

OB

POSTPARTUM HEMORRHAGE

Estimated Time: 30 minutes • Debriefing Time: 30 minutes



Scan to Begin



Patient Name: Olivia Brooks

SCENARIO OVERVIEW

Olivia Brooks is 28-year-old female who vaginally delivered a healthy baby earlier today. In State 1, as the students walk into the room, they find the patient standing up with blood dripping down her legs. The patient complains of dizziness as she sinks into the bedside chair. Students should initiate immediate care for the patient in this potentially emergent situation. In State 2, the nurse has assessed the patient and provides report. Students should assist in implementing the postpartum hemorrhage protocol.

This scenario can be used for high- or low-fidelity simulation. In high-fidelity simulation, the patient videos and tabbed chart content can be used to augment the reality of the simulation. In low-fidelity simulation, the instructor can use role play, in association with the scenario content, to stimulate student critical thinking and discussion about prenatal care topics.

LEARNING OBJECTIVES

1. Maintain a safe, effective health care environment for a patient experiencing postpartum bleeding
2. Implement nursing care based on evidence based practices for a patient experiencing postpartum bleeding
3. Provide therapeutic communication to the patient during a medical crisis

CURRICULUM MAPPING

WTCS NURSING PROGRAM OUTCOMES

- Implement one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving professional identity as a nurse committed to evidence-based practice, caring, advocacy and quality care
- Demonstrate appropriate written, verbal, and nonverbal communication in a variety of clinical contexts
- Integrate social, mathematical, and physical sciences, pharmacology, and pathophysiology in clinical decision making
- Provide patient centered care by utilizing the nursing process across diverse populations and health care settings
- Minimize risk of harm to patients, members of the healthcare team and self through safe individual performance and participation in system effectiveness
- Use information and technology to communicate, manage data, mitigate error, and support decision-making

NURSING FUNDAMENTALS

- Maintain a safe, effective care environment for adults of all ages
- Use appropriate communication techniques
- Use the nursing process
- Adapt nursing practice to meet the needs of diverse patients in a variety of settings

COMPLEX HEALTH ALTERATIONS II

- Evaluate nursing care for the high-risk perinatal patient

SIMULATION LEARNING ENVIRONMENT & SET-UP

ENVIRONMENT: LABOR AND DELIVERY ROOM

Inside room: Vital signs equipment

Inside or outside room: Sanitizer or sink for hand hygiene

Scenario time: Patient delivered the baby earlier today

PATIENT PROFILE

Name: Olivia Brooks

Number living: 0

DOB: 01/29/19XX

LMP: X/X/20XX

Age: 28

EDC: X/X/20XX

MR#: 12919

Gestational Age: 40w1d

Gender: Female

Blood Type: A neg

Height: 162.5 cm (5ft 5in)

Allergies: NKDA

Weight: 89.1 kg (196 lbs)

Code Status: Full

Gravida: 2

Ethnicity: Caucasian

Para: 0

Spiritual Practice: Lutheran

AB: 1

Primary Language: English

Facilitator Note: Before scenario, create the LMP and EDC based on current date so that gestational age is 40 weeks and 1 day.

EQUIPMENT/SUPPLIES/SETTINGS

Patient

- Wearing hospital gown with evidence of significant bleeding on the gown and sheets

Monitor Settings

- Vital signs: 84/44, HR 118, RR 24, Temp 98.6, O2 sat 94%

Supplies

- Medications:
 - Carboprost tromethamine 250 mcg ampule
 - Misoprostol 200 mcg tablets
 - Methylergonovine 0.2mg/ml vial
 - Oxytocin 30 units in LR 500 ml
 - Lactated Ringers 250 ml IV
- Oxygen and nonrebreather mask
- IV start kit

QR CODES

<p>START</p> 	<p>PATIENT</p> 	<p>REPORT</p> 	<p>FACILITATOR</p> 
<p>METHYLERGONOVINE MALEATE IM</p> 	<p>CARBOPROST TROMETHAMINE</p> 	<p>LACTATED RINGERS IV</p> 	<p>OXYTOCIN IV</p> 
<p>MISOPROSTOL</p> 	<p>PATIENT ID</p> 		

TEACHING PLAN

PREBRIEF

The facilitator should lead this portion of the simulation. The following steps will guide you through Prebrief.

- Scan the **QR Code: “Scan to Begin”** while students are in Prebrief.
- “Meet Your Patient” (on iPad) and explain how the iPad works in the simulated learning environment including:
 - Explain how to use the iPad scanner and QR codes. Remind students that there are multiple QR codes in the simulation, but they should only scan them if they think it will provide data necessary for their assessment and evaluation of the patient.
 - Medication Hyperlinks – Medications are hyperlinked to DailyMed, which is a medication reference housed by the National Library of Medicine. Students can click on these links during the simulation for up-to-date medication content, labels, and package insert information.
 - As the facilitator, you should be aware that throughout the simulation some QR codes are necessary to the programming of the iPad content. Directions for which QR codes are required (to be scanned) in each state are listed under each state of the documentation below. The QR codes are also in **BOLD** type.
 - Level tab – This tab “tells” the content in the iPad to change to what is needed for the next state of a simulation.
- Discuss the simulation “Learning Objective(s)” (on iPad) as well as any other Prebrief materials
- View Patient Video
 - Possible Facilitator Questions
 - What are your immediate clinical concerns and how will you address them?
 - Does the patient have any risk factors for postpartum hemorrhage? (Students may review the Delivery record.)

