SECTION I: SCENARIO OVERVIEW

Scenario Title:	Case C_Post-partum Hemorrhage in 15-year-old primipara with no prenatal care
Original Scenario Developer(s):	S. Vaughn, RN, MPH
Date - original scenario	08/09
Validation:	11/09 M. Miller, MA, RN, CHSE; M. Potkin, RN
Revision Dates:	04/10
Pilot testing:	11/09
QSEN revision: M. Miller, MA, RN, CHSE	06/12

Estimated Scenario Time: 15-20 minutes Debriefing time: 30-40 minutes

Target group: Pre-licensure RN students
Core case: 15-year-old primipara 6 hours after delivery – postpartum hemorrhage
QSEN Competencies:

- ❑ Safety
- ❑ Patient Centered Care
- ❑ Teamwork and Collaboration

Brief Summary of Case: Leticia Garcia 15-year-old, newly delivered 2 hours post precipitous delivery of 1.8 kg (4 lbs) baby girl. Vital Signs were within normal limits. OB nurse reported fundus firm, at midline, one finger above umbilicus. Patient's peripad was changed 10 minutes ago with moderate amount of rubra lochia. New Grad enters and patient states, "I'm so tired. I just felt a gush down there".
This scenario can be used as the second in a 4-part series or as a stand-alone scenario. It can also be combined for more advanced practitioners.

- ❑ Scenario A – New Admission – Fetal Distress
- ❑ Scenario B – Imminent Delivery – Normal
- ❑ Scenario C – Postpartum Hemorrhage
- ❑ Scenario D – Postpartum pain assessment

EVIDENCE BASE / REFERENCES

Burke Sosa, M. E. (2014). Bleeding in Pregnancy. In *Perinatal Nursing* (4th ed., pp. 143-165). Philadelphia, PA: Wolter Kluwer/Lippincott & Wilkins

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Leardal Medical Corporation, Wappingers Falls, NY. (n.d.). PROMPT Birth Simulator. Retrieved August 14, 2018, from https://www.laerdal.com/us/archive/prompt-birthing-simulator/

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SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Utilize principles and care practices related to immediate post-partum period
2. Implement critical thinking and clinical decision-making skills necessary to interpret data.
3. Integrate understanding of multiple dimensions of patient-family centered care.
4. Provide safe care to post-partum patients, prioritizing and implementing interventions
Specific Learning Objectives
1. Accurately assess the post-partum mother.
2. Recognize deviations from normal expectations.
3. Implement appropriate nursing interventions based on assessment.
4. Communicate relevant patient information to team using SBAR tool.
5. Effectively communicate with patient throughout simulation to keep informed and relieve anxiety.
6. Engage family members to support patient in post-partum period.
Critical Learner Actions
1. Identifies self and role to patient and family members.
2. Performs hand hygiene.
3. Identifies patient using 2 identifiers.
4. Prioritizes assessment for post-partum patient: lochia, fundus, heart rate and B/P
5. Recognizes patient complaint and clinical signs indicating post-partum hemorrhage.
6. Lowers head of bed to supine position
7. Calls for assistance and delivers SBAR to nurse while performing fundal massage
8. Increases IV flow rate on directions from charge nurse
9. Communicates calmly with patient and family members while implementing interventions

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies Required prior to participating in the scenario	
Knowledge	Skills/ Attitudes
❑ Normal findings in of fourth stage of labor.	❑ Normal findings in post-partum assessment
❑ Nursing interventions for post-partum complication.	❑ Abnormal findings in post-partum assessment
❑ Differentiating significant reportable findings in post-partum assessment.	❑ Assessment of vital signs.
❑ Pharmacology of uterotonic medications.	❑ Immediate interventions for abnormal post-partum bleeding, including fundal massage
❑ SBAR communication.	❑ Closed loop communication in acute situations

SECTION III: SCENARIO SCRIPT

A. Case summary
Leticia Garcia 15-year-old, unmarried teen visiting from Florida. Brought to hospital emergency room in severe abdominal cramping thought due to sister's cooking. Denied pregnancy. Currently is newly delivered 2 hours post precipitous delivery of 1.8 kg (4 lbs) baby girl. Vital Signs were within normal limits. OB nurse reported fundus firm, at midline, one finger above umbilicus. QBL 500 ml up to this point. Patient's peripad was changed 10 minutes ago with moderate amount of rubra lochia. New Grad enters and patient states, "I'm so tired. I just felt a gush down there".

