Student Developed Simulation Scenario Storyboard	
Identified Problem/Scenario Topic and Related Resources: **Uncomplicated Labor and Delivery** **Chapter 9 of Palmer/Coats "Safe Maternity and Pediatric Nursing Care"** **Kailee Felder, Tylie Dauch, Katie Shirley**	**Desired Overall Goal:** 1. **Able to successfully place mother on Fetal monitoring** 2. **Able to recognize the signs and symptoms of advance labor** 3. **Able to deliver baby with little to no complications caused to mother** 4. **Able to assess newborn** 5. **Able to perform a postpartum exam**
Case Summary: **Dani Thomas is a 23 year old female, 39 weeks and 4 days gestation primigravida. She arrived in the ER at 8 am stating that she "thinks her water broke" after experiencing a moderate amount of fluid running down her legs while she was doing the dishes. Reported feeling an intense pain in her lower abdomen every 8 minutes. Pt was admitted at 0900 and is with her husband and in seemingly well spirits. It is now 1000.**	**Expected Interventions of Students: (Minimum of 5 required.)** 1. **Leopold's maneuver** 2. **initiation of fetal monitoring** 3. **Vital signs** 4. **Pain management** 5. **Cervical check (patient is fully dilated and ready to push)** 6. **Help patient safely deliver the baby** 7. **Apgar score of newborn (1 and 5 minutes)** 8. **Place baby skin to skin** 9. **Deliver the placenta**
Supplies: 1. **Fetal monitor stuff** 2. **Bp cuff, thermometer, pulse ox** 3. **Baby blanket** 4. **Nalbuphine 10 mg/ml** 5. **Pediatric stethoscope** 6. **Sim- mom** 7. **Premie Anne** 8. **FHR and Contraction monitor** 9. **Warmer** 10. **Fluids** 11. **Pt's husband (Brian)**	

NCLEX Questions

1. **After assessing a 48 hour postpartum mother who previously expressed financial struggle, the nurse notices the patient only touch the newborn briefly with her fingertips and shows no interest in holding them. What does the nurse recognize the mother is at risk for?**
   a. **PTSD**
   b. **Nothing; this is normal**
   c. **Postpartum Depression**
   d. **Generalized Anxiety Disorder**

   Answer: c. Postpartum depression.
Rationale: Risk factors for postpartum depression includes personal history of depression, stressful life events, lack of societal support, unintended pregnancy and financial factors. (pg. 234 of Palmer-Coates).

2. **What should the nurse's follow up question be after the patient stated her water broke at home?**
   a. **"What color was the fluid?"**
   b. **"Are you sure it wasn't urine?"**
   c. **"Did you measure the amount of fluid?**
   d. **"Did you do something to cause your water to break?"**

Answer: a. "What color was the fluid?"

Rationale: Asking what color the amniotic fluid was is important because amniotic fluid should be clear. Yellow- stained fluid can indicate blood incompatibility and greenish tint could indicate fetal distress because the fetus passed meconium. (pg. 156 in Palmer-Coates).

Case Flow (15-20 Minute Simulation Time)

Initiation of Scenario: 1000

Case Study:
Patient in bed, report received
Patient groaning in pain with contractions, pain level 6/10 during contractions and 2/10 when relaxed
Patient expresses the want to do it all natural but expresses how much it hurts

Vital Signs	T	98.5	HR	88	RR	22	BP	118/72	SpO2	98%	Pain	6/10	BS	N/A
Cardiac	WNL													
Respiratory	WNL													
Neuro	WNL													
Skin	WNL													
GI	Abdomen tightening and softening every 3 minutes due to contractions													
GU	Light bloody show													
Other	Cervical exam performed and pt is 7 cm 70% effaced													

First Frame: 1030

Case Study:
Nurse introduces self and performs Leopold maneuver
Sets up fetal monitoring and strip is good with contractions and early decels
Educates about pain medication
Patient accepts pain medication

Vital Signs	T	98.5	HR	88	RR	22	BP	118/72	SpO2	98%	Pain	6/10	BS	N/A
Cardiac	WNL													
Respiratory	WNL													
Neuro	WNL													
Skin	WNL													
GI	Abdomen tightening and softening every 3 minutes due to contractions													
GU	Light bloody show													
Other	Cervical check shows 9 cm and 90% effaced													

Second Frame: 1045

Case Study:
Patient begins contracting more intensely
Nurse performs another cervical check and patient is fully dilated and starting to crown
Nurse calls Dr. and she rushes into room immediately

Vital Signs	T	98.5	HR	102	RR	24	BP	124/88	SpO2	96%	Pain	8/10	BS	N/A
Cardiac	WNL													
Respiratory	Pt is trying to Lamaze breathe													
Neuro	WNL													
Skin	WNL													

GI	Abdomen contracting every 2 minutes
GU	Baby's head is crowning, moderate bloody show
Other	

Case Study:
Patient is pushing
Nurses are delivering baby with husband supporting mother
Baby is delivered
Placenta is delivered

Vital Signs	T	98.5	HR	100	RR	24	BP	122/86	SpO2	96%	Pain	8/10	BS	N/a
Cardiac	Non pitting edema in legs													
Respiratory	WNL													
Neuro	WNL													
Skin	First degree laceration of perineum													
GI	Hypoactive													
GU	Bladder is normal, heavy lochia													
Other	Breasts soft, uterus at umbilicus and firm, pt crying and expressing happiness													

Scenario End Point: 1055

Case Study:
Nurse performing newborn assessment
Nurse performing postpartum assessment
Baby is placed on mother's chest skin to skin
APGAR at 1 minute and 5 minutes is performed

Vital Signs	T		HR		RR		BP		SpO2		Pain		BS	
Cardiac	Non pitting edema in legs													
Respiratory	WNL													
Neuro	WNL													
Skin	First degree laceration of perineum													
GI	Hypoactive bowel sounds													
GU	Bladder is normal, heavy lochia													
Other	Breasts soft, uterus at umbilicus and firm, pt crying and expressing happiness													

Debriefing Questions:
1. **What was a large teaching point in this scenario? (Pain management)**

2. **What other pain management techniques could you teach a patient who insists on no pain medication?**

Patient Report: 23-year-old female who came to the ER in active labor at 39 weeks and 4 days gestation. Reported water breaking at home around 6 am. Pt is primigravida and has a history of depression and anxiety. Last cervical check was done around 8 am and she was 7 cm dilated with 90% effacement. Baby is head down and patient wants to have a natural birth with no pain medicine. Patient needs to be hooked up to fetal monitoring and needs another cervical check done.

Additional information, Medical History:

Patient data: History of depression and anxiety

DOB: 06/21/2001

MR#: 5006724

Prior medical history:

Allergies: NKA

Social history:
Vaped at beginning of pregnancy but weaned self-down to nicotine free

Firelands Regional Medical Center
Sandusky, Ohio
Physician's Orders

NAME: Dani Thomas	STATUS: SIGNED
DATE ORD: 11/19/2024	ROOM: 3004
ORD PHYS: Dr. Ammanniti	MR# 5006724
ATTENDING: Dr. Ammanniti	DOB:6/21/2001
AGE:_23_years old	DATE: 11/19/2024

Date/Time	
XX/XX/XX	Admit to ___labor and delivery_____
	Diagnosis: _Active Labor_____
	VS every ___q30minutes_____
	Activity:_____As tolerated_____
	Diet:_____NPO w/Ice Chips_____
	I&O
	IV:___20g IV R wrist with saline running_____
	Medications: 0.9% Normal Saline at 125 mL/hour nalbuphine 10mg IVP q6h PRN for pain oxytocin 10 units/1mL IM PRN after delivery of placenta, discuss with physician prior to administration
	Other: initiate fetal monitoring
	Perform cervical check q30 minutes, report to physician
	Educate on pain relief methods
	Dr. Ammanniti

√	Start	Medication	Dose	Next Sched ↓	History	Assoc
	Stop		Route	Ack	Monograph	Asmnt

Current Status		Frequency	Adjustment	Co-sign	Ref Err
xx/xx/xxxx		10 mg	PRN		
xx/xx/xxxx	Nalbuphine	IV			
Active		q3h PRN			
xx/xx/xxxx		125 mL/hour	06:00		
xx/xx/xxxx	0.9% Normal Saline	IV	KS		
Active		q12h	x		
xx/xx/xxxx		10 units			
xx/xx/xxxx	Oxytocin	IM			
Active		ONE TIME			
xx/xx/xxxx					
xx/xx/xxxx					
Active					
xx/xx/xxxx					
xx/xx/xxxx					
Active					

[–] [–]   Label Comments

xx/xx/xxxx					
xx/xx/xxxx					
Active					

Label Comments									
Administer	Admin Comments	**Non-Admin Reasons**	Acknowledge	Undo	**Admin Schedule**	**View Order**	**+/- Admin Instructions**	**Additional Functions**	**Display Options**

Firelands Regional Medical Center
Sandusky, Ohio
LABORATORY

NAME: Dani Thomas	STATUS: SIGNED
DATE ORD: 11/19/2024	ROOM: 3004
ORD PHYS: Dr. Ammanniti	MR# 5006724
ATTENDING: Dr. Ammanniti	DOB: 6/21/2001
AGE:23 years old	DATE: 11/19/2024

HGB/HCT	XX/XX/XX Admission	Reference Range
HGB	13 g/dL	12-15 g/dL
HCT	35 %	36-44%

CMP	XX/XX/XX Admission	Reference Range
Na	140 mmol/L	135-145 mmol/L
CL	97 mEq/L	97-109 mEq/L
K	3.3 mmol/L	3.3-5.1 mmol/L
BUN	3 mg/dL	3-11 mg/dL
Creatinine	0.60 mg/dL	0.59-1.04 mg/dL
Blood Glucose	85 mg/dL	70-100 mg/dL
Blood pH	7.37	7.35-7.45

URINALYSIS	XX/XX/XX Admission	Reference Range
pH	6	4.5-8
Specific Gravity	1.015	1.005-1.025
Glucose	Normal	<130 mg/d
Protein	Normal	<150 mg/d
Blood	Normal	<3 rbc
Ketones	None	None
Nitrite	Negative	Negative
Leukocyte esterase	Negative	Negative
Clarity	cloudy	clear
Color	Light yellow	Light yellow