- Review the postpartum hemorrhage protocol (under the Protocol tab on the iPad) with students before they enter the room.

PATIENT PROFILE

Patient demographic information is displayed here

PROTOCOL

A protocol for Postpartum Hemorrhage is provided here. A printable form is available in Appendix A.

Suggested facilitator questions:

- What is your first priority nursing action in this situation? Why?
- Does the patient meet the criteria to implement the postpartum hemorrhage protocol? Why or why not?
- Why are the peripads weighed? (in grams)
- Review the Postpartum hemorrhage protocol and medication therapies.

DAILY RECORD

Vitals	Today, 8 hrs ago				
Pulse	88				
Resp. Rate	16				
BP Systolic	120				
BP Diastolic	80				
Temp (°C)	37				
O ₂ Saturation (%)	100%				
Applied Oxygen	RA				
Pain	3				

Assessments	
Cardio	heart rate strong and regular, bilateral lower extremities edema +1
Resp	bilateral lung sounds clear
GI	active bowel sounds all four quadrants
GU	voided 300cc without difficulty
Breasts	soft, slight filling
Fundus	u/u firm
Lochia	moderate rubra no clots noted
Incision/episiotomy	perineum intact, no swelling, no bruising
Legs	non-tender, no swelling, warmth or redness noted
Emotional status	pleasant, asking questions about infant
Bonding with infant	holding infant
Comfort measures	ice applied to perineum, using tucks, Kegels prior to sitting
Nutrition	general diet good appetite

Teaching Completed
<ul style="list-style-type: none"> • Positioning at breast • Breastfeeding frequency • Care of perineum • Lochia changes • Fundal changes • Infant feeding patterns • Pain relief measure for postpartum • Safe sleeping measures • Infant safety/identification • Handwashing for infant handling and caring for perineum • Importance of rest/sleep • Signs and symptoms to report to health care provider

Postpartum Fall Risk
<ul style="list-style-type: none"> • Epidural less than 3 hrs ago • Unstable blood pressure • Greater than 500ml blood loss • Numbness of lower extremities • Motor movement of extremities

Suggested facilitator questions:

- Compare your current findings with previous documented findings.

DELIVERY RECORD

The patient's delivery record is located here. A printable version is located in Appendix B.

OB/GYN HISTORY

OB/GYN History

PAST MEDICAL HISTORY: 28-year-old healthy female with history of genital herpes and mixed anxiety depressive disorder.

SURGICAL HISTORY: Tonsillectomy age 12; Wisdom teeth extraction age 18; D&C after miscarriage

FAMILY HISTORY: Father with hypertension; mother with diabetes mellitus, maternal grandmother with breast cancer

SOCIAL HISTORY: Lives in Anytown, WI with her husband and 2 cats.

TOBACCO USE: Smoked 1 ppd until discovered was pregnant.

ALCOHOL USE: Binge drinking on weekends (6 drinks or more/night) until discovered she was pregnant.

DRUG USE: Denies.

EDUCATION: High school graduate.

EMPLOYMENT HISTORY: Works as a C.N.A. at local skilled nursing facility where helps transfer patients from bed to wheelchair.

MENSTRUAL HISTORY:

ONSET: age: 12 yrs **CYCLE:** 30 days **DURATION:** 5 days

LMP: XX/XX/20XX

PAST PREGNANCY HISTORY:

Date	Weeks Gest.	Length Labor	Type Delivery	Anesth.	Weight	Remarks
2016	12 wks	---	---	---	---	Spontaneous AB

PRENATAL RECORD

Date	8wk	16wk	20wk	24wk	28wk	32wk	36wk	38k	40wk
Weeks Gestation	8w3d	16w5d	20w2d	24w5d	281d	32w6d	36w1d	38w	40w
Weight	156 lb	158 lb	161 lb	166 lb	169 lb	173 lb	178 lb	180 lb	182 lb
BP	110/64	112/68	118/72	114/70	116/76	120/72	122/74	124/76	126/76
Fundal Height	---	16 cm	20 cm	24 cm	28 cm	33 cm	37 cm	39 cm	41 cm
Position/ Presentation	---	---	---	vertex	vertex	vertex	vertex	vertex	vertex
Station	---	---	---	---	---	---	-3	-3	-2
FHT	---	150	168	132	150	156	132	144	156
Edema	neg	neg	neg	neg	1+	1+	2+	2+	2+
Urine glucose and protein	---	neg							
Contractions	---	---	---	---	---	---	---	---	+
Fetal Activity	---	---	---	Pos	Pos	Pos	Pos	Pos	Pos
Non-stress test	---	---	---	---	---	---	---	---	---
Provider	BB								

