Health Care Team Education: Interprofessional Simulation Toolkit for Midwifery Students and OB/GYN Residents

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Learners Interprofessional Practice Simulation Assignment

This activity builds on the Guiding Principles of Interprofessional Education, Team-Based Care, and Role Clarity, and SBAR materials that were done as prerequisites to this activity. Learners should apply the concepts from these activities during their simulation. Role clarity and types of collaborative management (consultation, collaboration and referral) should be intentionally discussed by learners during the simulation. Learners are encouraged to refer back to and review these materials prior to the simulation.

This is a simulation about communication. Students will need to apply the SBAR format when presenting your case during role play in the simulation. If you are a resident assume you are an OB/GYN attending. If you are a midwifery student, assume you are the midwife. Access prerequisite resources from the ACNM/ACOG IPE project website http://acnm-acog-ipe.org/. SBAR information can be obtained from TeamSTEPPS at: video https://www.ahrq.gov/teamstepps/instructor/videos/ts_SBAR_NurseToPhysician/SBAR_NurseToPhysician-400-300.html and an article at https://psnet.ahrq.gov/resources/resource/32434/Impact-of-the-communication-and-patient-hand-off-tool-SBAR-on-patient-safety-a-systematic-review. These materials are the same for all learners, but may be delivered in a way that is compatible with your educational program. For some that may be taught in the classroom, for others, it may mean adding it to your learning management system for delivery asynchronously at a distance.

Topic and Brief Introduction

Transitions of maternity care occur between providers and between settings based upon the woman's needs and preferences. Effective care transitions enhance client safety, quality of care, and health outcomes. A shared communication framework, common goals and content focus are essential to effective care transitions.

Background/ Context: The U.S. healthcare system often fails to meet the needs of women and their families during care transitions. Providers are rushed and responsibilities are often fragmented. A shared mental model for communication goals is not used across care settings and providers. Poor communication during transitions from one care setting to another or from one provider to another can lead to confusion about the woman's condition, inappropriate care, duplicative tests, inconsistent patient monitoring, medication errors, and delays in diagnosis. These failures cause confusion and concern for the patient, as well as cause safety, quality of care, and health outcome concerns. Additionally, they place significant financial burdens on clients and the U.S. healthcare system as a whole.

Objectives

At the completion of this activity, learners will be able to:

- Develop a plan of care for a patient scenario including diagnosis, plan and level of consultant involvement if needed.
- Critique patient plan of care using evidenced-based information
- Apply critical and reflective thinking as it relates to clinical decision making
- Utilize SBAR format to present to consultant.
- Utilize Interprofessional Education Core Competencies.

IPE Activity:

Step 1:

- Determine time frame for completion of pre-requisite module information and sign up for an available simulation slot that is convenient for you. Note which slots are available for what year resident. Make sure you are not on call for your simulation slot.
- If you are doing these from a distance, ensure you have a computer and a headset with a microphone. You can use an iphone headset.

Step 2:

- Obtain your patient scenario information 2 weeks prior to simulation slot via email.
- Test your computer and microphone equipment in your university's video conferencing system if doing this from a distance. If doing this in person, make sure you are aware where this simulation is occurring.

Step 3:

- Review scenario, critique management and compare it to evidence-based practice. Prepare your SBAR consultation utilizing interprofessional teamwork principles.

Step 4:

- Attend simulation and debriefing. Wear attire appropriate to your clinical setting. Plan to arrive at the simulation center, or if doing this from a distance, enter system at least 15 minutes prior to the simulation time to ensure all of the technology is working.

Step 5:

- Complete post simulation questionnaire.

Prebriefing

Introduce everyone and their roles (CNM faculty, MD faculty, students and their year, etc).

- You are here to simulate the roles of the midwife and the OB/GYN attending. Immerse yourself into the clinical situation and care for the woman during this role play.
- Faculty are here to facilitate learning; may hold back to see what learners have to say
- Ownership of learning is on students, so active participation is needed
- Faculty may use advocacy inquiry method to get at the thought process of a particular situation

Instructions for the 2 ½ hour session; overview of the time in the main room (15 minute prebrief), then simulation (30 minutes), break (15minutes), then back for debriefing (60-75 minutes), post-simulation questionnaire (15 minutes).

