Scenario	Student midwife response	Woman's response	Information to show student midwife	Equipment / avatar activities
Decision Point 1: When woman or support person first informs the midwife that she is in labour 0400hrs. Partner of woman having first baby rings BC to say she is in labour.	<u>General approach:</u> positive, sociable, reassuring, ask to speak to woman if possible. <u>Information to gather:</u> how are they feeling generally, history of contractions, time started (duration, strength, frequency), vaginal discharge (blood or liquor, colour, consistency, time, smell, amount), baby movements, bowel actions, pass urine, when last ate drank, sleep, activity. ? talk to woman through contraction, can she still talk, how is she behaving? <u>Actions and advice:</u> retrieve notes and check for anything significant (eg blood group, last Hb, key decisions eg management of 3rd stage labour), reassure, all is well, may be latent phase of labour, encourage to try and get some more sleep, contact if any concerns especially ROM, bleeding, concerns about baby movements,	Woman is feeling excited and happy a bit nervous. Contractions started 3am, woke her from sleep, currently every 10-15 (a bit irregular) minutes, strong, lasting 20 seconds, baby moving well, mucous vaginal discharge, no liquid, woman had mild diarrhea last night after partner fed her curry, had cup of tea before bed, has passed urine in last hour, just watching TV now. Woman can talk through contraction and sounds happy.	Notes for woman. Summary of pregnancy: all normal. Wants physiological third stage and wants to breast feed baby. Wants natural birth no pharmaceutical pain medication if possible. Doesn't mind water birth. Last visit details: (previous day): 40 weeks +2 days, BP 120/75, FHR 132, LOL, 3/5 engaged, fundus measures 39cm,	Phone in midwifery office, student midwife to answer and speak to woman or partner. Clinical notes Student midwife needs to document all actions and conversations.

	contractions become more strong and frequent. Document actions conversations and advice		Urine NAD, active baby	
Decision Point 2: When woman wants intermittent support from midwife 0700hrs. Woman has been in touch and contractions stronger and more frequent. While you offered to visit the couple at home to assess the situation they are very anxious and wanted to come to the birth centre. Woman and partner arrive at BC and midwife needs to settle in and do initial monitoring and management.	<u>General approach:</u> Welcoming, calm, reassuring. Let couple settle in before doing observations etc. Don't have medical equipment on display. <u>Information to gather:</u> How are they feeling? Update labour history, what happened after earlier phone call, contractions (duration, strength, frequency), vaginal discharge (blood or liquor, colour, consistency, time, smell, amount), baby movements, bowel actions, pass urine, when last ate drank, how did she sleep, what activity since awake, what is behavior of woman now, how does partner seem? <u>Actions:</u> Collect appropriate equipment from cupboards, wash hands, monitor contractions, BP, urinalysis, temp, palpation, pulse, FHR, vaginal discharge,	Partner and woman both a bit tired but excited. Had a sleep after phone call and woke up at 6am with contractions. Contractions regular, lasting 50 seconds, five minutes apart. Walking around house getting ready to come to BC since woke up. Passed urine then and had cup of tea. Small amount of blood stained mucous on toilet paper, wearing a sanitary pad now. Baby moving. Hasn't had anything to eat and doesn't really feel hungry. Both look a bit apprehensive.	Contractions every 5 minutes, moderate to strong intensity, lasting 50 seconds. Woman having to concentrate through contraction Observations: FHR 144,	Woman, partner and midwife in birthing room. All sit on chairs. Woman concentrating though contraction, hand on belly. Student midwife to collect equipment from cupboards (equipment not on display); sphygmomanometer, stethoscope, thermometer, watch, urine sticks

	vaginal examination. Void before palpation and VE <u>Advice and actions based on findings:</u> reassure everything progressing well. Labour is established. Explain ketones and advise to eat something light, advise to drink, encourage to be upright and active and explain why, show mantle, ledge, offer garden, swiss ball out of cupboard. Ensure they oriented to BC, feel free to use all areas. Ensure they can control temp, privacy, light, ambiance Explain frequency of	.	palpation LOL, fetal head 4/5 engaged, temp 36.5, pulse 82, urine + ketones, NOAD, BP 130/80, small bloody mucous show, vaginal examination; cervix soft, central, 3cm dilated, 75% effaced, well applied, head station 0. Head presenting. Fetal sutures not felt. No cord, moulding, or caput and no liquor.	Student midwife wash hands Take BP, temp and pulse, midwife hand on belly to assess contractions Woman to sit on toilet and void. Woman wearing sanitary pad for student midwife to check. Student midwife to collect equipment for palpation and vaginal examination: pinards, bed protector, sheet to put over woman, lubricant, gloves, new sanitary pad. Student midwife to wash hands Woman to lay on bed for student midwife to palpate and vaginal examination. Student midwife show partner and woman to kitchen to make toast. Get refreshments and water for room Show couple how to alter lighting, temperature, music. Lock door to room so no intrusions

	observations: four hourly temp, BP, hourly pulse, ½ hourly contractions, FHR 15 minutes (as per NICE) Document actions conversations and advice			
Decision Point 3: When woman wants continuous support from midwife 1100hrs. Woman has been progressing nicely and all observations have remained normal. Midwife in office and partner comes to say woman needs you, he thinks waters have broken. You find her on her back on the bed writhing in pain saying she can't take it any longer.	<u>General approach:</u> Calm, empathetic, confident, reassuring, encouraging. <u>Information to gather:</u> what is woman feeling, where is the pain, what is the nature of the pain (intermittent or constant), intensity, what has been happening, baby movement, last drink and void. How is the partner doing? <u>Advice and actions:</u> Observations; recommend observations and vaginal examination. Explain to couple rationale. Collect appropriate equipment from cupboards, wash hands, monitor contractions, BP, urinalysis, temp, palpation, pulse, FHR, vaginal discharge, vaginal examination. <u>Advice and actions based</u>	Woman has lots of pain low down in front, just with contraction. These have been building in intensity. She is too tired and wants to sleep that is why she got into bed. She can't take it anymore, she has changed her mind and wants to go home. Baby is moving, she is feeling nauseous, has been sipping water, last void an hour ago. Partner is looking a bit panicked and lost.	Observations: contractions; every 3 minutes lasting, 1 minute, strong. FHR 100, palpation LOA, fetal head 4/5 engaged, temp 36.8, pulse 92, urine +blood, +protein, BP 130/80, small bloody mucous, clear liquor, no odour, moderate amount, vaginal examination; cervix soft, central, 7cm dilated, 100% effaced, well applied, head station 0. Head presenting. Saggital suture right oblique, posterior fontanel felt anteriorly. No cord, moulding, or	Woman writhing on bed on back on bed. Woman to sit on bed for BP, temp pulse then a/a for urinalysis, palpation and vaginal examination

	<u>on findings:</u> things progressing well, difficult part labour coming to transition, various ways to assist at this point, lots continuous encouraging, comment on FHR, get her off back and check FHR again within 5 minutes. Suggest; pool, shower, swiss ball, rope, walk, hot pack, massage, changing position; leaning, hands and knees. ?Adjust lighting, music. Stay with woman continuously. Frequency of observations, four hourly temp, BP, hourly pulse, ½ hourly contractions, FHR 15 minutes (as per NICE) Document actions conversations and advice		caput, clear liquor draining. New FHR after woman upright 135	Sick bowl for nausea Woman to squat, and hands and knees (in pool or corner, swiss ball, bed), hang on rope, lean on mantle and bench or garden or living room furniture, partner massage lower back. Woman in shower. Adjust lighting
Decision Point 4: Second stage of labour 1400hrs. Woman hands and knees in corner of room starting to push with peak of each contraction.	<u>General approach:</u> Calm, empathetic reassuring, encouraging. <u>Information to gather:</u> what is woman feeling, where is the pain/pressure, what is the nature of the pain/pressure (intermittent or constant), intensity, baby movement, last drink and void. How is the partner doing?	Contractions are a bit easier to manage. Involuntary pushing with peak of each contraction, feels like wants to do poo. Pressure is in her bottom. Baby is moving a bit. Has been sipping		Woman hands and knees position corner of room pushing a little with contractions