B. Key contextual details
Change of shift. Fully staffed. Sister in room.

C. Scenario Cast		
Patient/ Patient	❑ High fidelity simulator	
	❑ Mid-level simulator	
	❑ Birthing manikin	
	or	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Standardized Participant (SP) or Learner (L)
New Grad in Orientation OB new grad	Checks – perineum, lochia and fundus, calls for help, gives SBAR	Learner
Primary nurse	Enters when new grad pulls emergency cord, directs new grad, gets SBAR	Learner
OB Charge Nurse (faculty)	Takes SBAR from new grad; notifies MD	Standardized Participant
Sister or brother	Cues: "she looks so pale". "Seems very sleepy." "Feels wet or in a puddle."	Standardized Participant

D. Patient/Patient Profile				
Last name:	Garcia		First name:	Leticia
Gender: Fe	Age: 15	Ht: 5'2"	Wt: 158#	Code Status: Full
Spiritual Practice: Catholic		Ethnicity: Puerto Rican		Primary Language spoken: English/Spanish

1. History of present illness

Chief Complaint: Increased vaginal bleeding

The patient is newly delivered 2 hours post precipitous delivery of 1.8 kg (4 lbs) baby girl. Vital Signs have been within normal limits. OB nurse reported fundus firm, at midline, one finger above umbilicus. QBL 500 ml up to this point. Patient's peripad was changed 10 minutes ago with moderate amount of rubra lochia. New Grad enters and patient states, "I'm so tired. I just felt a gush down there".

Primary Medical Diagnosis	Full term pregnancy

2. Review of Systems	
CNS	Alert, oriented, cooperative, fearful
Cardiovascular	Regular sinus rhythm, no gallops, rubs or murmurs, apical clear, pulses +4 radial and pedal
Pulmonary	Clear to A&P
Renal/Hepatic	Voiding clear urine, no hepatomegaly felt
Gastrointestinal	Distended, full term pregnancy
Endocrine	Full term pregnancy
Heme/Coag	No bruising or bleeding noted
Musculoskeletal	Moves all extremities well. Spine within normal limits
Integument	Clear without abrasions
Developmental Hx	Normal Hispanic teenager
Psychiatric Hx	None reported
Social Hx	Sexually active, no reported drug, smoking or alcohol history
Alternative/ Complementary Medicine Hx	unknown

Medication allergies:	None reported	Reaction:	
Food/other allergies:	NKDA	Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Routine post-partum medication orders – agency specific			

4. Laboratory, Diagnostic Study Results					
Na: 142	K: 4.2	Cl: 102	HCO3: 22	BUN:	Cr:
Ca: 9.3	Mg: 1.2	Phos:	Glucose:	HgA1C:	
Hgb: 11.6	Hct: 38	Plt: 200,000	WBC: 7000	ABO Blood Type:	
PT: 11.5	PTT: 25	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL: neg	GBS: pending	Herpes: neg	HIV: neg	Chlamydia: neg	
CXR:		ECG:			
CT:		MRI:			
Other:					

