HealthCare Simulation
SOUTH CAROLINA

Obstetric Emergencies for Hospital Nursing Scenario Set
Consolidated Instructor Manual

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Curricular Information

Obstetric Emergencies for Hospital Nursing set contains eighteen full-scale scenarios and four skills stations that were created by HealthCare Simulation South Carolina (HCSSC). All of the scenarios in this set can be licensed from the SimStore™. Additional information can be found on the HealthCare Simulation South Carolina website: http://www.healthcaresimulationsc.com/simstore/.

This set contains nine practice scenarios and nine testing scenarios based on mainstream Obstetric and Gynecology and leading Nursing textbooks and literature. Four skills station scenarios are also included for participant practice in various skills that may be necessary to recognize, assess, and provide initial treatment of the most common obstetric emergencies. The set includes the following scenarios and skills stations:

Skills Stations (4):

1. Apgar Scoring – Various infant clinical presentations for practice of assigning Apgar scores to the newborn.
2. Shoulder Dystocia – Nursing maneuvers performed to aid in resolution of shoulder dystocia are broken down in step-wise fashion.
3. Uterine Massage – External uterine massage, utilized to aid in resolution of uterine atony, is broken down in step-wise fashion.
4. Umbilical Cord Prolapse – Steps to alleviate compression of the prolapsed umbilical cord are presented and practiced.

Practice Cases (9):

1. OB Emerg Nurs Practice Postpartum Hemorrhage (Consuella) – Due to uterine atony, successfully treated with uterine massage.
2. OB Emerg Nurs Practice Postpartum Hemorrhage (Sarah) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications.
3. OB Emerg Nurs Practice Postpartum Hemorrhage (Ursula) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications.
4. OB Emerg Nurs Practice Eclampsia (Francine) – Treated with basic supportive therapy and magnesium sulfate.
5. OB Emerg Nurs Practice Eclampsia (Bonnie) – Treated with basic supportive therapy and magnesium sulfate.
6. OB Emerg Nurs Practice Eclampsia (Marilyn) – Treated with basic supportive therapy and magnesium sulfate complicated by magnesium toxicity.
7. OB Emerg Nurs Practice Shoulder Dystocia (Nora) – Includes nursing maneuvers and basic infant assessment.
8. OB Emerg Nurs Practice Shoulder Dystocia (Sarah) – Includes nursing maneuvers and basic infant assessment.

9. OB Emerg Nurs Practice Umbilical Cord Prolapse (Chelsea) – Necessitates vaginal elevation of fetal presenting part.

Testing Cases (9):

1. OB Emerg Nurs Testing Postpartum Hemorrhage (Shania) – Due to uterine atony, successfully treated with uterine massage.
2. OB Emerg Nurs Testing Postpartum Hemorrhage (Fancy) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications.
3. OB Emerg Nurs Testing Postpartum Hemorrhage (Victoria) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications.
4. OB Emerg Nurs Testing Eclampsia (Tatiana) – Treated with basic supportive therapy and magnesium sulfate.
5. OB Emerg Nurs Testing Eclampsia (Corrine) – Treated with basic supportive therapy and magnesium sulfate.
6. OB Emerg Nurs Testing Eclampsia (Tiffany) – Treated with basic supportive therapy and magnesium sulfate complicated by magnesium toxicity.
7. OB Emerg Nurs Testing Shoulder Dystocia (Madeline) – Includes nursing maneuvers and basic infant assessment.
8. OB Emerg Nurs Testing Shoulder Dystocia (Kendall) – Includes nursing maneuvers and basic infant assessment.
9. OB Emerg Nurs Testing Umbilical Cord Prolapse (Marsha) – Necessitates vaginal elevation of fetal presenting part.

Case Information

OB Emerg Nurs Practice PPH (Consuella) – Due to uterine atony, successfully treated with uterine massage:

Patient Name:	Consuella
Age:	20
Gender:	Female
Weight:	70 kg
Height:	160 cm
Setting:	Labor and Delivery
Background:	The patient is a 20 yo G1 P1 who just delivered by spontaneous vaginal delivery a 7 lb. 5 oz. baby girl after a prolonged labor. The placenta has been delivered. During her first postpartum check 15 minutes ago, you noticed her peripad was soaked through with blood.

OB Emerg Nurs Testing PPH (Shania) – Due to uterine atony, successfully treated with uterine massage:

Patient Name:	Shania
Age:	18
Gender:	Female
Weight:	90 kg
Height:	150 cm
Setting:	Labor and Delivery
Background:	Shania is an 18 yo G2 P2 who just delivered a 6 lb. 2 oz. baby boy at term. Her prenatal course has been complicated by chronic hypertension. You are meeting her for the first time, and are performing her first postpartum nursing assessment.

OB Emerg Nurs Practice PPH (Sarah) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications:

Patient Name:	Sarah
Age:	42
Gender:	Female
Weight:	77 kg

Height:	176 cm
Setting:	Labor and Delivery
Background:	Sarah is a 42 year old G3 P2 who just delivered twins vaginally at term. Her medical history is significant for asthma that is controlled with daily inhaler therapy. The placentation was dichorionic/diamnionic, and both placentas delivered. She had repair of a first degree perineal tear. You enter her room for a routine postpartum check.

OB Emerg Nurs Practice PPH (Ursula) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications:

Patient Name:	Ursula
Age:	33
Gender:	Female
Weight:	55 kg
Height:	150 cm
Setting:	Labor and Delivery
Background:	Ursula is a 33 yo G5 P2 Ab3 female who presented to the Labor Suite in active labor, which progressed normally without complication. Her prenatal course was complicated with a history of chronic hypertension which has been well controlled with medications. She pushed for one hour, and delivered the baby spontaneously. Her last nursing check by another nurse was 15 minutes ago, and minimal bleeding was noted at that time.

OB Emerg Nurs Testing PPH (Fancy) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications:

Patient Name:	Fancy
Age:	40
Gender:	Female
Weight:	80 kg
Height:	170 cm
Setting:	Labor and Delivery

Background:	The patient is a 40 yo G6 P6 with a history of polyhydramnios this pregnancy, who just delivered a 9 lb. 12 oz. baby boy. Her medical history is significant for asthma, for which she takes oral medications and uses an inhaler prn. She quickly delivered the baby upon arrival to the Labor Suite, and EBL was 300 cc. You enter her room for a routine postpartum check.

OB Emerg Nurs Testing PPH (Victoria) – Due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications:

Patient Name:	Victoria
Age:	24
Gender:	Female
Weight:	75 kg
Height:	172 cm
Setting:	Labor and Delivery
Background:	Victoria is a 24 year old G1 P1 who just delivered her first baby, weighing 9lbs. 5 oz. after a prolonged second stage of labor involving a full two hours of pushing. She has no significant medical history. You are performing her first postpartum check 15 minutes after delivery of the baby and intact placenta.

OB Emerg Nurs Practice Eclampsia (Francine) – Treated with basic supportive therapy and magnesium sulfate:

Patient Name:	Francine
Age:	39
Gender:	Female
Weight:	80 kg
Height:	162 cm
Setting:	Labor and Delivery
Background:	The patient is a 39 yo G1 P0 at 32 weeks gestation who presents to Labor and Delivery from the clinic due to suspected preeclampsia. She has 2+ proteinuria, and has pitting edema to her knees. She had a previously uncomplicated prenatal course. She had labs drawn, and an IV has been placed. You enter her room for a vital signs check.

OB Emerg Nurs Practice Eclampsia (Bonnie) – Treated with basic supportive therapy and magnesium sulfate:

Patient Name:	Bonnie
Age:	26
Gender:	Female
Weight:	70 kg
Height:	160 cm
Setting:	Labor and Delivery
Background:	The patient is a 26 yo G1 P0 at 38 weeks gestation who presented to Labor and Delivery in active, spontaneous labor. Prenatal course was unremarkable except for slight elevation in blood pressure and increasing ankle edema over the past week. You obtained her initial vital signs, placed an IV of Lactated Ringers running at 100 cc/hr, and sent lab work. You go into her room for another vital signs check.

OB Emerg Nurs Testing Eclampsia (Tatiana) – Treated with basic supportive therapy and magnesium sulfate:

Patient Name:	Tatiana
Age:	41
Gender:	Female
Weight:	85 kg
Height:	160 cm
Setting:	Labor and Delivery
Background:	The patient is a 41 yo G1 P0 at 33 weeks gestation who presents to Labor and Delivery for evaluation due to suspected preeclampsia. Her BP in the office was 156/100, and she has 2+ proteinuria. She has been noticing "spots" in front of her eyes. You go into the room to evaluate her. The admitting nurse drew labs and started IV fluids at 100 cc/hr.

OB Emerg Nurs Testing Eclampsia (Corrine) – Treated with basic supportive therapy and magnesium sulfate:

Patient Name:	Corrine
Age:	23

Gender:	Female
Weight:	60 kg
Height:	170 cm
Setting:	Labor and Delivery
Background:	The patient is a 23 yo G3 P0 Ab2 at 41 weeks gestation who presents to Labor and Delivery in active labor. Prenatal course has been unremarkable, except for some increased weight gain and lower leg edema for the past 2 weeks. She also complained of a headache upon admission. Her blood pressure was elevated upon admission, labs are pending, and an IV has been placed.

OB Emerg Nurs Practice Eclampsia (Marilyn) – Treated with basic supportive therapy and magnesium sulfate complicated by magnesium toxicity:

Patient Name:	Marilyn
Age:	17
Gender:	Female
Weight:	50 kg
Height:	160 cm
Setting:	Labor and Delivery
Background:	The patient is a 17 yo G2 P0 Ab1 at 41 weeks gestation being admitted for labor induction due to eclampsia diagnosed in the office this afternoon. She presented with hypertension and 2+ proteinuria, and complaints of ankle swelling and headaches. Her prenatal course was otherwise uncomplicated. You are reviewing her chart when you hear a loud crash from her room. Labs are pending, and she has an IV in place.

OB Emerg Nurs Testing Eclampsia (Tiffany) – Treated with basic supportive therapy and magnesium sulfate complicated by magnesium toxicity:

Patient Name:	Tiffany
Age:	19
Gender:	Female
Weight:	70 kg
Height:	155 cm
Setting:	Labor and Delivery

Background:	The patient is a 19 yo G1 at 41 weeks gestation who presents to Labor and Delivery with the complaint of uterine contractions, rupture of membranes, and severe headaches. Her prenatal course was unremarkable; however, she has not attended her prenatal visits for the past 3 weeks. Upon admission, she was noted to have 3+ proteinuria, deep pitting edema of the lower legs, and hyperactive reflexes.

OB Emerg Nurs Practice Shoulder Dystocia (Nora) – Includes nursing maneuvers and basic infant assessment:

Patient Name:	Nora
Age:	39
Gender:	Female
Weight:	60 kg
Height:	155 cm
Setting:	Labor and Delivery
Background:	The patient is a 39 yo G2 P1 at 41 2/7 weeks gestation for labor induction. Prior pregnancy and delivery were uncomplicated, with spontaneous vaginal delivery of a 4,227 gram infant. Her current prenatal course has been unremarkable, with maternal weight gain of 35 lbs and normal glucose screening. Prenatal ultrasound gave estimated fetal weight of 4,200 gms. You are called to assist with delivery. Labor induction commenced 10 hours ago, with AROM of clear fluid at 4 cm cervical dilation. Progression of labor is steady, and the cervix is complete. She has been pushing for 1.5 hours and the fetus is at +3 station. An episiotomy was performed due to anticipation of possible need for operative delivery.

OB Emerg Nurs Practice Shoulder Dystocia (Sarah) – Includes nursing maneuvers and basic infant assessment:

Patient Name:	Sarah
Age:	26
Gender:	Female
Weight:	65 kg
Height:	170 cm
Setting:	Labor and Delivery

Background: The patient is a 26 yo G1 P0 at 41 weeks gestation who presented in labor 8 hours ago. Her labor has progressed normally, and she has been pushing now for 1 hour. Her prenatal course was unremarkable. She is ready to deliver, and you are assisting.

OB Emerg Nurs Testing Shoulder Dystocia (Madeline) – Includes nursing maneuvers and basic infant assessment:

Patient Name: Madeline
Age: 19
Gender: Female
Weight: 60 cm
Height: 160 cm

Setting: Labor and Delivery

Background: The patient is a 19 yo G1 P0 at 42 weeks gestation who underwent induction of labor for postdates pregnancy. Her prenatal care was otherwise unremarkable, and her labor has progressed normally. She has been pushing for 45 minutes, and you are assisting with the delivery.

OB Emerg Nurs Testing Shoulder Dystocia (Kendall) – Includes nursing maneuvers and basic infant assessment:

Patient Name: Kendall
Age: 28
Gender: Female
Weight: 80 kg
Height: 165 cm

Setting: Labor and Delivery

Background: The patient is a 28 yo G3 P1 Ab1 at 39 weeks gestation who presented in active labor to Labor and Delivery 12 hours ago. Her prenatal course is remarkable for diet-controlled gestational diabetes mellitus. Labor progression has been slow, and she has been pushing for 2 hours. She is ready for delivery.

OB Emerg Nurs Practice Umbilical Cord Prolapse (Chelsea) – Necessitates vaginal elevation of fetal presenting part:

Patient Name:	Chelsea
Age:	28
Gender:	Female
Weight:	60 kg
Height:	160 cm
Setting:	Labor and Delivery
Background:	The patient is a 28 yo G1 P0 at 29 weeks gestation who is being managed expectantly for preterm rupture of membranes. She is awaiting transfer to the prenatal floor, as evaluation revealed adequate amniotic fluid and no uterine contractions. You enter her room to meet her after beginning your shift. She has an IV in place.

OB Emerg Nurs Testing Umbilical Cord Prolapse (Marsha) – Necessitates vaginal elevation of fetal presenting part:

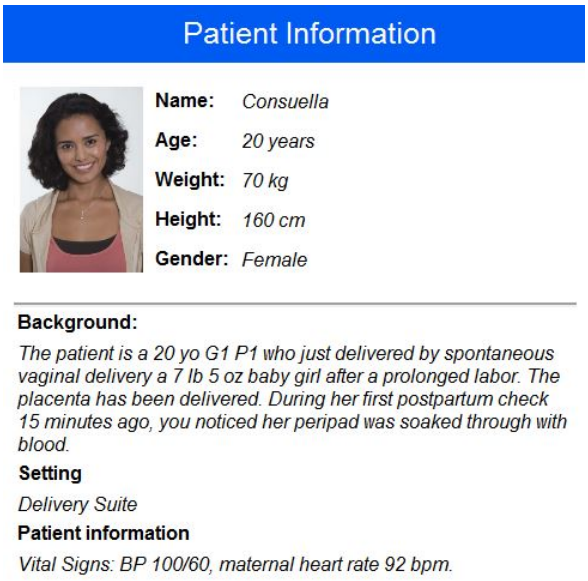
Patient Name:	Marsha
Age:	19
Gender:	Female
Weight:	65 kg
Height:	170 cm
Setting:	Labor and Delivery
Background:	The patient is a 19 yo G1 at 34 weeks gestation who presents to Labor and Delivery with complaint of contractions. She denies leakage of fluid. Evaluation revealed a 34 week fetus in frank breech presentation with adequate fluid. Her cervix is 2 cm, 80% effaced. Her prenatal course has been unremarkable. She has had labs drawn, and is receiving IV hydration. You enter her room to obtain routine vital signs.

Facilitator Information – General Instructions

General Instructions for Running Obstetric Emergencies for Hospital Nursing Scenarios

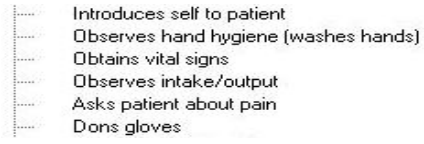
The Obstetric Emergencies for Hospital Nursing scenarios are designed for the participant who has completed review of the Obstetric Emergencies for Hospital Nursing online course material. Required participant actions are based on the accepted steps and treatments that are recommended in the obstetric and nursing literature for the recognition, assessment, and initial treatment of the most common obstetric emergencies.

1. Scenarios will open in Pause mode, with patient information appearing on the simulated patient monitor.

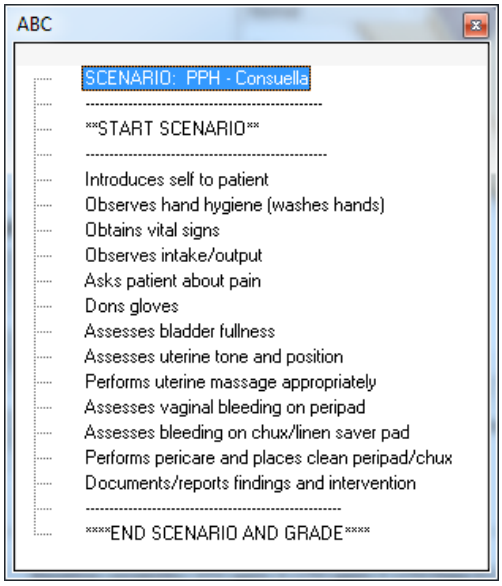


2. Take the scenario out of Pause mode to begin the scenario. Patient information will disappear, but can be recalled at any time during the scenario by selecting the patient name in the upper left hand corner of the patient monitor.

3. “Undock” the ABC menu to run the scenario.



4. Select the menu item **START SCENARIO** to begin the software for the particular scenario case you have chosen.



5. If any other menu items are chosen prior to **START SCENARIO**, the following message will appear, prompting the facilitator to select the proper **START SCENARIO** menu item.

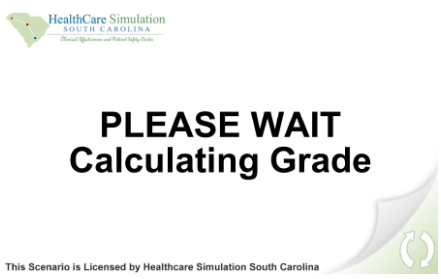
6. Once the scenario has started correctly, the following message will appear:

7. Select each menu item as the participant verbalizes or performs the action represented by the menu item. Be sure to instruct participants **to verbalize actions** and decisions that may not be apparent otherwise.

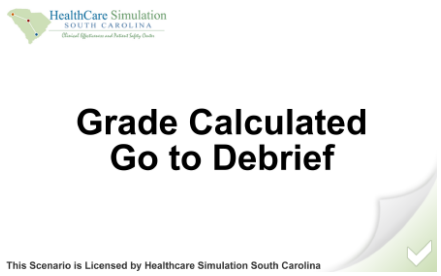
   - Each menu item should only be selected once, as selecting more than once on a menu item will result in a second count for that particular menu item, resulting in erroneous counting and improper grading.

   - Certain menu items are additional information requested by the participant. The answers will appear as a multimedia flag on the patient monitor.

8. Once the participant has performed all steps, select the menu item **END SCENARIO and GRADE** in the event menu and the following message will appear:



9. Wait to go to debriefing until the following message appears on the monitor. (Please note, it takes several seconds to determine the grade.)

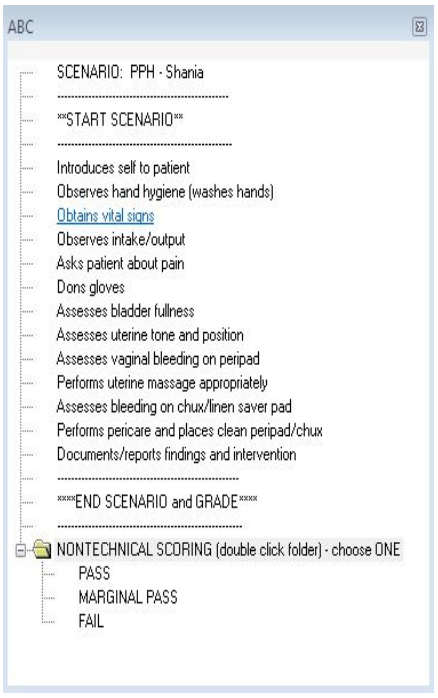


10. Once in debriefing, review performance as necessary. The debriefing record may be saved as a permanent, objective record of the evaluation.

Additional Nontechnical Scoring for Testing Scenarios

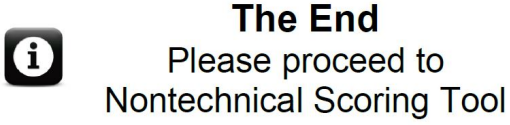
The testing scenarios have an additional grading component that is not included in the practice scenarios for enhanced subjective evaluation of the participant by the facilitator. There is a technical grade, which is graded based on the correct and incorrect steps that the participant does or does not perform, which is derived from the menu items that are selected by the facilitator. At the end of the testing scenario, the facilitator is instructed to proceed with "Nontechnical Scoring." This provides the facilitator with an opportunity to provide a subjective testing score to the participant's overall score, and will be reviewed in the debriefing log as well.

Nontechnical folder closed



Nontechnical grade choices revealed by double-clicking the folder

1. Selecting **END SCENARIO and GRADE** causes the following message to appear:



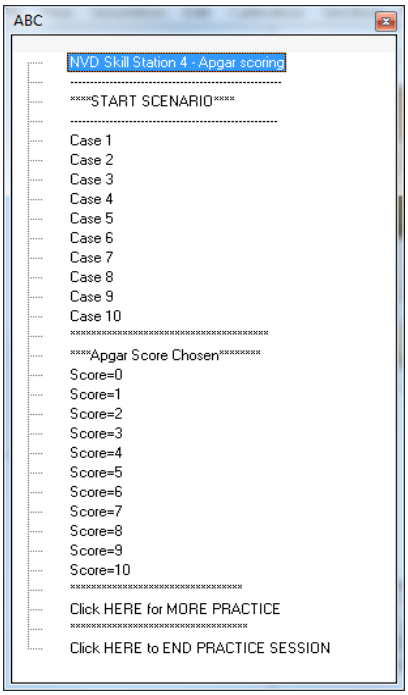
2. Selecting the appropriate Nontechnical Score (pass, marginal pass, or fail) causes the scenario to end and begins the grading process.

Facilitator Information – Skills Stations Specific Instructions

The skills station scenarios are not timed; however, it is recommended that the participants proceed through each of the stations and scenarios in a timely manner, so as to allow for maximum practice at each of the stations for all participants. A numeric grade is also not assigned for the work stations; however, the correct and incorrect menu item choices, along with explanations for each, are provided in the debrief log following the scenarios for ease of debriefing.

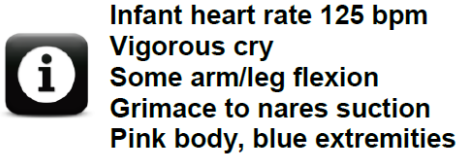
Skill Station 1 – Apgar Scoring:

Sample Event Menu for Skill Station 1 – Apgar Scoring:



Note: This skill station scenario may be run by participants for participants. These instructions are for the individual running the scenario.

