Maternity Education Program

Shoulder Dystocia

Facilitator Resource Kit

CSDS

Clinical Skills Development Service

Queensland Government

Maternity Education Program

The resources developed for Maternity Education Program (MEP) are designed for use in any Queensland Health facility that care for patients/ women who are pregnant/ birthing or postnatal. Each resource can be modified by the facilitator and adapted to the needs of the learner and the environment in which the education is being delivered- from tertiary to rural and remote facilities.

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Shoulder Dystocia – Facilitator Resource Kit

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csds.qld.edu.au/mep

Who is this resource kit for?

This resource kit provides healthcare workers with knowledge and skills on assessing and managing a shoulder dystocia.

Target audience

Midwifery and medical staff providing maternity care

Duration

45 mins – including simulation and debrief (allow 15 minutes for setup)

Group size

Suited to small groups (6 – 8)

Learning objectives

By the end of the session the learner should be able to:

- Identify shoulder dystocia.
- Employ manoeuvres to resolve shoulder dystocia.
- Demonstrate good use of resources and team members.
- Display clear and effective communication skills.

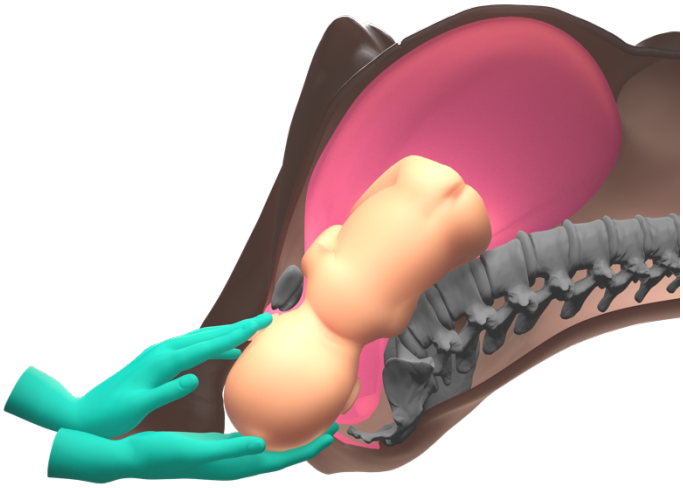
Facilitation guide

1. Provide Participant Resource Kit to the learner.
2. Utilise 2D pictures and 3D animation to demonstrate the manoeuvres required.
3. Utilise PowerPoint (Obcast) to assist learners prior to session.
4. Allow learner to apply actions in a simulated shoulder dystocia case.
5. Conduct group debrief following simulation.

Supporting documents

1. Participant Resource Kit
2. Interactive 3D animation tool
3. List of further readings
4. Shoulder dystocia flow diagram
5. Shoulder dystocia simulation

Overview



Shoulder dystocia is best defined as a vaginal cephalic delivery that requires additional manoeuvres to deliver the fetus after the head has delivered and gentle traction has failed to deliver the after coming shoulders.

Shoulder dystocia (SD) is a relatively uncommon event, with reported incidence around 0.4% - 1.4% of all vaginal deliveries. Almost half of all cases of shoulder dystocia have no indication making it difficult to predict, therefore anticipation and planning are the key to successful management.

In cases where risk factors are identified i.e. previous shoulder dystocia, macrosomia, diabetes, obesity, prolonged first and second stage, augmentation of labour, instrumental birth, a plan needs to be in place for safe and successful management.

After delivery of the fetal head:

- Normal downward traction has failed to deliver the shoulders – excessive downward traction **SHOULD NOT** be performed in order to prevent brachial plexus injury.
- Specific manoeuvres are employed to birth the fetus and minimise risk to both the mother and fetus.

Early detection and a coordinated plan of care for a woman with suspected or diagnosed shoulder dystocia will optimise fetal and maternal outcome, plus minimise associated complications.

Obstetric emergency is any clinical situation involving a maternity patient where immediate medical/ midwifery assistance is required.

Further Readings

Royal College of Obstetricians and Gynaecologists, Green-top Guideline No. 42, 2nd Edition / March 2012

This Green-top guideline's purpose is to review the current evidence regarding the possible prediction, prevention and management of shoulder dystocia; it does not cover primary prevention of fetal macrosomia associated with gestational diabetes mellitus.

King Edward Memorial Hospital Obstetric and Gynaecology, Government of WA, Clinical Guideline – Shoulder Dystocia

King Edward Memorial Hospital Obstetric and Gynaecology's clinical guideline on shoulder dystocia.

Guideline Shoulder Dystocia, The Royal Women's Hospital

The Royal Women's Hospital's (Victoria, Australia) clinical guideline on shoulder dystocia.

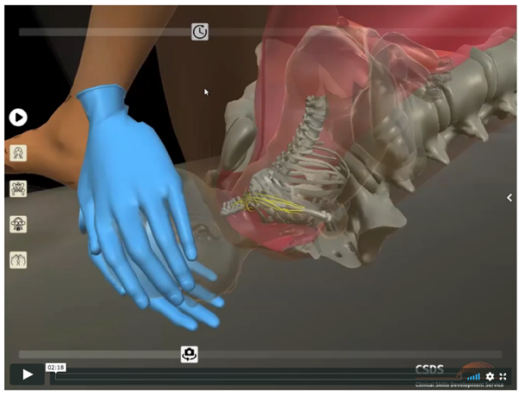
Emergency Management

Interactive 3D Animation Tool

The interactive 3D animation tool was developed to be used as a training aid to teach the mechanisms and manoeuvres of shoulder dystocia.

Access the tool via https://bit.ly/2Br2gx8

This interactive animation requires a modern browser capable of running WebGL. To check if your browser supports WebGL, visit https://get.webgl.org/.

Below is an introductory video on how to use the interactive 3D animation tool.	
	Scan me on your phone
https://csdsesystems.github.io/mep/shoulder-dystocia-1.html	

Management of Shoulder Dystocia

Adapted from Algorithm for the Management of Shoulder Dystocia. Royal College of Obstetricians & Gynaecologists. Shoulder Dystocia, Green-top Guideline No.42, March 2012, Appendix 2.