Progress Notes

Date/Time	Note
8 wks	First prenatal visit; no complaints, excited regarding pregnancy. --- BB
12 wks	Missed appointment; called and stated had mandatory call at work. --- BB
16 wks	Doing well, denies any complaints. Reviewed 2 nd trimester changes and to schedule 20-week ultrasound. --- BB

20 wks	Ultrasound prior to appointment confirmed due date. Has backache, will try occasional Tylenol and stretching exercises. --- BB
24 wks	Backache improving, feeling quickening. Discussed prep for GCT at next appointment. --- BB
28 wks	1+ edema, worse after shift standing at work. Discussed L&D prep classes. GCT and Rhogam today. --- BB
32 wks	Edema same, trying to keep legs elevated after work. Discussed pain management option for L&D, prefers IM, IV meds. Possible epidural OK. Group B strep culture at next appointment. No herpes breakouts during pregnancy. --- BB
36 wks	Discussed signs of preterm labor and when to go to L&D. --- BB
38 wks	Discussed need for IV antibiotics in labor due to positive Group B strep culture. --- BB
40 wks	Reports some occasional Braxton Hicks contractions. Feels baby moving frequently. Discussed birth plan and desire for epidural. ----BB

GENETICS SCREENING

Genetics Screening	Response (Yes/No)	Family Member
Patient Age > 35 years?	No	
Italian, Greek, Mediterranean, Oriental Background (if MCV<80)	Yes	
Jewish background (Tay Sachs)	No	
History of Neural Tube Defect?	No	
History of Down's Syndrome?	Yes	Paternal uncle's baby
History of Sickle Cell Disease or Trait?	No	
History of Hemophilia?	No	
History of Cystic Fibrosis?	No	
History of Congenital Heart Disease?	Yes	Sister's baby
History of Muscular Dystrophy?	No	
History of Huntington Chorea?	No	
Patient had child with birth defect not listed above, >3 first trimester abortions, or stillbirths?	No	
Baby's father had child with birth defect not listed above, >3 first trimester abortions, or stillbirths?	No	
Medications or street drugs since LMP?	Yes	

VITAL SIGNS

This is an enterable screen where students may enter vital signs. The following previous values are displayed: Pulse 78, RR 16, Systolic BP 108, Diastolic BP 78, Temp 36.8, O2 sat 100%

ORDERS

Date	Time	Order
Today	On Admission	Order Set: Admission for Routine Postpartum
		Admit for Postpartum vaginal delivery
		Vitals: routine, vital signs and assess fundus, lochia q 30 minutes X3, then Q hr X2, then Q 4 hrs X24Hrs then Q shift until discharge
		IV fluids: Saline lock IV Discontinue IV when the following are met: <ul style="list-style-type: none"> - Patient toleration oral intake without nausea or vomiting - After antibiotics completed - 18-24 hours post spinal anesthesia
		Diet: As tolerated
		Activity: up ad lib
		Labs: <ul style="list-style-type: none"> - Hemoglobin in the morning - Hematocrit in the morning - If mother is Rh negative and delivers Rh positive baby with a negative Coombs test then obtain a fetal screen test
		Urinary care If unable to void: in and out catheterization PRN once
		MEDICATIONS For mild pain rated 1 to 3 or less than patient's comfort goal: Acetaminophen 1000 mg PO every 6 hours PRN for pain Ibuprofen 600 mg PO every 6 hours prn Post-delivery Uterotonic medications Oxytocin 60 mU/ml (30 units/500 ml) at 250 ml/hour IV continuous infusion immediately after delivery <ul style="list-style-type: none"> - Discontinue Oxytocin after 500 ml infused if patient stable

		<p>Antacids Calcium Carbonate 500 mg chewable tablet, 2 tablets PO every 2 hours PRN for indigestion</p> <p>Bowel Care Docusate 100 mg PO twice daily Bisacodyl 10 mg suppository PRN Magnesium hydroxide 400 mg/5ml suspension, 30 ml PO every 8 hours PRN</p> <p>Vaccines</p> <ul style="list-style-type: none"> - If non-immune to rubella administer Measles-Mumps-Rubella vaccine 0.5 ml subq first morning after delivery - If mother has not had during this pregnancy: Tdap 0.5ml intramuscularly first morning after delivery - Seasonal influenza virus vaccine PRN <p>Other</p> <ul style="list-style-type: none"> - If mother is Rh negative: Rho D immune globulin (RhoGAM) 333 mcg IM and order Rh Antibody testing - Apply heat or ice for abdominal pain PRN
		<p>Notify Provider if:</p> <ul style="list-style-type: none"> - Temperature greater than 38.5 degrees Celsius - Systolic BP greater than 140 or less than 90 - Diastolic BP greater than 100 or less than 55 - Heart rate greater than 120 or less than 50 bpm - Oxygen saturation less than 90% - Urine output less than 30 ml/hr for 2 consecutive hours
		---- B. Barker, MD

MAR

Medication Administration Record

Scheduled			
Docusate 100 mg PO twice daily	Due Today		Last Given
	0800	1800	
Continuous Infusion			
Oxytocin 60 mU/ml (30 units/500 ml) at 250 ml/hour IV until fundus firm PRN per PPH protocol	Started		
Lactated Ringers IV 1000 ml over 1 hour PRN per PPH protocol	Started		

NURSING | LEVEL: 4

PRN	
Methylergonovine maleate 0.2 mg IM single dose PRN per PPH protocol	Last Given
Carboprost tromethamine 250 mcg IM single dose PRN per PPH protocol	Last Given
Misoprostol 800 mcg rectally single dose per PPH protocol	Last Given

IMMUNIZATIONS

A link is also provided to the CDC Guidelines for Vaccinating Pregnant Women.