1. Selecting a particular case causes a message to appear detailing the baby's presentation.



2. Selecting the participant's verbalized Apgar Score, followed by the menu item **Apgar Score Chosen**, causes the following message to appear (if the choice is correct):

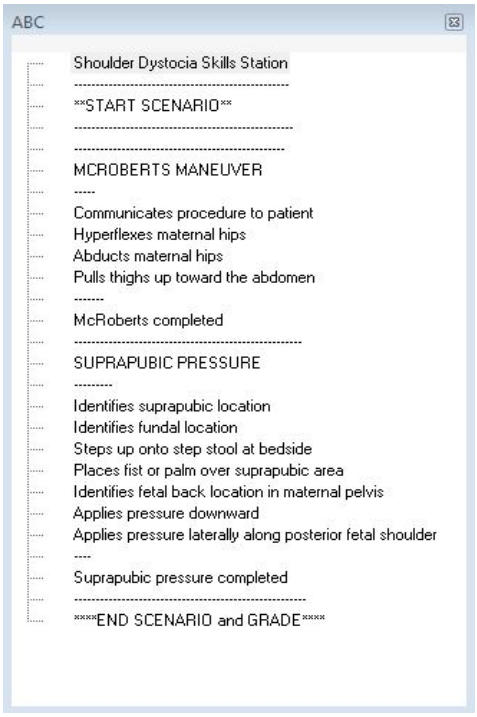
And (if the choice is incorrect):

3. If more practice is desired for the same participant, select the menu item **Click HERE for MORE PRACTICE**, followed by **START SCENARIO** to restart the software, and then choose another case from the menu. Note: the following message will appear as a reminder to only use multiple practice sessions for a single participant:

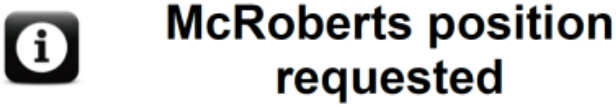
4. As each participant completes their practice at this skill station, select the menu item **Click HERE to END PRACTICE SESSION**, and the session will end for that particular participant, displaying the following message:

Skill Station 2 – Shoulder Dystocia:

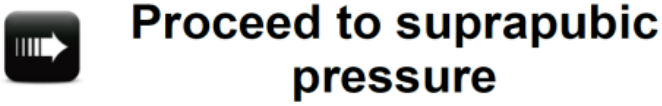
Sample Event Menu for Skill Station 2 – Shoulder Dystocia:



1. After the **Scenario Started** message appears, the following message will appear. Proceed to the skill set under the heading **MCROBERTS MANEUVER**.



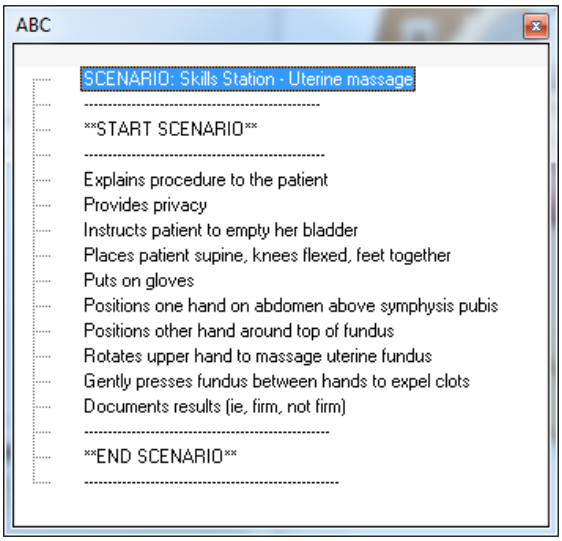
2. Once the participant has completed the four required steps, select “McRoberts completed.” The following message will then appear. Proceed to the skill set under the heading **SUPRAPUBIC PRESSURE**.



Note: By selecting each of the skills sets individually as directed (i.e., McRoberts set first, then Suprapubic pressure), each skill set is then able to be debriefed separately, as shown in the Debriefing Information section of this manual.

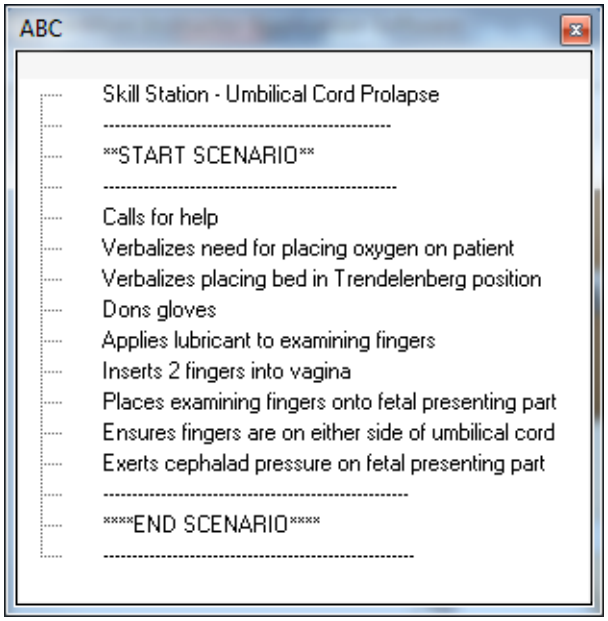
Skill Station 3 – Uterine Massage:

Sample Event Menu for Skill Station 3 – Uterine Massage:



Skill Station 4 – Umbilical Cord Prolapse:

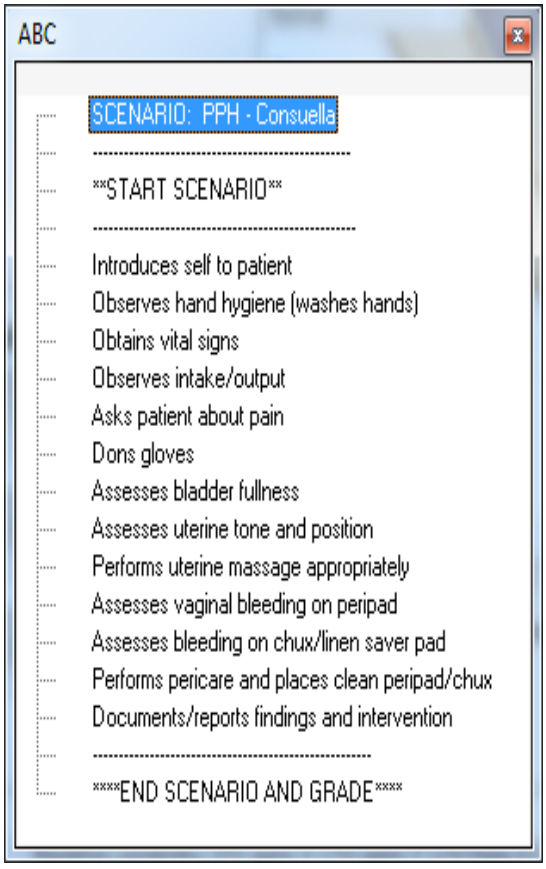
Sample Event Menu for Skill Station 4 – Umbilical Cord Prolapse:



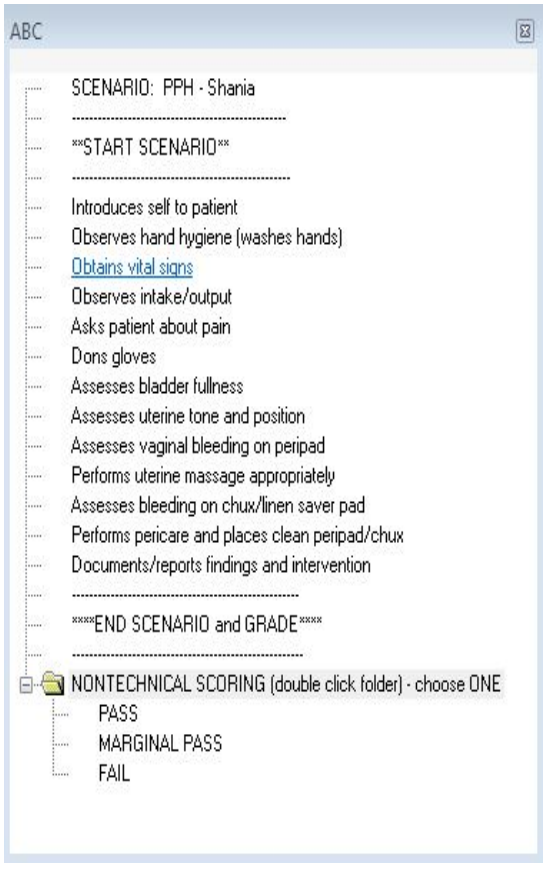
Facilitator Information – Practice and Testing Scenario Specific Instructions

Postpartum Hemorrhage due to uterine atony, successfully treated with uterine massage:

The practice scenarios for postpartum hemorrhage are timed in order to allow for the maximum number of participants to practice the scenarios. Therefore, a total of 7 minutes is given for the scenario to run, with all actions expected to be performed within this timeframe. If the participant has not completed the required steps to assess and treat the patient within 7 minutes, the scenario will automatically "time out" and end, and the score will be calculated based on the participant's actions.



OB Emerg Nurs Practice PPH (Consuella)



OB Emerg Nurs Testing PPH (Shania)

1. Selecting "observes intake/output" causes the following message to appear:

Intake: 300 cc
Output: 250 cc

2. Selecting "asks patient about pain" causes the manikin to reply, "I'm cramping a little bit, but, it's not too bad."

3. Selecting "assesses bladder fullness" causes the following message to appear:

No bladder fullness

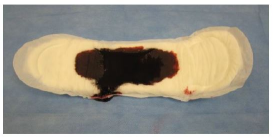
4. Selecting “assesses uterine tone and position” causes the following message to appear:

The uterus is boggy.

5. Selecting "performs uterine massage appropriately" causes the following message to appear:

The uterus becomes firm with external massage

6. Selecting "assesses vaginal bleeding on peripad" causes the manikin to inquire, "Is my bleeding okay?" The following message will appear:

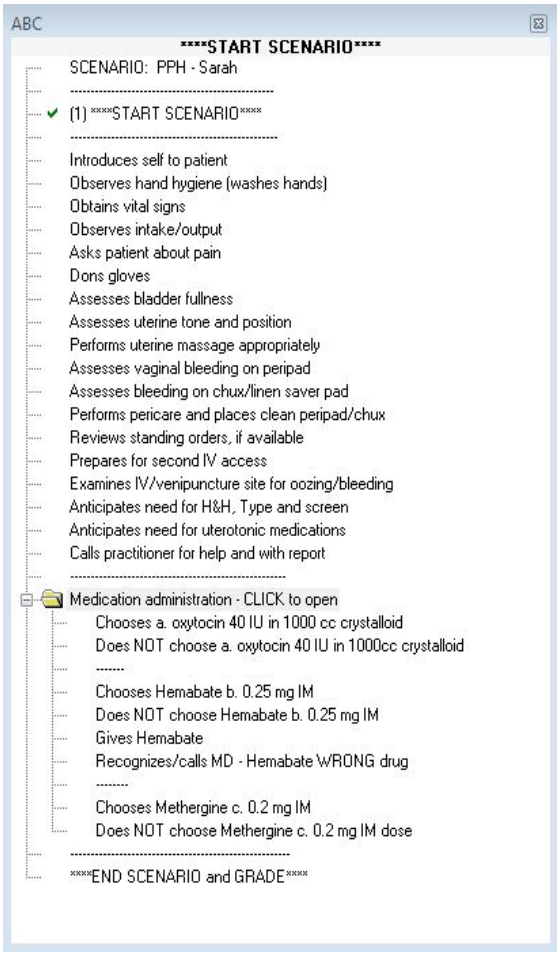


Note: Alternatively, the facilitator may choose to apply fake blood in the proportions shown on the multimedia flags to peripads/chux/linen saver pads for these simulations.

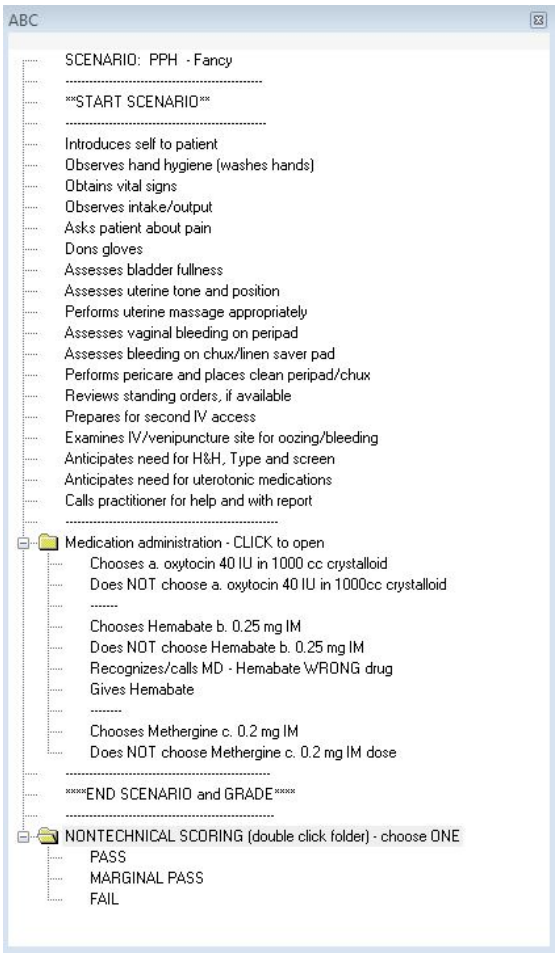
7. Selecting "assess bleeding on chux/linen saver pad" causes the following message to appear:

Postpartum Hemorrhage due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications:

As the various medications are ordered, based on the multimedia flag prompts, the participant will choose which dosage is appropriate. Select the menu item that represents the participant's choice. Note: In the scenarios in which a particular uterotonic is not an appropriate choice (i.e., methergine in a hypertensive patient), select the menu item that represents whether the participant "Recognizes/calls MD – Methergine inappropriate choice" or "Did NOT recognize Methergine inappropriate choice."



OB Emerg Nurs Practice PPH (Sarah)



OB Emerg Nurs Testing PPH (Fancy)

1. Selecting "observes intake/output" causes the following message to appear:

Intake: 300 cc
Output: 250 cc

2. Selecting "asks patient about pain" causes the manikin to reply, "I'm not having any pain at all."

3. Selecting "assesses bladder fullness" causes the following message to appear.

No bladder fullness

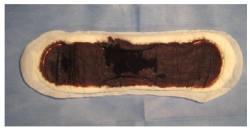
4. Selecting "assesses uterine tone and position" causes the following message to appear:

The uterus is boggy.

5. Selecting "performs uterine massage appropriately" causes the manikin to reply, "Ouch! That kind of hurts a little bit," and the following flag will appear:

The uterus remains boggy despite external massage

6. Selecting "assesses vaginal bleeding on peripad" causes the manikin to inquire, "Is something wrong? Am I bleeding too much?" Also, the following flag will appear:



7. Selecting "assesses bleeding on chux/linen saver pad" causes the following message to appear:

Linen saver/chux pad has a very small amount of blood on it

8. Selecting "reviews standing orders, if available" causes the following message to appear:

No standing orders available; what do you anticipate is needed?

9. Selecting "prepares for second IV access" causes the following message to appear:

The second IV has been successfully placed

10. Selecting "examines IV/venipuncture site for oozing/bleeding" causes the following message to appear:

No oozing/bleeding at the IV and venipuncture sites

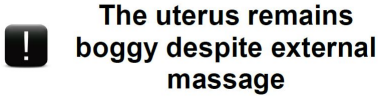
11. Selecting "anticipates need for H&H, type and screen" causes the following message to appear:

Lab personnel has arrived to draw blood

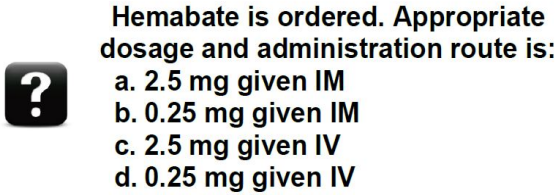
12. Selecting "calls practitioner for help and with report" causes the following message to appear:

Oxytocin is ordered. Appropriate dosage and administration route is:
a. 40 IU in 1000 cc crystalloid IV
b. 20 IU given directly in IV
c. 100 IU in 1000 cc crystalloid IV
d. 80 IU given directly in IV

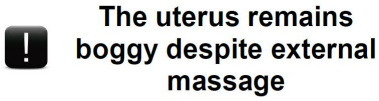
13. Selecting "chooses a. oxytocin 40 IU in 1000 cc crystalloid" causes the following message to appear:



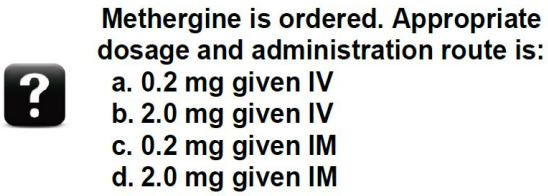
Followed by:



14. Selecting "recognizes/calls MD - Hemabate WRONG drug" causes the following message to appear:

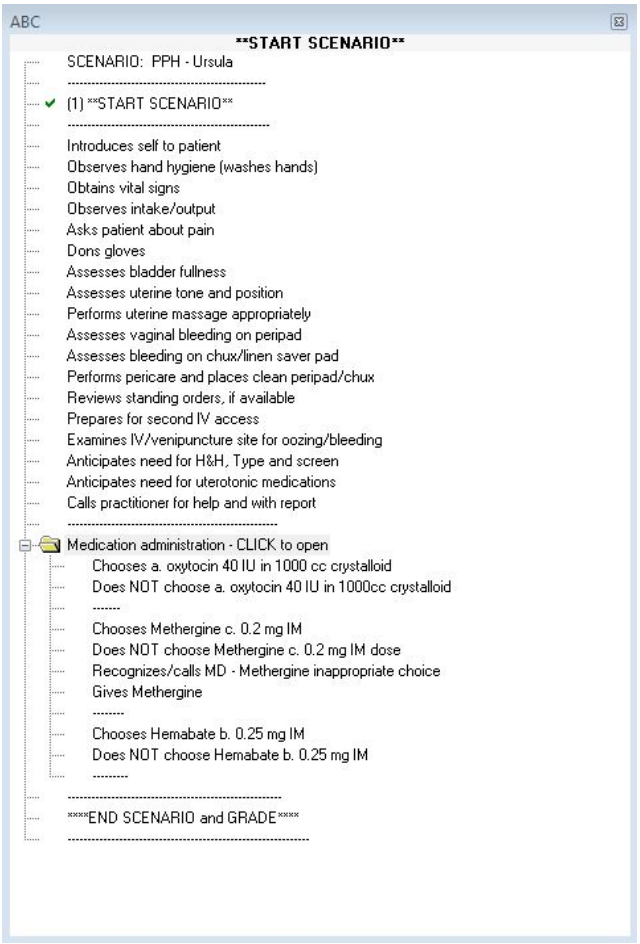


Followed by:



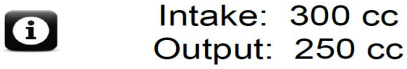
15. Selecting "chooses Methergine c. 0.2 mg IM dose" causes the following message to appear and causes the scenario's grade to be calculated.

Postpartum Hemorrhage due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications (continued):



OB Emerg Nurs Practice PPH (Ursula)

1. Selecting "observes intake/output" causes the following message to appear:



2. Selecting "asks patient about pain" causes the manikin to reply, "I'm not having any pain at all."

3. Selecting "assesses bladder fullness" causes the following message to appear:

No bladder fullness

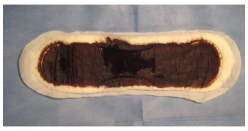
4. Selecting "assesses uterine tone and position" causes the following message to appear:

The uterus is boggy.

5. Selecting "performs uterine massage appropriately" causes the manikin to reply, "Ouch! That kind of hurts a little," and the following message to appear:

The uterus remains boggy despite external massage

6. Selecting "assesses vaginal bleeding on peripad" causes the manikin to inquire, "Is something wrong? Am I bleeding too much?" Also, the following message will appear:



7. Selecting "assesses bleeding on chux/linen saver pad" causes the following message to appear:

8. Selecting "reviews standing orders, if available" causes the following message to appear:

No standing orders available; what do you anticipate is needed?

9. Selecting "prepares for second IV access" causes the following message to appear:

The second IV has been successfully placed

10. Selecting "examines IV/venipuncture site for oozing/bleeding" causes the following message to appear:

No oozing/bleeding at the IV and venipuncture sites

11. Selecting "anticipates need for H&H, type and screen" causes the following message to appear:

Lab personnel has arrived to draw blood

12. Selecting “calls practitioner for help and with report” will result in an order for medication administration, displaying the following message:

Oxytocin is ordered. Appropriate dosage and administration route is:
a. 40 IU in 1000 cc crystalloid IV
b. 20 IU given directly in IV
c. 100 IU in 1000 cc crystalloid IV
d. 80 IU given directly in IV

13. Selecting "chooses a. oxytocin 40 IU in 1000 cc crystalloid" causes the following message to appear:

The uterus remains boggy despite external massage

Followed by the flag below:

Methergine is ordered. Appropriate dosage and administration route is:
a. 0.2 mg given IV
b. 2.0 mg given IV
c. 0.2 mg given IM
d. 2.0 mg given IM

14. Recognizes/calls MD - Methergine inappropriate choice" causes the following message to appear:

The uterus remains boggy despite external massage

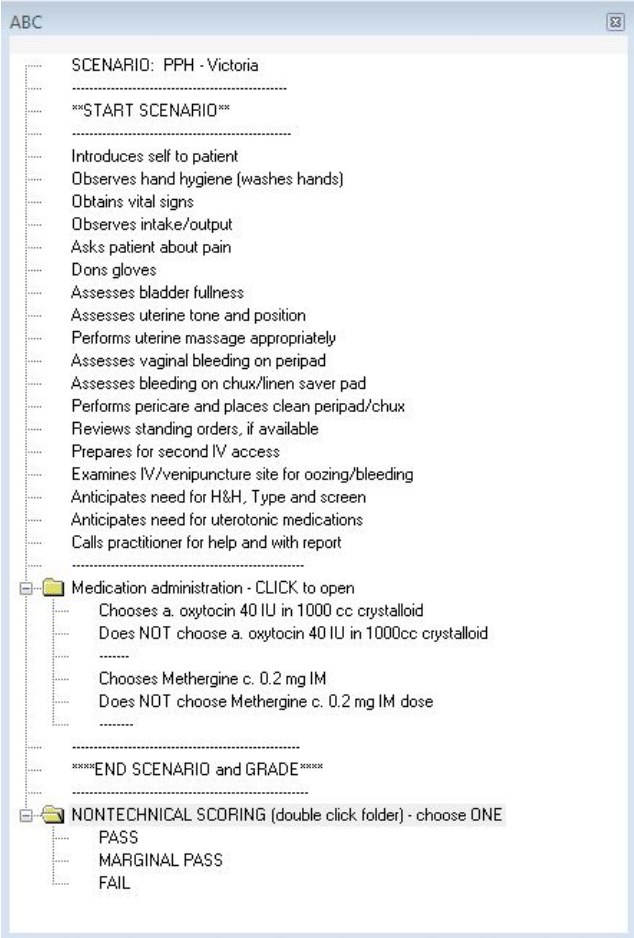
Followed by:

Hemabate is ordered. Appropriate dosage and administration route is:
a. 2.5 mg given IM
b. 0.25 mg given IM
c. 2.5 mg given IV
d. 0.25 mg given IV

15. Selecting "chooses Hemabate b. 0.25 mg IM" causes the following message to appear:

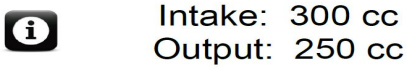
The uterus becomes firm with external massage

Postpartum Hemorrhage due to uterine atony, successfully treated with uterine massage and appropriate uterotonic medications (continued):



OB Emerg Nurs Testing PPH (Victoria)

1. Selecting "observes intake/output" causes the following message to appear:



2. Selecting "asks patient about pain" causes the manikin to reply, "I'm not having any pain at all."

3. Selecting "assesses bladder fullness" causes the following message to appear:

No bladder fullness

4. Selecting "assesses uterine tone and position" causes the following message to appear:

The uterus is boggy.