CALL FOR HELP
Experienced midwife/obstetrician
Neonatal team

Discourage pushing
Lie flat, move buttocks to edge of bed

MCROBERTS MANOEUVRE
(Knees to chest)

Consider ALL FOURS position
(if appropriate)

SUPRAPUBIC PRESSURE
(Rubins 1)

(routine axial traction)

Consider episiotomy if it may assist internal manoeuvres

Can be performed in any order

INTERNAL ROTATIONAL MANOEUVRES
Rubins II: Woodscrew : Reverse woodscrew

DELIVERY OF POSTERIOR ARM

Inform consultant and anaesthetist

If above manoeuvres fail, consider:
Repeat all the above and/or changing operator

Consider cleidotomy, Zavanelli or symphysiotomy

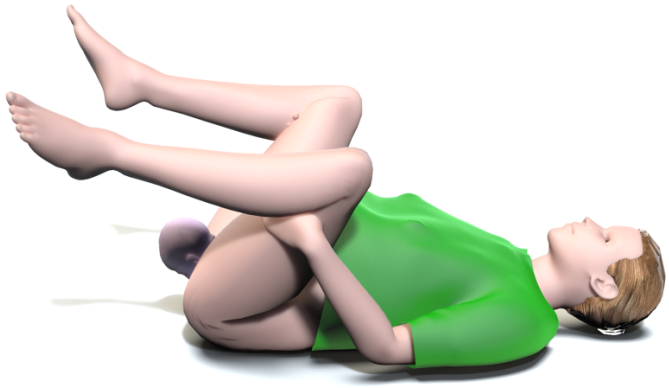
Baby reviewed by Neonatal Team. Document all actions and complete a clinical incident report

Debrief patient, support people and staff

Specific Management

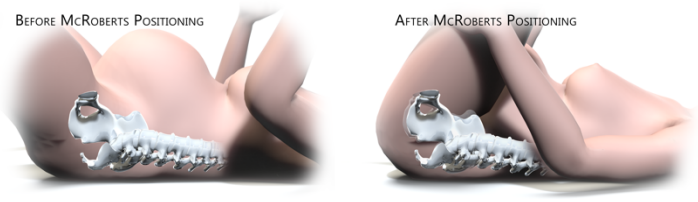
The following diagrams depict the different manoeurves used to eleviate shoulder dystocia. Some of the treatments are external and some involve internal manoeuvres. They are listed with external manoeuvres first followed by internal manoeuvres, the order of management is the decision of the clinician and **does not have to follow order**.

External manoeuvres



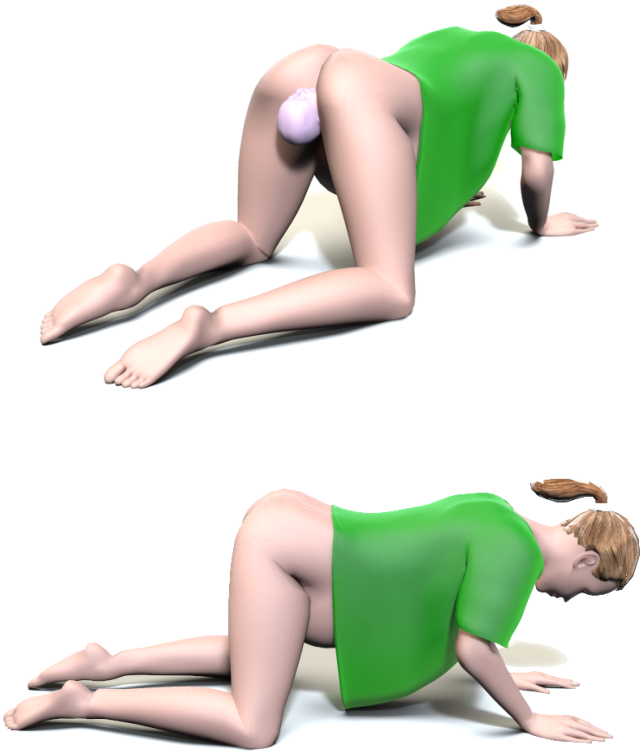
McRoberts position

Woman laying completely flat, legs elevated towards chest, this widens the pelvic outlet.



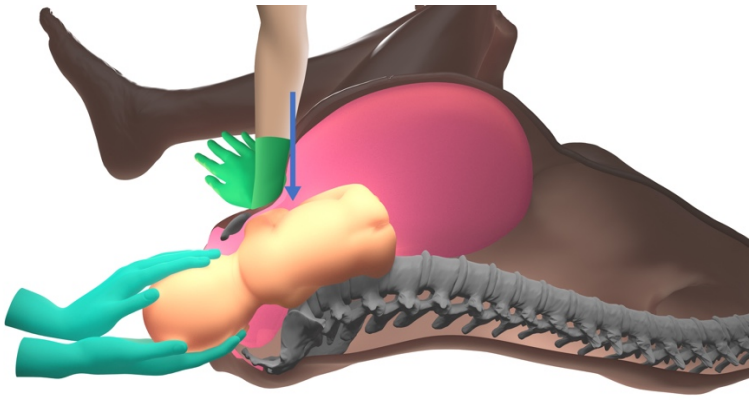
Pelvic angle

Change of pelvic angle during McRoberts Position.



All fours position (Gaskin manoeuvre)

This position may also work like McRoberts in widening the pelvic outlet.

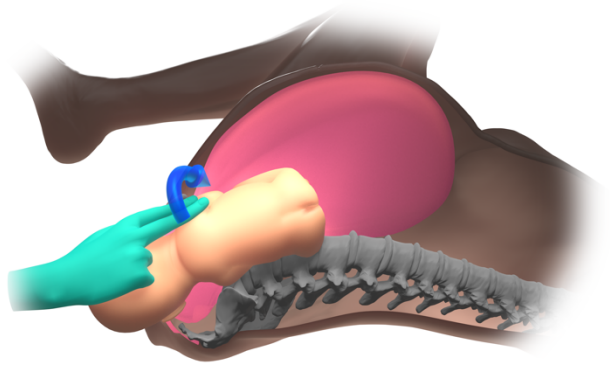


Rubins I (external manoeuvre)

An assistant applies pressure above the symphysis pubis in a downward and lateral motion over the fetal shoulder to attempt to release the anterior shoulder from the pubic bone.

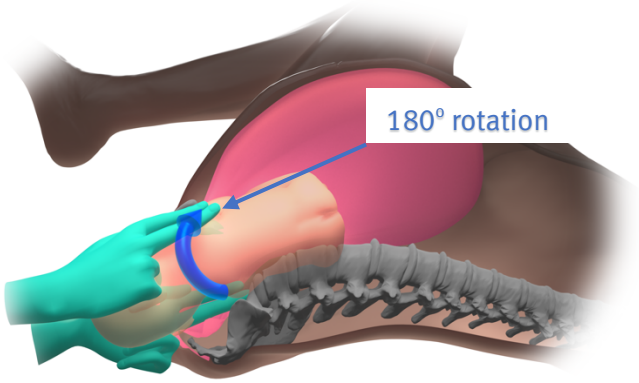
A rocking action can also be applied with this manoeuvre.

