E-NEWS

Perinatal Simulation: Saving Lives Every Day

Perinatal regionalization was pioneered to improve Maternal and Neonatal outcomes. Georgia embarked on this quest back in the 70's. As regionalization developed each Regional Perinatal Center (RPC) was tasked with providing quality, evidence-based education to the geographical region they serve. RPC's have evolved not only providing the minimal requirements, but have advanced with the changing needs of healthcare. While the use of high-fidelity simulators has transformed hands on learning, it doesn't replace the potential learning from the use of mannequins, involvement of student participation and exposure to real-life situations.

According to the Joint Commission Sentinel Event Alert #30: Preventing infant death and injury during delivery: "For high-risk events, such as shoulder dystocia, emergency cesarean delivery, maternal hemorrhage and neonatal resuscitation, conduct

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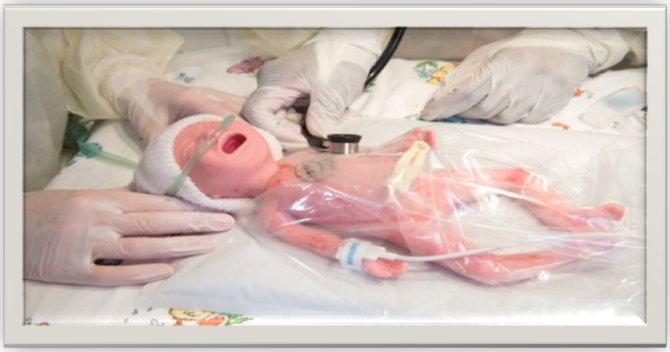
clinical drills to help staff prepare for when such events actually occur, and conduct debriefings to evaluate team performance and identify areas for improvement."

The Institute of Medicine (IOM) issued a report recommending simulation training as a strategy to prevent errors: " ….healthcare organizations and teaching institutions should participate in the development and use of simulation for training novice practitioners, problem solving, and crisis management, especially when new and potentially hazardous procedures and equipment are introduced."



This is Nursing education has utilized the various types of simulation to include:

- Part Task Trainers- also known as low-tech trainers that help develop specific tasks or skills. These may include CPR mannequin, maternal palpation abdomen, cervical dilation model and neonatal resuscitation baby.
- Simulated Patients- role playing between team members
- Screen Based Computer Simulators- E-sims were developed and released by the American Academy of Pediatrics –Neonatal Resuscitation Program in January 2017. This is a required exercise for completion of The 7th Edition NRP Provider Curriculum. Allowing learners to immerse themselves into

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a virtual environment, utilizing the NRP algorithm in real time and provides immediate feedback.

- Interactive High Fidelity Mannequins – state of the art technology includes capabilities of realistic physiologic responses. “These unique integrated models imitate the human response in a multilayered, real-time manner, providing a realistic clinical presentation.” (Enhancing Patient Safety in Nursing Education Through Patient Simulation: Durham, Alden)

Everyday hospitals are demonstrating the value of simulation based training. The Columbus Regional Perinatal Center has witnessed first-hand the benefit of their simulation training provided to referral hospitals in their region. Educational offerings include: Perinatal Hemorrhage, Preeclampsia, Shoulder Dystocia, Umbilical Cord Prolapse, Neonatal Resuscitation and S.T.A.B.L.E Simulation Drills.

Imagine you are a nurse in a Level I – Labor and Delivery unit with 3 nurses on duty…..it was a Tuesday morning and a G3P2 was scheduled for a repeat cesarean delivery. The patient had a placenta previa with a subsequent postpartum hemorrhage in her previous pregnancy. This pregnancy was also complicated with a placenta previa. The provider determined cesarean delivery at 39.0 weeks was necessary. At incision, the

Obstetrician identified a placenta accreta which was efficiently managed. The patient voiced concerns of shortness of breath; however, the operative staff felt this was due to the pressure placed on her abdomen at the time of birth. Following delivery, the patient was moved to PACU where she rapidly deteriorated. Again, she complained of shortness of breath. The nurse called for the Obstetrician immediately. Gross bleeding began, with no response to interventions. For this small birthing hospital, this is something that just does not happen. Fortunately, they had been participating in simulation drills for the last three months, focusing on perinatal hemorrhage. Because they practiced for this type of obstetrical emergency, they did not panic and they were able to save this mother's life. Unfortunately, a hysterectomy was unavoidable. She ended up in ICU for seven days, four of which she was on a ventilator. They gave her 32 units of packed RBC's, platelets, fresh frozen plasma, albumin, and cryoprecipitate which was flown in from Atlanta. Final diagnosis was placenta accreta, massive hemorrhage, DIC, hypovolemic shock and Anaphylactoid Syndrome. When she regained consciousness, the first words she wrote were "can I nurse my baby?" To this day, this still gives us chills, knowing that what we provide to our referral hospitals does make a difference and does save lives. The nurse caring for this patient had this to say, "If we did not have simulation drills every month, we wouldn't have known what to do, we could not have saved her."


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