Immunization Record	Date Received
Hepatitis A	Never
Hepatitis B	1/30/1990, 3/2/1990, 7/5/1990
Haemophilus influenzae type b4 (Hib)	3/2/1990, 5/7/1990, 2/1/1991
HPV	Never
Influenza	12/14/2016
Measles, mumps, rubella (MMR)	2/1/1991
Pneumococcal	Never
IPV – Inactivated Polio	3/2/1990, 5/7/1990, 2/1/1991
Diphtheria, tetanus, & acellular pertussis (DTaP)	3/2/1990, 5/7/1990, 7/5/1990
Td booster	11/14/2000, 9/9/2010
Varicella Vaccine or had Chicken Pox	Reported chicken pox 8/1995
Rhogam	Xx/xx/20xx (28 wks gestation)

LABS

Hospital Laboratory Results

CBC with Differential					
	Today on Admission			Units	Reference Range for Pregnant Females
WBC	16			x10 ³ uL	3rd trimester: 5.6 - 16.9

RBC	4.8			x10 ⁶ uL	3rd trimester: 2.72 - 4.43
Hgb	11			g/dL	3rd trimester: 9.5 -15
HCT	33.0			%	3rd trimester: 28 - 40
MCV	82.6			fL	3rd trimester: 82.4 - 100.4
MCH	30			pg	3rd trimester: 25-32
MCHC	320			g/L	3rd trimester: 319-355
RDW	12.3			%	3rd trimester: 11.4- 16.6
Platelet	355			x10 ⁹ uL	3rd trimester: 146 - 429
MPV	9.0			fl	3rd trimester: 8.2-10.4
Neutro	6.2			X 10 ³	3rd trimester: 3.9-13.1
Lymph	2.7			X 10 ³	3rd trimester: 1.0-3.6
Mono	0.5			X 10 ³	3rd trimester: 0.1 – 1.4
Eos	0.5			X 10 ³	3rd trimester: 0-0.6
Baso	0.1			X 10 ³	3rd trimester: 0-0.1

PRENATAL Laboratory Results

Group B Strep					
	36 week Visit				Reference Range
Group B Strep	Positive				Negative

CBC					
	8 week Visit	28 week visit		Units	Reference Range for Pregnant Females
WBC	5.4	6.1		x10 ³ uL	1st trimester: 5.7 - 13.6 2nd trimester: 5.6 - 14.8 3rd trimester: 5.6 - 16.9
RBC	4.3	4.8		x10 ⁶ uL	1st trimester: 3.42 - 4.55 2nd trimester: 2.81 - 4.49 3rd trimester: 2.72 - 4.43
Hgb	11.4	12.7		g/dL	1st trimester: 11.6 - 13.9

					2nd trimester: 9.7 - 14.8 3rd trimester: 9.5 -15
HCT	34	33		%	1 st trimester: 31 – 41 2 nd trimester: 30 – 39 3 rd trimester: 28 - 40
MCV	79.3	80.1		fL	1st trimester: 85 -97.8 2nd trimester: 85.8 - 99.4 3rd trimester: 82.4 - 100.4
Platelet	234	242		x10 ⁹ uL	1st trimester: 174 – 391 2nd trimester: 155 – 409 3rd trimester: 146 - 429

Glucose Tests

		28 week visit		Units	Normal Reference Range
GCT	1 hour	144		mg/dl	< 140
GTT	fasting	90		mg/dl	< 95
	1 hour	160		mg/dl	<180
	2 hour	110		mg/dl	< 155
	3 hour	100		mg/dl	< 140

Prenatal Panel

	8 week visit	28 week visit			Normal Reference Range
ABO Group	A				A,B, AB, O
Rh Typing	neg				Pos or Neg
Rh Antibody screen	neg	neg			neg
HBsAg (Hepatitis B)	neg				neg

HIV	neg				neg
HSV 1 &2 by PCR	pos				neg
RPR	neg				neg
Rubella	immune				immune
PAP	normal				normal
Chlamydia	neg				neg
Gonorrhea	neg				neg

Urine					
	8 wks				Reference Range
Urine culture	No growth				No growth
Urine pregnancy	Positive				

DIAGNOSTICS

Ultrasound Report #1

DESCRIPTION: First trimester ultrasound for dates. EDC by LMP: xx/xx/20xx.

DISCUSSION:

Vaginal scan carried out with consent. Chaperone declined.
 Intrauterine pregnancy.
 Single live embryo. CRL = 18mm.
 Gestational age = 8 weeks + 3 days.
 USEDD = XX.YY.20ZZ

Ultrasound Report #2

DESCRIPTION: Second trimester ultrasound at 20 weeks gestation by LMP

DISCUSSION:

Single live pregnancy.

HC = 130mm

AC = 105mm

FL = 22mm

Anterior placenta, not low.

Gestational age, based on dating parameters of HC and FL = 20 weeks and 4 days.

USED = XX.YY.20ZZ

Measurement notes: crown rump length (CRL), femur length (FL), head circumference (HC), abdominal circumference (AC), and humerus length (HL)

LEVEL

Level 1 is displayed here.

SCANNER

Use this tab to scan QR codes

EXIT

The message, “Are you sure you want to exit? All data will be lost? Yes/No” is displayed until the **QR Code: Facilitator** is scanned, indicating expected student behaviors have been met.

STATE 1

INITIALLY RESPOND TO PATIENT STATUS

- Patient Overview
 - The patient video simulates what students find upon entering the room. State 1 allows students to problem solve and prioritize what to do first when they are alone in the room without assistance.
- Expected Student Behaviors
 - Provide appropriate hand hygiene and standard precautions throughout scenario
 - Introduce themselves to the patient
 - Verify patient identity with name and date of birth and/or by scanning **QR Code: Patient ID**
 - Assist patient into bed
 - Address patient's concerns therapeutically while providing emergent care
 - Request assistance in the room
- Technician Prompts
 - Olivia is becoming very dizzy and weak as her blood loss continues.
 - “Why am I so dizzy?”
 - “Why is there so much blood everywhere?”
 - “Am I going to die?”
 - “Where is my husband?”
 - “Who is taking care of my baby?”
 - Facilitator may direct to become increasingly confused
- Suggested Facilitator Questions
 - What are your priorities of care at this point?
 - What resources can you call into the room for assistance?
- Tabbed iPad changes

- When the student has performed the immediate expected behaviors in the room, you may scan the **QR Code: Facilitator** to progress to State 2 where a nurse report is received.

STATE 2

ASSIST IN IMPLEMENTING POSTPARTUM BLEEDING PROTOCOL

- Patient Overview
 - State 2 begins with a video of the nurse report describing interventions that she has already initiated based on the postpartum bleeding protocol. In State 2, students will assist in implementing the rest of the protocol. The facilitator has flexibility in determining how quickly the patient responds to interventions and how much of the postpartum hemorrhage should be implemented.
- Expected Student Behaviors
 - Provide appropriate hand hygiene and standard precautions throughout scenario
 - Address patient's concerns therapeutically while providing emergent care
 - Continue to implement orders from Postpartum Hemorrhage protocol order set based on patient status
 - Initiate Methergine appropriately and evaluate patient response
 - Note: **QR Code: Patient ID** must be scanned before administering medication
 - Update the provider using SBAR format
 - The facilitator can decide how quickly the patient responds to interventions, or deteriorates and progresses to shock
- Technician Prompts
 - Facilitator may direct "patient" to become increasingly confused
- Suggested Facilitator Questions
 - Explain how you will evaluate patient status and continue to implement interventions based on the protocol.
- Tabbed iPad changes
 - When student has performed the expected behaviors, you may scan the **QR Code: Facilitator** to exit.

ORDERS

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		Diet: As tolerated
		Activity: up ad lib
		Labs: <ul style="list-style-type: none"> - Hemoglobin in the morning - Hematocrit in the morning - If mother is Rh negative and delivers Rh positive baby with a negative Coombs test then obtain a fetal screen test
		Urinary care If unable to void: in and out catheterization PRN once
		MEDICATIONS For mild pain rated 1 to 3 or less than patient's comfort goal: Acetaminophen 1000 mg PO every 6 hours PRN for pain Ibuprofen 600 mg PO every 6 hours prn Post-delivery Uterotonic medications Oxytocin 60 mU/ml (30 units/500 ml) at 250 ml/hour IV continuous infusion immediately after delivery <ul style="list-style-type: none"> - Discontinue Oxytocin after 500 ml infused if patient stable Antacids Calcium Carbonate 500 mg chewable tablet, 2 tablets PO every 2 hours PRN for indigestion Bowel Care Docusate 100 mg PO twice daily

		<p>Bisacodyl 10 mg suppository PRN</p> <p>Magnesium hydroxide 400 mg/5ml suspension, 30 ml PO every 8 hours PRN</p> <p>Vaccines</p> <ul style="list-style-type: none"> - If non-immune to rubella administer Measles-Mumps-Rubella vaccine 0.5 ml subq first morning after delivery - If mother has not had during this pregnancy: Tdap 0.5ml intramuscularly first morning after delivery - Seasonal influenza virus vaccine PRN <p>Other</p> <ul style="list-style-type: none"> - If mother is Rh negative: Rho D immune globulin (RhoGAM) 333 mcg IM and order Rh Antibody testing - Apply heat or ice for abdominal pain PRN
		<p>Notify Provider if:</p> <ul style="list-style-type: none"> - Temperature greater than 38.5 degrees Celsius - Systolic BP greater than 140 or less than 90 - Diastolic BP greater than 100 or less than 55 - Heart rate greater than 120 or less than 50 bpm - Oxygen saturation less than 90% - Urine output less than 30 ml/hr for 2 consecutive hours
		---- B. Barker, MD
Today	Now	Initiate Postpartum Hemorrhage protocol
		---- B. Barker, MD

MAR

Medication Administration Record

Scheduled		
Docusate 100 mg PO twice daily	Due Today	Last Given
	0800 1800	
Continuous Infusion		
Oxytocin 60 mU/ml (30 units/500 ml) at 250 ml/hour IV until fundus firm PRN per PPH protocol	Started	10 mins ago
Lactated Ringers IV 1000 ml over 1 hour PRN per PPH protocol	Started	10 mins ago
PRN		
		Last Given

NURSING | LEVEL: 4

Methylergonovine maleate 0.2 mg IM single dose PRN per PPH protocol	
Carboprost tromethamine 250 mcg IM single dose PRN per PPH protocol	Last Given
Misoprostol 800 mcg rectally single dose per PPH protocol	Last Given

DEBRIEF

Nothing needed from the iPad.

QUESTIONS

1. How did you feel this scenario went?
2. Review the learning objective: Maintain a safe, effective health care environment for a postpartum patient
 - a. What emergency measures did you implement when you first discovered the patient had excessive bleeding?
 - b. Review the steps of the Postpartum Hemorrhage protocol
 - i. What criteria did the patient demonstrate for initiation of the protocol?
 - ii. What interventions did you implement?
 - iii. How did you evaluate if the interventions were effective?
3. Review the learning objective: Provide patient centered care by utilizing the nursing process for a patient experiencing postpartum hemorrhage. Tie this scenario to the nursing process:
 - a. Identify 3 priority nursing problems you identified.
 - b. Create a patient centered goal for each nursing problem you identified.
 - c. Describe focused assessments for each nursing problem.
 - d. Discuss nursing interventions for each nursing diagnosis.
 - e. Re-evaluate the simulation in terms of the nursing process; what was actually accomplished? What could be improved in the future?
4. Review the learning objective: Provide therapeutic communication to the patient during a medical crisis
 - a. What therapeutic communication did you provide during this crisis situation?
 - b. Was it effective?
 - c. If you could “do over,” is there anything different you would do?
5. Summarize/Take away Points: “In this scenario you care for a patient experiencing postpartum bleeding. What is one thing you learned from participating in this scenario

that you will take into your nursing practice?” (Ask each student to share something unique from what the other students share.)

NOTE: Debriefing technique is based on INASCL Standard for Debriefing and NLN Theory-Based Debriefing by Dreifuerst.

APPENDIX A: POSTPARTUM PROTOCOL PATIENT EDUCATION HANDOUT

POSTPARTUM HEMORRHAGE PROTOCOL

Initiation Criteria (if one criteria met, proceed with protocol)

1. Boggy uterus and evidence of vital signs changes:
 - a. Heart Rate greater than 110 bpm or 15% greater increase in value from previous reading
 - b. Blood pressure less than or equal to 85/45 or 15% decrease in value from the previous reading
 - c. Oxygen saturation less than 95%

Saturating the peripad in less than or equal to 15 minutes and evidence of one or more of the following:

- a. Heart Rate greater than 110 bpm or 15% greater increase in value from previous reading
- b. Blood pressure less than or equal to 85/45 or 15% decrease in value from the previous reading
- c. Oxygen saturation less than 95%

PROTOCOL

Notification: Notify OB provider to respond to bedside

Vital Signs and Monitoring:

- Check vital signs every 10 minutes until stable then every 30 minutes x 4, then every 1 hour x 4 then every 4 hours x 24 hours
- Check fundal height and vaginal flow every 10 minutes until stable then every 30 minutes x 4, then every 1 hour x 4, then every 4 hours x 24 hours. Massage uterus if increased flow or boggy uterus
- Monitor vaginal bleeding by pad weight

- Record I and O
- Oxygen saturation continuous measurement until vital signs within normal limits

Activity: Bedrest with legs elevated at 30 degrees. Avoid Trendelenburg.

Diet/Nutrition: Nothing by mouth

Patient Care: Oxygen via non-rebreather mask, at 10 liters per minute

IV fluids/medications:

- If no IV access then give Oxytocin 10 units intramuscularly single dose STAT
- Insert 2 peripheral IV lines, using 16 to 18-gauge catheter, blood tubing and anesthesia extension line
- Oxytocin 60 mU/ml (30 units in 500 ml concentration) at 250 mL/hr until fundus firm and flow within normal limits, then titrate to flow and continue IV until discontinued
- Lactated Ringers IV 1000 ml total volume over 1 hour

Labs-Hematology:

- CBC STAT
- Blood bank type and crossmatch STAT in preparation for 2 units PRBCs

Medication Interventions: (Recommend 5-minute interval between medication interventions)

Step 1: If patient is not responding to oxytocin infusion as evidenced by inclusion criteria AND all of the following boxes are met:

- Systolic BP less than 139 mmHg
- Diastolic BP less than 90 mmHg
- Not pre-eclamptic

THEN: Administer methylergonovine maleate (Methergine) 0.2 mg intramuscularly single dose STAT. Evaluate response and assess blood pressure 2-5 minutes after administration and proceed to step 2 if needed.

Step 2: If pt does not have asthma and methylergonovine maleate (Methergine) dose is ineffective:

- If patient does not have asthma, THEN** administer Carboprost tromethamine (Hemabate) 250 mcg IM single dose STAT
- If patient has asthma, THEN** administer additional dose of methylergonovine maleate (Methergine) do not give methergine if BP 160/90 or greater or proceed to step 3

Step 3: If patient is not responding to the above therapies, THEN:

- Administer Misoprostol (Cytotec) 800 mcg rectally single dose STAT
- If clinical picture is consistent with developing shock, notify Rapid Response team, Anesthesia and OB provider
- Order additional Labs:
 - partial thromboplastin time STAT
 - Prothrombin time/international normalized ratio STAT
 - Fibrinogen STAT

APPENDIX B: DELIVERY RECORD

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MNRS
Maternal/Newborn
Record System™

Labor and Delivery Summary

Page 1 of 2
To order call: 1.800.245.4080 Re-order No. 5712N

Patient Name: Olivia Brooks
DOB: 1/29/19xx
MR#: 12919

Labor Summary

G	T	PI	A	L	Type and Rh	EDD
2	0	0	1	0	A neg	xx/xx/20xx

Prenatal Events None

No Prenatal Care Late Prenatal Care
 Preterm Labor (less than or equal to 37 Weeks)
 Postterm Labor (greater than or equal to 42 Weeks)
 Previous Cesarean
 Prenatal Complications Refer to Prenatal Records

Intrapartal Events

Maternal

Febrile (greater than or equal to 100.4°F/38°C)
 Bleeding—Site Undetermined
 Preeclampsia (mild) (severe)
 Seizure Activity See Labor Progress Chart
 Medications None

Date	Time	Medication	Dose	Route
Yesterday	0830	Penicillin	5 mil	IV
Yesterday	1230	Penicillin	2.5 mil	IV
Yesterday	1630	Penicillin	2.5 mil	IV
Yesterday	2030	Penicillin	2.5 mil	IV
Yesterday	1930	Fentanyl	100 mcg	IV

Transfusion _____ units
 Blood Component _____

Amniotic Fluid

SROM AROM Date yesterday _____
 Time 0900
 Premature ROM Prolonged ROM
 Clear
 Meconium-Stained (describe) _____
 Bloody
 Foul Odor
 Cultures Sent _____ Time _____
 Polyhydramnios
 Oligohydramnios

Placenta

Placenta Previa
 Abruptio Placenta

Labor

Precipitous Labor (less than 3 hrs)
 Prolonged Labor (greater than or equal to 20 hrs)
 Prolonged Latent Phase
 Prolonged Active Phase
 Prolonged 2nd Stage (greater than 2.5 hrs)
 Secondary Arrest of Dilatation
 Induction None Cervical Ripening
 AROM Oxytocin
 Augmentation None
 AROM Oxytocin

Labor Summary (Cont'd.) Fetus

Gestational Age (Wks) 40 By Dates
 40 By Ultrasound

Presentation

Vertex
 Face/Brow
 Breech Frank Complete
 Single Footling
 Double Footling
 Transverse Lie Back-up Back-Down
 Compound
 Unknown
 Cephalopelvic Disproportion (CPD)
 Cord Prolapse
 Dystocia

Position

R	O	A
---	---	---

Monitor None FHR UC

External x x
 Internal

Fetal Bradycardia
 Fetal Tachycardia
 Sinusoidal Pattern

Accelerations Spont. Uniform
 Decelerations Early Late
 Variable Prolonged

Scalp pH less than or equal to 7.2

FM Discontinued _____ Time _____
 FHR Prior to Delivery _____ bpm Time _____

Delivery Data

Support Person Present Yes No
 Delivery Location
 LDR LDRP DR OR
 Birthing Center _____

Method of Delivery

Vaginal VBAC
 Number Previous Cesareans _____

Vertex
 Spontaneous
 Assisted _____ to _____
 Manual Rotation
 Forceps (type _____)
 Outlet Low Mid
 Vacuum Extraction Duration 10 _____ Min.
 Degree of suction _____ kg/cm²

Breech (type _____)
 Spontaneous
 Partial Extraction (assisted)
 Total Extraction
 Forceps Assist
 Piper _____

Method of Delivery (Cont'd.)

Cesarean

Scheduled Emergency
 Primary Repeat (x _____)
 Other

Operative Indication

Previous Uterine Surgery
 Failure to Progress
 Placenta Previa
 Abruptio Placenta
 Fetal Malpresentation
 Non reassuring FHR Pattern
 Other _____

Uterine Incision

Low Cervical, Transverse
 Low Cervical, Vertical
 Classical
 Hysterectomy No Yes
 Tubal Ligation No Yes

Skin Incision
 Vertical
 Pfannenstiel

Episiotomy None

Midline
 Mediolateral L R
 Laceration/Episiotomy Extension None
 Perineurethral
 Vaginal
 Cervical
 Uterine
 Perineal 1" 2" 3" 4"
 Repair Agent Used _____
 Vagina free of sponges

