

SCENARIO

Cord Prolapse

LEARNING OBJECTIVES

Be aware of the risk factors for cord prolapse

Use of SBAR to communicate with members of the multidisciplinary team

Initiate emergency management of cord prolapse

Facilitate safe delivery of the fetus

EQUIPMENT LIST

Noelle/ SimMom
Fluids / giving sets
Foley's catheter
ODP grab bag

Baby and placenta with cord
GA drug box for T/F to theatre
IVC packs/Blood Bottles
CTG- Abnormal tracing

PERSONNEL

MINIMUM: 3
ROLES:
Obstetric Junior/Reg
Midwife
Anaesthetic Reg

FACULTY

MINIMUM: 3
Facilitator
Observer
Debrief Lead

TIME REQUIRMENTS

TOTAL 1.5hours

Set up: 30 mins
Pre Brief: 10 mins

Simulation: 15mins
Debrief: 30mins

INFORMATION TO CANDIDATE

PATIENT DETAILS

Name: Sarah Gray
Age: 24
Weight/BMI: 35
39 weeks

Phx: PROM- 24 hours
Allergies: Nil
G1P0

SCENARIO BACKGROUND

Location: Labour Ward

Situation: Lucy has just been examined by the midwife and found to be fully dilated. The midwife has asked you for a review of the CTG due to persistent decelerations. Lucy has spontaneously laboured after rupturing her membranes 24 hours ago.

Task: Please assess the patient and manage accordingly

RCOG CURRICULUM MAPPING

Module 10 Management of Labour:

Interpret CTG

Cord prolapse

Liaise with other staff

Advanced Training Skills Module:

Advanced labour ward practice- Non reassuring fetal status in labour

INFORMATION FOR ROLEPLAYERS**BACKGROUND**

Your name is Lucy Gray. You are 25 years old and this is your first pregnancy. You have had no problems in the pregnancy, other than requiring aspirin to reduce your risk of high blood pressure. Yesterday your waters broke. You attended the hospital and there were no problems so you opted to wait to see if labour started. You were due to come in today anyway but you stated to regularly contract and when you arrived on the labour ward you were already 4 cm dilated. Your labour has progressed well. You are only using gas and air for pain relief. The midwife has just examined you and you are now fully dilated. She has informed you that she needs to get the doctor to review the baby's heart monitor.

When the doctor reviews you –if they perform a vaginal examination they will diagnose a cord prolapse that will require immediate delivery, the doctor may request you to change your position and get your verbal consent to take you to theatre to deliver you by caesarean section.

Some candidates may attempt to perform an instrumental delivery.

If the doctor does not perform a vaginal examination as part of their assessment the baby's heart rate drops very low and this should prompt a vaginal examination and the diagnosis of cord prolapse.

RESPONSES TO QUESTIONS

You are not allergic to any medications
You have had no previous surgeries
You are a non- smoker
You last ate 6 hours ago

INFORMATION TO FACILITATOR

SCENARIO DIRECTION

Candidate makes initial introductions to patient and team.
Request SBAR hand over from midwife for all relevant information.
Review of CTG: (amend to CTG example available- overall Abnormal)
C- 4:10, 145 bpm, variability 5 bpm, non- reassuring decelerations with every contraction for 30 mins.

Candidate to make full assessment of patient;
MEOWS chart- score of zero BP 130/85, pulse 95, temp 36.7, RR14, sats 98%
liquor colour- clear,
partogram/progress- good progress, contractions strong and regular
VE by midwife – fully dilated, LOT/LOA, presenting part at spines, 1+ caput 1+moulding

If candidate attempts to perform FBS or initiates conservative management WITHOUT including vaginal examination;
CTG changes to profound bradycardia 60bpm with no signs of recovery.

If candidate performs a vaginal examination as part of their assessment findings;
Fully dilated, cord prolapse (adjacent to fetal head) PP at spines LOT position, 1+ caput/1+moulding

Likely direction- decision for caesarean section.
If attempt to perform instrumental – allow, discuss in debrief.
Declare obstetric emergency- delegate member of team to call 2222 with correct/required information for obstetric emergency
Communicate findings with patient and family.
Using all members of the multidisciplinary team- assist women onto all fours in the head down knees to chest position, keep hand on presenting part to elevate off cord- fully explaining actions to patient at all times. Maintaining patient dignity with blanket whilst transferring to theatre.

Discuss with anaesthetist – GA given fetal heart rate abnormalities – if persistent decelerations may consider one shot spinal if profound bradycardia GA.
Important to maintain PP elevation whilst preparing for anaesthesia (GA/Spinal) may require midwife to take over VE or consider filling bladder with foley's catheter

SCENARIO DEBRIEF

TOPICS TO DISCUSS

Leadership in emergency situation- was clear leader identified?

Importance of vaginal examination in complete assessment of women with CTG abnormalities

Communication of urgency to member of the team and patient

Correct techniques to elevate presenting part from cord and avoiding

Mode of delivery – presenting part at spines /OT not straight forward delivery in primip with no analgesia in the presence of fetal heart rate abnormalities

Management of cord prolapse at gestations on the verge of viability (23+⁰-24+⁶)

Management in the community setting

REFERENCES

Royal College of Obstetricians and Gynaecologists. (2014) *Green Top Guideline No. 50 Umbilical Cord Prolapse*. RCOG press: London