Safe space/confidentiality-This is a formative assignment, so the focus is on learning, not having all of the correct answers. This is a place where less than ideal performance will not harm anyone. Other classmates have not done this assignment yet, so it is essential to keep the activity confidential, so they get the benefit of learning when their time comes. While this is not a real scenario, please stay in your role as much as possible to benefit everyone's learning. Assume that your hospital/birth setting has a wide range of possibilities, not just what you all have seen in your actual birth settings.

Debriefing basic assumption: We believe that everyone here today is intelligent, capable, cares about doing their best and wants to improve.

Review Learning Objectives:

- Develop a plan of care for a patient scenario including diagnosis, plan and level of consultant involvement if needed.
- Critique patient plan of care using evidenced-based information
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- Utilize Interprofessional Education Core Competencies.

Logistics of room/environment (where the bathroom is located, if in distance format need to keep the microphone on and take turns speaking, etc)

Instructions for in the room:

The first SNM will have 3-4 minutes to present SBAR to the resident, then 3-4 minutes for discussion of plan of care. Then the second midwifery student will present their case.
Then the resident will present their SBAR to the SNMs for discussion of plan of care.
Then the final SNM will present their SBAR to the resident for discussion of plan of care. Each scenario/student will have 3-4 minutes to do SBAR, then discussion for 3-4 minutes.

Faculty Implementation of IPE Simulation

This activity builds on the Guiding Principles of Interprofessional Education, Team-Based Care, and Role Clarity materials that were done as prerequisites to this activity. Students will also need to know about SBAR format. Access these resources from the ACNM/ACOG IPE project website http://acnm-acog-ipe.org/ . SBAR information can be obtained from TeamSTEPPS at : video https://www.ahrq.gov/teamstepps/instructor/videos/ts_SBAR_NurseToPhysician/SBAR_NurseToPhysician-400-300.html and an article at https://psnet.ahrq.gov/resources/resource/32434/Impact-of-the-communication-and-patient-hand-off-tool-SBAR-on-patient-safety-a-systematic-review. Alter the modules to meet the needs of your learners, delivered in a way that is compatible with your educational program. For some that may be taught in the classroom, for others, it may mean adding it to your learning management system for delivery asynchronously at a distance.

IPEC IPE Competency Domains:

1. Values/ethics for interprofessional practice
2. Roles/responsibilities
3. Interprofessional communication
4. Teams and teamwork

The following is information that is also given to the learners, via the Learners Interprofessional Practice Simulation Assignment.

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Background/ Context: The U.S. healthcare system often fails to meet the needs of women and their families during care transitions. Providers are rushed and responsibilities are often fragmented. A shared mental model for communication goals is not used across care settings and providers. Poor communication during transitions from one care setting to another or from one provider to another can lead to confusion about the woman's condition, inappropriate care, duplicative tests, inconsistent patient monitoring, medication errors, and delays in diagnosis. These failures cause confusion and concern for the patient, as well as cause safety, quality of care, and health outcome concerns. Additionally, they place significant financial burdens on clients and the U.S. healthcare system as a whole.

Objectives

At the completion of this activity, learners will be able to:

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- Critique patient plan of care using evidenced-based information.
- Apply critical and reflective thinking as it relates to clinical decision making.
- Utilize SBAR format to present to consultant.
- Utilize Interprofessional Education Core Competencies.

IPE Activity:

Step 1:

- Determine time frame for completion of pre-requisite module information and sign up for an available simulation slot that is convenient for you. Note which slots are available for what year resident. Make sure you are not on call for your simulation slot.
- If you are doing these from a distance, ensure you have a computer and a headset with a microphone. You can use an iphone headset.

Step 2:

- Obtain your patient scenario information 2 weeks prior to the simulation slot via email.
- Test your computer and microphone equipment in your university's video conferencing system if doing this from a distance. If doing this in person, make sure you are aware where this simulation is occurring.

Step 3:

- Review scenario, critique management and compare it to evidence-based practice. Prepare your SBAR consultation utilizing interprofessional teamwork principles.

Step 4:

- Attend simulation and debriefing. Wear attire appropriate to your clinical setting. Plan to arrive at the simulation center, or if doing this from a distance, enter system at least 15 minutes prior to the simulation time to ensure all of the technology is working.

Step 5:

- Complete post simulation questionnaire.

Faculty

In order to accomplish all aspects of this simulation activity as faculty, you will need at least OB/GYN residents and midwifery students. Other professions can be added into the simulation, but their roles have not been added here. Coordination between the midwifery and OB/GYN departments is necessary. If you do not have one of these departments at your university, do not rule out coordinating with another university. This assignment can be done synchronously in your simulation lab, or asynchronously with a synchronous component via a distance learning format.

In order to be successful, identify champions in the midwifery and OB/GYN departments. Once your champions are found, collectively work on a time frame for implementation. There is quite a bit of coordinating of schedules and materials.

What you will need:
1-Simulation center or video conferencing software to allow for distance simulations.
2-Learners from midwifery and residency programs.
3-Method to deliver pre-requisite content to learners prior to simulation either via lecture or learning management system for distance format.
4- Faculty development needs, as well as other resources that may be needed, are determined by level of comfort/knowledge about simulation, debriefing, the platform for delivery of simulation, etc.

Faculty Implementation Steps:

Step 1:

- Review Guiding Principles of IPE, Team-Based Care, Role Clarity materials, SBAR information, simulation scenarios, grading rubric and post simulation questionnaire and make edits that will work for both the midwifery and residency programs. This will ensure all learners are getting the same information and preparation materials.
- Embed these materials in your learning management system or use them for in-class lectures.

Step 2:

- Levels of learners: This assignment is appropriate for midwifery students as they are nearing the end of their program. They should be proficient in patient management, as well as feel comfortable enough with consultation. If you will be using all residents in your assignment, then pairing them appropriately with advanced midwifery students is

needed. We recommend starting with your fourth-year residents. Allowing first-year residents to get closer to the end of their first year of training before they partake in this exercise. However, this does not mean they cannot have the didactic training before then, and just review it prior to the simulation experience.

- Scheduling: The simulations were developed to run with 3 residents and 6-9 midwifery students (1 resident with 2-3 midwifery students). However, numbers can be altered. It is probably best to not increase numbers for any given simulation to allow for active participation with debriefing. Determine if the simulation will be done in person or from a distance. If they are done in person, plan on using 3 simulation rooms per group and also a debriefing room afterward. If they are done from a distance determine video conferencing capabilities. These were developed using Big Blue Button and breakout rooms within Big Blue Button. The breakout rooms allow for one resident and 2-3 midwifery students to conduct their simulation separately from the rest of the group. Then everyone goes back to the main Big Blue Button room for a group debriefing.
    - Determine simulation slots based on availability of midwifery and OB/GYN faculty. Will need one faculty for each room (whether virtual or in person); should be mix of CNMs and OB/GYNs to attend simulation and debriefing. Slot at least ½ hour after simulation for faculty debriefing (so faculty will block 3 hours at least from their schedule even though the simulation will only last 2 ½ hours).
    - Utilize current simulation center scheduling procedures. If these will be conducted from a distance determine what sign up system will work for both schools. Sign up Genius was used for this project. This platform allows each school to post a link to a sign-up and learners can asynchronously sign up for a slot. Faculty just need to make sure to note which is a resident slot and which is a midwifery slot.
- Contingency plans; Determine how faculty should handle any unexpected issues. What if a student does not show up? If it is one midwifery student, that is less detrimental than one resident. What if there are major technical glitches? What if only one faculty attends?

Step 3:

- Faculty training: Need to determine faculty comfort with simulations and debriefing. The amount of faculty development will vary from school to school. If you have a simulation center, access those resources for conducting the simulation, as well as debriefing. Midwifery and OB/GYN faculty should be in attendance even if simulation center staff are present. If you do not have a simulation center or will be conducting these from a distance, determine faculty strengths and weaknesses. How comfortable are you with the video conferencing software? What if there are IT issues? Are you trained in debriefing techniques? Answers to these questions will determine faculty development needs. Included in this packet are some basic simulation and debriefing materials, as well as links to other resources.
- Plan plenty of time for whatever faculty development needs you have determined.