Placenta Delivery Time _____

Spontaneous
 Expressed
 Manual Removal
 Adherent (type _____)
 Uterine Exploration
 Curettage
 Configuration
 Normal
 Abnormal _____
 Weight _____ gms
 Disposition _____

Cord

Nuchal Cord (x 1 _____)
 True Knot Length _____ cms
 2 Vessels
 3 Vessels
 Cord Blood To Lab Refrig Discard
 Lab Type + Rh Cultures Coombs
 pH _____

Surgical Data

Sponge Counts Correct
 N/A Yes No
 Needle Counts Correct
 N/A Yes No

Date _____
 Kathy Smith, RN Completed xx /xx /xx
 (Signature)

NURSING | LEVEL: 4

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MNRS
Maternal/Newborn
Record System™

Labor and Delivery Summary Page 2 of 2

To order call: **1.800.245.4080** Re-order No. **5712N**

Olivia Brooks
DOB: 1/29/19xx
MR#: 12919

Delivery Data (Cont'd.)

Surgical Data (Cont'd.)

Vaginal Pack Count Correct
 N/A Yes No
 Estimated Blood Loss 300 mL

Delivery Anesthesia None
 Local Pudendal General
 Epidural Spinal

Date	Time	Medication	Dose	Effect
Yesterday		per anesthesia		

Complications None

Delivery Medications None

Date	Time	Medication	Dose	Route	Site	Init
Today	1015	pitocin	10u	IV		KS

Infant Data (Cont'd.)

Airway

Bulb Suction
 Suction Catheter Size _____ Fr
 Mouth Pressure _____
 Nose _____ millimeters Hg
 Pharynx At Delivery
 Endotracheal Tube Size _____ Fr
 Meconium Below Cords Times _____

Breathing

Spontaneous
 O₂ _____ Liters
 Free Flow Time Init. _____
 PPV
 Bag/Mask Time Init. _____
 ET Tube Size _____ Fr Time Init. _____
 CPAP _____ millimeters
 minutes to First Gasp _____
 minutes to Sustained Respiration _____

Circulation

Spontaneous
 External Cardiac Massage
 Time Initiated _____ Time Completed _____
 minutes for HR greater than 100
 Heart Rate (bpm) _____
 Time _____
 Time _____
 Time _____

IV Access

Umbilical Catheter
 Peripheral Line
 Person Managing Resuscitation: _____

Neonatal Medications None

Date	Time	Medication	Dose	Route	Site	Init
Today	1030	Vitamin K	1mg	IM		KS
Today	1030	Erythromycin	0.5	eyes		KS

Lab Data None

Blood Gases	Sent	Umb Art	Umb Vein
pH			
pO ₂			
pCO ₂			
HCO ₃			

Test _____ Result _____
 Dextrostix _____

Initial Newborn Exam

Weight 3742 gms 8 lbs 4 ozs Deferred
 Length 50.8 cms 20 ins Deferred
 Head 33 cms 13 ins Deferred
 Chest _____ cms _____ ins Deferred
 Abdomen _____ cms _____ ins Deferred
 Temp 99.6 Rectal Axillary
 AP 120 Resp 44 BP n/a

No Observed Abnormalities

Initial Newborn Exam (Cont'd.)

Abnormalities Noted
 Meconium Staining Cephalhematoma
 Petechiae Other _____
 Describe _____

Intake None
 Breast Fed Formula Glucose Water

Output None
 Urine Stool (type _____)
 Gastric Aspirate _____ mL per hour

Examined By kathy Smith, RN
 Transfer With Mother
 To Newborn Nursery
 To NICU
 mom's room

Date ____ / ____ / ____ Time _____
 Mode of Transport _____

Delivery Personnel

RN (1) Kathy Smith, RN
 (2) Joe Olson, RN
 Anesthesiologist/CRNA Mary Schneider
 CNM _____
 Physician—Attending B. Barker, MD
 Physician—Assist (1) _____
 (2) _____
 Technician _____
 Pediatric Provider _____
 Notified Present at Birth
 Others Present _____

Remarks _____

Chronology

Date	Time	Total Time Hrs/Min
EDD	xx/xx	
Admit to Hospital	yesterday 0800	
Membranes Ruptured	yesterday 0900	
Onset of Labor	yesterday 0800	
Complete Cervical Dilatation	today 0800	2 4
Delivery of Infant	today 1000	2
Delivery of Placenta	today 1010	10
		26 10

Total Labor _____

Infant Data Male Female
 ID/Band No. 90518
 Condition Alive Stable Fair Critical
 Stillbirth Antepartum Intrapartum
 Neonatal Death
 Birth Order 1 of 1 2 3 4
 Repeat Apgar every 5 min until score greater than or equal to 7

Apgar Score	1 min	5 min	10 min
Heart Rate	2	2	
Respiratory Effort	2	2	
Muscle Tone	2	2	
Reflex Irritability	2	2	
Color	1	1	
Total	9	9	

Scored by Kathy Smith, RN

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LABOR AND DELIVERY SUMMARY (Page 2 of 2)

Kathy Smith, RN Date Completed xx / xx / xx
 (Signature)

CREDITS

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