E. Baseline Simulator/Standardized Patient State (This may vary from the baseline data provided to learners)					
1. Initial physical appearance					
Gender: Fe		Attire: hospital gown			
Alterations in appearance (moulage): Long black curly wig and bright lipstick. Make up to make patient look very pale. Pale, cool and clammy skin. Pack manikin in ice packs for at least 20 minutes between scenarios. Apply thin layer of Vaseline on skin of face, arms, neck and chest. Spray with glycerin and water and be sure to remove ice packs before learners enter room. Peri pad, bright red lochia with clots, chux full of blood. Place additional bloody chux folded under first one so when learner removes first one, second can be easily unfolded by Standardized Participant					
x	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
	Allergy band present, accurate information		Allergy band present, inaccurate information	x	Allergy band absent or not applicable

2. Initial Vital Signs Monitor display in simulation action room:							
	No monitor display		Monitor on, but no data displayed	x	Monitor on, standard display		

BP: 98/58	HR: 100	RR: 24	T:98	SpO2: 94%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC02:	FHR:		
Lungs: Sounds/mechanics	Left:		Right:	
Heart:	Sounds:	S1, S2 no ectopy		
	ECG rhythm:	Sinus tachycardia		
	Other:			
Bowel sounds:	Active x 4		Other:	

ALL DATA IN THIS SCENARIO IS FICTITIOUS

3. Initial Intravenous line set up							
	Saline lock	Site:					IV patent (Y/N)
	IV #1 Main	Site: RA		Fluid type: D5 LR with 20 U Pitocin	Initial rate: 125 mL/hr		IV patent (Y/N)

4. Initial Non-invasive monitors set up					
x	NIBP		ECG First lead:		ECG Second lead:
x	Pulse oximeter		Temp monitor/type		Other:

5. Initial Hemodynamic monitors set up					
	A-line Site:		Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:

6. Other monitors/devices					
	Foley catheter	Amount:		Appearance of urine:	
	Epidural catheter	x	Infusion pump:	Pump settings: Primary	125 mL/hr.
	Fetal Heart rate monitor/tocometer			Internal	External

Environment, Equipment, Props (Recommend standardized set up for each commonly simulated environment)

1. Scenario setting: (example: patient room, home, ED, lobby)
Perinatal Unit

2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)							
x	Bedpan/ Urinal	x	Foley catheter kit	x	Straight cath. kit		Incentive spirometer
x	IV Infusion pump		OB delivery kit		Pressure bag	x	Wall suction
	Nasogastric tube		ETT suction catheters	x	Oral suction cath		Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line kit		Dressing Δ equipment
x	IV fluid	Lactated Ringers with Pitocin		Blood product ABO Type:		# of units:	

3. Respiratory therapy equipment/devices							
x	Nasal cannula		Face tent	x	Simple Face Mask	x	Non re-breather mask
x	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Provider orders	x	Med Admin Record	x	H & P	x	Lab Results
	Progress Notes	x	Graphic record	x	Medication recon.		Prenatal record
x	Nurses' Notes	x	Actual medical record binder				Other

5. Medications (to be available in sim action room)								
#	**Medication**	**Dosage**	**Route**		**#**	**Medication**	**Dosage**	**Route**
3	Tylenol with Codeine	#3	PO		3	Colace	100 mg	PO
3	Ibuprofen	600 mg	PO					

ALL DATA IN THIS SCENARIO IS FICTITIOUS

CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES			
Initiation of Scenario: Leticia Garcia 15-year-old, newly delivered 2 hours post precipitous delivery of a 5 lb. 8 oz. baby girl, 2 hours following admission into ED. Vital signs were within normal limits. OB nurse reported fundus firm, at midline, one finger above umbilicus. Patient's peripad was changed 10 minutes ago with moderate amount of rubra lochia.			
STATE / PATIENT STATUS	**DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE**		
1. Baseline Patient in high fowler's position, covered up to chest with bed linens (chux with hemorrhage – learner must look under covers to see) Patient states, "I feel so cold and tired. I felt a little gush down there."	**Operator** NO MONITOR – VS shown if learner performs task of putting on BP cuff or taking pulse, respirations and pulse ox BP = 98/58 Pulse = 100 RR = 24 Temp = 98 O_2 Sat = 97% **Triggers:** Learner Actions completed within 5 -7 minutes	**Learner Actions** 1. Performs hand hygiene 2. Introduces self, team mate and roles to patient and family 3. Identifies patient 4. Reacts to client statements – a. Pulls back cover and visualizes hemorrhage b. Pulls emergency cord c. Position bed flat d. Begin fundal massage 5. Communicates interventions to patient and family members 6. Reassures patient and family appropriately	**Debriefing Points:** 1. National Patient Safety Goals 2. Strategies to gain patient and family cooperation in escalating situation. 3. Risk factors for post-partum hemorrhage 4. Relevant assessment data indicating need to check perineum 5. Rationale for interventions