- Also, plan time to have a dry run of the simulations and debriefing with all midwifery and OB/GYN faculty prior to implementation with students. This will be vital for a smooth implementation, as well as effective debriefing.

Step 4:

- Roll out simulations. Plan to enter sim center or video conferencing software early, so you are set prior to student entry.
- Troubleshoot any unexpected outcomes, hopefully, based on prior contingency plans.
- Conduct debriefing.
- Have learners fill out post simulation questionnaire.
- Conduct faculty debriefing. What edits need to be made to pre-requisite materials, if any? With simulation or debriefing? Technology or sim center set up?

Step 5:

- Post implementation: Determine how it went from the faculty perspective. Make edits as necessary. Review learners post-simulation questionnaire results. Make edits to materials and implementation as needed.
- Plan for next term or years implementation. Some residents will already have been through experience in this previous year. Determine if they will be exempt from this activity or if they will have an altered form next year.

Faculty Notes During Simulation

Simulation Date:
Learners:

Faculty in attendance:

Learning Objective	Feedback
Management of plan of care, including a critique of evidence-based care	
SBAR presentation; communication between resident and SNM	
Roles and responsibilities; Scope of practice	
Values/ethics for IP practice; Professionalism, collegiality	
Teamwork	
Other notes	

Grading Rubric

Criteria	Ratings			Total Points
Plan of Care	30 points Formulates complete plan of care for patient.	15 points Missing information from plan of care	0 points Numerous counts of missing information in plan of care	30 points
Critique Plan of Care	20 points Complete critique of plan of care using evidence-based information.	10 points Incomplete critique of plan of care using evidence-based information.	0 points No evidence of critique of plan of care using evidence-based information.	20 points
SBAR consultation	20 points Complete SBAR presentation during IPE simulation.	10 points Incomplete SBAR presentation during IPE simulation.	0 points Multiple errors in SBAR formatting or presentation during IPE simulation.	20 points
Debriefing	30 points Active participation during debriefing. Able to critically reflect on care and interprofessional interaction and answer questions posed. Professional and collegial in interactions.	15 points Minimal interaction, or minimal critical reflection on care and IP interaction or minimal professionalism or collegiality in interactions.	0 points Limited or no interactions, does not critically reflect on care or IP interaction or is not professional or collegial in interactions.	30 points
				Total points=100

Debriefing

Room:

Debrief in a separate environment than where the simulation took place, ideally around a table.

Faculty:

Ensure midwifery and OB/GYN faculty present for debriefing.

Goal is collegial discourse and modeling of teamwork among faculty, as well as learners.

Act as facilitators of discussion; do not lecture.

Prebrief:

Re-establish this being a safe space, where they do not need to know all of the answers, but focus is on learning and improvement. Faculty may use the advocacy inquiry method of debriefing. Faculty note a situation, and what actions led up to the situation, and help the leaner(s) determine how they were thinking that led to that conclusion. It might feel uncomfortable, but the goal is to get at the thought process.

Review Learning objectives again:

1. Develop a plan of care for a patient scenario including diagnosis, plan and level of consultant involvement if needed.
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Questionnaire to be completed at the end.

Explain how feedback and grading will be done.

Debriefing: Utilize Debriefing with Good Judgement model of debriefing.

Shared mental model of the experience they just had. Ask learners to share, or can just state what they all just experienced.

Initial learner reaction to the simulation experience.

Scenario 1-Sandy Shane, OOH birth, transferred to hospital for extensive tear repair, wants to leave ASAP

Was there evidence of the patient/family being involved in the plan of care and how might this influence the actual plan?

Scenario 2-Judy Smith-GYN patient with menorrhagia

What were the benefits of a team model of care for the patient?
- Were there any hindrances to implementing that model?
- How could these hindrances be mitigated?

Scenario 3-Kelly Wilcox-prolonged second stage of labor

What was one new thing they learned about the other provider's role with this experience, that they did not know previously?

What is everyone's role in consulting vs collaborating vs referring?

Scenario 4-Jane Black- HELLP

How could this experience extend beyond this one simulation?
- What other types of encounters might be helpful to use SBAR?
- When should teamwork be used in patient care?

What did everyone think of using SBAR for communication?
- Pros?
- Cons?

During each scenario were they clear on their role and what the other provider would be doing?

Was specific language used to communicate and ensure that roles were clear? (like consultation, collaboration or referral)

What one thing will they take away from this experience that you will change in future encounters?

Summary:

The goal of this simulation experience was to increase knowledge and exposure of midwifery students and OB/GYN residents to each other prior to graduation and real life work together with patients. Hopefully, everyone is feeling more comfortable with scope of practice and utilizing the team approach to meet patient needs. Communication downfalls are a major determinant in errors, and so the more we can establish collegial teamwork using best practices with communication, the safer patients will be.

Review learning objectives:

1. Develop a plan of care for a patient scenario including diagnosis, plan and level of consultant involvement if needed.
2. Critique patient plan of care using evidenced-based information
3. Apply critical and reflective thinking as it relates to clinical decision making
4. Utilize SBAR format to present to consultant.
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Thank you for your active participation in this learning experience. You all need to fill out the post-simulation questionnaire in order to receive credit for this assignment.

Post Simulation Questionnaire

Specialty:

OB/GYN
Midwifery

Likert Scale:

5 Strongly agree
4 Agree
2 Disagree
1 Strongly disagree

The information, done as preparatory work for this experience, on guiding principles, role clarity and interprofessional collaboration were useful for my learning.

The prebrief/orientation was helpful.

I clearly understood the objectives of this assignment.

I felt well prepared for the simulation.

The time provided for participation in the simulation was adequate (there will be a separate question about debriefing time).

The amount of time for debriefing was adequate.

The facilitators of the debriefing encouraged active participation.

The facilitators of the debriefing modeled collegial teamwork and communication during the debriefing.

This was a positive learning experience.

I feel better prepared for future practice to work as a team.

I am more clear on the scope of practice of the other profession.

I can use SBAR to communicate information in future encounters.

Resident Simulation Key

Key Points:

- Prolonged second stage due to dense epidural
- Category II tracing: No signs of fetal asphyxia and need for expedited delivery
- CNM part of care team with expertise in non-intervention
- Collaborative care can go from MD to CNM as well as CNM to MD

Plan:

- Assess fetal position and make decisions based on whether fetal head may rotate in specific maternal position
- Position changes to side-lying, hands and knees as able
- Collaborate with CNM on non-interventive methods to facilitate SVD
- Consult with anesthesia to turn epidural down or off prn
- Laboring down with epidural
- Assess hydration and voiding status
- Re-evaluate in 30 minutes

Kelly Wilcox
32yo
G1P0
41.1 weeks gestation

HPI:

IOL at 41.1 weeks by OBs and residents. Pregnancy and induction have been uncomplicated. Cytotec X 4; then Pitocin induction. Epidural was placed when Pitocin was started, with good relief. Began pushing 3 hours ago. Pushing in semi-Fowler's position. Just recently started feeling rectal pressure. Patient states she is exhausted and is not sure how much longer she can do this. Patient declines, c/s, vacuum and forceps. GBS negative.

Medical history:

Mild, intermittent asthma-no medications or intubations

Surgical history:

Negative

OB History:

Started prenatal care at 10 weeks with physician group. No complications.
Normal routine labs.

Physical exam:

Vital signs:

Pulse:90 bpm
Respirations: 20/min
BP: 132/80 mmHg
Temp: 36.2*C

Labor course:

VE: 10/100%/+2/+3; 1+ molding of the parietal bones and minimal caput
FHR 140's with intermittent variables down to 100 with pushing, moderate variability, accels present.
Contractions every 2-3 minutes, lasting 60 seconds, strong by palpation.
Pitocin @ 12mU/min
SROM X5 hours; clear fluid

Resident is going to midwifery student for assistance with this situation.

SNM Collaborate Simulation Key

Key Points:

- 3rd degree laceration with bilateral sulcus tear
- Probable PPH (pulse, type of laceration, took vigorous massage and breastfeeding to firm uterus)
- History of asthma
- Newborn at birth center
- Patient desires very little intervention, no IV narcotics and wants to leave ASAP
- Each member of care team has a role to play

Plan:

- Admit short stay
- Heparin lock (patient does not want IV, this will allow IV access)
- Labs: CBC, Type and Cross
- Education of patient and doula: Risks associated with PPH and repair, need for fluid replacement, labs to assess extent of blood loss, IV sedation to facilitate repair prn, nitrous prn
- Collaborative care with OB (MD will do at least 3rd degree and sulcus repair, CNM may take over at 2nd degree, especially due to new grad CNM)
- Consult anesthesia options for relaxation to facilitate repair (nitrous might be ideal if available, pudendal, IV sedation or spinal narcotics)
- Ideally CNM, out-of-hospital midwife, OB and anesthesiologist present care options to patient

Sandy Shane
23yo
G2P2002
Old Order Mennonite
8th grade education
Self pay, no insurance
2 hours postpartum
You, as CNM, graduated 6 months ago.

HPI:

You are the birth center CNM with hospital privileges. You are transferring a patient from the birth center who you have attended for birth and provided continuity in her care. Status is about 2 hours post SVD at 41.4 weeks complicated by 6 minute shoulder dystocia. Large vaginal/perineal laceration that will require repair. Estimated blood loss ~400ml. Uterus firmed with vigorous massage and breastfeeding, but continues to bleed. Neonate weighs 4220 g and had APGARs of 3, 6, and 8 and is stable at the birth center with father and RN. Newborn infant will be staying at birth center for 4 hours observation. Newborn breastfed with swallowing observed prior to maternal transfer to hospital. BG of newborn appropriate.

Patient consents to transport to the hospital for self only, but wants to leave as soon as possible. She has no family/support with her. She is concerned about the cost of care and generally feels uncomfortable in the hospital environment. She desires to get back to her newborn infant as soon as possible, but will not assert desires to medical staff. Tells you that she wants to get home as soon as possible and does not want an epidural.

Past Medical History:

Mild-Intermittent asthma treated with Albuterol inhaler PRN. Last use: last week.
All immunizations current.
NKDA

Past surgical History:

Denies

OB/GYN History:

Pregnancy 1: SVD at term 3 years ago, at home. No complications.
Pregnancy 2: current; Began prenatal care at 8 weeks gestation. No complications. All routine labs normal. Prenatal records brought by out-of-hospital midwife.

ROS:

Denies lightheadedness, dizziness, chest pain or headache.

Physical Exam:

Vital signs:

Pulse: 112 bpm
Respirations: 20/min
BP: 92/60 mmHg
Temp: 36.4*C

Lungs:

Clear to auscultation bilaterally.
Respirations even and unlabored.

Heart:

Normal heart sounds auscultated.

Vaginal exam:

Exam difficult due to patient discomfort.
3rd-degree perineal laceration, with bilateral sulcus tears
Uterus fundus: firm
Moderate amount of blood on pad; changed 30 minutes ago.

SNM Consult Simulation Key

Key points:

- Menorrhagia
- Anemia
- Probable fibroids
- Dysmneorrhea
- Paragrad IUD-need to ensure placement
- ASC-US pap, negative HPV
- AUB-L vs AUB-I

Plan:

- Urine pregnancy test
- Pap smear every three years
- CBC-to confirm fingerstick and determine POC
- U/S-irregular shaped uterus and IUD placement
- Offer STI testing
- Consult physician-fibroids and plan of care
- Ferrous sulfate 325mg po qd
- Iron-rich foods
- Call patient with lab and u/s reports

Judy Smith
39yo
G2P2002
LMP: 2 weeks ago, every 28 days, heavy flow x 7 days, using super plus tampons every 1-2 hours x 2 days, no clots

HPI:

In office for evaluation of heavy period bleeding that started 3 months ago. Has 1-2 days of really heavy bleeding where she changes her tampon every 1-2 hours; no clots. Painful cramping x first 5 days requiring OTC treatment.

Family history:

Parents alive- father with HTN diagnosed at age 65, mother with diabetes diagnosed at age 59.
Siblings alive and well.
PGF alive at age 80.
PGM alive with HTN.
MGF died of lung cancer at age 62.
PGM died in MVA at age 50.
Children alive and well.

Past medical history:

Last annual exam 1 year ago.
Seasonal allergies treated with Flonase.
Occasional heartburn treated with tums with relief.
Tdap given last year, tetanus 3 years ago.

Past surgical history:

T+A at age 10.
Appendectomy at age 20.

OB/GYN History:

Menarche age 13, every 28 days lasting x4-5 days, medium flow.
Has used OCPs and condoms in past for contraception. Currently has Paragard IUD, inserted 5 years ago.
Pap smear last year: endocervical cells present, ASC-US, negative HPV. No other hx of abnormal paps
Pregnancy 1: 9 years ago, boy, SVD no complications
Pregnancy 2: 6 years ago, girl, SVD no complications

Social History:

Married x12 years, lives with husband and 2 children. Reports monogamy.
Nonsmoker
Drinks 1-2 glasses of wine weekly
Drinks 2 cups of coffee a day
Exercise 4 times a week with 45 minutes of cardio
Works FT as a physical therapist at the hospital

Physical Exam

Vital signs:

Pulse-68 bpm

Respirations-16/min

BP- 102/68 mmHg

Temp- 37*C

Weight:

138 lbs

Height:

5'4"

Lungs:

Clear to auscultation throughout

Respirations easy and unlabored

Heart:

Regular rate and rhythm, no extra heart sounds

Abdomen:

+ Bowel sounds x 4

Abdomen soft nontender

No hepatosplenomegaly

Breast exam:

Soft, no masses noted bilaterally

Pelvic Exam:

Normal mons hair distribution

No moles or lesions noted

Vaginal walls pink with rugae

Cervix midline with no obvious anomalies; IUD strings visible

Bimanual:

Irregularly shaped uterus with nodularity noted in left portion of uterus, approximate size 4 cm

ovaries smooth, not enlarged, nontender

Office fingerstick:

Hgb 11.6 g/dL

SNM Refer Simulation Key

Key Points:

HELLP
Category 1 FHR
Need for referral between CNM to OB (in some places, and with enough CNM experience, may be collaborative care)-even with referral CNM may take social role in care
Patient as a member of care team
Present plan of care as team

Plan:

Nifedipine 10mg po; if not effective Nifedipine 20mg po X 2 separate doses, then on to labetalol (may have discussion about nifedipine use vs labetalol 20mg IV with 40mg after 20 minutes prn or hydralazine 5-10mg every 15-20 minutes)
Repeat BP every 15 minutes.
Begin Mag Sulfate 4gm loading does, then 2 gm/hr IV (may have discussion about 1gm vs 2 gm maintenance dose)
Maintain LR at 100cc/hr
Misoprostil 25mcg
Strict I + O
Labs: repeat CBC, AST/ALT, Uric acid, LDH, PT/PTT
Bedrest
Seizure precautions

References:

ACOG Committee Opinion Number 767 (2019). Emergent therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. *Obstetrics & Gynecology,* 133(2), e174-e180.

Jane Black
29 yo
G2P1001
38 weeks gestation

HPI:

Out-of-hospital midwives weekly appointment noted to have elevated BPs. Transferred to tertiary hospital CNM care after consulting OBs for induction. The client desires minimal intervention. Induction began 3 hours ago with Misoprostol 25mcg. Cervical exam 1/60%/-3. BP 130-165/80-120. Patient notes mild occasional cramping. Patient requests to ambulate; declines epidural. Out-of-hospital midwife acting as doula.

OB/GYN History:

Pregnancy 1: SVD 4 years ago at term. No complications

Pregnancy 2: began prenatal care at 10 weeks. Consistent care with no risk factors; planned homebirth. BP 110/64 at new OB visit. Routine labs done; normal findings.

ROS:

Severe headache with flashing visual changes started 30 minutes ago.

Denis n/v and epigastric pain.

Labs in admission:

Hgb/Hct: 9.7/29.2

PLT: 96,000

AST: 70 U/L

ALT: 50 U/L

Total protein/creatinine ratio: 1.2

Creatinine: 1.2mg/dL

Physical Exam

Vital Signs:

Pulse: 86 bpm

Respirations: 20/min

BP: 200/118, repeat 210/115 mmHg

Temp: 36.8*C

OB Course:

Cervical exam 2/70%/-3.

FHR 130's, accels to 150s. No decelerations.

Contractions:1 every 15 minutes, mild on palpation.

Lungs:

Clear to auscultation throughout

Respirations easy and unlabored

Heart:

Regular rate and rhythm

Extremities:

+ 1 pitting pedal edema

2+ DTRs

Debriefing Tips

Debriefing is where the majority of the learning occurs during a simulation experience.

Adult learners want to make meaning out of what they are being asked to learn. Helping them connect the experience to previous knowledge and future needs is helpful.

Role of faculty is as a facilitator of discussion. Faculty should not be lecturing. Try to pull information out of students and help them realize why they arrived at where they did.

Plan debriefing to last 1-2 times the length of the simulation experience. Ex: if the simulation is 20 minutes, debriefing should be 20-40 minutes.

Conduct debriefing in a separate space than where simulation occurred. Ideally with everyone around a table or on equal space, if doing it in a distance environment.

Conduct a prebrief prior to debriefing: note expectation of active participation but no need to answer every question, how to get most from the learning experience, faculty role, brief review of safe space/confidentiality

After prebrief: begin by asking for reactions to the simulation experience.

Debriefing with Good Judgment:

Debriefing with good judgment: any area noted to be done exceptionally well and /or an area for improvement.

This method is considered an advocacy inquiry method as it uses both components. It starts with the facilitator making a statement about what they saw (advocacy) and then asking about the frame of reference that led to that with a question (inquiry).

Three-step approach:

1. state the result (I saw..here is my perspective)
2. list what actions led to the result (I think...I am concerned/pleased because....)
3. ask what frame of reference led to those actions (I wonder...walk me through your thinking...)

Faculty may need to practice not sounding accusatory when using this method. The focus should be on learning and realizing that faculty may not always have the best answers either.

Query, query, query the students. Do not take their answer at face value, but ask them to explain how they arrived at that answer. What else were they thinking?, Were there areas that were harder or easier to do? etc.

If someone is not participating, then the next question you ask direct it to them. This helps bring in shyer more reserved students.

If a student had many issues during the simulation, speak to them privately. Do not use the debriefing to mention all of their errors in front of the group.

At the end of debriefing: Ask everyone to reflect back on their performance and list one thing they will change or modify in future IPE encounters, summarize key points, review learning objectives, clarify any misconceptions or learning that occurred during the session.

Simulation Tips

Dress rehearsal

- Plan to run through the whole thing with just faculty prior to implementing with students
    - This allows faculty to work through IT or sim center kinks, as well as make sure faculty is on the same page

Faculty active participation

- Make sure faculty are actively engaged during simulation
    - Allows for quick response if issues arise
    - Allows for the observance of issues that may need to be addressed during debriefing or with a leaner afterward
- Take notes!
    - Invaluable for debriefing afterward
    - Note any edits/tweaks that need to be made in future iterations of the simulation

Contingency plans

- Plan ahead what will happen if one or more learners are not there
    - How will sim run
    - Will whole thing be rescheduled
    - Consequences for learner
- Plan ahead for technology issues, if doing this from a distance

Resources

Management:

ACOG Committee opinions on Pre-eclampsia: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Emergent-Therapy-for-Acute-Onset-Severe-Hypertension-During-Pregnancy-and-the-Postpartum-Period

California Maternal Quality Care collaborative: https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit

SBAR:

Systematic review: https://psnet.ahrq.gov/resources/resource/32434/Impact-of-the-communication-and-patient-hand-off-tool-SBAR-on-patient-safety-a-systematic-review

Review article: https://psnet.ahrq.gov/resources/resource/32213/Situation-background-assessment-recommendation-SBAR-communication-tool-for-handoff-in-health-care-a-narrative-review

Simulations:

ACOG: https://www.acog.org/search#q=simulation%20consortium&sort=relevancy

California Maternal Quality Care collaborative: https://www.cmqcc.org/resources-tool-kits/toolkits/preeclampsia-toolkit

TeamSTEPPS:

https://www.ahrq.gov/teamstepps/index.html

Debriefing with Good Judgment:

https://www.sciencedirect.com/science/article/abs/pii/S1932227507000237