ago it is better to not have her in her life. Ish has a very close family and they both feel well supported but Martha has a difficult time relating to them since they do come from a very different culture. Ish's parents were hesitant about their relationship starting out but they have grown to accept her since the wedding.

Housing: Martha and Ish live in a small 3-bedroom home. They have a nursery for the baby all set up and very excited to welcome them home.

Profession: Ish works as a relator and Martha works as a first-grade teacher.

Social History: No smoking, drinking or drugs during pregnancy. Martha does drink 2-3 times during the week when she is not pregnant.

Interaction Guidelines: Martha will be in extreme pain and really struggling to get comfortable. She will be walking around the room and taking sharp deep breaths. Ish will be rubbing her shoulders and encouraging her to keep moving. He is trying to be supportive, but Martha will be a bit snappy with him and he is just following her around trying to help. Martha will need to watch the contractions and when they are their peak Martha will be making loud deep grunts. She will be holding onto on the side of the bed and really unable to move or talk through the contraction. Contractions should be visualized like waves building, becoming increasingly more painful then crashing and slowly coming in and decreasing.

When Martha is not in pain her and Ish will talk about going home. Ish will be very supportive holder her hand leaning in close to support her. He will trying to comfort her by reminder her that his mom will take care of everything and she won't have to do anything when they get home. Martha will push back a little bit and they will go back and forth a few times but when Martha's next contraction happens the conversation will be dropped. Contractions will get closer and closer together and once 30 seconds apart Martha will feel the need to push. Martha will start to push and once the head is out the baby will go back in.

This will be the sign that the baby is in distress and is a sign that the baby is too large to get out of the birth canal. The first step will be adjusting Martha's legs, her legs will be held by the nurses and possibly Ish will be asked to hold one of her legs. They will continue to encourage Martha to push and she will be doing her best to get the baby out. They may then revert to using pressure on the lower abdomen to try to get baby out. Martha will just be listening to the nurse's directions but asking what is going on and ask why they are doing. Ish will be very concerned and be holding Martha's hand and asking what is happening and why are they changing position

or pushing on the baby. Ish may look in shock but he will be asking a lot of questions and doing his best to verbally offer support to Martha.

***SP tip* Make sure you are breathing through every contraction. It is normal to hold your breath when acting out pushing during labor but that can cause dizziness or being light headed after simulation. Do not scrunch your face when pushing or tense up your body. This can cause headaches and soreness.**

Once baby is out they will put the baby on Martha's chest. She will make comments about how beautiful he is and will be engaging with Ish (holding hands, being close together). When delivering the placenta Martha will push again but this will not be extremely painful (3/10). If asked about a name you have not decided because Ish recently decided he wants something more traditional, but Martha has not agreed to that. They will go back and forth a bit, but resolution will not be had at the hospital. Both Ish and Martha will feel extremely relieved to have the baby out and Ish might make a comment about calling his parents.

DRY RUN BEST PRACTICES

- ✓ Should be completed the first time a simulation is done in a facility, or any time major changes are made to simulation (i.e. changing a sim from Manikin sim to an SP sim).
- ✓ Be sure to complete during a quiet (or quieter) time in the simulation center if possible.
- ✓ If the SP is not a subject matter expert, schedule a meeting between SP Educator and Subject Matter Expert the day prior to the dry run to be sure there is understanding.

DRESS REHEARSAL ESSENTIALS

- ✓ Dress rehearsal should be scheduled in advance of the first scheduled simulation.
- ✓ If possible, have all SPs who will be playing this role attend the same dress rehearsal. A second "best" option is joining remotely by video.
- ✓ SP Educator is lead for dress rehearsal. If this is a new simulation, Subject matter Expert should also be included in the dress rehearsal.
- ✓ Begin with a BRIEF simulation overview (5-10 minutes max)- they should be coming prepared). Include information on bedside hand off report and the safe container, if appropriate. Include an introduction to the Avkin product line.
- ✓ Begin the dress rehearsal with bedside hand off report so the SPs can hear what the learners will be told if planned for simulation.
- ✓ Each SP should practice wearing the appropriate Avkin products for dress rehearsal.
- ✓ Dress rehearsal structure should include a round robin where 1 SP starts the dress rehearsal while the other SPs observe from the control room or remain quiet observing from a different vantage point in the room. The dress rehearsal is paused after 5 minutes for coaching notes from the SP educator and / or subject matter expert.
- ✓ The next SP then assumes the role after coaching notes have been given and discussion is complete.
- ✓ The first SP will stay to observe the remaining SPs performance(s) from the control room. The dress rehearsal is completed once all individuals have had an opportunity to play in character, and all have observed each other play the same roles.
- ✓ Review flow of debriefing for simulation.
- ✓ Discuss SP "safe" word to be used by SP to stop simulation
- ✓ Be sure all questions are answered before leaving.

- ✓ Helpful Tip- review simulation hours while all SPs are present and have them “sign off” on their assigned simulations. If there is a conflict with one of the SPs, the others are there to check their availability and resolve the issues immediately.

SIMULATED PATIENT DRESS/ AVKIN PRODUCTS/ NEEDED EQUIPMENT/ SUPPLIES/ PROPS

Simulated Patient Equipment, Supplies, and Prop Requirements: (Moulage make-up, arm/leg sling, etc.)

Moulage: n/a

Dress: hospital gown

Prop: n/a

Avkin Products: Avbirth

SIMULATED PATIENT PREPARATORY INFORMATION/ ASSIGNMENT

Memorize Character Description

Attend Dress Rehearsal, be prepared, and fully engage in this experience

<https://www.babycenter.in/a1021145/post-delivery-confinement-practices-in-india>

Scenario Progression			
Phase ID & Patient Presentation	SP interaction/ Cues	Expected Actions and Progression	
Pre-brief (see notes) <i>0-5 minutes</i>	<p>***SP should not be in the room if pre-brief is conducted in the patient room</p> <ul style="list-style-type: none"> Give an overview of scenario 	Notes: Facilitator led: Fiction contract, confidentiality statement, appropriate information regarding videotaping, SBAR Report	
		Note: Learners should not see SP prior to start of the simulation	
Initial Assessment: HR: 102 BP: 138/88 RR: 20 T: 98.4 ECG:	<p>SP Interaction/Ques</p> <ul style="list-style-type: none"> Patient has contractions, grunting and moans with contractions. Labor progresses normally and fetal heart monitoring baseline remains 140-150 bpm. No decelerations are noted. Pain medication is administered about an hour after admission and dilation I 7-8 cm. Artificial rupture of membranes (AROM) reveals clear fluid, and a fetal scalp electrode is placed for monitoring. 	<p>Correct Action:</p> <ul style="list-style-type: none"> Primary nurse enters the room and introduces his/her name, designation and intentions and considers the stages and phases of labor. <p>Takes Martha's vital signs and positions fetal heart monitor.</p> <p>Inspects abdomen to perform Leopold's Maneuvers and palpate the intensity of her contractions.</p> <p>Determines the stage and phase of labor by eliciting questions about the frequency and duration of the</p>	
<i>5-10 minutes</i>		<p>Incorrect Action:</p> <ul style="list-style-type: none"> Assure introduction to client and the family Importance of identifying and responding to the appropriate stages and phases of labor Listing the pharmacological and non-pharmacological methods of pain relief. 	

		<p>contractions.</p> <p>Performs a vaginal examination to determine presentation, effacement, dilation, station.</p> <p>Assess comfort and response to the contraction by considering non-pharmacological and pharmacological pain relief.</p> <p>Administers narcotic opioid analgesia as ordered.</p>	
<p>2. Depression Assessment</p> <p>Second stage of labor begins, and she is diaphoretic and pushing with contractions. Her family member is present and offering her positive encouragement. They are offering her a cold face cloth and ice chips.</p> <p>TPR 99.0, 112, 24 BP 132/82 FHR 132</p>	<p>SP Interaction/Ques</p> <ul style="list-style-type: none"> • Martha continues to grunt and moan with each contraction. Calls out for help and screams with fear that the "baby is coming" • She is ready to push, fetal baseline remains 150 and variable decelerations continue. Fetal descent is slow. Second stage is completed in approximately 2.5 hours. The presenting part finally reaches the perineum but there is no 	<p>Correct Action:</p> <ul style="list-style-type: none"> • Nurse performs a vaginal examination to determine presentation, effacement, dilation, and station. • Vital signs and fetal heart rate are taken • Calls obstetrician (or midwife) into the delivery • Calls for assistance of a secondary nurse to prepare for the birth of the baby (radiant warmer, oxygen, suction, weight scale, neonatal 	<p>Incorrect Action:</p> <ul style="list-style-type: none"> • Have a clear understanding of performing a vaginal examination to determine presentation, effacement, dilation, and station. • Normal values for fetal heart rate. • Recognize the cardinal movements of labor (mechanism of labor) • ALARMER response to shoulder dystocia

10-15 minutes	crowning.	<p>resuscitative equipment)</p> <ul style="list-style-type: none"> Identifies risk factors and the clinical manifestations of shoulder dystocia and recognizes the ALARMER response for shoulder dystocia 	
<p>3. Safety Assessment</p> <p><i>Second stage of labor continues.</i></p>	<p>SP Interaction/Ques</p> <ul style="list-style-type: none"> The vaginal delivery is managed by the nurses and the obstetrician (or midwife). The vacuum extractor is required to deliver the head of the newborn. Shoulder dystocia is encountered, and the practitioner is unable to deliver the anterior shoulder with moderate downward traction on the fetal head. The nurse is asked to flex the mother's legs onto her abdomen (McRoberts's maneuver) and apply suprapubic pressure. A left medio-lateral episiotomy is performed, and the anterior shoulder is delivered 	<p>Correct Action:</p> <ul style="list-style-type: none"> Vital signs and fetal heart rate are reassessed. Nurse calls for assistance of a pediatrician and RT to prepare for the birth of the baby (radiant warmer, oxygen, suction, weight scale, neonatal resuscitative equipment). Identifies the tight diameter between the fetal head and perineum, identifies the "turtle" sign as clinical manifestations of shoulder dystocia. Performs McRoberts maneuvers as instructed by the physician for midwife and applies suprapubic pressure (Rubin's maneuver) with success to deliver 	<p>Incorrect Action:</p> <ul style="list-style-type: none"> Clarification of roles Identifying the strategies utilized within a collaborative team during an emergency childbirth Review of neonatal resuscitation guidelines. Review of APGAR scoring. Review of maternal and neonatal complications of shoulder dystocia.
15-20 minutes			

	<p>following rotation to an oblique position. The posterior shoulder is then delivered without further difficulty.</p> <ul style="list-style-type: none"> • Baby is delivered the. Estimated blood loss is 450 mL and there is trickling of blood with a gush on palpation of the fundus. • Martha is asking questions about her baby's condition at the radiant warmer. • Fundus is boggy with trickling bright red blood. • The neonate is limp, flaccid, cyanotic and does not cry spontaneously at delivery. The baby's pulse is 100 beats per minute. He requires immediate resuscitation of oxygen with positive pressure ventilation, and he begins to breathe 40 breaths per minute. The nurse notices no spontaneous movement of his right arm. The is transferred to the NICU. 	<p>the anterior should.</p> <ul style="list-style-type: none"> • Administers oxytocin IV as per MD order. Informs Martha and her family throughout the birth process. • Identifies the need to take the baby to NICU for post resuscitative care. Explains the outcomes to Martha and her family allowing her time to hold her infant prior to the transfer. • Reassess Martha's vital signs and perineal bleeding and her fundus. 	
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4. Debriefing	<ul style="list-style-type: none"> SP preparing notes for debriefing 	Note: See debriefing points below
<i>20-40 minutes</i>		

SECTION 4 STANDARDIZED PATIENT INFORMATION

SIMULATION OBJECTIVES FOR HEALTHCARE LEARNER(S)

Basic classwork (didactic) and skills lab education. No clinical experiences in the simulation topic necessary.

LEVEL OF HEALTHCARE LEARNER(S)

Foundations Pre-licensure: Has basic class work (didactic) and skills lab education. No clinical experiences in the simulation topic.

Intermediate Pre-licensure - Has had all necessary class work (didactic) and skills lab education for simulation presented. Learners are minimally in their first semester/ rotation of clinical experiences in the simulation topic.

Advanced Pre-licensure- Has completed all class work (didactic) and skills lab education in curriculum. Learners have had at least 1 semester of clinical experiences in the simulation topic.

Beginning Post Licensure- Transitioning for academic to clinical practice, passed licensure exam, within first 3 months of professional practice/ residency.

Intermediate Post Licensure- 3 months to 1 year of professional practice/ residency.

Advanced Post Licensure- Has practiced specific discipline for at least

CHARACTER DESCRIPTION

Simulated Patient Name: Martha Patel

Simulated Husband Name: Ishaan Patel

Age: 24

Birth Date: 06/24/XXXX

Overall Emotional State: In extreme pain

Environment/setting/location of visit: Labor & Delivery

Background: (41 weeks' gestation) Martha and Ishaan (Ish) have been married for four years. He goes by Ish and will introduce himself to the nurses that way. He moved to the US when he was 8 years old. He still has memories of being in India but very much considers himself an American. He became a citizen at 21. Ish very much assimilated to American culture but his parents are very traditional, he always feels like a bridge between his parents and the American culture. Ish and his parents are a part of tightknit India group in their area. About ten families that live in the areas are very close. Ish refers to the mothers of these other families as aunties, they are the closest thing he has to extended family in the US and they are very involved in what is going on in his life.

Ish never realized how important his culture was to him until he got closer to the due date and wanted to make sure his culture was represented with his son. Martha wants her child to know about her husband's culture but feels a hesitation about some of the requests. Ish requested to have his mother in the room but Martha pushed back because she was not comfortable having her in the room. Ish is also aware that his mother will want Martha to stay home for about a month. This is important to her for the babies and mother's health. This is something that Martha rolls her eyes at this; she thinks it is completely unnecessary but Ish will be a bit persistent because he knows it is important to his family. Ish might hint at this or talk to Martha about this during labor and they will have a bit of back and forth but not get into an argument over this.

Martha is not close to her mom. She has been an alcoholic Martha's entire life and she does not feel the need to have her in her life. This has been difficult for Martha because she does not feel like she has the normal support

that women get in labor. She loves her mother in law but feels like she has different expectations since she comes from a different culture. Martha will really look to the nurses and midwife to know what is normal. Martha was diagnosed with gestational diabetes at 28 weeks. This was a big shock to Martha and really required her to change her diet. Martha has not been great at checking her sugars. Normally every other day she will remember to do it once or twice but has not been able to keep up with checking it. Since she was having uncontrolled sugars and the baby was growing rapidly, they planned an induction, but her water broke a few days ahead of time. Martha is concerned about risks with the baby and will have a lot of questions. Martha does not want an epidural and wants to try to labor as naturally as possible.

Health: Martha was diagnosed with gestational diabetes at 28 weeks. She has had a difficult time managing her sugars and did not regularly check them. She was around 130-160 when she would check after eating but did not do much to adjust. The baby was starting to grow very quickly, and they planned to induce her, but her water broke before then. She is been in active labor for a few hours now and is in a lot of pain.

Family: Martha's family is not in her life. Her mom is an alcoholic and Martha decided a few years ago it is better to not have her in her life. Ish has a very close family and they both feel well supported but Martha has a difficult time relating to them since they do come from a very different culture. Ish's parents were hesitant about their relationship starting out but they have grown to accept her since the wedding.

Housing: Martha and Ish live in a small 3-bedroom home. They have a nursery for the baby all set up and very excited to welcome them home.

Profession: Ish works as a relator and Martha works as a first-grade teacher.

Social History: No smoking, drinking or drugs during pregnancy. Martha does drink 2-3 times during the week when she is not pregnant.

Interaction Guidelines: Martha will be in extreme pain and really struggling to get comfortable. She will be walking around the room and taking sharp deep breaths. Ish will be rubbing her shoulders and encouraging her to keep moving. He is trying to be supportive, but Martha will be a bit snappy with him and he is just following her around trying to help. Martha will need to watch the contractions and when they are their peak Martha will be making loud deep grunts. She will be holding onto on the side of the bed and really unable to move or talk through the contraction. Contractions should be visualized like waves building, becoming increasingly more painful then crashing and slowly coming in and decreasing.

When Martha is not in pain her and Ish will talk about going home. Ish will be very supportive holder her hand leaning in close to support her. He will trying to comfort her by reminder her that his mom will take care of everything and she won't have to do anything when they get home. Martha will push back a little bit and they will go back and forth a few times but when Martha's next contraction happens the conversation will be dropped. Contractions will get closer and closer together and once 30 seconds apart Martha will feel the need to push. Martha will start to push and once the head is out the baby will go back in.

This will be the sign that the baby is in distress and is a sign that the baby is too large to get out of the birth canal. The first step will be adjusting Martha's legs, her legs will be held by the nurses and possibly Ish will be asked to hold one of her legs. They will continue to encourage Martha to push and she will be doing her best to get the baby out. They may then revert to using pressure on the lower abdomen to try to get baby out. Martha will just be listening to the nurse's directions but asking what is going on and ask why they are doing. Ish will be very concerned and be holding Martha's hand and asking what is happening and why are they changing position or pushing on the baby. Ish may look in shock but he will be asking a lot of questions and doing his best to verbally offer support to Martha.

SP tip Make sure you are breathing though every contraction. It is normal to hold your breath when acting out pushing during labor but that can cause dizziness or being light headed after simulation. Do not scrunch your face when pushing or tense up your body. This can cause headaches and soreness.

Once baby is out, they will put the baby on Martha's chest. She will make comments about how beautiful he is and will be engaging with Ish (holding hands, being close together). When delivering the placenta Martha will push again but this will not be extremely painful (3/10). If asked about a name you have not decided because Ish recently decided he wants something more traditional, but Martha has not agreed to that. They will go back and forth a bit, but resolution will not be had at the hospital. Both Ish and Martha will feel extremely relieved to have the baby out and Ish might make a comment about calling his parents.

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SIMULATED PATIENT DRESS/ AVKIN PRODUCTS/ NEEDED EQUIPMENT/ SUPPLIES/ PROPS

Simulated Patient Equipment, Supplies, and Prop Requirements: (Moulage make-up, arm/leg sling, etc.)

Moulage: n/a

Dress: hospital gown

Prop: n/a

Avkin Products: Avbirth

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SIMULATED PATIENT PREPARATORY INFORMATION/ ASSIGNMENT

Memorize Character Description

Attend Dress Rehearsal, be prepared, and fully engage in this experience

<https://www.babycenter.in/a1021145/post-delivery-confinement-practices-in-india>

FLOW OF SIMULATION

Scenario Progression			
Phase ID & Patient Presentation	SP interaction/ Cues	Expected Actions and Progression	
Pre-brief (see notes) <i>0-5 minutes</i>	<p>***SP should not be in the room if pre-brief is conducted in the patient room</p> <ul style="list-style-type: none"> Give an overview of scenario 	<p>Notes: Facilitator led: Fiction contract, confidentiality statement, appropriate information regarding videotaping, SBAR Report</p>	
		<p>Note: Learners should not see SP prior to start of the simulation</p>	
Initial Assessment: HR: 102 BP: 138/88 RR: 20 T: 98.4 ECG:	<p>SP Interaction/Ques</p> <ul style="list-style-type: none"> Patient has contractions, grunting and moans with contractions. Labor progresses normally and fetal heart monitoring baseline remains 140-150 bpm. No decelerations are noted. Pain medication is administered about an hour after admission and dilation I 7-8 cm. Artificial rupture of membranes (AROM) reveals clear fluid, and a fetal scalp electrode is placed 	<p>Correct Action:</p> <ul style="list-style-type: none"> Primary nurse enters the room and introduces his/her name, designation and intentions and considers the stages and phases of labor. <p>Takes Martha's vital signs and positions fetal heart monitor.</p> <p>Inspects abdomen to perform Leopold's Maneuvers and palpate the intensity of her contractions.</p> <p>Determines the</p>	<p>Incorrect Action:</p> <ul style="list-style-type: none"> Assure introduction to client and the family Importance of identifying and responding to the appropriate stages and phases of labor Listing the pharmacological and non-pharmacological methods of pain relief.
<i>5-10 minutes</i>			

	for monitoring.	<p>stage and phase of labor by eliciting questions about the frequency and duration of the contractions.</p> <p>Performs a vaginal examination to determine presentation, effacement, dilation, station.</p> <p>Assess comfort and response to the contraction by considering non-pharmacological and pharmacological pain relief.</p> <p>Administers narcotic opioid analgesia as ordered.</p>	
<p>2. Depression Assessment</p> <p>Second stage of labor begins, and she is diaphoretic and pushing with contractions. Her family member is present and offering her positive encouragement. They are offering her a cold face cloth and ice chips.</p>	<p>SP Interaction/Ques</p> <ul style="list-style-type: none"> • Martha continues to grunt and moan with each contraction. Calls out for help and screams with fear that the "baby is coming" • She is ready to push, fetal baseline remains 150 and variable decelerations continue. Fetal descent is slow. Second stage is completed in 	<p>Correct Action:</p> <ul style="list-style-type: none"> • Nurse performs a vaginal examination to determine presentation, effacement, dilation, and station. • Vital signs and fetal heart rate are taken • Calls obstetrician (or midwife) into the delivery • Calls for assistance of a secondary nurse 	<p>Incorrect Action:</p> <ul style="list-style-type: none"> • Have a clear understanding of performing a vaginal examination to determine presentation, effacement, dilation, and station. • Normal values for fetal heart rate. • Recognize the cardinal movements of labor (mechanism of labor) • ALARMER response to shoulder dystocia

TPR 99.0, 112, 24 BP 132/82 FHR 132	approximately 2.5 hours. The presenting part finally reaches the perineum but there is no crowning.	to prepare for the birth of the baby (radiant warmer, oxygen, suction, weight scale, neonatal resuscitative equipment) <ul style="list-style-type: none">Identifies risk factors and the clinical manifestations of shoulder dystocia and recognizes the ALARMER response for shoulder dystocia	
10-15 minutes			
3. Safety Assessment <i>Second stage of labor continues.</i>	SP Interaction/Ques <ul style="list-style-type: none">The vaginal delivery is managed by the nurses and the obstetrician (or midwife). The vacuum extractor is required to deliver the head of the newborn. Shoulder dystocia is encountered, and the practitioner is unable to deliver the anterior shoulder with moderate downward traction on the fetal head. The nurse is asked to flex the mother's legs onto her abdomen (McRoberts's maneuver) and apply suprapubic pressure. A left	Correct Action: <ul style="list-style-type: none">Vital signs and fetal heart rate are reassessed.Nurse calls for assistance of a pediatrician and RT to prepare for the birth of the baby (radiant warmer, oxygen, suction, weight scale, neonatal resuscitative equipment).Identifies the tight diameter between the fetal head and perineum, identifies the "turtle" sign as clinical manifestations of shoulder dystocia.Performs McRoberts maneuvers as instructed by the physician for	Incorrect Action: <ul style="list-style-type: none">Clarification of rolesIdentifying the strategies utilized within a collaborative team during an emergency childbirthReview of neonatal resuscitation guidelines.Review of APGAR scoring.Review of maternal and neonatal complications of shoulder dystocia.
15-20 minutes			

	<p>medio-lateral episiotomy is performed, and the anterior shoulder is delivered following rotation to an oblique position. The posterior shoulder is then delivered without further difficulty.</p> <ul style="list-style-type: none"> • Baby is delivered the. Estimated blood loss is 450 mL and there is trickling of blood with a gush on palpation of the fundus. • Martha is asking questions about her baby's condition at the radiant warmer. • Fundus is boggy with trickling bright red blood. • The neonate is limp, flaccid, cyanotic and does not cry spontaneously at delivery. The baby's pulse is 100 beats per minute. He requires immediate resuscitation of oxygen with positive pressure ventilation, and he begins to breathe 40 breaths per minute. The nurse notices no 	<p>midwife and applies suprapubic pressure (Rubin's maneuver) with success to deliver the anterior should.</p> <ul style="list-style-type: none"> • Administers oxytocin IV as per MD order. Informs Martha and her family throughout the birth process. • Identifies the need to take the baby to NICU for post resuscitative care. Explains the outcomes to Martha and her family allowing her time to hold her infant prior to the transfer. • Reassess Martha's vital signs and perineal bleeding and her fundus. 	
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	spontaneous movement of his right arm. The is transferred to the NICU.		
4. Debriefing	<ul style="list-style-type: none"> SP preparing notes for debriefing Co Debriefing With an SP 	Note: See debriefing points below	
<i>20-40 minutes</i>			