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
2. Sister cues, "Why is she so pale and sweaty? She seems sleepy now."	**Operator:** BP = 94/50 HR = 114 RR = 26 O_2 = 94% **Triggers:** Learner Actions completed within 5 minutes	**Learner Actions:** 1. Increases IV rate on direction of charge nurse according to agency protocol 2. Continues fundal massage 3. Updates family member on status and treatment 4. Directs assisting nurse to weigh chux and estimate blood loss 5. Delivers SBAR to charge nurse 6. Communicates with arriving nurses using closed loop communication throughout	**Debriefing Points:** 1. Closed loop communication 2. Rationale for fundal massage 3. Rationale for increasing fluid rate and Pitocin drip

STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
3. Pt. c/o pain with fundal massage States she feels better and wants massage to stop.	**Operator:** BP = 100/70 HR = 100 RR = 22 O_2 = 96% **Triggers**: Learner ctions completed within 5 minutes	**Learner Actions:** 1. Explains purpose of interventions to patient and family member 2. Explains that checks will be performed frequently	**Debriefing Points:** 1. Nursing priorities during and following excessive post-partum bleeding 2. Strategies for integrating patient/ family preferences with nursing priorities for safe care
Scenario End Point: Patient's vital signs improve, and bleeding reduced with interventions. Charge nurse receives SBAR from learners and relieves them for break.			
Suggestions to <u>decrease</u> complexity: Normal post-partum findings			
Suggestions to <u>increase</u> complexity: Condition does not respond to initial interventions requiring transfer to OR for removal of placental fragments (process and system issues interfering with safe transfer) Test blood bank on emergency release of blood products in a timely manner. Test Learner re: administration, set up and checking of blood products per protocol (two patient identifiers). Test security/MSW/management's ability to handle a family member that becomes escalated.			

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: **DOB:** **Age:** **MR#:**		**Diagnosis:**
† No Known Allergies † Allergies & Sensitivities		
Date	Time	**HEALTH CARE PROVIDER ORDERS AND SIGNATURE**
Signature		

APPENDIX B: Digital images of manikin and/or scenario milieu	
Insert digital photo here	Insert digital photo here
Insert digital photo here	Insert digital photo here

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
☐ Individual	☐ Group	☐ With Video	☐ Without Video
Debriefing Materials			
☐ Debriefing Guide	☐ Objectives	☐ Debriefing Points	☐ QSEN
QSEN Competencies to consider for debriefing scenarios			
☐ Patient Centered Care	☐ Teamwork/Collaboration	☐ Evidence-based Practice	
☐ Safety	☐ Quality Improvement	☐ Informatics	

Sample Questions for Debriefing

1. How did the experience of caring for this patient feel for you and the team?
2. Did you have the knowledge and skills to meet the learning objectives of the scenario?
3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?
4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?
5. How would you handle the scenario differently if you could?
6. In what ways did you feel the need to check ACCURACY of the data you were given?
7. In what ways did you perform well?
8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members?
9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?
10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?
11. Discuss actual experiences with diverse patient populations.
12. Discuss roles and responsibilities during a crisis.
13. Discuss how current nursing practice continues to evolve considering new evidence.
14. Consider potential safety risks and how to avoid them.
15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care.

Notes for future sessions: