CASE SCENARIO – FACILITATOR INFORMATION

The purpose of this activity is for the participant to demonstrate their knowledge of COMPASS principles in a simulated patient case scenario.

LEARNING OUTCOMES:

• Recognise the deteriorating neonate
• Initiate appropriate and timely interventions
• Demonstrate effective communication (ISBAR)

EXPLANATION OF HOW TO RUN CASE SCENARIO:

Prior to beginning the scenario explain to the participants that this is a low fidelity simulation/role play. The participants should try as much as possible to simulate (verbally) what they would really do on the ward.

Allocation of roles.

• There is one “Actor” card. This participant will interact with the “players” as directed on the “Actor” card
• There are several “player” cards
• Start by allocating the Actor card and RM 1 player card

You can allocate further roles and hand out appropriate player cards as the scenario progresses:

• Team Leader/CMC
• Registrar

Try to include all participants in the role play.

The “player” and “actor” cards have information that the participant should read out to the group at the beginning of the scenario. When each new “player” joins the role play they should read out their “player card.”

The facilitator may prompt and direct the participants as required. Note that all participant contributions are valuable and should be heard within the group.

Other useful materials that can help to guide participants:

• Oxygen delivery chain (recognise deteriorating patient and understand why observations have changed)
• ISBAR chart/forms (for communication during role play)
• NEWS escalation process (appropriate and timely interventions)

Materials required for this scenario:

• Observation chart
• Blood test results
• Medication chart

The facilitator can hand these materials out to participants as the role play progresses.
SCENARIO: Case study (NEWS)

Baby-Angel Ratcliffe

Scenario overview: facilitator reads out the following (in **bold**) to the group

Angel is 3 days old. She was born at 39 1/2 weeks by vacuum extraction.
Wt 3.220kg
Apgars 9 and 9
Vigorous and breast feeding well.
Visible swelling on head.

Angel’s mother is Peta.

- Peta’s membranes ruptured 8 hours prior to birth
- High vaginal swab at 36 weeks was -ve for group B strep
- This is Peta’s 2nd baby, the first baby was born in Central Africa 2 years ago
- Peta is still in hospital as she had a large (grade 3) tear
- Peta breast fed her first baby for 12 months

Angel had hourly then 4 hourly observations for first 24 hours, she is now on 8 hourly observations (per neonatal risk assessment). Angel’s NEWS score has been between 0-1 since birth.

It is Day 3, Angel is lethargic and not feeding well
The scenario commences at 1300 hours.

*Invite the Actor and Player One to read out their cards to start the scenario.*

*Explain to the participants that they may ask the “patient” or the facilitator questions to try and work out what is going on*

**During the scenario:**
If the RM needs prompting
1. What assessments would you make on the baby?
2. Who would you notify? Why?
   - Team Leader or CMC
   - Registrar

   *The RM should simulate a phone conversation with discussion with Registrar*

   Communication should be clear expressing concerns and what he/she would like the Registrar to do (use ISBAR)

   - Indicate the severity of symptoms and increasing NEWS score
   - Describe the
   - State what she would like the registrar to do ie. review the baby
Registrar comes to review the baby:

3. What information do you require from the RM?
   - Observations, increasing NEWS score, weight, physical assessment

4. What assessment would you do? (Prioritise)
   - ABC
   - Physical examination
   - Electrolytes, BSL, Bilirubin (blood results available)

5. What is your management plan for the baby?
   - Admit to NICU
   - Phototherapy

The Registrar should simulate a phone conversation with discussion with Neonatal Registrar
Communication should be clear expressing concerns and what he/she would like the neonatal Registrar to do (use ISBAR)

Neonatal Registrar comes to review the baby:

6. What information do you require from the obstetric registrar?
   - Assessment
   - Vital signs

7. Who would you notify?
   - Fellow/Consultant
   - Provide explanation to the woman

8. What is your management plan for the baby?
   - Admit to SCN
   - Insert IV
   - Commence IV fluids and phototherapy
   - Observations and monitoring
   - Respiratory support if required

9. What are your next actions as a group
   - Transfer to SCN
   - Notify SCN team leader
   - Explanation to parents
During the role play the facilitator may ask the participants –

How often should observations be done?
- Every 15-30 minutes until stable
- If MET activated observations recorded every 5 minutes until medical management plan established

Can you explain vital signs using the oxygen delivery chain?

What do participants think went well?

What suggestions would they make to improve their roles?

