Drill pre-brief (instructor to read out)

“Welcome to this Resus Drill. Drills are for situations which happen quickly, are not common, and need a time-critical response. They need practice, so when the time comes, you’ve already had the dress rehearsal. This is not a Simulation. Drills are for practising teamwork and speed. We will run a scenario for 5 minutes, chat and reflect on it, then run the same scenario again for another 5 minutes.”

Assurances

Learning, NOT assessment: The drill is for practice and for learning. We’re concentrating on how fast you can think, and how well you work as a team.

Safe zone: Learning and mistakes are shared here, not any further.

5-min reflection rules: Please be constructive in the debrief. We’re all here to learn. These are deliberately tough scenarios. That’s the whole point of a drill.

Pretend it’s real: we’ll try to make the drill realistic, but this is not meant to be a high fidelity Simulation. Although it’s not real, we need you to help us by acting as you’d do in real life, in your normal role, and we’ll try to run it in real time.

Take-away pack: there is some information that you can take away for further learning. We recommend “spaced repetition” for the best learning:

➔ make some reflective notes while it’s fresh in your mind
➔ make yourself read them again in a couple of weeks

How does it work?

These ER drill packs will be laminated and left in the Simulation Bay (Bay 5) for teaching purposes, as well as “take-home” cards for those who want to brush up on their learning. The team can then choose a scenario or roll the dice to decide!

Each Resus drill pack contains: location of equipment, “Red call” sheet (optional), decision algorithm, scenario script, debrief questions, procedure and additional learning resources.
UNEXPECTED DELIVERY

S.E.T.U.P. (before patient arrives)

SELF... physical readiness (stay calm) & cognitive readiness (accept the challenge)

ENVIRONMENT... dangers, space, lighting, crowd control, appropriate equipment?

TEAM... initial briefing, identify Team Leader, allocate team roles

UPDATE... if possible, recap for the team (and yourself) before patient’s arrival

PATIENT... the patient has now arrived

Location of Equipment

The Emergency Delivery Pack can be located inside of the Resus/ER equipment stacks next to Bay 9 and opposite Bay 10.
Unexpected Delivery

Location of Equipment (continued)

Neonatal Equipment required can be found inside Paediatric Resus Bays 1 & 2.
1. **Cord clamping:**
   a. Place one clamp approximately 15 cm from the baby’s abdomen.
   b. A second clamp 2–3 cm distally to the first.
   c. Ensure that they are firmly closed and cut between.

2. **Basic neonatal resuscitation:**
   a. Dry and rub (stimulate) with warm towels.
   b. Be firm and vigorous yet gentle at the same time.
   c. Discard wet towels and wrap in fresh towels.
   d. Apply TransWarmer below wrapped baby and a hat.

3. **3rd stage delivery:**
   a. Support the mother in a comfortable position...
      i. Upright at ~45° if no bleeding, never flat.
   b. Passively assist the mother, do not pull the cord...
      i. Expulsion of placenta + membranes can take >15–20 mins.
      ii. Deliver straight into a bowl or plastic bag and keep.
      iii. Blood loss should not exceed 300 ml.
   c. Once placenta is delivered (end of 3rd stage)...
      i. Massage can be applied with a cupped hand to the top of the fundus (abdomen) using a circular motion to stimulate uterine contraction.
      ii. Syntometrine should be administered.
Unexpected Premature Delivery Decision Algorithm

Baby delivered unexpectedly
- No known medical history
- No known social circumstances

Initial immediate visual assessment <1 min
1. Mother – any signs of haemorrhage or collapse?
2. Baby – any signs of life? Breathing?

Cord is clamped and cut safely

Immediately move Mother and Baby to clinical area in adjoining cubicles

CUBICLE 1
Allocate a team to Mother (Team 1)
Check for signs of haemorrhage and shock:
- ABC assessment
- Estimate blood loss so far (>300 ml?)

Focus on 3rd stage:
- Site intravenous cannula (wide bore)
- Send group & save
- Stimulate uterine fundus
- Syntometrine 500 mcg (1ml) IM

In parallel CALL FOR HELP and GET EQUIPMENT:
- Call 2222 obstetric emergency team and paediatric ED team
- Get delivery stack and neonatal stack

CUBICLE 2
Allocate a team to Baby (Team 2)
Check condition:
- Tone
- Colour
- Breathing
- Heart rate

Focus on basics:
- Stimulate baby whilst drying
- Apply hat, wrap in towels
- Put on TransWarmer
An alarm goes out in Paediatric ED patient toilet opposite the main work-station. A 15-year-old female presented with abdominal pain gives birth unexpectedly. You are first on scene. A baby is on the toilet floor attached by its cord.”

Minute One
“Baby is breathing and starting to cry, mother is alert, distraught but looking OK”. Team Leader should call for a trolley to move to clinical area. Should ask for the normal delivery pack and neonatal pack from the ER stacks and request 2222 obstetric emergency team and paediatric ED senior staff help. Cord should be ideally be clamped before moving. Do not prompt if incorrect.

Minute Two
Whole team, mother and baby should be moved to adjoining cubicles in the resus area. Prompt if not done (scenario cannot continue in the toilet). “The baby looks small.”

Minute Three
Team Leader should allocate 3x team leader roles – Overseeing Team Leader (OTL) plus one per cubicle (TL1 and TL2). ED consultant would facilitate this, but do not prompt.

➔ Cubicle 1, Mother – Time check, vital signs “HR 100, RR 25, BP 120/80, SpO2 96% air, GCS 15, Temp normal.” Mother to be positioned comfortably.

➔ Cubicle 2, Baby – condition recheck. Auscultation for heart rate. “HR 120.” Resuscitation is not needed. “Baby is crying and active with a good colour.” Dry the baby and keep warm (towels and TransWarmer). Do not prompt.

Minute Four
➔ Cubicle 1, Mother – Obstetric team has not arrived. “Mother remains alert, minimal blood loss per vaginally, cord intact, and placenta not visible if she is inspected.” TL1 to focus on 3rd stage and IV access.

➔ Cubicle 2, Baby – Paediatric team has not arrived. “Baby’s condition is unchanged but the baby appears very small.”

Minute Five
➔ Cubicle 1, Mother – Prompt TL1 to describe what they would do next. Includes Incopads on floor, bowl for placenta, syntometrine IM. TL1 to lead discussion as to who should take over as TL1 if specialist help arrives.

➔ Cubicle 2, Baby – Prompt TL2 to describe what they would do next. Includes assessing prematurity and getting the right equipment. TL2 to lead discussion as to who should take over as TL2.
Debrief and Feedback

You should aim to cover the following points **within 5 minutes**, then re-run the scenario:

1. Was the correct help immediately called for? *(obstetric emergency team and paediatric ED senior staff)*
2. Was there a rapid decision to move out of the toilet?
3. How did the team pull together?
4. Were 2 teams formed? *(mother and baby)*
5. Were the right stacks brought? *(normal delivery stack, neonatal resuscitation stack)*
6. Were the right actions taken to for the baby? *(rapid assessment, keeping warm)*
7. Were the right actions taken for the mother? *(basic assessment, 3rd stage management)*
8. Was ownership of the patients established once specialist teams arrived?
9. Were there any instances of:
   a. Equipment issues?
   b. Human factors negatively impacting communication or patient care?

**Additional Resources**