Internal manoeuvres



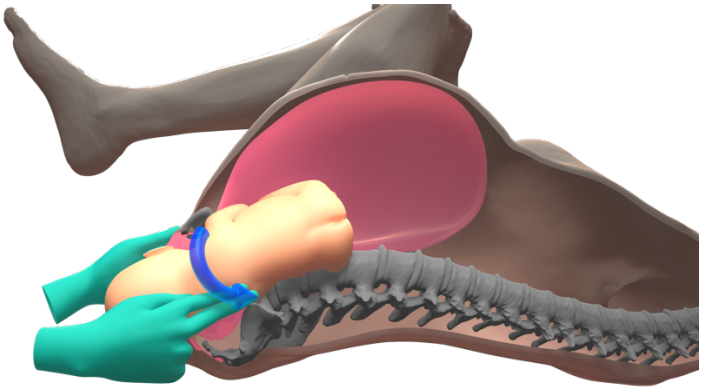
Rubins II (internal manoeuvre)

The accoucheur places two fingers on the anterior shoulder of the fetus (internally) and pushes in a forward and downward direction to attempt to dis-impact the anterior shoulder from the pubic bone.



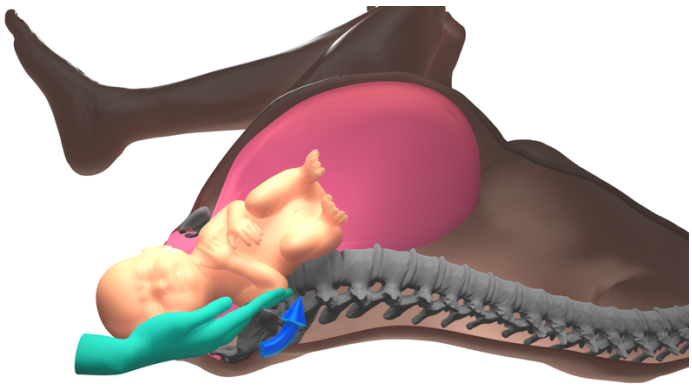
Woodscrew Manoeuvre (internal)

The accoucheur places two fingers on the posterior aspect of the anterior shoulder of the fetus (internally) and two fingers on the anterior aspect of the posterior shoulder, then rotates the fetus forward through 180° so the posterior shoulder will now be anterior



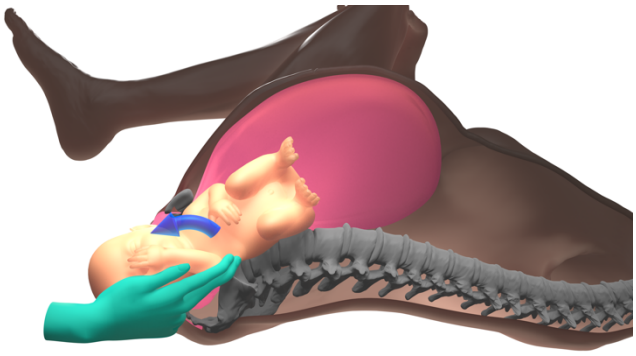
Reverse woodscrew manoeuvre (internal)

The accoucheur places two fingers on the posterior shoulder and two fingers on the anterior aspect of the anterior shoulder and rotates the fetus backwards through 180° so that the posterior shoulder will now be anterior.



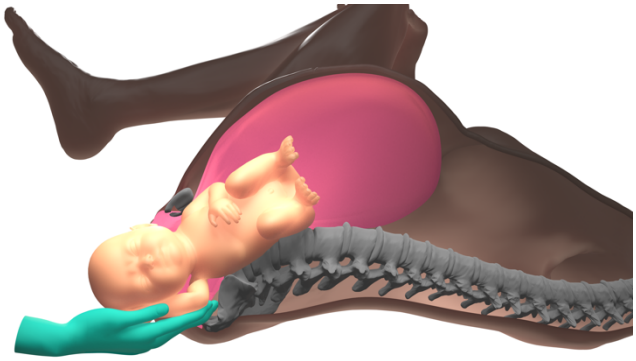
Removal of the posterior arm step 1

The accoucheur inserts their whole hand posteriorly and follows the posterior arm down the humerus to the fetal elbow. Once the elbow has been located go to step 2 below.



Removal of the Posterior Arm Step 2

Using the fetal elbow, the fetal arm is brought towards the fetal face.



Removal of the Posterior Arm Step 3

The arm is brought past and sweeps the fetal face and then brought out of the vagina. Once this has occurred then deliver the anterior shoulder using axial traction.

Simulation Event

This section contains the following documents:

1. Pre-simulation briefing poster
2. Immersive in-situ scenario
3. Physical resources
4. Human resources
5. Simulated patient script information
6. Handover card
7. Additional information
8. Stage 1 – Initial assessment
9. Stage 2 – Ongoing management
10. Stage 3 – Resolution

Pre-simulation Briefing

Establishing a safe container for learning in simulation.

1 Clarify objectives, roles and expectations

- Introductions.
- Learning objectives.
- Assessment (formative vs summative).
- Facilitators and learners' roles.
- Active participants vs observers.

2 Maintain confidentiality and respect

- Transparency on who will observe.
- Individual performances.
- Maintain curiosity.

3 Establish a fiction contract

Seek a voluntary commitment between the learner and facilitator.

- Ask for buy-in.
- Acknowledge limitations.

4 Conduct a familiarisation

- Manikin/simulated patient.
- Simulated environment.
- Calling for help.

5 Address simulation safety

Identify risks.

- Medications and equipment.
- Electrical or physical hazards.
- Simulated and real patients.

Note: Adjust the pre-simulation briefing to match the demands of the simulation event, contexts or the changing of participant composition.

Adapted from Rudolph, J., Raemer, D. and Simon, R. (2014). Establishing a Safe Container for Learning in Simulation. Simulation in Healthcare: Journal of the Society for Simulation in Healthcare, 9(6), pp.339-349.