**Group discussion/reflection at the end of the scenario**

**Key points:**
- Identify the risk factors for dehydration and jaundice
- Recognise the baby is deteriorating and when to refer a registrar
- Identify changes in the neonatal condition

**The important things to get across in this case are:**

- Babies with jaundice can become lethargic and dehydrated very quickly
- All babies at risk of jaundice must be observed according to the SOP
- Signs and symptoms of jaundice and dehydration include
  - unstable temperature,
  - lethargy,
  - poor feeding,
  - tachypnoea,
  - apnoea,
  - hypoglycaemia
  - seizures
- Taking a history and asking about previous babies can be as helpful as may alert to the risk of jaundice as does a physical examination detecting bruising or a cephalhematoma.
- When assessing feeding, it is important not to just assess the breastfeeding effort but efficiency, i.e. urine output.
- Ensure compliance with NEWS
Risks for Jaundice include:
- Bruising
- Cephalhematoma
- Blood group incompatibility
- Sibling with jaundice

Physiological changes reflected in the vital sign readings:

Management should include:
- ABC
- Electrolytes, BSL, Bilirubin
- IV access
- IV fluids
- Admit to NICU
- Phototherapy

Information noted from patient charts and results:
- Increasing NEWS
- Lethargy
- ↓ feeding
Player Card 1 - RM

Please read out the wording in **bold** when scenario commences.

I am an RM on afternoon shift on the postnatal ward. I am performing regular observations on baby Angel and her mum, Peta. I have not met Peta or baby Angel before.

Angel is asleep in the cot.

What I know about Angel:
- Angel is 3 days old
- Birth weight 3.220kg
- Breast feeding well

What do you do next?
- Talk to Peta (Angel’s mum)
- Assessment (look at vital signs, do you need any other information? Ask Peta)
- Do you need to refer this baby for review?

ROLE-PLAY YOUR NEXT ACTIONS.
Actor Card – Peta (Angel’s mum)

Please read out the wording in bold when scenario commences.

My name is Peta. I am a bit worried because Angel seems more sleepy than usual and has not been feeding so well today.

If asked:
- **When did you last feed Angel?** She hasn’t woken for a feed since 0800 this morning, although that was not a great feed, she kept falling asleep.
- **How many wet nappies has Angel had today?** She was a bit wet at 0800, but nothing since then.
- **Has Angel had her bowels open today?** Not today.
- **What was her last poo like?** Yesterday her poo was quite dark.
- **How does Angel seem to you?** I am worried as the midwife said she was a bit cold this morning and wrapped her up to try and warm her, and she seems so tired and sleepy.
- **Did you have any concerns with your previous baby?** My daughter had jaundice and needed to go under the lights before I could take her home.
Player Card 2 - Registrar

You are the Registrar. You are answering a page from the postnatal ward.

The RM will try to discuss the case with you using ISBAR. Allow the RM to finish before responding.

THEN

How do you respond?

What do you do next?

ROLE-PLAY YOUR NEXT ACTIONS.

Player Card 3 - Neonatal Registrar

You are the Neonatal Registrar. You are answering a page from the postnatal ward.

The Registrar will try to discuss the case with you using ISBAR. Allow the Registrar to finish before responding.

THEN

How do you respond?

What do you do next?

ROLE-PLAY YOUR NEXT ACTIONS.
<table>
<thead>
<tr>
<th>Blood Test</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRP</td>
<td>0-10</td>
</tr>
<tr>
<td>Hb</td>
<td>155-210</td>
</tr>
<tr>
<td>WCC</td>
<td>10-26</td>
</tr>
<tr>
<td>Platelets</td>
<td>150-400</td>
</tr>
<tr>
<td>Bands</td>
<td>0-0.5</td>
</tr>
<tr>
<td>Neuts</td>
<td>7-14.5</td>
</tr>
<tr>
<td>Lymph</td>
<td>2-11.5</td>
</tr>
<tr>
<td>BSL</td>
<td>&gt;2.6</td>
</tr>
<tr>
<td>SBR</td>
<td>&lt;380</td>
</tr>
</tbody>
</table>
Case study 3 – Neonatal – Angel

Neonatal Risk Assessment

1. Within 1 hour of birth, all neonates require a risk assessment.
2. Complete the following for all neonates prior to transfer between wards:
   a. Check head size, respiratory rate, temperature, oxygen saturation on foot (or 95%) and record on Neonatal Early Warning Score (NEWS) chart.
   b. Review card gas if known.
   c. Record temperature. Review risk assessment checklist and continue NEWS observation as per Procedure.
3. Observations may be performed at random.
4. When recording vital signs, observations are recorded once per hour. These scores are totaled to give a total NEWS. SCORE: Frequency of observation intervals outlined below do not dictate timing of discharge.
5. All neonates without risk factors are to have 8-hourly observations and risk assessed by Hypoglycaemia and Jaundice according to the relevant Procedures: Hypoglycaemia and Jaundice in the Newborn.

