**Pre-brief**

1. The purpose of this mock birth is to increase confidence and skill in a safe/non-judgemental learning environment. The focus is on learning- if you don’t know something, please ask. This is not a test!
2. The mock code will last for 20 minutes, followed by a 5 minute de-brief.
3. Please treat this as you would with a regular emergency- get the actual supplies you need, from wherever you keep them.
4. We will need a Primary Nurse and a secondary nurse, plus at least one more person to help out.
5. Remember to communicate with the patient, family and each other.
6. Provide the scenario…

*You are called to the Triage desk where a 34 year old female is standing/leaning on the triage chair. She is obviously pregnant and in obvious discomfort. Her partner is beside her and he is looking slightly panicked. She is holding her lower abdomen and states that she is in labour and it feels like the baby is coming. Her partner tells you that they were on their way to Stratford, but she felt like there wasn’t enough time. You help her to the stretcher.*

1. The mock code starts now.

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| Next steps? | * FIRST – Reassure the patient that you are there to help her. * Call for help |
| The patient is moaning and breathing heavily, states she feels like she has to push. | |
| Next steps? | * Since the head is presenting, tell the patient to try her best to breathe through contractions and not to push (this will help minimize tearing). Instruct her to inhale through her mouth and exhale slowly through pursed lips or pant. If necessary, breathe this way with her to gain her cooperation. * Get her undressed |
| What Questions might you ask the patient? | * **Due Date? Figure out the fetal gestational age. (use wheel) –** 37 weeks + 2 days * **How many babies are expected? – Single** * **How far apart are the contractions (start to start)? – 2 minutes** * **Any Complications with this pregnancy? – No** * **GTPAL - 32002** * **Membranes intact? –** No   + **What colour was the fluid?** Clear   + **When did they rupture? –** approximately 15minutes ago in the car while they were driving to Stratford. * **GBS Status** – the patient doesn’t know * **Blood Type (Rh Negative?)** – O positive |
| As you help her get undressed, you are able to assess her perineum and you see this … \_\_\_\_\_\_\_ (the perineum is bulging even between contractions and you see some of the head… “crowning”) | |
| What are your next steps? | * Wash hands and don gloves and if time permits gown, mask & eye protection * Call for help… call the on call physician STAT * Positions in a dorsal lithotomy position with her knees bent, or if mother is not receptive to this position, allow her to choose the position that she prefers unless there is a complication. * Get the Delivery Kit |
| The primary nurse now assists with the delivery, the secondary nurse assists | |
| Next steps? | * Don sterile gloves * Note colour of amniotic fluid * If time permits, clean perineum with soap & water, or pour Proviodine antiseptic solution in an anterior to posterior direction. * Continue to reassure the patient that you know what you are doing * Get the following ready at hand:   • sterile towels (place 1 towel below the buttocks and 2 towels on each side over the legs/groin.)  • scissors  • umbilical cord clamps (4 kellys)   * With 1 hand, provide gentle pressure on the perineum just above the rectum (may want to use a sterile towel or gauze) to support the perineum, place the other hand on the head as the head emerges to minimize an expulsive delivery * Encourage her to push during contractions until the head remains visible at the perineum, even between contractions.   + Aim for 10 seconds of pushing repeated X3 for each contraction (discourage the patient from holding her breath, rather, allow some air out while pushing) |
| The head is now delivered | |
| Next steps? | * Sweep neck for a nuchal cord |
| You do not feel the cord around the neck | |
| Next steps? | * Provide downward (gentle) traction to deliver anterior shoulder. * Once anterior shoulder is delivered, provide gentle upward traction to deliver posterior shoulder… baby should deliver as soon as posterior shoulder is delivered… so have towels ready to “catch” baby (baby will be slippery!) |
| The baby is now delivered | |
| Next steps by **primary** nurse? | * ID time of birth * Assess for signs of respiratory attempts and movement in baby |
| The baby is moving, grimacing and making respiratory attempts | |
| Next steps by **primary** nurse | * Immediately place infant on mother’s chest/abdomen & begin drying (help from Second Nurse/Assist) * Clamp cord about 4 – 5 cm (1 ½” to 2”) from the neonate’s abdomen with two Kelly forceps. * If infant does not require any resuscitation, delay cord clamping for at least 30 seconds after delivery. * Cut the cord between the two Kellys. |
| Next steps by **secondary** nurse | * Dry and stimulate baby and assesses for respiratory effort * Begin Apgar Scoring at 1 minute of age. * Dry, wipe any secretions from mouth & nose and stimulate (gently rub back/trunk/extremities) * Replace any wet blankets with warm dry ones |
| Next steps by **primary** nurse | * Watch for signs of placental separation (usually occurs approx. 5 minutes after delivery * Apply gently traction to the umbilical cord (do not tug on the cord! This may tear cord or placenta or cause uterus to invert) * Instruct mother to bear down to deliver placenta * Place delivered placenta in a basin or plastic bag and label with mother’s identification. * Once placenta is delivered:   + Administer Oxytocin IM   + Examine perineum for lacerations. Apply pressure if present. (physician will suture) * Assess uterine fundus and note: Is it firm? Where is it? * Assess vaginal flow: Colour (Should be Rubra), amount (Should be small – moderate with a firm fundus) |
| Fundus is at umbilical level, small amount of red blood, there is a fairly significant tear | |
| Next steps by primary nurse | * Apply pressure to perineum. (physician will suture) * Reassess Fundus & Flow every 15 minutes * Apply identification bands to Mother and Baby * Arrange transfer to appropriate Maternal-Child Unit |
| Next steps by secondary nurse | * Complete Apgar Scoring again at 5 minutes after birth and if required, at 10 minutes. |

**De-brief**

How did that go?

What went well and why?

What was the most challenging?

In what way is there room for improvement?

What do *we* need to do to adjust?

Was communication clear during the Mock Code?

Was it clear to everyone who had each role and their responsibilities during the code?

Did the team have everything they needed to run the code?

What resources are available to you for your continuing education needs?