5. Selecting "performs uterine massage appropriately" causes the manikin to reply, "Ouch! That kind of hurts a little," and the following message to appear:

The uterus remains boggy despite external massage

6. Selecting "assesses vaginal bleeding on peripad" causes the manikin to inquire, "Is my bleeding okay?" Also, the following message appears:

7. Selecting "assesses bleeding on chux/linen saver pad" causes the manikin to inquire, "Is something wrong? Am I bleeding too much?" Also, the following message appears:

8. Selecting "reviews standing orders, if available" causes the following message to appear:

No standing orders available; what do you anticipate is needed?

9. Selecting "prepares for second IV access" causes the following message to appear:

The second IV has been successfully placed

10. Selecting "examines IV/venipuncture site for oozing/bleeding" causes the following message to appear:

No oozing/bleeding at the IV and venipuncture sites

11. Selecting "anticipates need for H&H, type and screen" causes the following message to appear:

Lab personnel has arrived to draw blood

12. Selecting “calls practitioner for help and with report” will result in an order for medication administration, displaying the following message:

Oxytocin is ordered. Appropriate dosage and administration route is:
a. 40 IU in 1000 cc crystalloid IV
b. 20 IU given directly in IV
c. 100 IU in 1000 cc crystalloid IV
d. 80 IU given directly in IV

13. Selecting "chooses a. oxytocin 40 IU in 1000 cc crystalloid" causes the following message to appear:

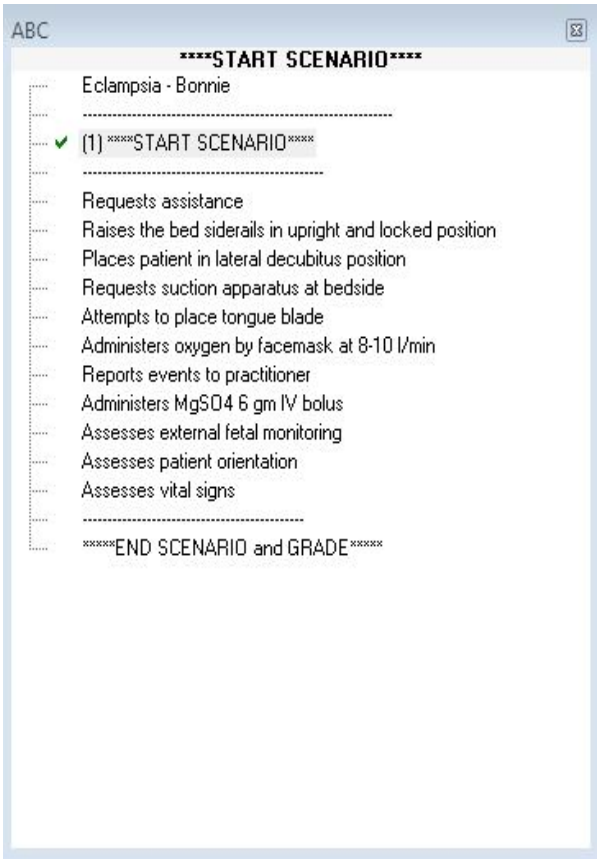
The uterus remains boggy despite external massage

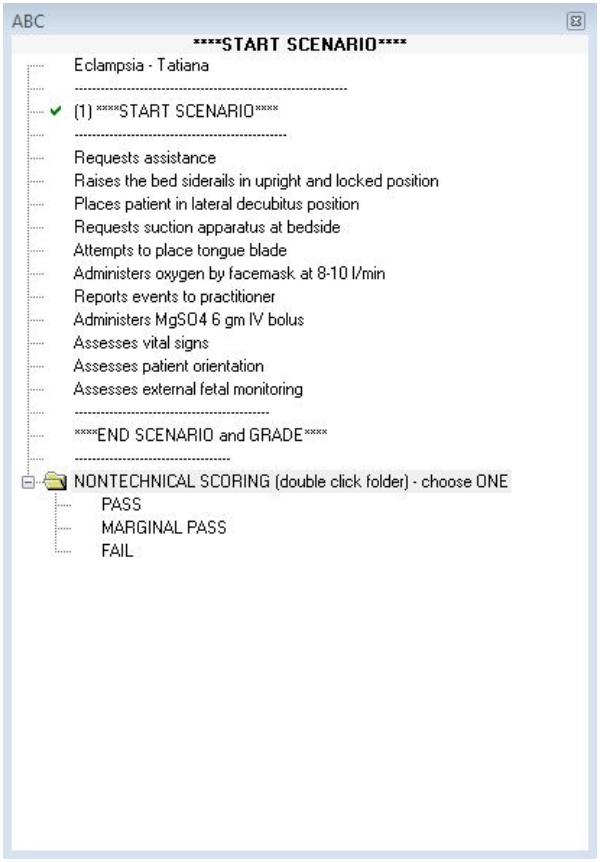
Followed by:

Methergine is ordered. Appropriate dosage and administration route is:
a. 0.2 mg given IV
b. 2.0 mg given IV
c. 0.2 mg given IM
d. 2.0 mg given IM

14. Selecting "chooses Methergine c. 0.2 mg IM" causes the following message to appear:

Eclampsia treated with basic supportive therapy and magnesium sulfate:

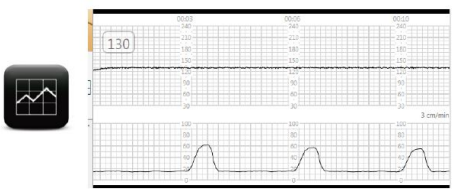




OB Emerg Nurs Practice Eclampsia (Bonnie) *OB Emerg Nurs Testing Eclampsia (Tatiana)*

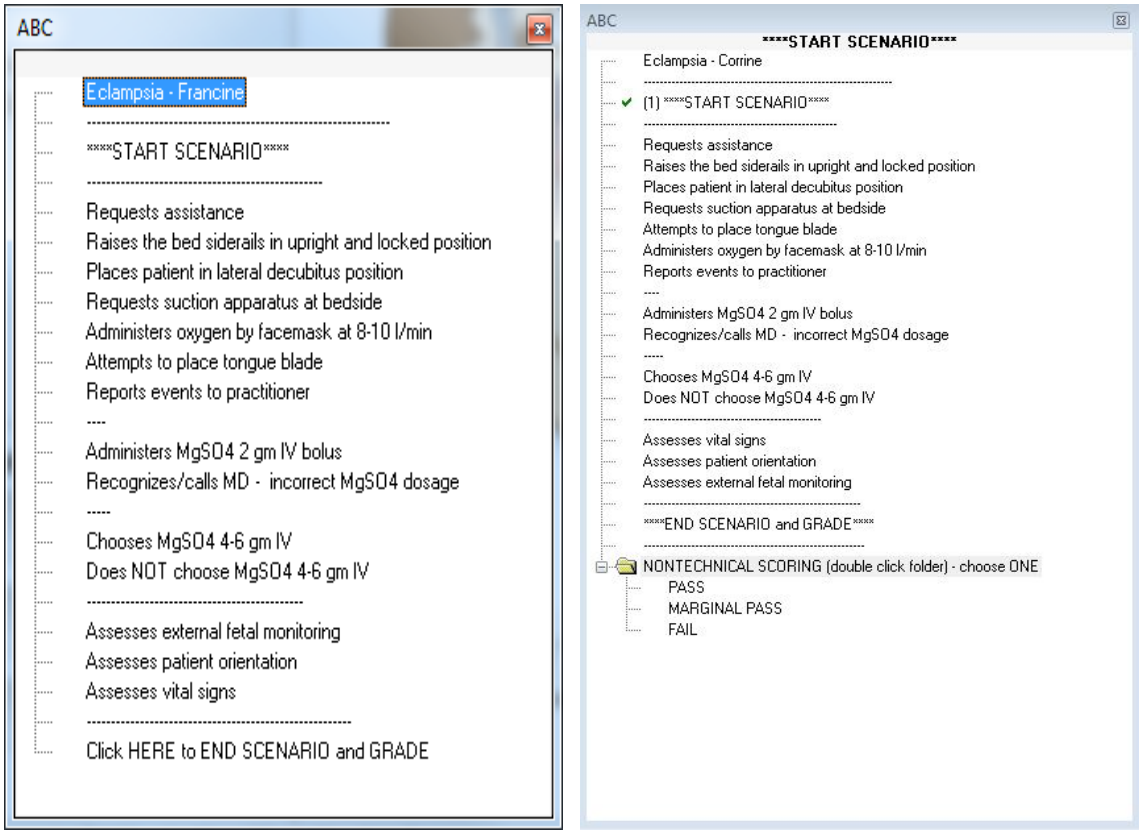
1. Selecting "reports events to practitioner" causes the following message to appear:

2. Selecting "assesses external fetal monitoring" causes the following message to appear:



3. Selecting "assesses patient orientation" causes the manikin to reply, "I'm okay. I'm just not sure what happened, or what's going on."

Eclampsia treated with basic supportive therapy and magnesium sulfate (continued):



OB Emerg Nurs Practice Eclampsia (Francine) & OB Emerg Nurs Testing Eclampsia (Corrine)

1. Selecting "reports events to practitioner" causes the following message to appear:

Magnesium sulfate 2 gm IV bolus is ordered

2. In these particular scenarios, an incorrect initial bolus dose of Magnesium sulfate is ordered on the multimedia flag. If the participant administers/states that they administered the inappropriate dose, select the menu item “Administers MgSO4 2 gm IV bolus," causing the following message to appear:

Incorrect dosage

3. If the participant recognizes that this is an inappropriate initial MgSO4 dose in the eclamptic patient, select the menu item “Recognizes/calls MD – incorrect MgSO4

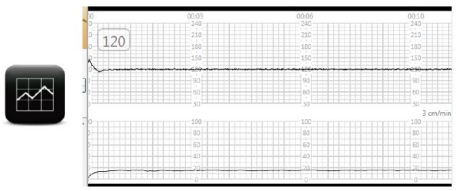
dosage.” The following message appears, asking the participant for the correct medication dosage:

Correct medication dosage/route for first eclamptic seizure is:
a. Valium 1 mg IV
b. Valium 10 mg po
c. MgSO4 2 gm IV
d. MgSO4 4-6 gm IV

4. Selecting "chooses MgSO4 4-6gm IV" causes the following message to appear:

Correct

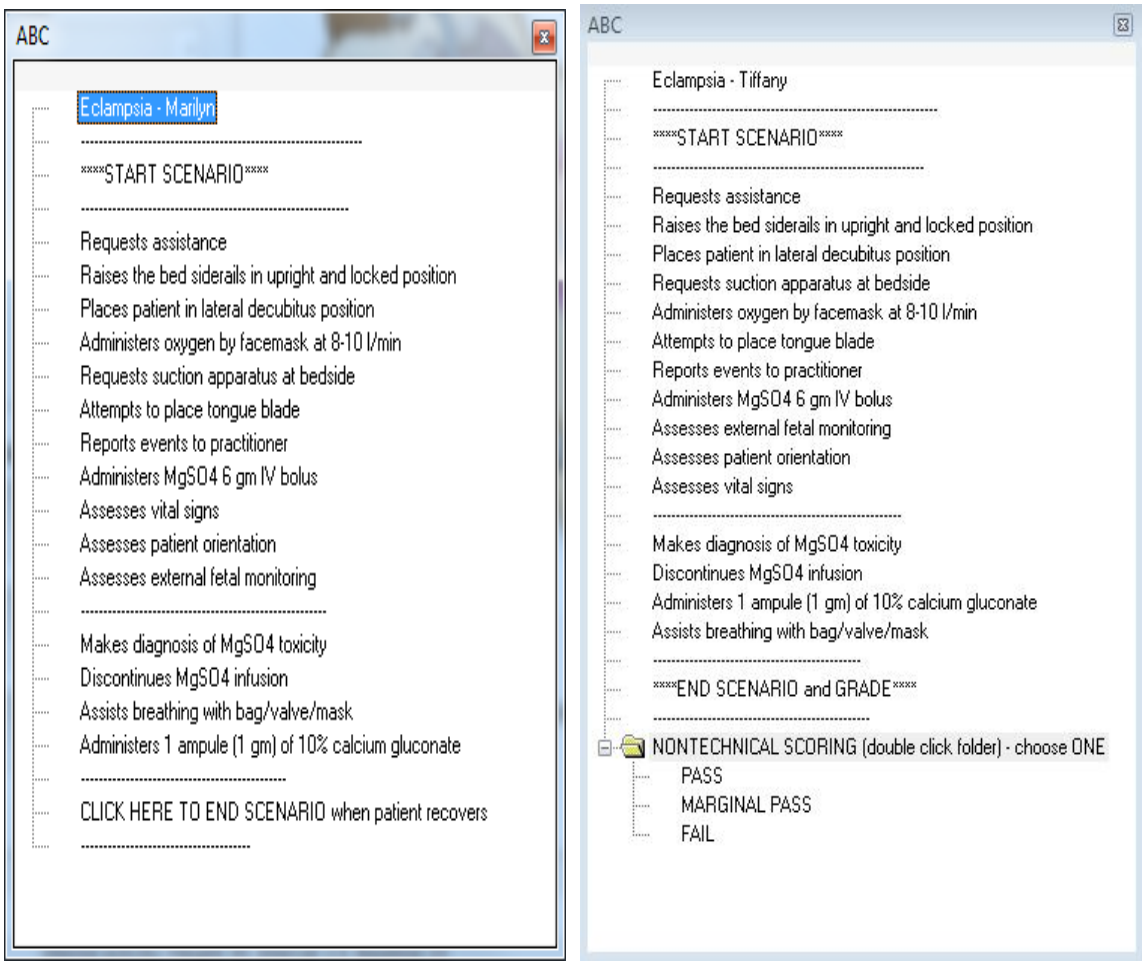
5. Selecting "assesses external fetal monitoring" causes the following message to appear:



6. Selecting "assesses patient orientation" will prompt the manikin to state, "I'm okay. I'm just not sure what happened, or what's going on."

Eclampsia treated with basic supportive therapy and magnesium sulfate complicated by magnesium toxicity:

In these scenarios, the participant proceeds with basic treatment of the eclamptic patient; however, after administration of Magnesium sulfate, the signs of Magnesium toxicity occur, with respiratory rate decreasing to 2 breaths per minute. The participant is expected to perform or instruct the performance of the steps that are indicated in the treatment of Magnesium toxicity. Only when all menu items indicated in the treatment of Magnesium toxicity are selected, will the patient recover with a normal respiration rate and become alert.



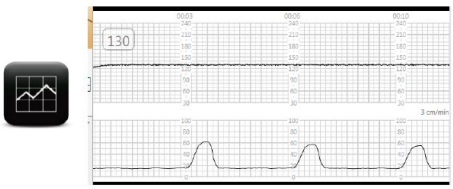
OB Emerg Nurs Practice Eclampsia (Marilyn) & OB Emerg Nurs Testing Eclampsia (Tiffany)

1. Selecting "reports events to practitioner" causes the following message to appear:

Magnesium sulfate 6 gm IV bolus is ordered

2. Selecting "assesses patient orientation" causes the manikin to reply, "I'm okay. I'm just not sure what happened, or what's going on."

3. Selecting "assesses external fetal monitoring" causes the following message to appear:



4. Selecting "assists breathing with bag/valve mask" causes the manikin to exclaim, "Oh my gosh! Did something happen?" Also, the following message appears. Please note, this action does not occur in Practice Scenario 6 (Marilyn).

Patient becomes more alert

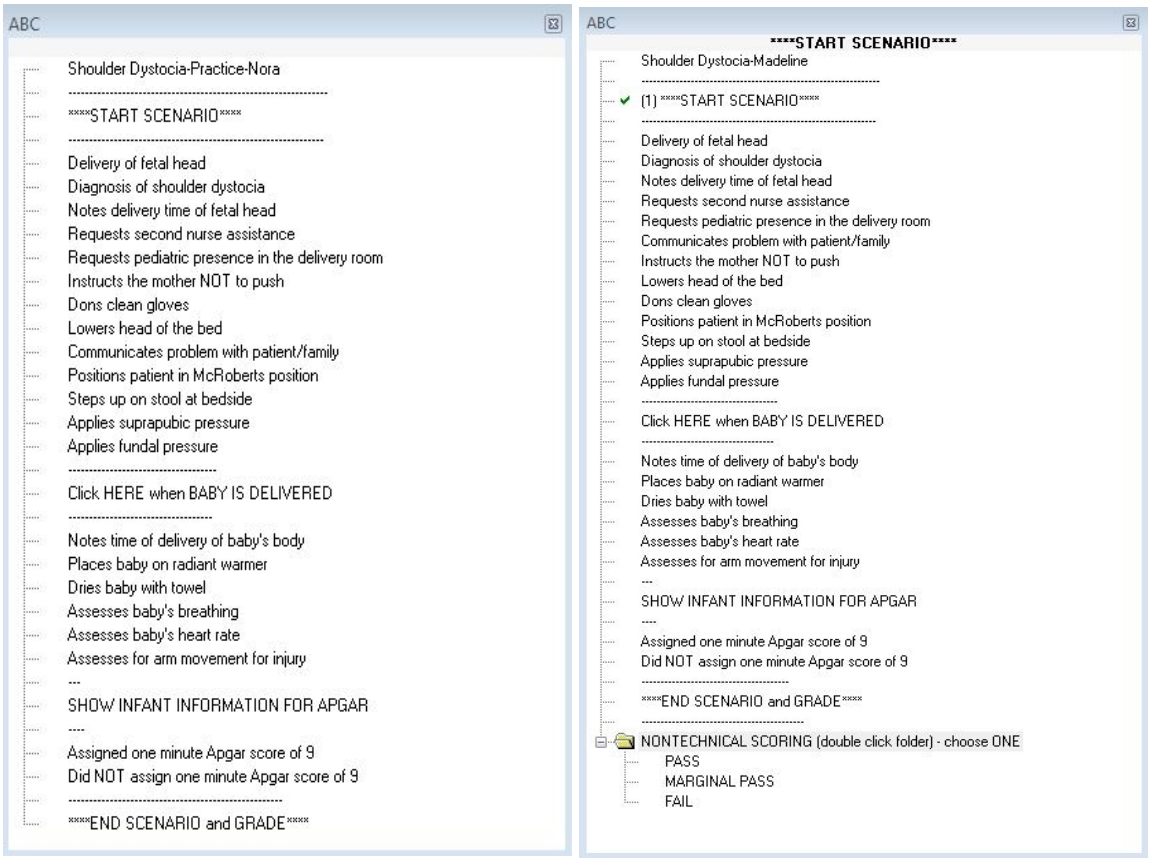
5. For Practice Scenario 6 (Marilyn) only, selecting "administer 1 ampule (1 gm) of 10% calcium gluconate" causes the following messages to appear:

Correct treatment administered for presumed MgSO4 toxicity

Patient becomes more alert

Shoulder dystocia with nursing maneuvers and basic infant assessment:

Once shoulder dystocia has been recognized, multimedia flags appear as a request from the delivering practitioner to perform the various nursing maneuvers. Instruct the person performing the delivery to deliver the baby's shoulder and body only after performance of both McRoberts position and suprapubic pressure by the participant.



OB Emerg Nurs Practice Shoulder Dystocia (Nora) & OB Emerg Nurs Testing Shoulder Dystocia (Madeline)

1. Selecting "delivery of the fetal head" causes the following message to appear:

Fetal shoulder delivery not successful

2. The following message appears after the previous message:

McRoberts position requested

3. Selecting "positions patient in McRoberts position" causes the following messages to appear:

Shoulders still unable to be delivered

Delivery not successful; suprapubic pressure requested

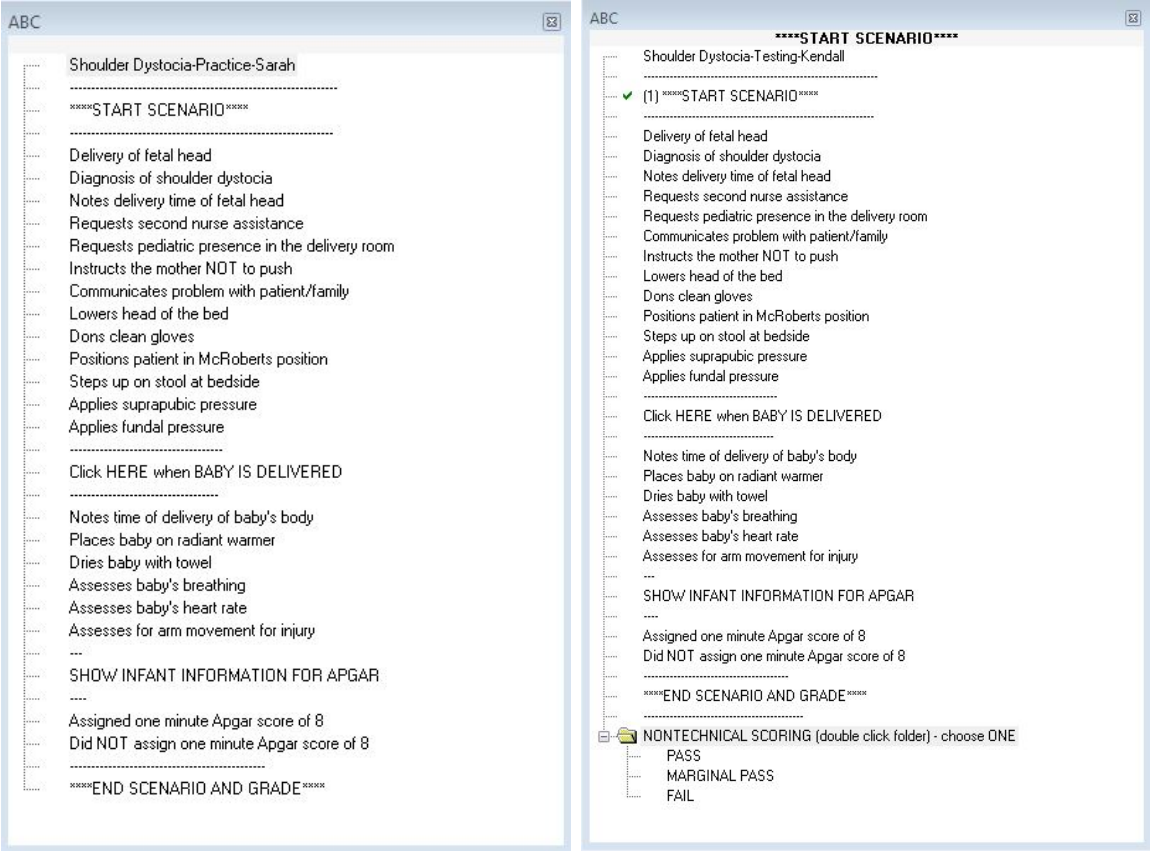
4. Selecting "assesses arm movement for injury" causes the following message to appear:

Baby is moving both arms well

5. Selecting **SHOW INFANT INFORMATION FOR APGAR** causes the following message to appear:

Infant heart rate 140 bpm
Crying
Actively moving
Sneezes to nares suction
Pink body, blue extremities

Shoulder dystocia with nursing maneuvers and basic infant assessment (continued):



OB Emerg Nurs Practice Shoulder Dystocia (Sarah) & OB Emerg Nurs Testing Shoulder Dystocia (Kendall)

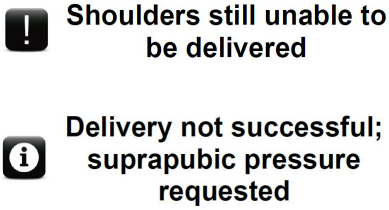
1. Selecting "delivery of the fetal head" causes the following message to appear:

Fetal shoulder delivery not successful

2. The following message appears after the previous message:

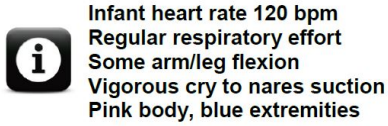
McRoberts position requested

3. Selecting "positions patient in McRoberts position" causes the following messages to appear:



4. Selecting "assesses arm movement for injury" causes the following message to appear:

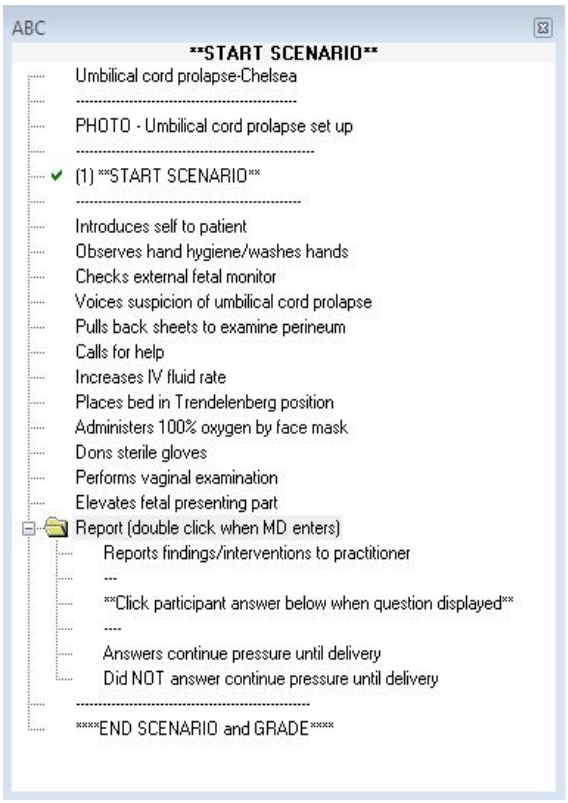
5. Selecting **SHOW INFANT INFORMATION FOR APGAR** causes the following message to appear:



Umbilical cord prolapse necessitating vaginal elevation of fetal presenting part:

The run time for the umbilical cord prolapse scenarios is 5 minutes. Once 5 minutes has elapsed, the scenario program will automatically end, and grading will begin. The scenarios may also be ended by the facilitator by selecting **END SCENARIO AND GRADE**.

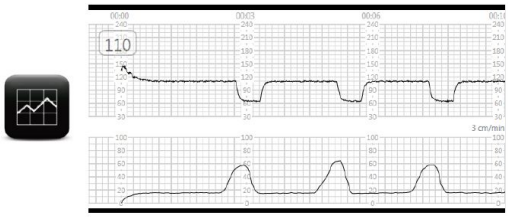
At the top of the Umbilical Cord Prolapse menu is an item entitled “PHOTO – Umbilical cord prolapse set up.” Selecting this menu item will provide the facilitator with a photo of the umbilical prolapse set up for each particular scenario. For example, one scenario is set up such that the umbilical cord is visualized at the patient’s introitus, whereas loops of umbilical cord in the other scenario are completely prolapsed onto the bed.



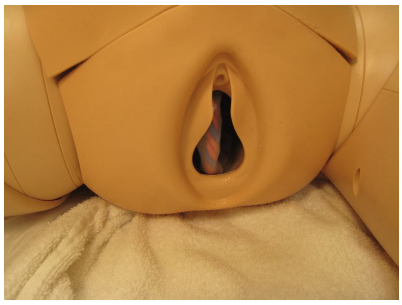
OB Emerg Nurs Practice Umbilical Cord Prolapse (Chelsea)

1. Selecting "introduces self to patient" causes the manikin to reply, "Well, the baby moved and I had a gush of fluid. Now, I'm having a lot of abdominal pain."

2. Selecting "checks external fetal monitor" causes the following message to appear:



3. Selecting "pulls back sheets to examine perineum" causes the following image to appear:



4. Selecting "performs vaginal examination" causes the following message to appear:

Cervix exam: 3 cm dilated, loops of cord in vagina

5. Opening the Report folder causes the following message to appear:

The physician enters the room and requests a report

6. Selecting “reports finding/interventions to practitioner” causes the following message to appear:

Emergent Cesarean delivery is planned

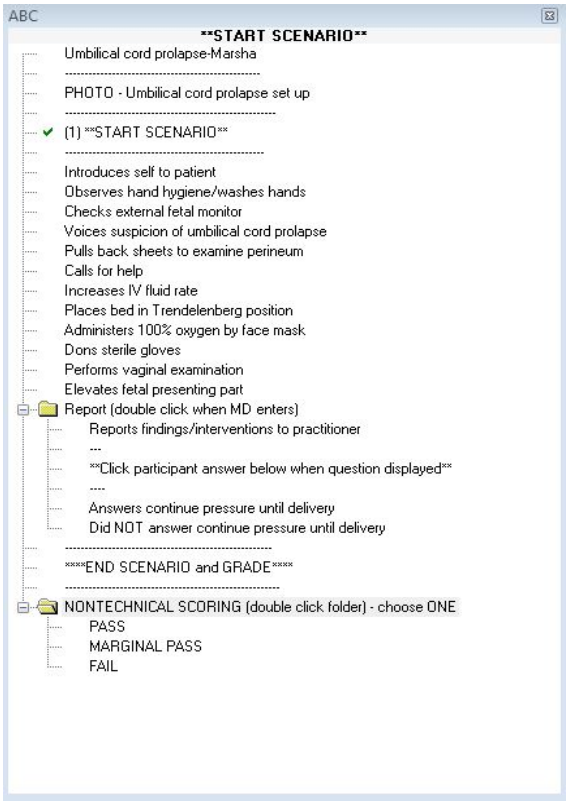
Followed by:

The physician orders delivery by cesarean section – how long will you maintain pressure on the fetal presenting part?

7. Selecting "answers continue pressure until delivery" causes the following message to appear:

☑ **Correct**

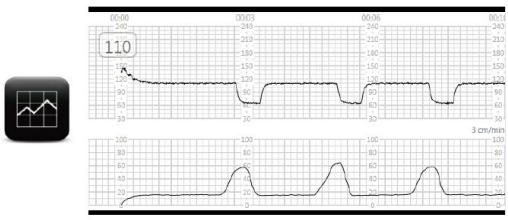
Umbilical cord prolapse necessitating vaginal elevation of fetal presenting part (continued):



OB Emerg Nurs Testing Umbilical Cord Prolapse (Marsha)

1. Selecting "introduces self to patient" causes the manikin to reply, "I think that I may have broken my water when I went to the bathroom. Now I feel like there is something in my vagina."

2. Selecting "checks external fetal monitor" causes the following message to appear:



3. Selecting "pulls back sheets to examine perineum" causes the following image to appear:

4. Selecting "performs vaginal examination" causes the following message to appear:

Cervix exam: 3 cm dilated, loops of cord in vagina

5. Opening the Report folder causes the following message to appear:

The physician enters the room and requests a report

6. Selecting “reports finding/interventions to practitioner” causes the following message to appear:

Emergent Cesarean delivery is planned

Followed by:

The physician orders delivery by cesarean section – how long will you maintain pressure on the fetal presenting part?

Setup and Equipment

Suggested scenario logistics:

- Based on Obstetric and Nursing Obstetric curriculum, derived from Obstetric and Nursing Obstetric textbooks and mainstream literature.
- Eighteen (18) in-hospital training scenarios involving various presentations of the most common Obstetric emergencies, requiring recognition, assessment, and initial treatment of the emergency for hospital nurses.
- Individual scenario run time (varies depending on scenario) – 5 - 7 minutes.
- Debriefing time – varies. Estimate 5 - 10 minutes per training scenario.

Equipment needed:

- SimMom, with infant and placenta
- Infant radiant warmer with towels, stethoscope
- Pelvic trainer may be used for certain skills stations.
- Hospital Delivery bed with ability to lower head of bed, to be placed in Trendelenberg position, and contains siderails that are able to be raised and lowered.
- Blankets or pillows for siderail padding (eclampsia).
- Intravenous bag/line hung on bed, one IV line in the patient.
- Second IV line and bag set up.
- Suction apparatus at bedside.
- Oxygen mask with tubing to wall/canister oxygen.
- Bag/valve/mask
- Bedside standing stool
- Bedside table, with:
    - Gloves – nonsterile and sterile
    - Sterile lubricant
    - Tonsil suction
    - Kidney/emesis basin
    - Medication syringes/small IV bags labeled with medication names/dosages
    - Small towels
    - Bulb syringe
    - Red rubber urinary catheter
    - Reflex hammer
- Medication syringes/small IV bags labeled with medication names/dosages:
    - MgSO4 2 gm
    - MgSO4 6 gm
    - Calcium gluconate 1 gm
    - Oxytocin 40 IU in 1000 cc crystalloid

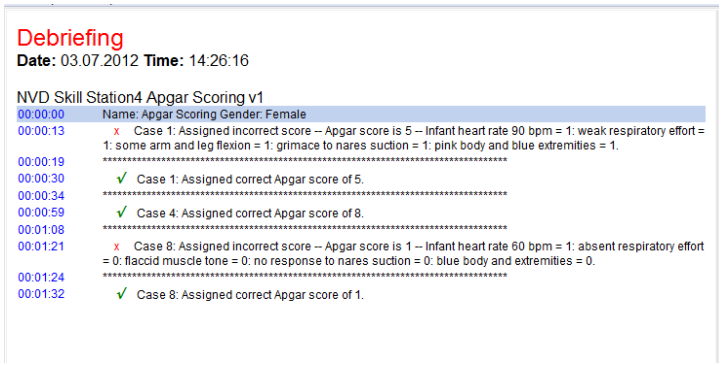
    - Methergine 0.2 mg
    - Hemabate 0.25 mg
- Washcloths and water available
- Peripads
- Chux/linen saver pads
- If desired, fake blood to apply to peripads/chux/linen saver pads in appropriate amounts for the particular scenario (Not necessary - multimedia photos of bloody peripads/chux are programmed into the scenarios).

Debriefing Information

The Obstetric Emergencies for Hospital Nursing scenarios are designed and programmed for debriefing using the Diagnostic Educational Objective-based Reflection (DEOR) methodology. John J. Schaefer, III, MD of HealthCare Simulation South Carolina (HCSSC) developed DEOR methodology to provide objective-based feedback to scenario participants.

For more information regarding the DEOR methodology please visit: www.healthcaresimulationsc.com/simstore/.

Skill Station 1 - Apgar Scoring Debrief Log:

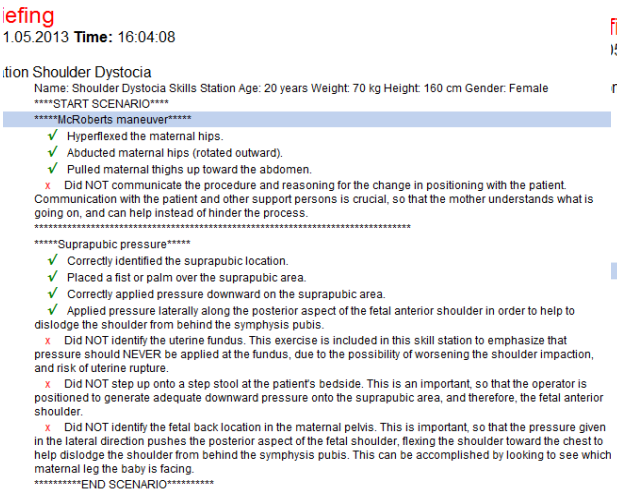


Debriefing
Date: 03.07.2012 **Time:** 14:26:16

NVD Skill Station4 Apgar Scoring v1

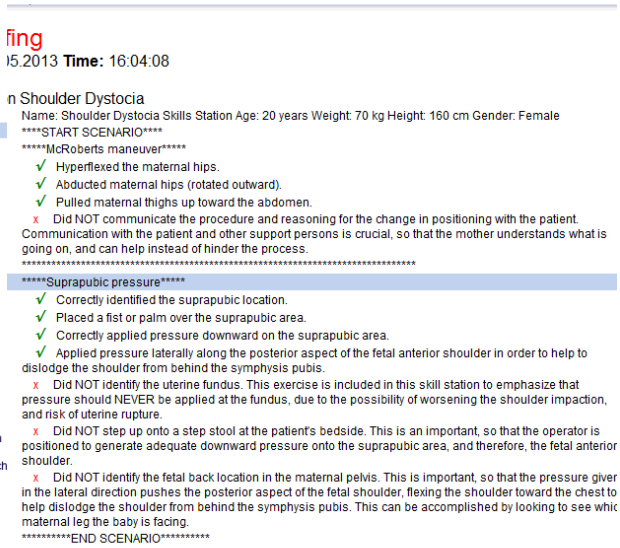
00:00:00	Name: Apgar Scoring Gender: Female
00:00:13	x Case 1: Assigned incorrect score -- Apgar score is 5 -- Infant heart rate 90 bpm = 1: weak respiratory effort = 1: some arm and leg flexion = 1: grimace to nares suction = 1: pink body and blue extremities = 1.
00:00:19	**********
00:00:30	✓ Case 1: Assigned correct Apgar score of 5.
00:00:34	**********
00:00:59	✓ Case 4: Assigned correct Apgar score of 8.
00:01:08	**********
00:01:21	x Case 8: Assigned incorrect score -- Apgar score is 1 -- Infant heart rate 60 bpm = 1: absent respiratory effort = 0: flaccid muscle tone = 0: no response to nares suction = 0: blue body and extremities = 0.
00:01:24	**********
00:01:32	✓ Case 8: Assigned correct Apgar score of 1.

Skill Station 2 – Shoulder Dystocia Debrief Log:



efing
1.05.2013 **Time:** 16:04:08

tion Shoulder Dystocia
Name: Shoulder Dystocia Skills Station Age: 20 years Weight: 70 kg Height: 160 cm Gender: Female
****START SCENARIO****
*****McRoberts maneuver*****
✓ Hyperflexed the maternal hips.
✓ Abducted maternal hips (rotated outward).
✓ Pulled maternal thighs up toward the abdomen.
x Did NOT communicate the procedure and reasoning for the change in positioning with the patient. Communication with the patient and other support persons is crucial, so that the mother understands what is going on, and can help instead of hinder the process.
****
*****Suprapubic pressure*****
✓ Correctly identified the suprapubic location.
✓ Placed a fist or palm over the suprapubic area.
✓ Correctly applied pressure downward on the suprapubic area.
✓ Applied pressure laterally along the posterior aspect of the fetal anterior shoulder in order to help to dislodge the shoulder from behind the symphysis pubis.
x Did NOT identify the uterine fundus. This exercise is included in this skill station to emphasize that pressure should NEVER be applied at the fundus, due to the possibility of worsening the shoulder impaction, and risk of uterine rupture.
x Did NOT step up onto a step stool at the patient's bedside. This is an important, so that the operator is positioned to generate adequate downward pressure onto the suprapubic area, and therefore, the fetal anterior shoulder.
x Did NOT identify the fetal back location in the maternal pelvis. This is important, so that the pressure given in the lateral direction pushes the posterior aspect of the fetal shoulder, flexing the shoulder toward the chest to help dislodge the shoulder from behind the symphysis pubis. This can be accomplished by looking to see which maternal leg the baby is facing.
**********END SCENARIO**********



fing
)5.2013 **Time:** 16:04:08

n Shoulder Dystocia
Name: Shoulder Dystocia Skills Station Age: 20 years Weight: 70 kg Height: 160 cm Gender: Female
****START SCENARIO****
*****McRoberts maneuver*****
✓ Hyperflexed the maternal hips.
✓ Abducted maternal hips (rotated outward).
✓ Pulled maternal thighs up toward the abdomen.
x Did NOT communicate the procedure and reasoning for the change in positioning with the patient. Communication with the patient and other support persons is crucial, so that the mother understands what is going on, and can help instead of hinder the process.
****
*****Suprapubic pressure*****
✓ Correctly identified the suprapubic location.
✓ Placed a fist or palm over the suprapubic area.
✓ Correctly applied pressure downward on the suprapubic area.
✓ Applied pressure laterally along the posterior aspect of the fetal anterior shoulder in order to help to dislodge the shoulder from behind the symphysis pubis.
x Did NOT identify the uterine fundus. This exercise is included in this skill station to emphasize that pressure should NEVER be applied at the fundus, due to the possibility of worsening the shoulder impaction, and risk of uterine rupture.
x Did NOT step up onto a step stool at the patient's bedside. This is an important, so that the operator is positioned to generate adequate downward pressure onto the suprapubic area, and therefore, the fetal anterior shoulder.
x Did NOT identify the fetal back location in the maternal pelvis. This is important, so that the pressure giver in the lateral direction pushes the posterior aspect of the fetal shoulder, flexing the shoulder toward the chest to help dislodge the shoulder from behind the symphysis pubis. This can be accomplished by looking to see whic maternal leg the baby is facing.
**********END SCENARIO**********

Note: Both of the debrief logs shown above are identical. They are presented to demonstrate that each separate nursing maneuver is separated in the debrief log to allow for debriefing of each step for each of the maneuvers. McRoberts maneuver is highlighted in the first example, with each of the steps performed/not performed by the participant for this maneuver being detailed under this heading. Suprapubic pressue is highlighted in the second example, with each of the steps performed/not performed by the participant for this procedure being detailed under this heading.

Skill Station 3 – Uterine Massage Correct Debrief Log:

Debriefing

Date: 07.11.2013 **Time:** 10:00:28

SMom Skill Uterine Massage_Grade 1_0

00:00:00	Name: Skills station - Uterine massage Age: 20 years Weight: 60 kg Height: 160 cm Gender: Female Description: Not applicable to this skills station practice.
00:00:03	*****START SCENARIO*****
00:00:06	√ Explained the procedure to the patient.
00:00:09	√ Provided privacy for the patient, ie, drew curtain around bed, closed room door to hallway.
00:00:12	√ Instructed the patient to empty her bladder. A full bladder may displace the uterus and result in inaccurate assessment of the uterine tone.
00:00:15	√ Appropriately positioned patient in supine position, with knees slightly flexed and feet together. Proper positioning enhances visualization during procedure, and effectiveness of procedure.
00:00:17	√ Appropriately put on gloves.
00:00:19	√ Properly positioned one hand on the abdomen just above the symphysis pubis to anchor the lower uterine segment during massage.
00:00:22	√ Properly positioned the second hand over the top of the uterine fundus, in preparation for massage.
00:00:24	√ Appropriately rotated the upper abdominal hand to gently massage the uterine fundus.
00:00:26	√ Appropriately gently pressed the uterine fundus between the operator's hands to expel any clots that may be present within the uterine cavity.
00:00:28	√ Documented whether uterus became firm after uterine massage, or remained boggy despite uterine massage.
00:00:33	**********END SCENARIO**********
00:00:36	**********
00:00:38	
00:00:38	**********OVERALL SCORE**********
00:00:38	Completed 10/10 steps. 100%

Skill Station 3 – Uterine Massage Incorrect Debrief Log:

Debriefing

Date: 07.11.2013 **Time:** 10:02:14

SMom Skill Uterine Massage_Grade 1_0

00:00:00	Name: Skills station - Uterine massage Age: 20 years Weight: 60 kg Height: 160 cm Gender: Female Description: Not applicable to this skills station practice.
00:00:03	*****START SCENARIO*****
00:01:05	x Did NOT explain the procedure to the patient.
00:01:05	x Did NOT provide privacy for the patient.
00:01:05	x Did NOT instruct the patient to empty her bladder. A full bladder may result in displacement of the uterus, and inaccurate assessment of uterine tone.
00:01:05	x Did NOT appropriately position patient in supine position, with knees slightly flexed and feet together. Proper positioning enhances visualization during procedure, and effectiveness of procedure.
00:01:05	x Did NOT put on gloves.
00:01:05	x Did NOT properly position one hand on the abdomen just above the symphysis pubis to anchor the lower uterine segment during massage.
00:01:05	x Did NOT properly position the second hand over the uterine fundus in preparation for massage.
00:01:05	x Did NOT rotate the upper hand to gently massage the uterine fundus.
00:01:05	x Did NOT gently press the uterine fundus between the operator's hands to expel clots that may be present in the uterine cavity.
00:01:05	x Did NOT document whether uterus became firm after uterine massage, or remained boggy despite uterine massage.
00:01:07	**********END SCENARIO**********
00:01:10	**********
00:01:12	
00:01:13	
00:01:14	
00:01:15	
00:01:16	
00:01:17	
00:01:18	
00:01:19	
00:01:20	
00:01:21	
00:01:22	
00:01:22	**********OVERALL SCORE**********
00:01:22	Completed 0/10 steps. 0%

Skill Station 4 – Umbilical Cord Prolapse Correct Debrief Log:

Debriefing

Date: 07.11.2013 **Time:** 09:55:44

SMom Skill Umbilical Cord Prolapse_Grade 1_0

00:00:00	Name: Umbilical Cord Prolapse Skill station Age: 20 years Weight: 50 kg Height: 150 cm Gender: Female Description: Not applicable to this skills station practice.
00:00:03	**********START SCENARIO**********
00:00:03	Fetal heart pattern: Variable dec: 0.8
00:00:03	Baseline variability: Minimal
00:00:03	Uterine activity: 06:10
00:00:03	FHR base: 120
00:00:06	√ Called for help. Additional personnel (ie, nursing, delivering practitioner, pediatric/neonatal) will be needed to aid in the emergent care of the patient with umbilical cord prolapse, to include alleviation of the cord prolapse, decision for delivery, emergent delivery, and resuscitation of the infant in the event of emergent delivery.
00:00:09	√ Verbalized the need for providing supplemental oxygen to the patient. Maternal supplemental oxygen is indicated in umbilical cord prolapse to ensure maximum oxygen may be available to the fetus, as the blood supply through the prolapsed cord (and therefore, to the fetus) is compromised due to umbilical cord compression.
00:00:11	√ Verbalized the need to position the patient to attempt to decrease umbilical cord compression - this most commonly involves placing the bed in Trendelenberg position, but may include placing the patient in the knee-chest position, or lateral Sims position.
00:00:14	√ Placed gloves on hands prior to performing vaginal examination. Putting on sterile gloves is indicated when examining a patient with ruptured membranes. For purposes of this skill station, nonsterile gloves may be used.
00:00:29	√ Applied lubricant to examining fingers prior to vaginal examination. Lubricant is used on the examining fingers for the comfort of the patient during examination. Sterile lubricant is indicated for examination of a patient with ruptured membranes, however, for the purposes of this skills station, nonsterile lubricant may be used.
00:00:32	√ Inserted 2 examining fingers into the patient's vagina. Placement of 2 examining fingers improves the ability of the examiner to elevate the fetal presenting part in a careful, controlled manner, which is an indicated maneuver in the patient with fetal heart rate decompensation due to compression of the prolapsed umbilical cord.
00:00:34	√ Placed examining fingers on the fetal presenting part, in preparation for elevation of the fetal presenting part to decrease umbilical cord compression resulting from the cord prolapse.
00:00:36	√ Ensured that both examining fingers were on either side of the umbilical cord while resting against the fetal presenting part. This caution is necessary, as direct pressure of the examining fingers on the umbilical cord will result in compression of the cord and therefore, decreased blood flow through the umbilical cord to the fetus.
00:00:39	Fetal heart pattern: Normal
00:00:39	FHR base: 130
00:00:39	√ Exerted cephalad (in relation to the mother) pressure to the fetal presenting part to elevate the part out of the maternal pelvis. This maneuver helps to alleviate the compression of the umbilical cord between the fetal presenting part and maternal pelvis that may occur in a prolapsed umbilical cord, with the resultant aim of resuming blood flow through the umbilical cord to the fetus.
00:00:49	**********END SCENARIO**********
00:00:54	
00:00:54	**********OVERALL SCORE**********
00:00:54	Completed 9/9 steps. 100%

Skill Station 4 – Umbilical Cord Prolapse Incorrect Debrief Log:

Debriefing

Date: 07.11.2013 **Time:** 10:02:14

SMom Skill Uterine Massage_Grade 1_0

00:00:00	Name: Skills station - Uterine massage Age: 20 years Weight: 60 kg Height: 160 cm Gender: Female Description: Not applicable to this skills station practice.
00:00:03	*****START SCENARIO*****
00:01:05	x Did NOT explain the procedure to the patient.
00:01:05	x Did NOT provide privacy for the patient.
00:01:05	x Did NOT instruct the patient to empty her bladder. A full bladder may result in displacement of the uterus, and inaccurate assessment of uterine tone.
00:01:05	x Did NOT appropriately position patient in supine position, with knees slightly flexed and feet together. Proper positioning enhances visualization during procedure, and effectiveness of procedure.
00:01:05	x Did NOT put on gloves.
00:01:05	x Did NOT properly position one hand on the abdomen just above the symphysis pubis to anchor the lower uterine segment during massage.
00:01:05	x Did NOT properly position the second hand over the uterine fundus in preparation for massage.
00:01:05	x Did NOT rotate the upper hand to gently massage the uterine fundus.
00:01:05	x Did NOT gently press the uterine fundus between the operator's hands to expel clots that may be present in the uterine cavity.
00:01:05	x Did NOT document whether uterus became firm after uterine massage, or remained boggy despite uterine massage.
00:01:07	**********END SCENARIO**********
00:01:10	**********
00:01:12	
00:01:13	
00:01:14	
00:01:15	
00:01:16	
00:01:17	
00:01:18	
00:01:19	
00:01:20	
00:01:21	
00:01:22	
00:01:22	**********OVERALL SCORE**********
00:01:22	Completed 0/10 steps. 0%

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage Correct Debrief Logs:

Debriefing
Date: 07.11.2013 **Time:** 10:12:51

SMom Nurs OB Emerg Practice PPH Massage (Consuella) 1_0

00:00:00 Name: Consuella Age: 20 years Weight: 70 kg Height: 160 cm Gender: Female
Description: Vital Signs: BP 100/60, maternal heart rate 92 bpm.
00:00:04 *****START SCENARIO*****
00:00:06 √ Introduced self to patient.
00:00:08 √ Observed hand hygiene (washed hands).
00:00:10 √ Obtained vital signs.
00:00:12 √ Observed patient's fluid intake/output.
00:00:14 √ Asked the patient about her level of pain.
00:00:17 √ Put on gloves.
00:00:19 √ Assessed bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:00:23 √ Assessed uterine tone and position.
00:00:34 √ Performed uterine massage appropriately.
00:00:40 √ Assessed the amount of vaginal bleeding on the peripad.
00:00:43 √ Assessed the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:00:47 √ Performed pericare, and placed clean peripad/chux/linen saver pad as needed.
00:00:49 √ Appropriately documented/reported findings and intervention performed.
00:01:00 **********END SCENARIO**********
00:01:03 **********
00:01:05
00:01:05 **********OVERALL GRADE**********
00:01:05 GRADE: Completed 13/13 steps. 100%

Debriefing
Date: 14.11.2013 **Time:** 15:43:13

SMom Nurs OB Emerg Testing PPH Massage (Shania) 1_0

00:00:00 Name: Shania Age: 18 years Weight: 90 kg Height: 150 cm Gender: Female
Description: Vital Signs: BP 142/92, maternal heart rate 84 bpm.
00:00:03 *****START SCENARIO*****
00:00:05 √ Introduced self to patient.
00:00:09 √ Observed hand hygiene (washed hands).
00:00:15 √ Obtained vital signs.
00:00:19 √ Observed patient's fluid intake/output.
00:00:22 √ Asked the patient about her level of pain.
00:00:25 √ Put on gloves.
00:00:28 √ Assessed bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:00:31 √ Assessed uterine tone and position.
00:00:34 √ Assessed the amount of vaginal bleeding on the peripad.
00:00:37 √ Performed uterine massage appropriately.
00:00:40 √ Assessed the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:00:42 √ Performed pericare, and placed clean peripad/chux/linen saver pad as needed.
00:00:45 √ Appropriately documented/reported findings and intervention performed.
00:00:52
00:00:53 **********NONTECHNICAL SCORE**********
00:00:59 PASS. Learner appears ready for clinical practice.
00:01:03 **********END SCENARIO**********

OB Emerg Nurs Practice PPH (Consuella) & OB Emerg Nurs Testing PPH (Shania)

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage Incorrect Debrief Log:

Debriefing
Date: 07.11.2013 **Time:** 10:15:02

SMom Nurs OB Emerg Practice PPH Massage (Consuella) 1_0

00:00:00		Name: Consuella Age: 20 years Weight: 70 kg Height: 160 cm Gender: Female Description: Vital Signs: BP 100/60, maternal heart rate 92 bpm.
00:00:03		*****START SCENARIO*****
00:01:01		**********END SCENARIO**********
00:01:01	x	Did NOT introduce self to patient.
00:01:01	x	Did NOT observe hand hygiene, ie, did not wash hands.
00:01:01	x	Did NOT obtain vital signs.
00:01:01	x	Did NOT observe patient's fluid intake/output.
00:01:01	x	Did NOT ask the patient about her current level of pain.
00:01:01	x	Did NOT put on gloves.
00:01:01	x	Did NOT assess bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:01:01	x	Did NOT assess uterine tone and position.
00:01:01	x	Did NOT assess the amount of bleeding on the patient's peripad.
00:01:01	x	Did NOT assess the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:01:01	x	Did NOT perform uterine massage, or performed it inappropriately.
00:01:01	x	Did NOT perform pericare, or did NOT place clean peripad/chux/linen saver pad as needed.
00:01:01	x	Did NOT appropriately document/report findings or intervention performed.
00:01:04		**********
00:01:06		
00:01:07		
00:01:08		
00:01:09		
00:01:10		
00:01:11		
00:01:12		
00:01:13		
00:01:14		
00:01:15		
00:01:16		
00:01:17		
00:01:18		
00:01:19		
00:01:19		**********OVERALL GRADE**********
00:01:19		GRADE: Completed 0/13 steps. 0%

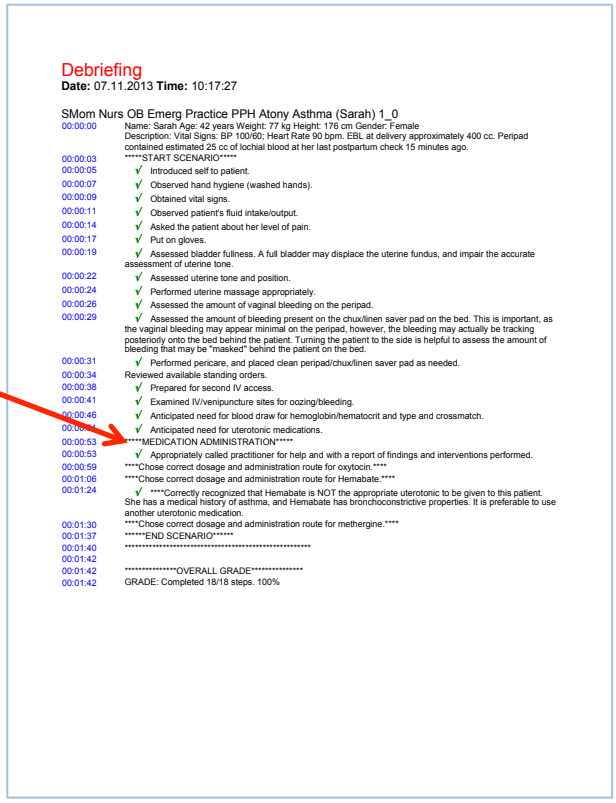
Debriefing
Date: 14.11.2013 **Time:** 15:45:23

SMom Nurs OB Emerg Testing PPH Massage (Shania) 1_0

00:00:00		Name: Shania Age: 18 years Weight: 90 kg Height: 150 cm Gender: Female Description: Vital Signs: BP 142/92, maternal heart rate 84 bpm.
00:00:03		*****START SCENARIO*****
00:01:05	x	Did NOT introduce self to patient.
00:01:05	x	Did NOT observe hand hygiene, ie, did not wash hands.
00:01:05	x	Did NOT obtain vital signs.
00:01:05	x	Did NOT observe patient's fluid intake/output.
00:01:05	x	Did NOT ask the patient about her current level of pain.
00:01:05	x	Did NOT put on gloves.
00:01:05	x	Did NOT assess bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:01:05	x	Did NOT assess uterine tone and position.
00:01:05	x	Did NOT assess the amount of bleeding on the patient's peripad.
00:01:05	x	Did NOT assess the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:01:05	x	Did NOT perform uterine massage, or performed it inappropriately.
00:01:05	x	Did NOT perform pericare, or did NOT place clean peripad/chux/linen saver pad as needed.
00:01:05	x	Did NOT appropriately document/report findings or intervention performed.
00:01:08		
00:01:09		**********NONTECHNICAL SCORE**********

OB Emerg Nurs Practice PPH (Consuella) & OB Emerg Nurs Testing PPH (Shania)

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage and Appropriate Uterotonic Medications Correct Debrief Log:



Debriefing
Date: 07.11.2013 **Time:** 10:17:27

SMom Nurs OB Emerg Practice PPH Atony Asthma (Sarah) 1_0

00:00:00 Name: Sarah Age: 42 years Weight: 77 kg Height: 176 cm Gender: Female
Description: Vital Signs: BP 100/60; Heart Rate 90 bpm. EBL at delivery approximately 400 cc. Peripad contained estimated 25 cc of lochial blood at her last postpartum check 15 minutes ago.
00:00:03 *****START SCENARIO*****
00:00:05 √ Introduced self to patient.
00:00:07 √ Observed hand hygiene (washed hands).
00:00:09 √ Obtained vital signs.
00:00:11 √ Observed patient's fluid intake/output.
00:00:14 √ Asked the patient about her level of pain.
00:00:17 √ Put on gloves.
00:00:19 √ Assessed bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:00:22 √ Assessed uterine tone and position.
00:00:24 √ Performed uterine massage appropriately.
00:00:26 √ Assessed the amount of vaginal bleeding on the peripad.
00:00:29 √ Assessed the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:00:31 √ Performed pericare, and placed clean peripad/chux/linen saver pad as needed.
00:00:34 Reviewed available standing orders.
00:00:38 √ Prepared for second IV access.
00:00:41 √ Examined IV/venipuncture sites for oozing/bleeding.
00:00:46 √ Anticipated need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:00:[illegible] √ Anticipated need for uterotonic medications.
00:00:53 *****MEDICATION ADMINISTRATION*****
00:00:53 √ Appropriately called practitioner for help and with a report of findings and interventions performed.
00:00:59 ****Chose correct dosage and administration route for oxytocin.****
00:01:06 ****Chose correct dosage and administration route for Hemabate.****
00:01:24 √ ****Correctly recognized that Hemabate is NOT the appropriate uterotonic to be given to this patient. She has a medical history of asthma, and Hemabate has bronchoconstrictive properties. It is preferable to use another uterotonic medication.
00:01:30 ****Chose correct dosage and administration route for methergine.****
00:01:37 ******END SCENARIO******
00:01:40 **********
00:01:42
00:01:42 **********OVERALL GRADE**********
00:01:42 GRADE: Completed 18/18 steps. 100%

Debriefing
Date: 14.11.2013 **Time:** 15:36:53

SMom Nurs OB Emerg Testing PPH Atony Asthma (Fancy) 1_0

00:00:00 Name: Fancy Age: 40 years Weight: 80 kg Height: 170 cm Gender: Female
Description: Vital Signs: BP 132/78, maternal heart rate 80 bpm, RR 16. Peripad contained 100 cc of lochial blood on last postpartum check 15 minutes ago.
00:00:03 *****START SCENARIO*****
00:00:06 √ Introduced self to patient.
00:00:09 √ Observed hand hygiene (washed hands).
00:00:12 √ Obtained vital signs.
00:00:16 √ Observed patient's fluid intake/output.
00:00:19 √ Asked the patient about her level of pain.
00:00:22 √ Put on gloves.
00:00:24 √ Assessed bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:00:26 √ Assessed uterine tone and position.
00:00:28 √ Performed uterine massage appropriately.
00:00:31 √ Assessed the amount of vaginal bleeding on the peripad.
00:00:35 √ Assessed the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:00:37 √ Performed pericare, and placed clean peripad/chux/linen saver pad as needed.
00:00:39 Reviewed available standing orders.
00:00:41 √ Prepared for second IV access.
00:00:43 √ Examined IV/venipuncture sites for oozing/bleeding.
00:00:45 √ Anticipated need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:00:47 √ Anticipated need for uterotonic medications.
00:00:50 *****MEDICATION ADMINISTRATION*****
00:00:50 √ Appropriately called practitioner for help and with a report of findings and interventions performed.
00:00:53 ****Chose correct dosage and administration route for oxytocin.****
00:01:00 ****Chose correct dosage and administration route for Hemabate.****
00:01:07 √ ****Correctly recognized that Hemabate is NOT the appropriate uterotonic to be given to this patient. She has a medical history of asthma, and Hemabate has bronchoconstrictive properties. It is preferable to use another uterotonic medication.
00:01:13 ****Chose correct dosage or administration route for methergine.****
00:01:18
00:01:19
00:01:20 **********NONTECHNICAL SCORE**********
00:01:21 PASS. Learner appears ready for clinical practice.
00:01:26 **********END SCENARIO**********
00:01:29 **********
00:01:31
00:01:31 **********TECHNICAL SCORE**********
00:01:31 GRADE: Completed 18/18 steps. 100%

OB Emerg Nurs Practice PPH (Sarah) & OB Emerg Nurs Testing PPH (Fancy)

Note: The highlighted **MEDICATION ADMINISTRATION** section of the log details the correct choice of medication dosage and correct recognition that incorrect medication for this patient was ordered.

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage and Appropriate Uterotonic Medications Correct Debrief Log (Continued):

Debriefing
Date: 07.11.2013 **Time:** 10:26:26

SMom Nurs OB Emerg Practice PPH Atony HTN (Ursula) 1_0

00:00:00 Name: Ursula Age: 33 years Weight: 55 kg Height: 150 cm Gender: Female
Description: Vital Signs: BP 142/90, maternal heart rate 82 bpm, RR 14
00:00:03 *****START SCENARIO*****
00:00:05 √ Introduced self to patient.
00:00:07 √ Observed hand hygiene (washed hands).
00:00:09 √ Obtained vital signs.
00:00:12 √ Observed patient's fluid intake/output.
00:00:14 √ Asked the patient about her level of pain.
00:00:17 √ Put on gloves.
00:00:19 √ Assessed bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:00:22 √ Assessed uterine tone and position.
00:00:26 √ Performed uterine massage appropriately.
00:00:29 √ Assessed the amount of vaginal bleeding on the peripad.
00:00:32 √ Assessed the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:00:35 √ Performed pericare, and placed clean peripad/chux/linen saver pad as needed.
00:00:38 Reviewed available standing orders.
00:00:40 √ Prepared for second IV access.
00:00:43 √ Examined IV/venipuncture sites for oozing/bleeding.
00:00:46 √ Anticipated need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:00:49 √ Anticipated need for uterotonic medications.
00:00:51 *****MEDICATION ADMINISTRATION*****
00:00:51 √ Appropriately called practitioner for help and with a report of findings and interventions performed.
00:00:58 ****Chose correct dosage and administration route for oxytocin.****
00:01:03 ****Chose correct dosage and administration route for methergine.****
00:01:07 √ ****Recognized that methergine is not an appropriate choice for a patient with hypertension.****
00:01:20 ****Chose correct dosage and administration route for Hemabate.****
00:01:28 **********END SCENARIO**********
00:01:31 **********
00:01:33
00:01:33 **********OVERALL GRADE**********
00:01:33 GRADE: Completed 18/18 steps. 100%

OB Emerg Nurs Practice PPH (Ursula)

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage and Appropriate Uterotonic Medications Correct Debrief Log (Continued):

Debriefing
Date: 14.11.2013 **Time:** 15:30:34

SMom Nurs OB Emerg Testing PPH Atony (Victoria) 1_0

00:00:00 Name: Victoria Age: 24 years Weight: 75 kg Height: 172 cm Gender: Female
Description: Vital Signs: BP 110/70, maternal heart rate 76 bpm.
00:00:03 *****START SCENARIO*****
00:00:05 √ Introduced self to patient.
00:00:08 √ Observed hand hygiene (washed hands).
00:00:10 √ Obtained vital signs.
00:00:12 √ Observed patient's fluid intake/output.
00:00:15 √ Asked the patient about her level of pain.
00:00:18 √ Put on gloves.
00:00:21 √ Assessed bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:00:24 √ Assessed uterine tone and position.
00:00:27 √ Performed uterine massage appropriately.
00:00:30 √ Assessed the amount of vaginal bleeding on the peripad.
00:00:33 √ Assessed the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:00:36 √ Performed pericare, and placed clean peripad/chux/linen saver pad as needed.
00:00:40 Reviewed available standing orders.
00:00:43 √ Prepared for second IV access.
00:00:46 √ Examined IV/venipuncture sites for oozing/bleeding.
00:00:48 √ Anticipated need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:00:50 √ Anticipated need for uterotonic medications.
00:00:53 *****MEDICATION ADMINISTRATION*****
00:00:53 √ Appropriately called practitioner for help and with a report of findings and interventions performed.
00:00:57 ****Chose correct dosage and administration route for oxytocin.****
00:01:08 *****Chose correct dosage and administration route for methergine.*****
00:01:16
00:01:17 **********NONTECHNICAL SCORE**********
00:01:22 PASS. Learner appears ready for clinical practice.
00:01:26 **********END SCENARIO**********
00:01:29 **********
00:01:31
00:01:31 **********TECHNICAL SCORE**********
00:01:31 GRADE: Completed 17/17 steps. 100%

OB Emerg Nurs Testing PPH (Victoria)

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage and Appropriate Uterotonic Medications Incorrect Debrief Log:

Debriefing
Date: 07.11.2013 **Time:** 10:20:28

SMom Nurs OB Emerg Practice PPH Atony Asthma (Sarah) 1_0

00:00:00 Name: Sarah Age: 42 years Weight: 77 kg Height: 176 cm Gender: Female
Description: Vital Signs: BP 100/60; Heart Rate 90 bpm; EBL at delivery approximately 400 cc. Peripad contained estimated 25 cc of lochial blood at her last postpartum check 15 minutes ago.
00:00:03 *****START SCENARIO*****
00:01:30 x Did NOT introduce self to patient.
00:01:30 x Did not observe hand hygiene, ie, did not wash hands.
00:01:30 x Did NOT obtain vital signs.
00:01:30 x Did NOT observe patient's fluid intake/output.
00:01:30 x Did NOT ask the patient about her current level of pain.
00:01:30 x Did NOT put on gloves.
00:01:30 x Did NOT assess bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:01:30 x Did NOT assess uterine tone and position.
00:01:30 x Did NOT assess the amount of bleeding on the patient's peripad.
00:01:30 x Did NOT assess the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:01:30 x Did NOT perform uterine massage, or performed it inappropriately.
00:01:30 x Did NOT perform pericare, or did NOT place clean peripad/chux/linen saver pad as needed.
00:01:30 x Did NOT call the practitioner for help and to report findings and interventions performed.
00:01:30 Did NOT review available standing orders.
00:01:30 x Did NOT prepare for second IV access.
00:01:30 x Did NOT anticipate need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:01:30 x Did NOT anticipate need for uterotonic medications.
00:01:30 x Did NOT examine IV/venipuncture sites for oozing/bleeding.
00:01:32 *******END SCENARIO******
00:01:35 **********
00:01:37
00:01:38
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00:01:54
00:01:55
00:01:55 **********OVERALL GRADE**********
00:01:55 GRADE: Completed 0/18 steps. 0%

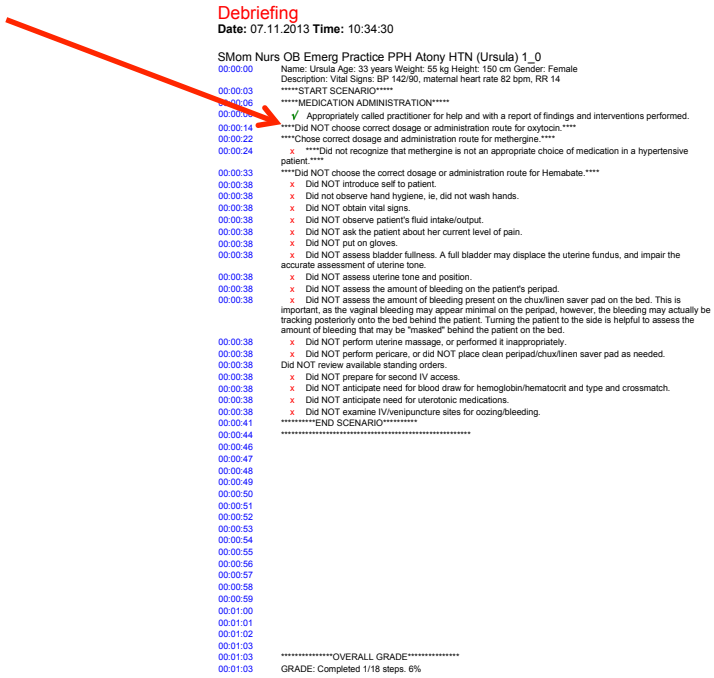
Debriefing
Date: 14.11.2013 **Time:** 15:39:28

SMom Nurs OB Emerg Testing PPH Atony Asthma (Fancy) 1_0

00:00:00 Name: Fancy Age: 40 years Weight: 80 kg Height: 170 cm Gender: Female
Description: Vital Signs: BP 132/78, maternal heart rate 80 bpm, RR 16. Peripad contained 100 cc of lochial blood on last postpartum check 15 minutes ago.
00:00:05 *****START SCENARIO*****
00:01:23 *****MEDICATION ADMINISTRATION*****
00:01:23 √ Appropriately called practitioner for help and with a report of findings and interventions performed.
00:01:26 ****Did NOT choose correct dosage or administration route for oxytocin.****
00:01:48 ****Did NOT choose correct dosage or administration route for Hemabate.****
00:01:54 √ ****Correctly recognized that Hemabate is NOT the appropriate uterotonic to be given to this patient. She has a medical history of asthma, and Hemabate has bronchoconstrictive properties. It is preferable to use another uterotonic medication.
00:01:58 ****Did NOT choose correct dosage or administration route for methergine.****
00:02:03
00:02:03 x Did NOT introduce self to patient.
00:02:03 x Did not observe hand hygiene, ie, did not wash hands.
00:02:03 x Did NOT obtain vital signs.
00:02:03 x Did NOT observe patient's fluid intake/output.
00:02:03 x Did NOT ask the patient about her current level of pain.
00:02:03 x Did NOT put on gloves.
00:02:03 x Did NOT assess bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:02:03 x Did NOT assess uterine tone and position.
00:02:03 x Did NOT assess the amount of bleeding on the patient's peripad.
00:02:03 x Did NOT assess the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:02:03 x Did NOT perform uterine massage, or performed it inappropriately.
00:02:03 x Did NOT perform pericare, or did NOT place clean peripad/chux/linen saver pad as needed.
00:02:03 Did NOT review available standing orders.
00:02:03 x Did NOT prepare for second IV access.
00:02:03 x Did NOT anticipate need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:02:03 x Did NOT anticipate need for uterotonic medications.
00:02:03 x Did NOT examine IV/venipuncture sites for oozing/bleeding.
00:02:04
00:02:05 **********NONTECHNICAL SCORE**********
00:02:07 FAIL. Learner not ready for clinical practice. Needs significant retraining.
00:02:12 *********END SCENARIO*********
00:02:15 **********

OB Emerg Nurs Practice PPH (Sarah) & OB Emerg Nurs Testing PPH (Fancy)

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage and Appropriate Uterotonic Medications Incorrect Debrief Log (Continued):



Debriefing
Date: 07.11.2013 **Time:** 10:34:30

SMom Nurs OB Emerg Practice PPH Atony HTN (Ursula) 1_0

00:00:00 Name: Ursula Age: 33 years Weight: 55 kg Height: 150 cm Gender: Female
Description: Vital Signs: BP 142/90, maternal heart rate 82 bpm, RR 14
00:00:03 *****START SCENARIO*****
00:00:06 *****MEDICATION ADMINISTRATION*****
00:00:08 √ Appropriately called practitioner for help and with a report of findings and interventions performed.
00:00:14 ****Did NOT choose correct dosage or administration route for oxytocin.****
00:00:22 ****Chose correct dosage and administration route for methergine.****
00:00:24 x ****Did not recognize that methergine is not an appropriate choice of medication in a hypertensive patient.****
00:00:33 ****Did NOT choose the correct dosage or administration route for Hemabate.****
00:00:38 x Did NOT introduce self to patient.
00:00:38 x Did not observe hand hygiene, ie, did not wash hands.
00:00:38 x Did NOT obtain vital signs.
00:00:38 x Did NOT observe patient's fluid intake/output.
00:00:38 x Did NOT ask the patient about her current level of pain.
00:00:38 x Did NOT put on gloves.
00:00:38 x Did NOT assess bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:00:38 x Did NOT assess uterine tone and position.
00:00:38 x Did NOT assess the amount of bleeding on the patient's peripad.
00:00:38 x Did NOT assess the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:00:38 x Did NOT perform uterine massage, or performed it inappropriately.
00:00:38 x Did NOT perform pericare, or did NOT place clean peripad/chux/linen saver pad as needed.
00:00:38 Did NOT review available standing orders.
00:00:38 x Did NOT prepare for second IV access.
00:00:38 x Did NOT anticipate need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:00:38 x Did NOT anticipate need for uterotonic medications.
00:00:38 x Did NOT examine IV/venipuncture sites for oozing/bleeding.
00:00:41 **********END SCENARIO**********
00:00:44 **********
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00:00:58
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00:01:00
00:01:01
00:01:02
00:01:03
00:01:03 **********OVERALL GRADE**********
00:01:03 GRADE: Completed 1/18 steps. 6%

OB Emerg Nurs Practice PPH (Ursula)

Note: The participant did not choose the correct medication dosage or administration route (highlighted comment). Also, note the comment that the participant did not recognize that the medication ordered was not the appropriate choice in this patient.

Postpartum Hemorrhage Due to Uterine Atony, Successfully Treated with Uterine Massage and Appropriate Uterotonic Medications Incorrect Debrief Log (Continued):

Debriefing
Date: 14.11.2013 **Time:** 15:33:15

SMom Nurs OB Emerg Testing PPH Atony (Victoria) 1_0

00:00:00	Name: Victoria Age: 24 years Weight: 75 kg Height: 172 cm Gender: Female
	Description: Vital Signs: BP 110/70, maternal heart rate 76 bpm.
00:00:03	*****START SCENARIO*****
00:01:41	*****MEDICATION ADMINISTRATION*****
00:01:41	√ Appropriately called practitioner for help and with a report of findings and interventions performed.
00:01:45	*****Did NOT choose correct dosage or administration route for oxytocin.*****
00:01:52	*****Did NOT choose correct dosage or administration route for methergine.*****
00:01:57	x Did NOT introduce self to patient.
00:01:57	x Did not observe hand hygiene, ie, did not wash hands.
00:01:57	x Did NOT obtain vital signs.
00:01:57	x Did NOT observe patient's fluid intake/output.
00:01:57	x Did NOT ask the patient about her current level of pain.
00:01:57	x Did NOT put on gloves.
00:01:57	x Did NOT assess bladder fullness. A full bladder may displace the uterine fundus, and impair the accurate assessment of uterine tone.
00:01:57	x Did NOT assess uterine tone and position.
00:01:57	x Did NOT assess the amount of bleeding on the patient's peripad.
00:01:57	x Did NOT assess the amount of bleeding present on the chux/linen saver pad on the bed. This is important, as the vaginal bleeding may appear minimal on the peripad, however, the bleeding may actually be tracking posteriorly onto the bed behind the patient. Turning the patient to the side is helpful to assess the amount of bleeding that may be "masked" behind the patient on the bed.
00:01:57	x Did NOT perform uterine massage, or performed it inappropriately.
00:01:57	x Did NOT perform pericare, or did NOT place clean peripad/chux/linen saver pad as needed.
00:01:57	Did NOT review available standing orders.
00:01:57	x Did NOT prepare for second IV access.
00:01:57	x Did NOT anticipate need for blood draw for hemoglobin/hematocrit and type and crossmatch.
00:01:57	x Did NOT anticipate need for uterotonic medications.
00:01:57	x Did NOT examine IV/venipuncture sites for oozing/bleeding.
00:02:00	
00:02:01	**********NONTECHNICAL SCORE**********
00:02:04	FAIL. Learner not ready for clinical practice. Needs significant retraining.
00:02:08	**********END SCENARIO**********
00:02:11	**********
00:02:13	
00:02:14	
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00:02:27	
00:02:28	
00:02:29	**********TECHNICAL SCORE**********
00:02:29	GRADE: Completed 1/17 steps. 6%

OB Emerg Nurs Testing PPH (Victoria)

Eclampsia Treated with Basic Supportive Therapy and Magnesium Sulfate Correct Debrief Log:

Debriefing
Date: 07.11.2013 **Time:** 10:40:47

SMom Nurs OB Emerg Practice Eclampsia (Bonnie) 1_0

00:00:00 Name: Bonnie Age: 26 years Weight: 70 kg Height: 160 cm Gender: Female
Description: BP 142/88, P82, RR14
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Variable dec: 0.2
00:00:03 Baseline variability: Minimal
00:00:03 Uterine activity: 03:10
00:00:03 FHR base: 111
00:00:05 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:07 √ Ensured the bedrails were in the upright, locked position.
00:00:09 √ Placed patient in left lateral decubitus position.
00:00:10 √ Requested suction apparatus at the bedside.
00:00:12 Attempted to place tongue blade - while major textbooks advise tongue blade placement, it may not be practical to attempt this maneuver due to the difficulty of the maneuver during active seizure activity. THIS IS NOT A GRADED STEP, AND THEREFORE NOT INCLUDED IN THE FINAL GRADE FOR THE SCENARIO.
00:00:14 √ Administered oxygen by facemask.
00:00:15 √ Reported seizure activity to practitioner for plan of treatment.
00:00:17 Baseline variability: Minimal
00:00:17 Uterine activity: 03:10
00:00:17 FHR base: 130
00:00:17 √ Administered a MgSO4 6 gm IV bolus.
00:00:19 √ Assessed the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:00:21 √ Assessed patient orientation after the seizure.
00:00:23 √ Assessed the patient's vital signs after seizure activity - this is important, as further treatment with hypertensives may be needed.
00:00:32 ********END SCENARIO********
00:00:37
00:00:37 **********OVERALL GRADE**********
00:00:37 GRADE: Completed 10/10 steps. 100%

Debriefing
Date: 14.11.2013 **Time:** 15:16:20

SMom Nurs OB Emerg Testing Eclampsia (Tatiana) 1_0

00:00:00 Name: Tatiana Age: 41 years Weight: 85 kg Height: 160 cm Gender: Female
Description: BP 150/96, P 84, RR 16
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Late dec: 0.57
00:00:03 Baseline variability: Absent
00:00:03 Uterine activity: Not in labor
00:00:03 FHR base: 110
00:00:04 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:09 √ Ensured the bedrails were in the upright, locked position.
00:00:13 √ Placed patient in left lateral decubitus position.
00:00:19 √ Requested suction apparatus at the bedside.
00:00:23 Attempted to place tongue blade - while major textbooks advise tongue blade placement, it may not be practical to attempt this maneuver due to the difficulty of the maneuver during active seizure activity. THIS IS NOT A GRADED STEP, AND THEREFORE NOT INCLUDED IN THE FINAL GRADE FOR THE SCENARIO.
00:00:26 √ Administered oxygen by facemask.
00:00:32 √ Reported seizure activity to practitioner for plan of treatment.
00:00:36 Fetal heart pattern: Normal
00:00:36 Baseline variability: Minimal
00:00:36 FHR base: 120
00:00:36 √ Administered a MgSO4 6 gm IV bolus.
00:00:39 √ Assessed the patient's vital signs after seizure activity - this is important, as further treatment with hypertensives may be needed.
00:00:42 √ Assessed patient orientation after the seizure.
00:00:47 √ Assessed the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:00:52
00:00:53 **********NONTECHNICAL SCORE**********
00:00:57 PASS. Learner appears ready for clinical practice.
00:01:01 ********END SCENARIO********
00:01:06
00:01:06 **********TECHNICAL SCORE**********
00:01:06 Completed 10/10 steps. 100%

OB Emerg Nurs Practice Eclampsia (Bonnie) & OB Emerg Nurs Testing Eclampsia (Tatiana)

Eclampsia Treated with Basic Supportive Therapy and Magnesium Sulfate Correct Debrief Log (Continued):

Debriefing
Date: 07.11.2013 **Time:** 10:46:46

SMom Nurs OB Emerg Practice Eclampsia (Francine) 1_0

00:00:00 Name: Francine Age: 39 years Weight: 80 kg Height: 162 cm Gender: Female
Description: BP 140/90 HR 82, RR 12
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Late dec: 0.57
00:00:03 Baseline variability: Absent
00:00:03 Uterine activity: Not in labor
00:00:03 FHR base: 110
00:00:09 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:11 √ Ensured the bedrails were in the upright, locked position.
00:00:13 √ Placed patient in left lateral decubitus position.
00:00:15 √ Requested suction apparatus at the bedside.
00:00:17 √ Administered oxygen by facemask.
00:00:19 Attempted to place tongue blade - while major textbooks advise tongue blade placement, it may not be practical to attempt this maneuver due to the difficulty of the maneuver during active seizure activity. THIS IS NOT A GRADED STEP, AND THEREFORE NOT INCLUDED IN THE FINAL GRADE FOR THE SCENARIO.
00:00:21 *******MEDICATION*******
00:00:21 √ Reported seizure activity to practitioner for plan of treatment.
00:00:23 √ Recognized that the MgSO4 2 gm IV bolus dosage is an inadequate dosage for a first eclamptic seizure, and/or calls the practitioner for clarification.
00:00:32 Baseline variability: Minimal
00:00:32 Uterine activity: 05:10
00:00:32 FHR base: 120
00:00:32 √ Chose to administer the correct MgSO4 IV bolus dose of 4-6 gm for a first eclamptic seizure in a patient not currently on magnesium therapy.
00:00:36 √ Assessed the fetal heart rate tracing and external uterine monitor. Assessment of fetal well being and evaluation of uterine activity is indicated after the seizure activity has ceased.
00:00:37 *****POSTSEIZURE RECOVERY ASSESSMENT*****
00:00:38 √ Assessed patient orientation.
00:00:40 √ Assessed the patient's vital signs after seizure activity - this is important, as further treatment with hypertensives may be needed.
00:00:45 ********END SCENARIO********
00:00:50
00:00:50 GRADE: Completed 11/11 steps. 100%

Debriefing
Date: 14.11.2013 **Time:** 15:08:59

SMom Nurs OB Emerg Testing Eclampsia (Corrine) 1_1

00:00:00 Name: Corrine Age: 23 years Weight: 60 kg Height: 170 cm Gender: Female
Description: BP 160/98, P 82, RR 14
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Periodic Variable Decelerations
00:00:03 Baseline variability: Minimal
00:00:03 Uterine activity: 05:10
00:00:03 FHR base: 111
00:00:06 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:09 √ Ensured the bedrails were in the upright, locked position.
00:00:12 √ Placed patient in left lateral decubitus position.
00:00:16 √ Requested suction apparatus at the bedside.
00:00:18 √ Administered oxygen by facemask.
00:00:22 *******MEDICATION*******
00:00:22 √ Reported seizure activity to practitioner for plan of treatment.
00:00:27 √ Recognized that the MgSO4 2 gm IV bolus dosage is an inadequate dosage for a first eclamptic seizure, and/or calls the practitioner for clarification.
00:00:32 Baseline variability: Minimal
00:00:32 Uterine activity: 05:10
00:00:32 FHR base: 120
00:00:32 √ Chose to administer the correct MgSO4 IV bolus dose of 4-6 gm for a first eclamptic seizure in a patient not currently on magnesium therapy.
00:00:36 √ Assessed the patient's vital signs after seizure activity - this is important, as further treatment with hypertensives may be needed.
00:00:37 *****POSTSEIZURE RECOVERY ASSESSMENT*****
00:00:38 √ Assessed patient orientation.
00:00:43 √ Assessed the fetal heart rate tracing and external uterine monitor. Assessment of fetal well being and evaluation of uterine activity is indicated after the seizure activity has ceased.
00:00:50
00:00:51 **********NONTECHNICAL SCORE**********
00:00:59 PASS. Learner appears ready for clinical practice.
00:01:03 ********END SCENARIO********
00:01:08
00:01:08 ***************TECHNICAL SCORE***************
00:01:08 GRADE: Completed 11/11 steps. 100%

OB Emerg Nurs Practice Eclampsia (Francine) & OB Emerg Nurs Testing Eclampsia (Corrine)

Eclampsia Treated with Basic Supportive Therapy and Magnesium Sulfate Incorrect Debrief Log:

Debriefing
Date: 07.11.2013 **Time:** 10:42:39

SMom Nurs OB Emerg Practice Eclampsia (Bonnie) 1_0
00:00:00 Name: Bonnie Age: 26 years Weight: 70 kg Height: 160 cm Gender: Female
Description: BP 142/88, P82, RR14
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Variable dec: 0.2
00:00:03 Baseline variability: Minimal
00:00:03 Uterine activity: 03:10
00:00:03 FHR base: 111
00:01:10 ********END SCENARIO********
00:01:10 x Did NOT request additional assistance. Assistance will be needed to help in positioning the patient, administering medications, and possibly securing the airway if needed, possible delivery of the baby.
00:01:10 x Did NOT ensure the bedrails were in the upright, locked position. This is important to ensure the patient does not fall out of the bed during seizure activity.
00:01:10 x Did NOT place patient in left lateral decubitus position. This is important to improve placental perfusion by displacing the uterus from the maternal great vessels in the pelvis, but especially to decrease the risk of aspiration from possible vomitus during seizure activity.
00:01:10 x Did NOT request suction apparatus at the bedside. This is needed to decrease the risk of aspiration from possible vomitus and patient oral secretions during seizure activity.
00:01:10 x Did NOT administer oxygen by facemask - supplemental oxygen should be administered.
00:01:10 x Did NOT assess the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:01:10 x Did NOT administer MgSO4 6 gm IV bolus. This is the appropriate medication to be given to a patient with an eclamptic seizure.
00:01:10 x Did NOT report seizure activity to practitioner for plan of treatment.
00:01:10 x Did NOT assess the patient's orientation after the seizure.
00:01:10 x Did NOT assess the patient's vital signs after seizure activity. This is important, as the patient may need further treatment for hypertension.
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00:01:25 **********OVERALL GRADE**********
00:01:25 GRADE: Completed 0/10 steps. 0%

Debriefing
Date: 14.11.2013 **Time:** 15:18:27

SMom Nurs OB Emerg Testing Eclampsia (Tatiana) 1_0
00:00:00 Name: Tatiana Age: 41 years Weight: 85 kg Height: 160 cm Gender: Female
Description: BP 150/96, P 84, RR 16
00:00:04 *******START SCENARIO*******
00:00:04 Fetal heart pattern: Late dec: 0.57
00:00:04 Baseline variability: Absent
00:00:04 Uterine activity: Not in labor
00:00:04 FHR base: 110
00:01:07 x Did NOT request additional assistance. Assistance will be needed to help in positioning the patient, administering medications, and possibly securing the airway if needed, possible delivery of the baby.
00:01:07 x Did NOT ensure the bedrails were in the upright, locked position. This is important to ensure the patient does not fall out of the bed during seizure activity.
00:01:07 x Did NOT place patient in left lateral decubitus position. This is important to improve placental perfusion by displacing the uterus from the maternal great vessels in the pelvis, but especially to decrease the risk of aspiration from possible vomitus during seizure activity.
00:01:07 x Did NOT request suction apparatus at the bedside. This is needed to decrease the risk of aspiration from possible vomitus and patient oral secretions during seizure activity.
00:01:07 x Did NOT administer oxygen by facemask - supplemental oxygen should be administered.
00:01:07 x Did NOT assess the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:01:07 x Did NOT administer MgSO4 6 gm IV bolus. This is the appropriate medication to be given to a patient with an eclamptic seizure.
00:01:07 x Did NOT report seizure activity to practitioner for plan of treatment.
00:01:07 x Did NOT assess the patient's orientation after the seizure.
00:01:07 x Did NOT assess the patient's vital signs after seizure activity. This is important, as the patient may need further treatment for hypertension.
00:01:10
00:01:11 **********NONTECHNICAL SCORE**********
00:01:11 FAIL. Learner not ready for clinical practice. Needs significant retraining.
00:01:15 ********END SCENARIO********
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00:01:30
00:01:30 **********TECHNICAL SCORE**********
00:01:30 Completed 0/10 steps. 0%

OB Emerg Nurs Practice Eclampsia (Bonnie) & OB Emerg Nurs Testing Eclampsia (Tatiana)

Eclampsia Treated with Basic Supportive Therapy and Magnesium Sulfate Incorrect Debrief Log (Continued):

Debriefing
Date: 07.11.2013 **Time:** 10:50:49

SMom Nurs OB Emerg Practice Eclampsia (Francine) 1_0

00:00:00 Name: Francine Age: 39 years Weight: 80 kg Height: 162 cm Gender: Female
Description: BP 140/90 HR 82, RR 12
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Late dec: 0.57
00:00:03 Baseline variability: Absent
00:00:03 Uterine activity: Not in labor
00:00:03 FHR base: 110
00:00:04 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:05 *******MEDICATION*******
00:00:05 √ Reported seizure activity to practitioner for plan of treatment.
00:00:09 x Administered MgSO4 2 gm IV bolus. This is not the appropriate first dose for an eclamptic seizure. A bolus dose of 6 gm of MgSO4 IV with a continuous infusion is recommended in pregnant patients with seizure activity due to eclampsia. MgSO4 2 gm IV bolus is appropriate in the patient with seizure activity occuring while already on a MgSO4 infusion.
00:00:13 x Did NOT choose the appropriate medication for a patient with a first eclamptic seizure, not currently on magnesium therapy. The appropriate medication is MgSO4 4-6 gm IV bolus, with a 2 gm/hr IV infusion.
00:00:16 x Did NOT ensure the bedrails were in the upright, locked position. This is important to ensure the patient does not fall out of the bed during seizure activity.
00:00:16 x Did NOT place patient in left lateral decubitus position. This is important to improve placental perfusion by displacing the uterus from the maternal great vessels in the pelvis, but especially to decrease the risk of aspiration from possible vomitus during seizure activity.
00:00:16 x Did NOT request suction apparatus at the bedside. This is needed to decrease the risk of aspiration from possible vomitus and patient oral secretions during seizure activity.
00:00:16 x Did NOT administer oxygen by facemask - supplemental oxygen should be administered.
00:00:18 *****POSTSEIZURE RECOVERY ASSESSMENT*****
00:00:21 x Did NOT attempt to assess patient orientation.
00:00:21 x Did NOT assess the patient's vital signs after seizure activity. This is important, as the patient may need further treatment for hypertension.
00:00:21 x Did NOT assess the fetal heart rate or external uterine monitor. Assessment of fetal well being and uterine activity is indicated after seizure activity has ceased.
00:00:24 ********END SCENARIO********
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00:00:37
00:00:38
00:00:38 **********OVERALL GRADE**********
00:00:38 GRADE: Completed 2/11 steps. 18%

Debriefing
Date: 14.11.2013 **Time:** 15:14:12

SMom Nurs OB Emerg Testing Eclampsia (Corrine) 1_1

00:00:00 Name: Corrine Age: 23 years Weight: 60 kg Height: 170 cm Gender: Female
Description: BP 160/98, P 82, RR 14
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Periodic Variable Decelerations
00:00:03 Baseline variability: Minimal
00:00:03 Uterine activity: 05:10
00:00:03 FHR base: 111
00:00:05 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:09 √ Ensured the bedrails were in the upright, locked position.
00:00:12 √ Placed patient in left lateral decubitus position.
00:00:15 Attempted to place tongue blade - while major textbooks advise tongue blade placement, it may not be practical to attempt this maneuver due to the difficulty of the maneuver during active seizure activity. THIS IS NOT A GRADED STEP, AND THEREFORE NOT INCLUDED IN THE FINAL GRADE FOR THE SCENARIO.
00:00:17 *******MEDICATION*******
00:00:17 √ Reported seizure activity to practitioner for plan of treatment.
00:00:19 x Administered MgSO4 2 gm IV bolus. This is not the appropriate first dose for an eclamptic seizure. A bolus dose of 6 gm of MgSO4 IV with a continuous infusion is recommended in pregnant patients with seizure activity due to eclampsia. MgSO4 2 gm IV bolus is appropriate in the patient with seizure activity occuring while already on a MgSO4 infusion.
00:00:25 x Did NOT choose the appropriate medication for a patient with a first eclamptic seizure, not currently on magnesium therapy. The appropriate medication is MgSO4 4-6 gm IV bolus, with a 2 gm/hr IV infusion.
00:00:28 x Did NOT request suction apparatus at the bedside. This is needed to decrease the risk of aspiration from possible vomitus and patient oral secretions during seizure activity.
00:00:28 x Did NOT administer oxygen by facemask - supplemental oxygen should be administered.
00:00:36 √ Assessed patient orientation.
00:00:41 x Did NOT assess the patient's vital signs after seizure activity. This is important, as the patient may need further treatment for hypertension.
00:00:41 x Did NOT assess the fetal heart rate or external uterine monitor. Assessment of fetal well being and uterine activity is indicated after seizure activity has ceased.
00:00:44
00:00:45 **********NONTECHNICAL SCORE**********
00:00:48 FAIL. Learner not ready for clinical practice. Needs significant retraining.
00:00:52 ********END SCENARIO********
00:00:57
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00:01:03 **********TECHNICAL SCORE**********
00:01:03 GRADE: Completed 5/11 steps. 45%

OB Emerg Nurs Practice Eclampsia (Francine) & OB Emerg Nurs Testing Eclampsia (Corrine)

Eclampsia Treated with Basic Supportive Therapy and Magnesium Sulfate Complicated by Magnesium Toxicity Correct Debrief Log:

Debriefing
Date: 14.11.2013 **Time:** 14:42:38

SMom Nurs OB Emerg Practice Eclampsia (Marilyn) 1_0

00:00:00 Name: Marilyn Age: 17 years Weight: 50 kg Height: 160 cm Gender: Female
Description: BP 140/100, HR 90, RR 16 She just had an IV placed upon arrival with 100 cc/hr crystalloid infusing.
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Normal
00:00:03 Baseline variability: Minimal
00:00:03 FHR base: 120
00:00:06 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:09 √ Ensured the bedrails were in the upright, locked position.
00:00:13 √ Placed patient in left lateral decubitus position.
00:00:17 √ Administered oxygen by facemask.
00:00:20 √ Requested suction apparatus at the bedside.
00:00:23 √ Reported seizure activity to practitioner for plan of treatment.
00:00:29 √ Administered a MgSO4 6 gm IV bolus.
00:00:32 √ Assessed the patient's vital signs after seizure activity - this is important, as further treatment with hypertensives may be needed.
00:00:35 √ Assessed patient orientation after the seizure.
00:00:40 √ Assessed the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:00:49 Fetal heart pattern: Normal
00:00:49 Baseline variability: Minimal
00:00:49 FHR base: 110
00:00:50 ----------MgSO4 toxicity----------
00:01:03 √ Correctly made the diagnosis of probable MgSO4 toxicity.
00:01:05 √ Correctly ordered discontinuation of the MgSO4 infusion.
00:01:07 √ Appropriately assisted breathing efforts with bag/valve/mask. As the breathing rate is only 2 breaths per minute, breathing assistance is indicated.
00:01:10 √ Correctly administered calcium gluconate to counteract the MgSO4 effects on the patient.
00:01:12 Correctly diagnosed probable MgSO4 toxicity, but did not complete all recommended procedures for resolution of MgSO4 toxicity in the 7 minutes allotted time for the scenario.
00:01:13 √ Correctly managed probable MgSO4 toxicity.
00:01:14 **********END SCENARIO**********
00:01:19
00:01:19 **********OVERALL GRADE**********
00:01:19 GRADE: Completed 14/14 steps. 100%

Debriefing
Date: 14.11.2013 **Time:** 15:20:59

SMom Nurs OB Emerg Testing Eclampsia (Tiffany) 1_0

00:00:00 Name: Tiffany Age: 19 years Weight: 70 kg Height: 155 cm Gender: Female
Description: BP 158/98, P 72, RR 14 Labs have been drawn, and an IV of 100 cc/hr of crystalloid has been placed.
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Normal
00:00:03 Baseline variability: Minimal
00:00:03 Uterine activity: 04:10
00:00:03 FHR base: 120
00:00:07 √ Requested additional assistance, consisting at least of additional nurse, physician, possibly anesthesia.
00:00:11 √ Ensured the bedrails were in the upright, locked position.
00:00:15 √ Placed patient in left lateral decubitus position.
00:00:18 √ Requested suction apparatus at the bedside.
00:00:20 √ Administered oxygen by facemask.
00:00:23 Attempted to place tongue blade - while major textbooks advise tongue blade placement, it may not be practical to attempt this maneuver due to the difficulty of the maneuver during active seizure activity. THIS IS NOT A GRADED STEP, AND THEREFORE NOT INCLUDED IN THE FINAL GRADE FOR THE SCENARIO.
00:00:25 √ Reported seizure activity to practitioner for plan of treatment.
00:00:28 √ Administered a MgSO4 6 gm IV bolus.
00:00:32 √ Assessed the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:00:34 √ Assessed patient orientation after the seizure.
00:00:39 √ Assessed the patient's vital signs after seizure activity - this is important, as further treatment with hypertensives may be needed.
00:00:48 Fetal heart pattern: Normal
00:00:48 Baseline variability: Minimal
00:00:49 ----------MgSO4 toxicity----------
00:01:02 √ Correctly made the diagnosis of probable MgSO4 toxicity.
00:01:06 √ Correctly ordered discontinuation of the MgSO4 infusion.
00:01:08 √ Correctly administered calcium gluconate to counteract the MgSO4 effects on the patient.
00:01:11 √ Appropriately assisted breathing efforts with bag/valve/mask. As the breathing rate is only 2 breaths per minute, breathing assistance is indicated.
00:01:14 FHR base: 120
00:01:14 √ Correctly managed probable MgSO4 toxicity.
00:01:26
00:01:27 **********NONTECHNICAL SCORE**********
00:01:28 PASS. Learner appears ready for clinical practice.
00:01:31 **********END SCENARIO**********
00:01:36
00:01:36 **********TECHNICAL SCORE**********
00:01:36 Completed 14/14 steps. 100%

OB Emerg Nurs Practice Eclampsia (Marilyn) & OB Emerg Nurs Testing Eclampsia (Tiffany)

Note: View the highlighted section “------MgSO4 toxicity-----," after which the steps that the participant performed to treat magnesium toxicity are outlined for review.

Eclampsia Treated with Basic Supportive Therapy and Magnesium Sulfate Complicated by Magnesium Toxicity Incorrect Debrief Log:

Debriefing
Date: 07.11.2013 **Time:** 10:55:50

SMom Nurs OB Emerg Practice Eclampsia (Marilyn) 1_0

00:00:00 Name: Marilyn Age: 17 years Weight: 50 kg Height: 160 cm Gender: Female
Description: BP 140/100, HR 90, RR 16 She just had an IV placed upon arrival with 100 cc/hr crystalloid infusing.
00:00:03 *******START SCENARIO*******
00:00:03 Fetal heart pattern: Normal
00:00:03 Baseline variability: Minimal
00:00:03 FHR base: 120
00:01:03 **********END SCENARIO**********
00:01:03 x Did NOT request additional assistance. Assistance will be needed to help in positioning the patient, administering medications, and possibly securing the airway if needed, possible delivery of the baby.
00:01:03 x Did NOT ensure the bedrails were in the upright, locked position. This is important to ensure the patient does not fall out of the bed during seizure activity.
00:01:03 x Did NOT place patient in left lateral decubitus position. This is important to improve placental perfusion by displacing the uterus from the maternal great vessels in the pelvis, but especially to decrease the risk of aspiration from possible vomitus during seizure activity.
00:01:03 x Did NOT request suction apparatus at the bedside. This is needed to decrease the risk of aspiration from possible vomitus and patient oral secretions during seizure activity.
00:01:03 x Did NOT administer oxygen by facemask - supplemental oxygen should be administered.
00:01:03 x Did NOT assess the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:01:03 x Did NOT administer MgSO4 6 gm IV bolus. This is the appropriate medication to be given to a patient with an eclamptic seizure.
00:01:03 x Did NOT report seizure activity to practitioner for plan of treatment.
00:01:03 x Did NOT assess the patient's orientation after the seizure.
00:01:03 x Did NOT assess the patient's vital signs after seizure activity. This is important, as the patient may need further treatment for hypertension.
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00:01:22 **********OVERALL GRADE**********
00:01:22 GRADE: Completed 0/14 steps. 0%

Debriefing
Date: 14.11.2013 **Time:** 15:25:26

SMom Nurs OB Emerg Testing Eclampsia (Tiffany) 1_0

00:00:00 Name: Tiffany Age: 19 years Weight: 70 kg Height: 155 cm Gender: Female
Description: BP 158/98, P 72, RR 14 Labs have been drawn, and an IV of 100 cc/hr of crystalloid has been placed.
00:00:02 *******START SCENARIO*******
00:00:02 Fetal heart pattern: Normal
00:00:02 Baseline variability: Minimal
00:00:02 Uterine activity: 04:10
00:00:02 FHR base: 120
00:02:25 √ Administered a MgSO4 6 gm IV bolus.
00:02:36 √ Assessed the fetal heart rate and external uterine monitoring. This is indicated to evaluate fetal well being and uterine activity after an eclamptic episode.
00:02:40 √ Assessed patient orientation after the seizure.
00:02:44 √ Assessed the patient's vital signs after seizure activity - this is important, as further treatment with hypertensives may be needed.
00:03:02 x Scenario ended due to participant's failure to notify the patient's practitioner to allow for appropriate treatment of the seizure within the allotted 3 minutes. Supportive treatment of the patient is appropriate, however, the patient's practitioner needs to be aware of the seizure event so that timely treatment can be begun to avoid repeat seizure activity.
00:03:05
00:03:06 **********NONTECHNICAL SCORE**********
00:03:39 FAIL. Learner not ready for clinical practice. Needs significant retraining.
00:03:42 **********END SCENARIO**********
00:03:42 x Did NOT request additional assistance. Assistance will be needed to help in positioning the patient, administering medications, and possibly securing the airway if needed, possible delivery of the baby.
00:03:42 x Did NOT ensure the bedrails were in the upright, locked position. This is important to ensure the patient does not fall out of the bed during seizure activity.
00:03:42 x Did NOT place patient in left lateral decubitus position. This is important to improve placental perfusion by displacing the uterus from the maternal great vessels in the pelvis, but especially to decrease the risk of aspiration from possible vomitus during seizure activity.
00:03:42 x Did NOT request suction apparatus at the bedside. This is needed to decrease the risk of aspiration from possible vomitus and patient oral secretions during seizure activity.
00:03:42 x Did NOT administer oxygen by facemask - supplemental oxygen should be administered.
00:03:42 x Did NOT report seizure activity to practitioner for plan of treatment.
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00:03:56
00:03:57
00:03:57 **********TECHNICAL SCORE**********
00:03:57 Completed 4/14 steps. 28%

OB Emerg Nurs Practice Eclampsia (Marilyn) & OB Emerg Nurs Testing Eclampsia (Tiffany)

Shoulder Dystocia with Nursing Maneuvers and Basic Infant Assessment Correct Debrief Log:

Debriefing
Date: 14.11.2013 **Time:** 14:53:25

SMom Nurs OB Emerg Practice SD (Nora) 1_0
00:00:00 Name: Nora Age: 39 years Weight: 60 kg Height: 155 cm Gender: Female
Description: Maternal vital signs: BP 116/70, pulse 80 bpm Fetal heart rate 125 - 130 bpm with good beat to beat variability, no fetal heart rate decelerations. Uterine contractions are occurring every 3 minutes.
00:00:08 **********START SCENARIO**********
00:00:08 Baseline variability: Minimal
00:00:08 Uterine activity: 05:10
00:00:08 FHR base: 125
00:00:15 √ Made the diagnosis of shoulder dystocia.
00:00:18 √ Noted delivery time of the fetal head.
00:00:21 √ Requested nursing assistance.
00:00:24 √ Requested pediatric presence in the room for possible resuscitation of the baby.
00:00:28 √ Instructed the mother NOT to push.
00:00:31 √ Put on clean gloves.
00:00:34 √ Lowered the head of the bed in preparation for maneuvers to free the fetal anterior impacted shoulder.
00:00:37 √ Communicated the problem with the patient and family in the room.
00:00:40 √ Positioned patient in the McRoberts position.
00:00:43 √ Stepped up on a bedside stepstool to aid in providing adequate downward pressure during suprapubic pressure maneuver.
00:00:47 √ Correctly applied suprapubic pressure.
00:00:53 FHR base: 30
00:00:53 *****NEWBORN ASSESSMENT*****
00:00:53 √ Correctly noted the time of delivery of the entire baby's body. Other necessary documentation includes the maneuvers attempted, and which maneuver resulted in successful delivery.
00:01:00 √ Placed the infant on a radiant warmer for evaluation of possible injury and in preparation for resuscitation if needed.
00:01:04 √ Dried the baby with a towel to allow for warming to occur.
00:01:10 √ Correctly communicated assessment of the baby's breathing efforts.
00:01:14 √ Correctly communicated assessment of the baby's heart rate.
00:01:19 √ Assessed the infant for evidence of injury. This assessment should include examination of the humerus and clavicle for fracture, and arm movement for possible brachial plexus injury.
00:01:34 √ Correctly assigned a one minute Apgar score of 9.
00:01:40 **********END SCENARIO**********
00:01:43 **********
00:01:45
00:01:45 **********OVERALL GRADE**********
00:01:45 GRADE: Completed 18/18 steps. 100%

Debriefing
Date: 14.11.2013 **Time:** 16:01:48

SMom Nurs OB Emerg Testing SD (Madeline) 1_0
00:00:00 Name: Madeline Age: 19 years Weight: 60 kg Height: 160 cm Gender: Female
Description: Maternal BP 110/68, pulse 76. Uterine contractions occurring every 3 minutes. Fetal heart rate 130 - 135 with good beat to beat variability and no decelerations.
00:00:04 **********START SCENARIO**********
00:00:04 Uterine activity: 03:10
00:00:04 FHR base: 135
00:00:08 √ Made the diagnosis of shoulder dystocia.
00:00:09 √ Noted delivery time of the fetal head.
00:00:11 √ Requested nursing assistance.
00:00:13 √ Requested pediatric presence in the room for possible resuscitation of the baby.
00:00:16 √ Communicated the problem with the patient and family in the room.
00:00:19 √ Instructed the mother NOT to push.
00:00:22 √ Lowered the head of the bed in preparation for maneuvers to free the fetal anterior impacted shoulder.
00:00:24 √ Put on clean gloves.
00:00:28 √ Positioned patient in the McRoberts position.
00:00:31 √ Stepped up on a bedside stepstool to aid in providing adequate downward pressure during suprapubic pressure maneuver.
00:00:34 √ Correctly applied suprapubic pressure.
00:00:39 FHR base: 30
00:00:39 *****NEWBORN ASSESSMENT*****
00:00:39 √ Correctly noted the time of delivery of the entire baby's body. Other necessary documentation includes the maneuvers attempted, and which maneuver resulted in successful delivery.
00:00:42 √ Placed the infant on a radiant warmer for evaluation of possible injury and in preparation for resuscitation if needed.
00:00:45 √ Dried the baby with a towel to allow for warming to occur.
00:00:48 √ Correctly communicated assessment of the baby's breathing efforts.
00:00:51 √ Correctly communicated assessment of the baby's heart rate.
00:00:54 √ Assessed the infant for evidence of injury. This assessment should include examination of the humerus and clavicle for fracture, and arm movement for possible brachial plexus injury.
00:01:00 √ Correctly assigned a one minute Apgar score of 9.
00:01:05
00:01:06 **********NONTECHNICAL SCORE**********
00:01:07 PASS. Learner appears ready for clinical practice.
00:01:10 **********END SCENARIO**********
00:01:13 **********
00:01:15
00:01:15 **********TECHNICAL SCORE**********
00:01:15 GRADE: Completed 18/18 steps. 100%

OB Emerg Nurs Practice Shoulder Dystocia (Nora) & OB Emerg Nurs Testing Shoulder Dystocia (Madeline)

Note: View the highlighted section **NEWBORN ASSESSMENT**. This section outlines the steps the participant did/did not perform in assessing and performing basic resuscitation efforts of the newborn after shoulder dystocia.

Shoulder Dystocia with Nursing Maneuvers and Basic Infant Assessment Correct Debrief Log (Continued):

Debriefing
Date: 07.11.2013 **Time:** 11:20:19

SMom Nurs OB Emerg Practice SD (Sarah) 1_0

00:00:00 Name: Sarah Age: 26 years Weight: 65 kg Height: 170 cm Gender: Female
00:00:04 **********START SCENARIO**********
00:00:04 Uterine activity: 05:10
00:00:04 FHR base: 125
00:00:12 √ Made the diagnosis of shoulder dystocia.
00:00:15 √ Noted delivery time of the fetal head.
00:00:17 √ Requested nursing assistance.
00:00:19 √ Requested pediatric presence in the room for possible resuscitation of the baby.
00:00:21 √ Instructed the mother NOT to push.
00:00:24 √ Communicated the problem with the patient and family in the room.
00:00:26 √ Lowered the head of the bed in preparation for maneuvers to free the fetal anterior impacted shoulder.
00:00:28 √ Put on clean gloves.
00:00:31 √ Positioned patient in the McRoberts position.
00:00:34 √ Stepped up on a bedside stepstool to aid in providing adequate downward pressure during suprapubic pressure maneuver.
00:00:35 √ Correctly applied suprapubic pressure.
00:00:41 FHR base: 30
00:00:41 *****NEWBORN ASSESSMENT*****
00:00:51 √ Correctly noted the time of delivery of the entire baby's body. Other necessary documentation includes the maneuvers attempted, and which maneuver resulted in successful delivery.
00:00:53 √ Placed the infant on a radiant warmer for evaluation of possible injury and in preparation for resuscitation if needed.
00:00:55 √ Dried the baby with a towel to allow for warming to occur.
00:00:56 √ Correctly communicated assessment of the baby's breathing efforts.
00:00:57 √ Correctly communicated assessment of the baby's heart rate.
00:00:58 √ Assessed the infant for evidence of injury. This assessment should include examination of the humerus and clavicle for fracture, and arm movement for possible brachial plexus injury.
00:01:02 √ Correctly assigned a one minute Apgar score of 8.
00:01:08 **********END SCENARIO**********
00:01:11 **********
00:01:13
00:01:13 **********OVERALL GRADE**********
00:01:13 GRADE: Completed 18/18 steps. 100%

Debriefing
Date: 14.11.2013 **Time:** 15:51:16

SMom Nurs OB Emerg Testing SD (Kendall) 1_0

00:00:00 Name: Kendall Age: 28 years Weight: 80 kg Height: 165 cm Gender: Female
Description: Maternal BP 130/78, pulse 82. Uterine contractions occurring every 3 minutes. Fetal heart rate 130 - 135 with good beat to beat variability and no decelerations.
00:00:03 **********START SCENARIO**********
00:00:03 Uterine activity: 03:10
00:00:03 FHR base: 135
00:00:03 *****DELIVERY OF BABY*****
00:00:08 √ Made the diagnosis of shoulder dystocia.
00:00:11 √ Noted delivery time of the fetal head.
00:00:15 √ Requested nursing assistance.
00:00:18 √ Requested pediatric presence in the room for possible resuscitation of the baby.
00:00:21 √ Communicated the problem with the patient and family in the room.
00:00:24 √ Instructed the mother NOT to push.
00:00:27 √ Lowered the head of the bed in preparation for maneuvers to free the fetal anterior impacted shoulder.
00:00:31 √ Put on clean gloves.
00:00:35 √ Positioned patient in the McRoberts position.
00:00:38 √ Stepped up on a bedside stepstool to aid in providing adequate downward pressure during suprapubic pressure maneuver.
00:00:41 √ Correctly applied suprapubic pressure.
00:00:48 Uterine activity: Not in labor
00:00:48 FHR base: 30
00:00:48 *****NEWBORN ASSESSMENT*****
00:00:49 √ Correctly noted the time of delivery of the entire baby's body. Other necessary documentation includes the maneuvers attempted, and which maneuver resulted in successful delivery.
00:00:53 √ Placed the infant on a radiant warmer for evaluation of possible injury and in preparation for resuscitation if needed.
00:00:56 √ Dried the baby with a towel to allow for warming to occur.
00:00:59 √ Correctly communicated assessment of the baby's breathing efforts.
00:01:03 √ Correctly communicated assessment of the baby's heart rate.
00:01:07 √ Assessed the infant for evidence of injury. This assessment should include examination of the humerus and clavicle for fracture, and arm movement for possible brachial plexus injury.
00:01:14 √ Correctly assigned a one minute Apgar score of 8.
00:01:19
00:01:20 **********NONTECHNICAL SCORE**********
00:01:21 PASS. Learner appears ready for clinical practice.
00:01:24 **********END SCENARIO**********
00:01:27 **********
00:01:29
00:01:29 **********TECHNICAL SCORE**********
00:01:29 GRADE: Completed 18/18 steps. 100%

OB Emerg Nurs Practice Shoulder Dystocia (Sarah) & OB Emerg Nurs Testing Shoulder Dystocia (Kendall)

Shoulder Dystocia with Nursing Maneuvers and Basic Infant Assessment Incorrect Debrief Log:

Debriefing

Date: 07.11.2013 **Time:** 11:17:57

SMom Nurs OB Emerg Practice SD (Nora) 1_0

00:00:00 Name: Nora Age: 39 years Weight: 60 kg Height: 155 cm Gender: Female
Description: Maternal vital signs: BP 116/70, pulse 80 bpm Fetal heart rate 125 - 130 bpm with good beat to beat variability, no fetal heart rate decelerations. Uterine contractions are occurring every 3 minutes.
00:00:03 **********START SCENARIO**********
00:00:03 Baseline variability: Minimal
00:00:03 Uterine activity: 05:10
00:00:03 FHR base: 125
00:00:10 √ Instructed the mother NOT to push.
00:00:14 √ Stepped up on a bedside stepstool to aid in providing adequate downward pressure during suprapubic pressure maneuver.
00:00:17 x Incorrectly applied FUNDAL pressure. Fundal pressure should NEVER be employed as a maneuver to relieve shoulder dystocia. This may result in worsening of the fetal shoulder impaction, or even uterine rupture.
00:00:25 √ Positioned patient in the McRoberts position.
00:00:35 x Incorrectly applied FUNDAL pressure. Fundal pressure should NEVER be employed as a maneuver to relieve shoulder dystocia. This may result in worsening of the fetal shoulder impaction, or even uterine rupture.
00:00:37 x Did NOT make the diagnosis of shoulder dystocia.
00:00:37 x Did NOT request nursing assistance. Nursing assistance is needed to help with maneuvers that may be necessary to facilitate delivery of the baby.
00:00:37 x Did NOT request pediatric presence in the delivery room. Pediatric presence is necessary for evaluation of the baby, and possible resuscitation of the baby, in the event of delay of delivery due to shoulder dystocia.
00:00:37 x Did NOT correctly apply suprapubic pressure.
00:00:37 x Did NOT note the delivery time of the fetal head.
00:00:37 x Did NOT communicate the problem with the patient and family in the room.
00:00:37 x Did NOT lower the head of the head in anticipation of performance of maneuvers to free the fetal anterior impacted shoulder.
00:00:37 x Did NOT put on clean gloves.
00:00:40 FHR base: 30
00:00:40 *****NEWBORN ASSESSMENT*****
00:00:52 √ Correctly noted the time of delivery of the entire baby's body. Other necessary documentation includes the maneuvers attempted, and which maneuver resulted in successful delivery.
00:00:54 √ Placed the infant on a radiant warmer for evaluation of possible injury and in preparation for resuscitation if needed.
00:00:56 √ Dried the baby with a towel to allow for warming to occur.
00:00:58 √ Correctly communicated assessment of the baby's breathing efforts.
00:00:59 √ Correctly communicated assessment of the baby's heart rate.
00:01:01 √ Assessed the infant for evidence of injury. This assessment should include examination of the humerus and clavicle for fracture, and arm movement for possible brachial plexus injury.
00:01:06 x Did NOT correctly assign the Apgar score. The Apgar score in this case is 9.
00:01:12 **********END SCENARIO**********
00:01:15 **********
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00:01:26
00:01:26 **********OVERALL GRADE**********
00:01:26 GRADE: Completed 9/18 steps. 50%

Debriefing

Date: 14.11.2013 **Time:** 16:04:17

SMom Nurs OB Emerg Testing SD (Madeline) 1_0

00:00:00 Name: Madeline Age: 19 years Weight: 60 kg Height: 160 cm Gender: Female
Description: Maternal BP 110/68, pulse 76. Uterine contractions occurring every 3 minutes. Fetal heart rate 130 - 135 with good beat to beat variability and no decelerations.
00:00:03 **********START SCENARIO**********
00:00:03 Uterine activity: 03:10
00:00:03 FHR base: 135
00:00:09 √ Made the diagnosis of shoulder dystocia.
00:00:22 √ Positioned patient in the McRoberts position.
00:00:29 √ Correctly applied suprapubic pressure.
00:00:34 x Incorrectly applied FUNDAL pressure. Fundal pressure should NEVER be employed as a maneuver to relieve shoulder dystocia. This may result in worsening of the fetal shoulder impaction, or even uterine rupture.
00:00:38 x Did NOT request nursing assistance. Nursing assistance is needed to help with maneuvers that may be necessary to facilitate delivery of the baby.
00:00:38 x Did NOT request pediatric presence in the delivery room. Pediatric presence is necessary for evaluation of the baby, and possible resuscitation of the baby, in the event of delay of delivery due to shoulder dystocia.
00:00:38 x Did NOT instruct the mother NOT to push. The mother must cease pushing in the event of shoulder dystocia, as her pushing efforts may further impact the fetal shoulder behind the pubic symphysis and worsen the dystocia. She may resume pushing once the shoulder is freed.
00:00:38 x Did NOT step up onto bedside stepstool. This is recommended so that the nurse/assistant is able to exert adequate downward pressure when performing suprapubic pressure to free the fetal anterior shoulder.
00:00:38 x Did NOT note the delivery time of the fetal head.
00:00:38 x Did NOT communicate the problem with the patient and family in the room.
00:00:38 x Did NOT lower the head of the head in anticipation of performance of maneuvers to free the fetal anterior impacted shoulder.
00:00:38 x Did NOT put on clean gloves.
00:00:41 FHR base: 30
00:00:41 *****NEWBORN ASSESSMENT*****
00:00:42 √ Correctly noted the time of delivery of the entire baby's body. Other necessary documentation includes the maneuvers attempted, and which maneuver resulted in successful delivery.
00:00:47 √ Assessed the infant for evidence of injury. This assessment should include examination of the humerus and clavicle for fracture, and arm movement for possible brachial plexus injury.
00:00:53 x Did NOT correctly assign the Apgar score. The Apgar score in this case is 9.
00:00:56 x Did NOT place the infant on a radiant warmer. This is necessary for full evaluation of the infant for possible injury to the clavicle or brachial plexus, as well as in preparation for possible need for resuscitation.
00:00:56 x Did NOT dry the baby with a towel on the radiant warmer. Drying the baby is recommended to aid in warming the infant, in anticipation of possible resuscitation.
00:00:56 x Did NOT communicate assessment of the baby's breathing efforts.
00:00:56 x Did NOT communicate assessment of the baby's heart rate.
00:00:58
00:00:59 **********NONTECHNICAL SCORE**********
00:00:59 MARGINAL PASS. May have met technical requirements, but it appears learner would benefit from more repetition prior to clinical practice.
00:01:02 **********END SCENARIO**********
00:01:05 **********
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00:01:15

OB Emerg Nurs Practice Shoulder Dystocia (Nora) & OB Emerg Nurs Testing Shoulder Dystocia (Madeline)

Shoulder Dystocia with Nursing Maneuvers and Basic Infant Assessment Incorrect Debrief Log (Continued):

Debriefing
Date: 07.11.2013 **Time:** 11:22:57

SMom Nurs OB Emerg Practice SD (Sarah) 1_0

00:00:00 Name: Sarah Age: 26 years Weight: 65 kg Height: 170 cm Gender: Female
00:00:04 **********START SCENARIO**********
00:00:04 Uterine activity: 05:10
00:00:04 FHR base: 125
00:00:13 √ Made the diagnosis of shoulder dystocia.
00:00:17 √ Requested pediatric presence in the room for possible resuscitation of the baby.
00:00:27 √ Positioned patient in the McRoberts position.
00:00:35 √ Stepped up on a bedside stepstool to aid in providing adequate downward pressure during suprapubic pressure maneuver.
00:00:39 x Incorrectly applied FUNDAL pressure. Fundal pressure should NEVER be employed as a maneuver to relieve shoulder dystocia. This may result in worsening of the fetal shoulder impaction, or even uterine rupture.
00:00:41 x Did NOT request nursing assistance. Nursing assistance is needed to help with maneuvers that may be necessary to facilitate delivery of the baby.
00:00:41 x Did NOT instruct the mother NOT to push. The mother must cease pushing in the event of shoulder dystocia, as her pushing efforts may further impact the fetal shoulder behind the pubic symphysis and worsen the dystocia. She may resume pushing once the shoulder is freed.
00:00:41 x Did NOT correctly apply suprapubic pressure.
00:00:41 x Did NOT note the delivery time of the fetal head.
00:00:41 x Did NOT communicate the problem with the patient and family in the room.
00:00:41 x Did NOT lower the head of the head in anticipation of performance of maneuvers to free the fetal anterior impacted shoulder.
00:00:41 x Did NOT put on clean gloves.
00:00:44 FHR base: 30
00:00:44 *****NEWBORN ASSESSMENT*****
00:00:56 x Did NOT correctly assign the Apgar score. The Apgar score in this case is 8.
00:00:59 x Did NOT make a note of the time of delivery of the baby's body. It is important to document the difference in time of delivery of the fetal head and body, and to document maneuvers performed and which resulted in successful delivery.
00:00:59 x Did NOT place the infant on a radiant warmer. This is necessary for full evaluation of the infant for possible injury to the clavicle or brachial plexus, as well as in preparation for possible need for resuscitation.
00:00:59 x Did NOT dry the baby with a towel on the radiant warmer. Drying the baby is recommended to aid in warming the infant, in anticipation of possible resuscitation.
00:00:59 x Did NOT assess the infant for injury that may have occurred during the shoulder dystocia maneuvers. This assessment should include assessing the humerus and clavicle for possible fracture, and brachial plexus injury by assessing arm movement.
00:00:59 x Did NOT communicate assessment of the baby's breathing efforts.
00:00:59 x Did NOT communicate assessment of the baby's heart rate.
00:01:02 **********END SCENARIO**********
00:01:05 **********
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00:01:21 **********OVERALL GRADE**********
00:01:21 GRADE: Completed 4/18 steps. 22%

Debriefing
Date: 14.11.2013 **Time:** 15:54:48

SMom Nurs OB Emerg Testing SD (Kendall) 1_0

00:00:00 Name: Kendall Age: 28 years Weight: 80 kg Height: 165 cm Gender: Female
Description: Maternal BP 130/78, pulse 82. Uterine contractions occurring every 3 minutes. Fetal heart rate 130 - 135 with good beat to beat variability and no decelerations.
00:00:03 **********START SCENARIO**********
00:00:03 Uterine activity: 03:10
00:00:03 FHR base: 135
00:00:03 *****DELIVERY OF BABY*****
00:00:07 √ Made the diagnosis of shoulder dystocia.
00:00:13 √ Positioned patient in the McRoberts position.
00:00:19 √ Correctly applied suprapubic pressure.
00:00:22 x Incorrectly applied FUNDAL pressure. Fundal pressure should NEVER be employed as a maneuver to relieve shoulder dystocia. This may result in worsening of the fetal shoulder impaction, or even uterine rupture.
00:00:44 x Scenario ended due to participant's failure to complete assistance of delivery and assessment of the baby within 7 minutes of diagnosis of shoulder dystocia.
00:00:44 x Did NOT request nursing assistance. Nursing assistance is needed to help with maneuvers that may be necessary to facilitate delivery of the baby.
00:00:44 x Did NOT request pediatric presence in the delivery room. Pediatric presence is necessary for evaluation of the baby, and possible resuscitation of the baby, in the event of delay of delivery due to shoulder dystocia.
00:00:44 x Did NOT instruct the mother NOT to push. The mother must cease pushing in the event of shoulder dystocia, as her pushing efforts may further impact the fetal shoulder behind the pubic symphysis and worsen the dystocia. She may resume pushing once the shoulder is freed.
00:00:44 x Did NOT step up onto bedside stepstool. This is recommended so that the nurse/assistant is able to exert adequate downward pressure when performing suprapubic pressure to free the fetal anterior shoulder.
00:00:44 x Did NOT note the delivery time of the fetal head.
00:00:44 x Did NOT communicate the problem with the patient and family in the room.
00:00:44 x Did NOT lower the head of the head in anticipation of performance of maneuvers to free the fetal anterior impacted shoulder.
00:00:44 x Did NOT put on clean gloves.
00:00:47
00:00:48 **********NONTECHNICAL SCORE**********
00:00:48 MARGINAL PASS. May have met technical requirements, but it appears learner would benefit from more repetition prior to clinical practice.
00:00:51 **********END SCENARIO**********
00:00:54 **********
00:00:56
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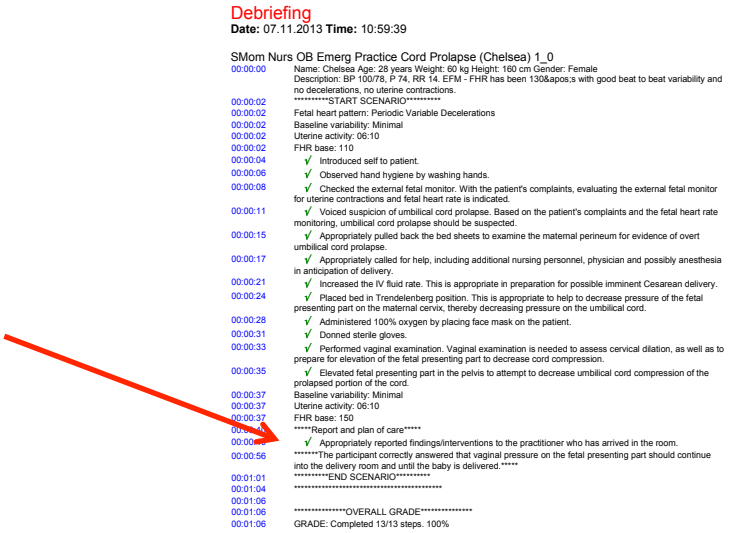
00:01:11 **********TECHNICAL SCORE**********
00:01:11 GRADE: Completed 3/18 steps. 17%

OB Emerg Nurs Practice Shoulder Dystocia (Sarah) & OB Emerg Nurs Testing Shoulder Dystocia (Kendall)

Umbilical Cord Prolapse Necessitating Vaginal Elevation of Fetal Presenting Part
Correct Debrief Log:



Debriefing
Date: 07.11.2013 **Time:** 10:59:39

SMom Nurs OB Emerg Practice Cord Prolapse (Chelsea) 1_0

00:00:00 Name: Chelsea Age: 28 years Weight: 60 kg Height: 160 cm Gender: Female
Description: BP 100/78, P 74, RR 14. EFM - FHR has been 130's with good beat to beat variability and no decelerations, no uterine contractions.
00:00:02 **********START SCENARIO**********
00:00:02 Fetal heart pattern: Periodic Variable Decelerations
00:00:02 Baseline variability: Minimal
00:00:02 Uterine activity: 06:10
00:00:02 FHR base: 110
00:00:04 √ Introduced self to patient.
00:00:06 √ Observed hand hygiene by washing hands.
00:00:08 √ Checked the external fetal monitor. With the patient's complaints, evaluating the external fetal monitor for uterine contractions and fetal heart rate is indicated.
00:00:11 √ Voiced suspicion of umbilical cord prolapse. Based on the patient's complaints and the fetal heart rate monitoring, umbilical cord prolapse should be suspected.
00:00:15 √ Appropriately pulled back the bed sheets to examine the maternal perineum for evidence of overt umbilical cord prolapse.
00:00:17 √ Appropriately called for help, including additional nursing personnel, physician and possibly anesthesia in anticipation of delivery.
00:00:21 √ Increased the IV fluid rate. This is appropriate in preparation for possible imminent Cesarean delivery.
00:00:24 √ Placed bed in Trendelenberg position. This is appropriate to help to decrease pressure of the fetal presenting part on the maternal cervix, thereby decreasing pressure on the umbilical cord.
00:00:28 √ Administered 100% oxygen by placing face mask on the patient.
00:00:31 √ Donned sterile gloves.
00:00:33 √ Performed vaginal examination. Vaginal examination is needed to assess cervical dilation, as well as to prepare for elevation of the fetal presenting part to decrease cord compression.
00:00:35 √ Elevated fetal presenting part in the pelvis to attempt to decrease umbilical cord compression of the prolapsed portion of the cord.
00:00:37 Baseline variability: Minimal
00:00:37 Uterine activity: 06:10
00:00:37 FHR base: 150
00:00:[illegible] *****Report and plan of care*****
00:00:[illegible] √ Appropriately reported findings/interventions to the practitioner who has arrived in the room.
00:00:56 *******The participant correctly answered that vaginal pressure on the fetal presenting part should continue into the delivery room and until the baby is delivered.*****
00:01:01 **********END SCENARIO**********
00:01:04 **
00:01:06
00:01:06 ***************OVERALL GRADE***************
00:01:06 GRADE: Completed 13/13 steps. 100%

OB Emerg Nurs Practice Umbilical Cord Prolapse (Chelsea)

Note: View the highlighted entry – this provides feedback as to whether the participant answered the directed question in the scenario regarding timing for continuance of performing vaginal pressure on the fetal presenting part.

Umbilical Cord Prolapse Necessitating Vaginal Elevation of Fetal Presenting Part
Correct Debrief Log (continued):

Debriefing
Date: 14.11.2013 **Time:** 15:04:02

SMom Nurs OB Emerg Testing Cord Prolapse (Marsha) 1_1

00:00:00	Name: Marsha Age: 19 years Weight: 65 kg Height: 170 cm Gender: Female Description: BP 106/68, P 68, RR 14. EFM - FHR has been 120's with good beat to beat variability and no decelerations, uterine contractions are irregular, spaced every 2 to 6 minutes.
00:00:06	**********START SCENARIO**********
00:00:06	Fetal heart pattern: Periodic Variable Decelerations
00:00:06	Baseline variability: Minimal
00:00:06	Uterine activity: 06:10
00:00:06	FHR base: 110
00:00:08	√ Introduced self to patient.
00:00:12	√ Observed hand hygiene by washing hands.
00:00:15	√ Checked the external fetal monitor. With the patient's complaints, evaluating the external fetal monitor for uterine contractions and fetal heart rate is indicated.
00:00:17	√ Voiced suspicion of umbilical cord prolapse. Based on the patient's complaints and the fetal heart rate monitoring, umbilical cord prolapse should be suspected.
00:00:19	√ Appropriately pulled back the bed sheets to examine the maternal perineum for evidence of overt umbilical cord prolapse.
00:00:22	√ Appropriately called for help, including additional nursing personnel, physician and possibly anesthesia in anticipation of delivery.
00:00:23	√ Increased the IV fluid rate. This is appropriate in preparation for possible imminent Cesarean delivery.
00:00:25	√ Placed bed in Trendelenberg position. This is appropriate to help to decrease pressure of the fetal presenting part on the maternal cervix, thereby decreasing pressure on the umbilical cord.
00:00:27	√ Administered 100% oxygen by placing face mask on the patient.
00:00:29	√ Donned sterile gloves.
00:00:30	√ Performed vaginal examination. Vaginal examination is needed to assess cervical dilation, as well as to prepare for elevation of the fetal presenting part to decrease cord compression.
00:00:33	√ Elevated fetal presenting part in the pelvis to attempt to decrease umbilical cord compression of the prolapsed portion of the cord.
00:00:35	Baseline variability: Minimal
00:00:35	Uterine activity: 06:10
00:00:35	FHR base: 150
00:00:41	*****Report and plan of care*****
00:00:41	√ Appropriately reported findings/interventions to the practitioner who has arrived in the room.
00:00:54	*******The participant correctly answered that vaginal pressure on the fetal presenting part should continue into the delivery room and until the baby is delivered.*****
00:00:59	
00:01:00	**********NONTECHNICAL SCORE**********
00:01:00	PASS. Learner appears ready for clinical practice.
00:01:03	**********END SCENARIO**********
00:01:06	**********
00:01:08	
00:01:08	**********TECHNICAL SCORE**********
00:01:08	GRADE: Completed 13/13 steps. 100%

OB Emerg Nurs Testing Umbilical Cord Prolapse (Marsha)

Umbilical Cord Prolapse Necessitating Vaginal Elevation of Fetal Presenting Part
Incorrect Debrief Log:

Debriefing
Date: 07.11.2013 **Time:** 11:01:57

SMom Nurs OB Emerg Practice Cord Prolapse (Chelsea) 1_0

00:00:00 Name: Chelsea Age: 28 years Weight: 60 kg Height: 160 cm Gender: Female
Description: BP 100/78, P 74, RR 14. EFM - FHR has been 130's with good beat to beat variability and no decelerations, no uterine contractions.
00:00:04 **********START SCENARIO**********
00:00:04 Fetal heart pattern: Periodic Variable Decelerations
00:00:04 Baseline variability: Minimal
00:00:04 Uterine activity: 06:10
00:00:04 FHR base: 110
00:00:19 √ Elevated fetal presenting part in the pelvis to attempt to decrease umbilical cord compression of the prolapsed portion of the cord.
00:00:21 Baseline variability: Minimal
00:00:21 Uterine activity: 06:10
00:00:21 FHR base: 150
00:00:21 x Did NOT introduce self to patient.
00:00:21 x Did NOT observe hand hygiene - did not wash hands.
00:00:21 x Did NOT check the external fetal monitor. With the patient's complaints, evaluating the external fetal monitor for uterine contractions and fetal heart rate is indicated so as to help determine management of the patient's care.
00:00:21 x Did NOT voice suspicion of umbilical cord prolapse. Based on the patient's complaints and the fetal heart rate monitoring, umbilical cord prolapse should be suspected in this patient due to symptoms and FHR variable decelerations.
00:00:21 x Did NOT pull back the bed sheets to evaluate the maternal perineum. Based on the patient history and fetal heart rate pattern, umbilical cord prolapse is suspected. The maternal perineum should be examined for evidence of overt cord prolapse, ie, umbilical cord prolapsing outside the maternal vagina.
00:00:21 x Did NOT call for help. Should call for additional nursing personnel, physician, and anesthesia personnel to help prepare for possible delivery.
00:00:21 x Did NOT increase the IV fluid rate. The IV fluid rate should be increased in anticipation of preparation for imminent Cesarean delivery.
00:00:21 x Did NOT place bed in Trendelenberg position. This is appropriate to help to decrease pressure of the fetal presenting part on the maternal cervix, thereby decreasing pressure on the umbilical cord.
00:00:21 x Did NOT don sterile gloves. Sterile gloves are necessary in preparation for vaginal examination to elevate the fetal presenting part to alleviate pressure on the umbilical cord.
00:00:21 x Did NOT perform vaginal examination. Vaginal examination is needed to assess cervical dilation, as well as to prepare for elevation of the fetal presenting part to decrease cord compression.
00:00:21 x Did NOT administer 100% oxygen by placing face mask on the patient. Due to the concerning fetal heart rate pattern, and most likely imminent delivery, oxygenation of the patient is indicated.
00:00:31 *****Report and plan of care*****
00:00:31 √ Appropriately reported findings/interventions to the practitioner who has arrived in the room.
00:00:44 *******The participant did NOT answer correctly. Vaginal pressure on the fetal presenting part should be maintained into the delivery room and until the baby is delivered.*******
00:00:49 **********END SCENARIO**********
00:00:52 **
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00:01:05 **********OVERALL GRADE**********
00:01:05 GRADE: Completed 2/13 steps. 15%

OB Emerg Nurs Practice Umbilical Cord Prolapse (Chelsea)

Umbilical Cord Prolapse Necessitating Vaginal Elevation of Fetal Presenting Part Incorrect Debrief Log (continued):

Debriefing
Date: 14.11.2013 **Time:** 15:06:09

SMom Nurs OB Emerg Testing Cord Prolapse (Marsha) 1_1

00:00:00	Name: Marsha Age: 19 years Weight: 65 kg Height: 170 cm Gender: Female Description: BP 106/68, P 68, RR 14. EFM - FHR has been 120's with good beat to beat variability and no decelerations, uterine contractions are irregular, spaced every 2 to 6 minutes.
00:00:04	**********START SCENARIO**********
00:00:04	Fetal heart pattern: Periodic Variable Decelerations
00:00:04	Baseline variability: Minimal
00:00:04	Uterine activity: 06:10
00:00:04	FHR base: 110
00:01:29	x The scenario ended due to the participant's failure to assess and manage the umbilical cord prolapse in the 5 minutes allotted for this scenario.
00:01:29	x Did NOT introduce self to patient.
00:01:29	x Did NOT observe hand hygiene - did not wash hands.
00:01:29	x Did NOT check the external fetal monitor. With the patient's complaints, evaluating the external fetal monitor for uterine contractions and fetal heart rate is indicated so as to help determine management of the patient's care.
00:01:29	x Did NOT voice suspicion of umbilical cord prolapse. Based on the patient's complaints and the fetal heart rate monitoring, umbilical cord prolapse should be suspected in this patient due to symptoms and FHR variable decelerations.
00:01:29	x Did NOT pull back the bed sheets to evaluate the maternal perineum. Based on the patient history and fetal heart rate pattern, umbilical cord prolapse is suspected. The maternal perineum should be examined for evidence of overt cord prolapse, ie, umbilical cord prolapsing outside the maternal vagina.
00:01:29	x Did NOT call for help. Should call for additional nursing personnel, physician, and anesthesia personnel to help prepare for possible delivery.
00:01:29	x Did NOT increase the IV fluid rate. The IV fluid rate should be increased in anticipation of preparation for imminent Cesarean delivery.
00:01:29	x Did NOT place bed in Trendelenberg position. This is appropriate to help to decrease pressure of the fetal presenting part on the maternal cervix, thereby decreasing pressure on the umbilical cord.
00:01:29	x Did NOT don sterile gloves. Sterile gloves are necessary in preparation for vaginal examination to elevate the fetal presenting part to alleviate pressure on the umbilical cord.
00:01:29	x Did NOT perform vaginal examination. Vaginal examination is needed to assess cervical dilation, as well as to prepare for elevation of the fetal presenting part to decrease cord compression.
00:01:29	x Did NOT elevate the fetal presenting part in the pelvis - this is a recommended step in order to attempt to decrease pressure on the prolapsed portion of the fetal umbilical cord.
00:01:29	x Did NOT administer 100% oxygen by placing face mask on the patient. Due to the concerning fetal heart rate pattern, and most likely imminent delivery, oxygenation of the patient is indicated.
00:01:31	
00:01:32	**********NONTECHNICAL SCORE**********
00:01:33	FAIL. Learner not ready for clinical practice. Needs significant retraining.
00:01:36	**********END SCENARIO**********
00:01:39	**********
00:01:41	
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00:01:47	
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00:01:52	
00:01:54	
00:01:54	**********TECHNICAL SCORE**********
00:01:54	GRADE: Completed 0/13 steps. 0%

OB Emerg Nurs Testing Umbilical Cord Prolapse (Marsha)