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Scenario

Type	Immersive in-situ scenario	
Target audience	Obstetric medical staff and midwives	
Overview	Birth suite, woman in labour **Situation:** Induction of labour for GDM and reduced fetal movements at 40 weeks. Maria has been labouring for 10 hours with an oxytocin infusion and had an epidural 3 hours ago. Fully dilated 2 hours ago with 1 hour of passive descent and 1 hour of active pushing. **Background:** • 35 year old G1P0. 40/40 gestation. GDM diet controlled BGLs normal. • Hb 121 @ 36/40 • A Pos • GBS Negative • All other serology NAD • Allergies – Nil • Nil medical history **Assessment:** • Observations NAD. • Vertex just visible but Maria becoming tired. • Last VE – 30 minutes ago to assess progress – OA +1 to +2cm, +2 caput +1 moulding, blood stained liquor, CTG abnormal unlikely decelerations with contraction but with good recovery. **Recommendations:** • Need to discuss with doctor and team leader as active pushing has taken place for just over an hour and progressing slowly. • Prepare for a normal birth but may need to consider an assisted birth due to prolonged second stage and slow progress.	
Learning objectives	Participants are required to: • Identify shoulder dystocia. • Employ manoeuvres to resolve shoulder dystocia. • Demonstrate good use of resources and team members. • Display clear and effective communication skills.	
Duration	Pre-brief: 10 minutes Orientation: 5 minutes Simulation: 15 mins Debrief: 15 mins	Total: 45 mins Allow 15 minutes for set up

Physical resources

Room set up	Standard birth suite set up
Simulator/s	• Simulated patient with a 40/40 week abdomen or • Manikin including software with a 40/40 week abdomen
Simulator/s setup	**If using a simulated patient:** Simulated patient semi recumbent in bed in a hospital gown with pelvic task trainer in-between legs and vertex visible draining pink blood-stained liquor. **If using a manikin:** Manikin semi recumbent in bed in a hospital gown with vertex visible, draining pink blood-stained liquor. Moulage: vertex visible with blood stained liquor and 'mucousy' show.
Clinical equipment	• Standard birth suite room • CTG and CTG trace attached • Epidural attached to patient and pump • Oxytocin infusion/ mainline fluids
Access	1 x IVC setups with IV stickers attached.
Other	PHR chart & relevant paperwork.

Human resources

Faculty	X 2 facilitators (Obstetric Reg/ consultant and midwife with debriefing experience) to take roles of scenario commander (primary debriefer) and co-debriefer.
Simulation Coordinators	Standardised patient X 1 for manikin set up and control
Confederates	Midwife as support person Facilitator to provide handover
Other	Initially x1 midwife to receive handover. The other midwives and doctors outside to be called when needed.

Simulated patient script information

You are Maria Stevenson and you're having your first baby.

You started contracting early yesterday morning after a dose of prostin gel to induce your labour. You were induced as you have GDM (diet controlled) and reduced fetal movements.

You have been in birth suite for 10 hours and have been slowly progressing, you are completely exhausted, and you had an epidural a few hours ago which has worked well. You are much more comfortable now but still having to use nitrous/O^2 as you have a lot of pressure which is distressing, you have been pushing now for over an hour and are really running out of energy.

> "I'm very tired and I want it to be all over, what do you want me to do, I'm so tired as I have been pushy for hours, is there any way you can help?"

If no instruction, ask again for help to deliver your baby – what can I do?

There will be a discussion regarding a possible assisted birth and allow staff to prepare for this but continue to push – once the staff are relatively organised you then manage to birth the fetal head and then there is a two minute pause with no restitution, you push but there is no progress.

Eventually after several manoeuvres the baby is born and requires a resuscitation.

Handover card

Handover from midwife caring for Maria to next shift.

(I) Introduction: This is Maria, this is … <staff name>

(S) Situation: Fully dilated 2 hours ago, 1 hour of passive decent and has been pushing for just over an hour becoming tired and progress is slow, PV loss pink liquor.

(B) Background: G1P0 Induction of labour with x1 dose of prostin gel at 40 weeks. GDM diet controlled BGL NAD and reduced fetal movements. ARM 8 hours ago slow progress so augmented. Epidural sited 3 hours ago and working well. EFW ›95%. Last Hb 122 Bloods NAD. GBS Neg.

(A) Assessment: Vertex just visible has been actively push for an over an hour. VE 30 minutes ago - OA, +1 - 0 comes down with pushing +2 caput, +1 moulding. CTG abnormal unlikely deceleration with pushing with good recovery.

(R) Recommendation: Inform team leader and doctor of slow progress.

Thanks for looking after her.

Additional information

Name	Maria Stevenson
Age	35 years old
Sex	Female
Weight	86 kg

Allergies	Nil known
Medications	Nil
Medical/Surgical	Nil
History	Nil
Social History/Employment	Administrator for QLD rail
Partner's name	Shane

Pregnancy history	G1P0
Blood Group	A Pos antibodies Neg
Hb	121 – 36 weeks
Serology	Neg
Rubella	Immune
GBS	Unknown

<table>
<tr><th colspan="4">State 1: Initial assessment</th></tr>
<tr><th colspan="2">Vital signs</th><th>Script</th><th>Details</th><th>Expected actions</th></tr>
<tr><td>RR</td><td>16</td><td rowspan="10">Maria:
Very tired wanting it to be all over, “what do you want me to do, I’m so tired as I have been pushy for hours, is there any way you can help?”</td><td rowspan="10">• Primary assessment
• Reviews CTG – abnormal unlikely deceleration with pushing but good recovery
• Assesses situation regarding status near birth
• Reviews IVC rates and patency
• Epidural rates and block
• Not enough time for observations
• Performs an abdominal examination</td><td rowspan="10">☐ Assess situation
☐ Establish a rapport with Maria
☐ Call for a 2nd midwife
☐ Prepare the room for birth
☐ Abdo palpation</td></tr>
<tr><td>SPO2</td><td>100%</td></tr>
<tr><td>BP</td><td>110/70</td></tr>
<tr><td>HR</td><td>80</td></tr>
<tr><td>Temp</td><td>36.9OC</td></tr>
<tr><td>Consciousness sedation score</td><td>Alert distressed</td></tr>
<tr><td>FH</td><td>130 with deceleration good recovery</td></tr>
<tr><td>PV loss</td><td>Pink blood stained</td></tr>
<tr><td>BGL</td><td>7</td></tr>
<tr><td>Abdo. palpation</td><td>Fundus = Lie long – back Rt anterior ROA
Cephalic 0/5</td></tr>
</table>

State 2: On going management				
Vital signs		**Script**	**Details**	**Expected actions**
RR	22	Maria: Follows instructions of the team If no instruction, ask again for help to deliver your baby – what can I do? Confederate: Pushes fetus out to its head then holds on until several manoeuvres have been implemented	With next few contraction fetus does not move Fetal heart rate unable to be heard during contraction at the end of the contraction fetal heart rate 100 (see CTG) After about 2 pushes head is born very slowly and burrows back in at the end of the contraction No restitution occurs	☐ Identification of shoulder dystocia-declare an emergency ☐ Call for help ☐ When help arrives clearly states "shoulder dystocia" ☐ End of bed removed ☐ Head of bed flattened Maria instructed and assisted into McRoberts position ☐ Encouraged to push with next contraction, suprapubic press to correct side ☐ Good clear instructions to team members and Maria
SPO_2	97%			
BP				
HR	98			
Temp				
Consciousness sedation score	Alert distressed			
FH	100 with deceleration slow recovery			
PV loss	Pink blood stained			
BSL				

State 3: Resolution				
Vital signs		**Script**	**Details**	**Expected actions**
RR	20	Maria: Follows instructions of the team If no instruction given become distressed and disruptive.	Allow baby to be born when manoeuvres employed Baby cries once given some resuscitation Placenta is delivered once all signs of placental separation checked for	☐ Clear communication to Maria and team of plan to do an internal manoeuvre ☐ Should be managed systematically using RCOG algorithm ☐ Support continues to Maria ☐ Infant resus trolley rechecked ☐ Any of the internal manoeuvres done and baby is born ☐ Baby stunned and not crying ☐ Cord clamped and "cut" baby taken to resus trolley ☐ Active management of 3rd stage ☐ 40% incidence of PPH with shoulder dystocia ☐ Perineum checked Increased incidence of 3rd and 4th degree tears
SPO_2				
BP				
HR	110			
Temp				
Consciousness sedation score	Alert distressed			
FH				
PV loss				
BSL				

Supporting Resources

This section contains the following supporting documents that will be essential in the delivery of this learning package:

1. Ultrasound scan report
2. Manikin set-up guide
3. Laboratory reports
4. CTG on admission
5. Current CTG - 2nd stage pushing
6. Simulation debriefing poster
7. Debriefing guide

More resources can be downloaded from our website csds.qld.edu.au/mep.

Document type	Ultrasound scan report

Ultrasound Scan Report
CLINICAL INDICATION:

- Large for dates fetal growth and wellbeing
- Previously established gestational age: 36 weeks
- Established EDD

FINDINGS:

- BPD: 9.4 cm (92 percentile)
- HC:33.5 cm (90 percentile)
- AC: 34 cm (90 percentile)
- FL: 73 cm (92 percentile)

Fetal heart rate: 126 bpm (normal range 110-170)
Presentation: cephalic presentation ROT
Fetal movements: normal activity, fetal breathing and limb movement seen
Estimated fetal weight: 3160 grams on the 90th percentile, customised
Previous EFW measurement and date if applicable: [ ]
Umbilical Artery: pulsatility index [ ] ([ ] percentile) +/- RI. As a minimum, the PI must be reported.
Umbilical artery end and middle cerebral artery normal with positive end diastolic flow in umbilical artery.

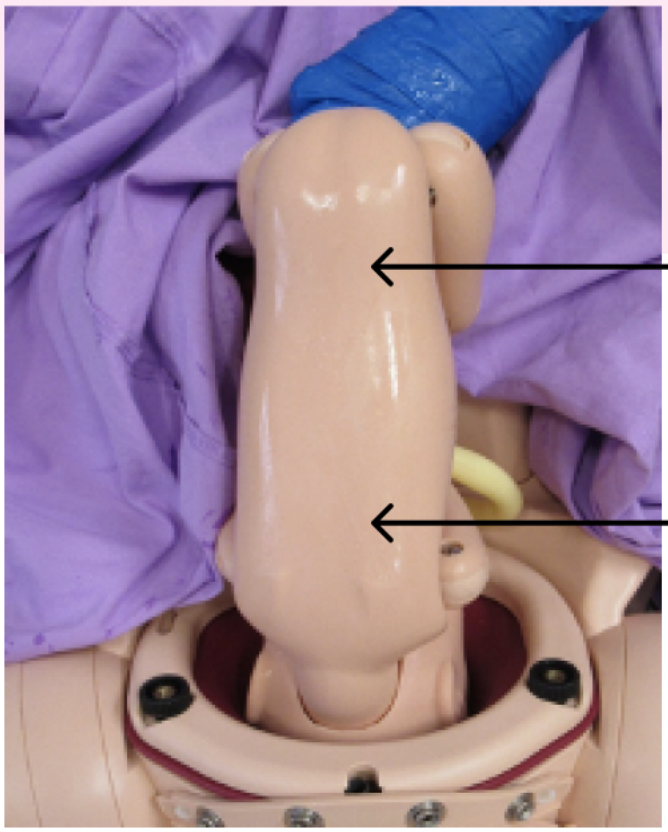
AFI: 15 (5-25 normal) deepest pocket 10 cm

Placental site: anterior and fundal
Cervix: 30 mm closed length, only if requested
Limited anatomy survey within the limits of late gestation.

CONCLUSION:

- Fetal EFW is on the [ ] percentile.
- Reassuring well-being with fetal biometry in normal range.
- ›90th centile, large for gestational age
- AN clinic follow up in 1/52

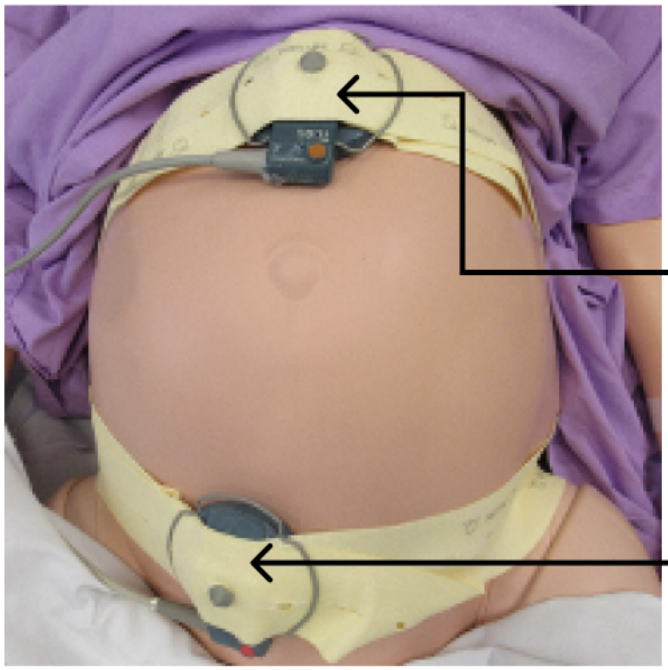
1. Fetal position



ROA
Back right
head in pelvis

0/5 head above
head well down in pelvis

2. CTG set-up

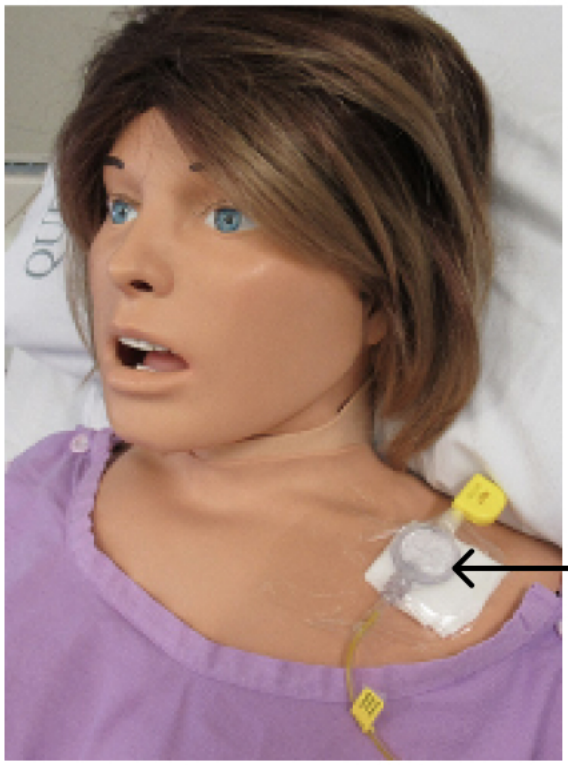


TOCO on top of uterus

USS over the fetal back ROA

3. Position of support person's hand under abdomen

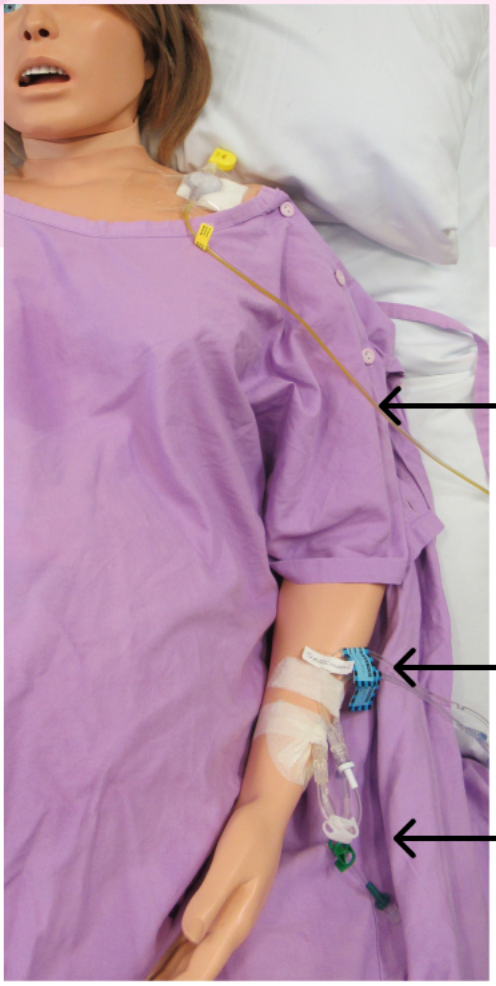
Support person holds onto fetal bottom to push fetus out and hold during shoulder dystocia



4. Epidural positioning and set-up

Epidural filter stuck to manikin skin on left side epidural line (yellow line) attached to epidural bag

5. IV lines and epidural line

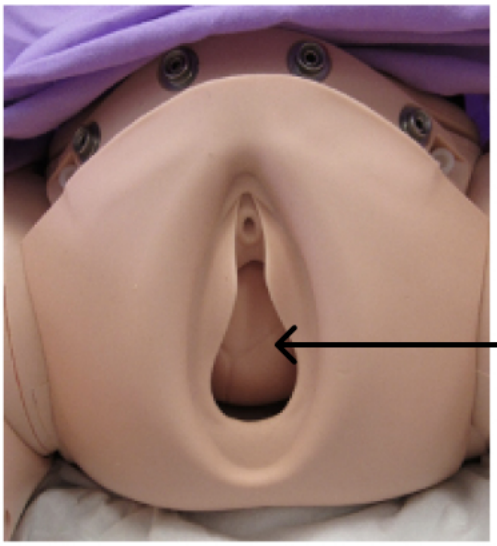


Epidural line

Syntocinon infusion through an infusion pump

Mainline N/saline 1000 mls on gravity line

6. Fetal head position in pelvis



Vertex visible at +1cm (fetal head visible in vagina)

36 week Routine
DATE:
PATIENT:
DOB:

LABORATORY REPORT
PAGE: 2
REF:

Test	Result	Comment
Group and Antibody Screen		
Group	A Rh (D) Positive	
Antibody	Negative	
		Nil
Expires in 7 days		