Neonatal Risk Assessment to be attended within 1 hour of birth

<table>
<thead>
<tr>
<th>Risk factor assessment (within or appropriate)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial observation-intervals</td>
<td>30 minutes</td>
<td>0 minute</td>
</tr>
<tr>
<td>Minimum ongoing monitoring frequency within 2 hours</td>
<td>Respiratory depression, Poor feeding</td>
<td>Observer for:</td>
</tr>
<tr>
<td>Is this neonate at risk of Respiratory Distress/Suffocation or Hypoglycaemia?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Meconium in liquor – Healthy and vigorous at birth</td>
<td>Hourly for 4 hours</td>
<td>0 hour</td>
</tr>
<tr>
<td>Meconium in liquor – Active resuscitation at birth</td>
<td>Hourly for 4 hours</td>
<td>0 hour</td>
</tr>
<tr>
<td>Low APGAR at 5 minutes or Low card pH (&lt;7.3)</td>
<td>Hourly for 4 hours</td>
<td>0 hour</td>
</tr>
<tr>
<td>GBS positive mother</td>
<td>0 hour for 24 hours</td>
<td>0 hour</td>
</tr>
<tr>
<td>GBS positive mother – vegtable cover or administered 4 hours after birth</td>
<td>0 hour for 48 hours</td>
<td>0 hour</td>
</tr>
<tr>
<td>Maternal fever &gt; 38°C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is this neonate premature?

<table>
<thead>
<tr>
<th>Before 37 weeks</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 hour for 48 hours</td>
<td>Respiratory distress, Temperature instability, Poor feeding</td>
<td>Hypoglycaemia</td>
</tr>
</tbody>
</table>

Is this neonate at risk of sepsis from hyperbilirubinaemia?

<table>
<thead>
<tr>
<th>Instrumental birth (neonate will also need blood examinations)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 hour for 48 hours</td>
<td>Respiratory distress, Temperature instability, Poor feeding</td>
<td>Hypoglycaemia</td>
</tr>
</tbody>
</table>

If no risk factors identified in following observation frequencyTable:

<table>
<thead>
<tr>
<th>Hypoglycaemia risk factors</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>0 hour for 48 hours</td>
<td>Poor feeding postnatal care</td>
</tr>
</tbody>
</table>

Neonatal birth review

<table>
<thead>
<tr>
<th>Time of birth</th>
<th>Type of birth</th>
<th>Apgars</th>
<th>Parity</th>
<th>Gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:55</td>
<td>Caesarean</td>
<td>10 7</td>
<td>2</td>
<td>39</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birthweight</th>
<th>Head circumference</th>
<th>Length</th>
<th>Urea passed</th>
<th>Mac passed</th>
<th>Blood Group</th>
<th>Rh factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>3200 g</td>
<td>35 cm</td>
<td>44 cm</td>
<td>Yes</td>
<td>No</td>
<td>O</td>
<td>Rh negative</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth dose Vitamin K given?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cord gas checked?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Time of First Feed: 09:55 am

<table>
<thead>
<tr>
<th>Midwife check at birth</th>
<th>Date:</th>
<th>Time:</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and face</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes (general observation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal breaths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular (apex beat)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory rate (RR)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cord / cord clamp</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arteries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitilia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle tone</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Respiratory effort</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the parent have any concerns about the neonate?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Summary of significant findings and actions:

<table>
<thead>
<tr>
<th>D/N/A</th>
<th>Refer to Neonatology</th>
<th>Yes</th>
<th>No</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
</table>

Signature

Oxygen saturation – Performed 4 hours post birth. Proben on for 2-3 minutes until stable recording observed.

Oxygen saturation: 96% 09:55

If <95% refer to Pulse Oximetry Screening – neonatal Procedure

Signature

Before Discharge/Transfer to Ward:

| Identify risk factors, record on NEWS observation chart. Attend observations as per risk assessment. | | |
| Sudden hypoglycaemia risk factors, begin parabyn if needed. See Hypoglycaemia Procedure | | |
| Obtain vital signs | | |
| Check blood group of neonate and mother for jaundice risk factors, begin parabyn if needed | | |
| NIBS data entered | | |

Indicate Additional Clinical Pathways used in conjunction with this pathway:

Signature

Print name

Designation

Date/Time