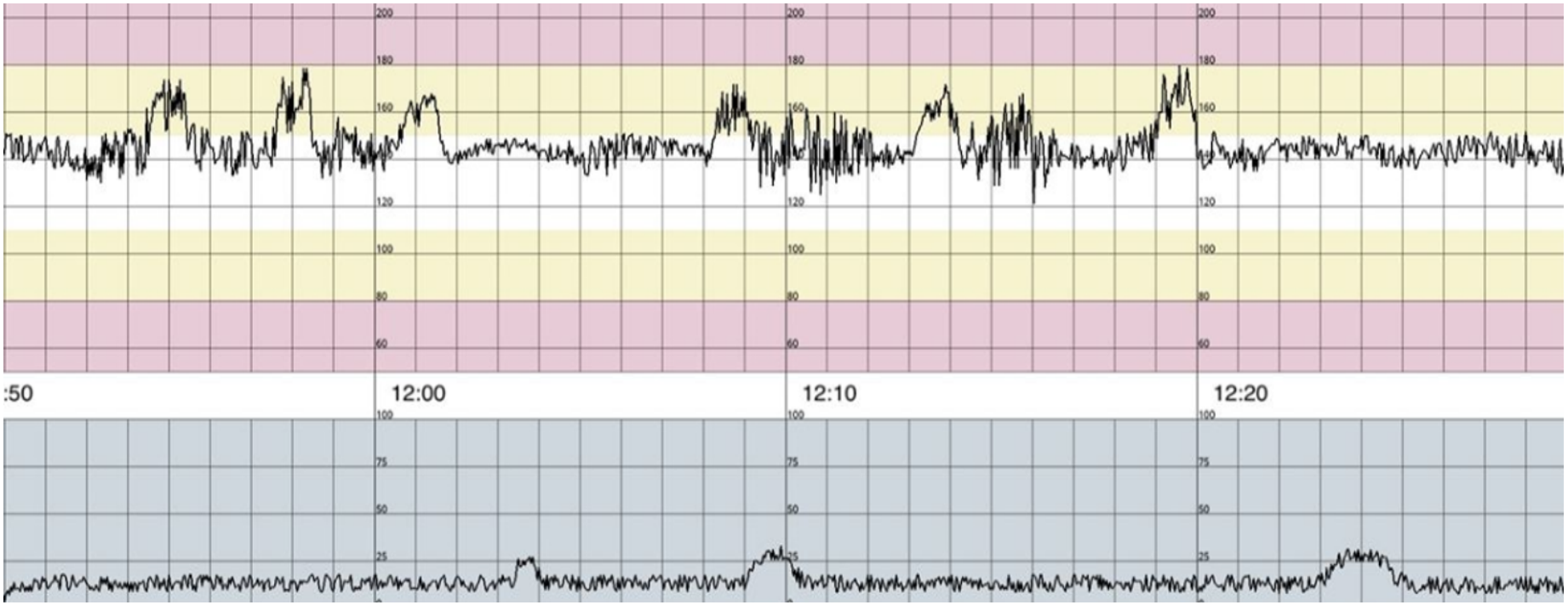
LABORATORY REPORT
DATE: **PAGE: 1**
PATIENT: **REF:**
DOB:

Test	Result	Reference	Comment
Haemoglobin	126 g/dL	13.7-17.7g/dL	
WCC	11.0 L	3.9-10.6 x 109/L	
Platelets	186 L	150-440 x 109/L	
Haematocrit	0.35	0.39 – 0.52	
RCC	3.85 L	4.50 – 6.0x10^{12}/L	
MCV	90 fL	80 – 100 fL	
Neutrophils	(83%) 9.15	2.0 – 8.0x10^{9}/L	
Lymphocytes	(10%) 1.15	1.0 – 4.0x10^{9}/L	
Monocytes	(6%) 0.65	0.1 – 1.0x10^{9}/L	
Eosinophils	(0%) 0.01	<0.60x10^{9}/L	
Basophils	(0%) 0.03	<0.20x10^{9}/L	

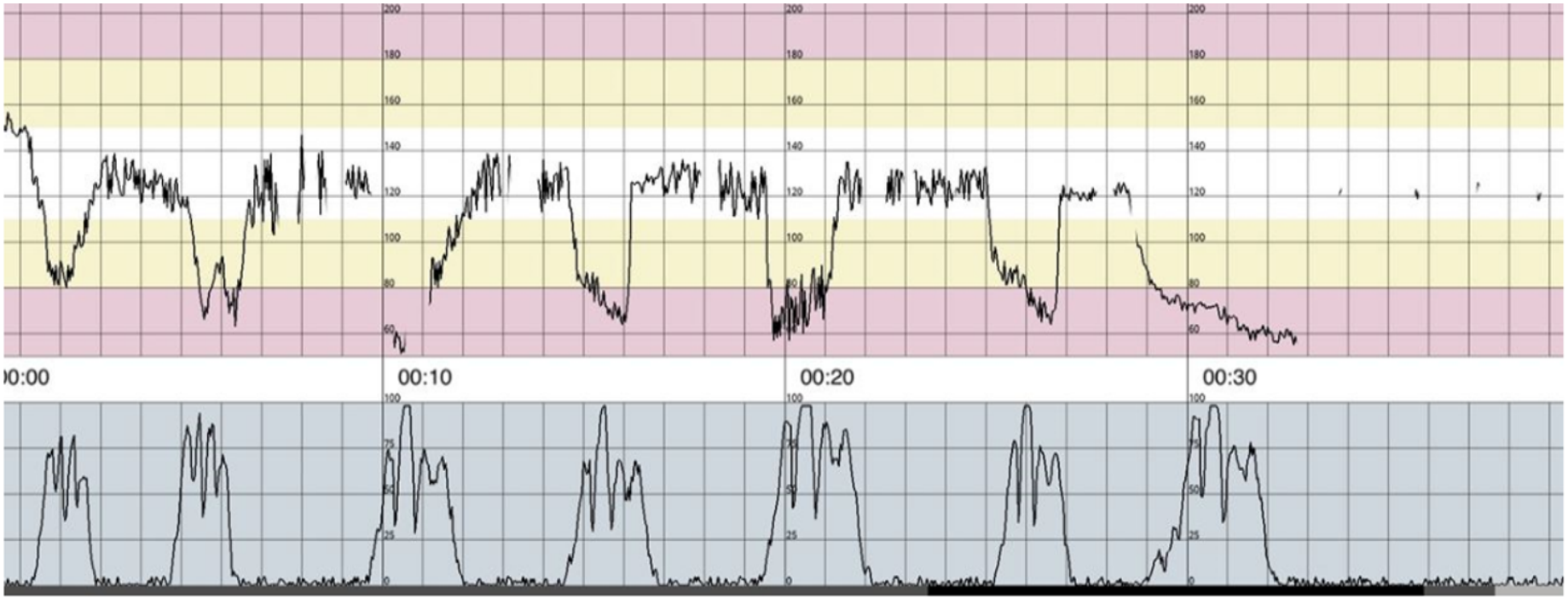
LABORATORY REPORT
DATE: **PAGE: 2**
PATIENT: **REF:**
DOB:

Test	Result	Reference	Test	Result	Reference
Sodium	135 L mmol/L	135-145 mmol/L	Urate		
Potassium	4.4 mmol/L	3.5-5.2 mmol/L	Protein (total)	61 g/L	60-83 g/L
Chloride	103 mmol/L	95-110 mmol/L	Albumin	30L g/L	35-50 g/L
sBicarb.	21 mmol/L	18-26 mmol/L	Bilirubin (total)	10 umol/L	<20 umol/L
Anion Gap	11 mmol/L	4-13 mmol/L	Bilirubin (conj)	<4 umol/L	<4 umol/L
Glucose	4.0 mmol/L	3.0-7.8 mmol/L	Gamma GT	8 umol/L	<55 u/L
Urea	3.9 mmol/L	2.1-7.1 mmol/L	AST	27 u/L	<35
Creatine	74 H umol/L	32-73 umol/L	ALT	22 u/L	<45
Urea/Creat	53	40 -100	ALP	183 u/L	56 - 119
eEFG	>90 ml/min	>60 ml/min	Calcium	2.28 mmol/L	2.10-2.60 mmol/L
Phosphate	1.55 H mmol/L	0.75-1.50 mmol/L	Corr ca	2.47 mmol/L	2.10-2.60 mmol/L
Magnesium	0.76 mmol/L	0.70-1.10 mmol/L	OSM (calc)	283 mmol/L	270-290 mmol/L

CTG on admission. Admission CTG prior to labour and IOL



CTG 2. Current CTG. 2nd stage pushing



Simulation Debriefing

Establishing a safe container for learning in simulation.

1 Reaction phase - "vent"

- How was that?
- How are you feeling?
- Any other initial reactions?
- Learners may reveal key areas that are important to them.

2 Description phase

- Clinical summary of the case.
- Can be shortened if it appears there is shared understanding of the case.

3 Analysis phase

Select which strategy is suited.

- Learner Self-Assessment - learner generates objectives

  What went well/what would you change?
  What well/did not go well and why?

- Focused Facilitation - analyse performance related to objective

4 Summary phase

- Discuss take-home learning points
- Learner guided approach or
- Facilitator guided approach

Adapted from Eppich, W. and Cheng, A., 2015. Promoting Excellence and Reflective Learning in Simulation (PEARLS). Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare, 10(2), pp.106-115.

CSDS
Clinical Skills Development Service
Queensland Government

Debriefing guide

Scenario objectives	Participants are required to: ☐ Identification of Shoulder dystocia ☐ Employ manoeuvres to resolve shoulder dystocia ☐ Demonstrate good use of resources and team members ☐ Display clear and effective communication skills
Vent phase	Example questions: • Initial thoughts of how the simulation went? • Acknowledge emotions (note body language and tone of participants)
What happened (phases)?	Example questions: • Tell us about your patient and what were your initial priorities? • What led to your decision to escalate management? • What clinical signs and symptoms led you to become concerned?
What was done well and why?	Example questions: • What could have been better at each phase?
Relevance to experience	Example questions: • How would you transfer knowledge from today into your workplace?
What has been learned?	Example questions: • What actions will you take to enhance your skills and knowledge post simulation?
Transfer to clinical settings	Example questions: • What will you take away from this session? • Can you give an example of how you could apply new skills or knowledge gained during this session in your clinical setting?
Key moments	• Recognition of shoulder dystocia (potential / actual) • Correct positioning • Performing external & internal manoeuvres • Having key team members present • Preparing and plan for ongoing adverse event – PPH, 3rd – 4th degree tear

Acronyms and Abbreviations

Term	Definition
BGL	Blood glucose level
CTG	Cardiotocograph
EFW	Estimated fetal weight
GBS	Group B streptococcus
GDM	Gestational diabetes mellitus
Hb	Haemoglobin
IOL	Induction of labour
IVC	Intra venous cannular
NAD	Nothing abnormal detected
OA	Occiputal anterior
PHR	Pregnancy Health Record
PPH	Postpartum haemorrhage
PV	Per vagina
RCOG	Royal College of Obstetricians & Gynaecologists
ROA	Right occiputal anterior
USS	Ultrasound scan

References

This resource kit has been inspired by the Optimus BONUS project of the Children's Health Queensland's "Simulation Training Optimising Resuscitation for Kids" (STORK) service. To find out more information about STORK and their Optimus project, visit their website.

1. Dahlke, JD; Bhalwal, A; Chauhan, SP (June 2017). "Obstetric Emergencies: Shoulder Dystocia and Postpartum Hemorrhage". Obstetrics and Gynecology Clinics of North America. 44 (2): 231-243.

2. Children's Health Queensland. 2020. Queensland Paediatric Emergency Care Education | CHQ. [online] Available at: ‹https://www.childrens.health.qld.gov.au/research/education/queensland-paediatric-emergency-care-education/› [Accessed 24 July 2020].

3. Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 42 2nd Edition / March 2012

Appendix

This section contains the following supporting documents that will be essential in the delivery of this learning package:

A. Pre-simulation briefing blank template
B. Simulation debrief blank template

Pre-simulation Briefing Notes

Establishing a safe container for learning in simulation.

1 Clarify objectives, roles and expectations

- Introductions.
- Learning objectives.
- Assessment (formative vs summative).
- Facilitators and learners' roles.
- Active participants vs observers.

2 Maintain confidentiality and respect

- Transparency on who will observe.
- Individual performances.
- Maintain curiosity.

3 Establish a fiction contract

Seek a voluntary commitment between the learner and facilitator.

- Ask for buy-in.
- Acknowledge limitations.

4 Conduct a familiarisation

- Manikin/simulated patient.
- Simulated environment.
- Calling for help.

5 Address simulation safety

Identify risks.

- Medications and equipment.
- Electrical or physical hazards.
- Simulated and real patients.

Simulation Debriefing Notes

Establishing a safe container for learning in simulation.

Crisis Resource Management Principles

1. Know your environment
2. Anticipate and plan
3. Call for help early
4. Take a leadership role
5. Communicate effectively
6. Allocate attention wisely & use all available information.
7. Distribute the workload & use all available resources.

1

Reaction phase - “vent”

- How was that?
- How are you feeling?
- Any other initial reactions?
- Learners may reveal key areas that are important to them.

2

Description phase

- Clinical summary of the case.
- Can be shortened if it appears there is shared understanding of the case.

3

Analysis phase

Select which strategy is suited.

- Learner Self-Assessment - learner generates objectives

  What went well/what would you change? What well/did not go well and why?

- Focused Facilitation - analyse performance related to objective

4

Summary phase

- Discuss take-home learning points
- Learner guided approach or
- Facilitator guided approach

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Shoulder Dystocia – Facilitator Resource Kit

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