	<u>Advice and actions:</u> Observations; recommend observations and vaginal examination. Explain to couple rationale. Collect appropriate equipment from cupboards, wash hands, monitor contractions, BP, urinalysis, temp, palpation, pulse, FHR, vaginal discharge, vaginal examination. <u>Advice and actions based on findings:</u> Reassure that things have progressed normally and well. Encourage to continue, "go with the flow", push as feels the urge (no directed pushing), suggest positions if appropriate e.g. supported squat, bath, hands knees, rope, stand, shower, cold flannel on head, or hot pack. Keep drinking, ice to suck, keep bladder empty. Frequency of observations; hourly temp, BP, pulse, ½ hourly contractions, FHR 5 minutely (as per NICE). Documentation. <u>Preparations for birth:</u> Inform second midwife. Check emergency	water and last voided about half hour ago. Couple seem calm and excited that things might be progressing	Observations: contractions; every 4 minutes lasting, 1.5 minutes, strong, urge to push. FHR 145, palpation LOA, fetal head fully engaged, temp 36.7, pulse 88, urine +blood, +protein, BP 125/80, small bloody mucous, clear liquor, no odour, moderate amount, vaginal examination; cervix fully dilated, head station +1. Head presenting. Saggital suture right oblique, posterior fontanel felt anteriorly. No cord, moulding, or caput, clear liquor draining. FHR monitoring. All FHR between 110-160. Reactive heart rate, no decelerations	a/a for observations and examination a/a for variety of positions Student to listen to FHR Student midwife to check emergency equipment and collect equipment for birth from cupboards (equipment not on

14.20pm. Woman has been pushing well. All observations have been within normal limits. Baby's head is on view now	equipment; open resuscitation bay check oxygen, suction, heating. Collect portable oxygen and suction and place nearby (not too obvious). Collect delivery set; (dish, clamps, scissors, cord clamp, swabs), gloves, torch or portable light, awareness of location of medication for bleeding and IV equipment. <u>General approach:</u> Calm, empathetic reassuring, encouraging, quiet <u>Information to gather:</u> watch for signs of progress, anal pouting decent of fetal head, <u>Advice and actions:</u> Gentle encouragement, monitor decent of fetal head, monitor FHR, hands off perineum unless mother wants a warm pack, warm baby clothes and towels within reach <u>Birth:</u> wash hands and glove. Mother to scoop up baby into arms, Dry baby offwith warm towel, place new warm towel over baby, note time, monitor bleeding, Apgars	Baby coming and can feel stretching of vagina. Wants warm pack on perineum	FHR monitoring. FHR between 110-160. Deceleration to 110 with contraction but promptly recovers after contraction. Reactive heart rate Observations. Live baby girl born 14.30 hours. Apgars. 1 min; HR 130, colour slightly blue extremities while body and mucous membranes pink, arms and legs	display); portable oxygen and suction and place nearby (not too obvious). Collect delivery set; (dish, clamps, scissors, cord clamp, swabs), gloves, torch or portable light, awareness of location of medication for bleeding and IV equipment (In treatment room: iv fluids, drip stand, fridge and drugs, giving set) Student midwife to listen to FHR Women squatting in corner of room between partners knees (who is sitting on couch/bench). Midwife kneeling in front of woman. Student midwife to apply warm pack to perineum Student midwife wash hands, don gloves assist mother to scoop up baby. Dry baby off with towel and place towel over baby.

	and baby wellbeing after birth. Documentation		flexed but not moving a lot, irregular breathing, grimacing. 5 minutes: HR 140, colour slightly blue extremities while body and mucous membranes pink, arms and legs flexed, baby active, baby crying and grimacing. Total blood loss: 300 mL	Mother gives birth, picked up by mother and hugged to bare chest, small amount blood between legs.
Decision Point 5: 3rd stage 1430hrs. Woman requested physiological third stage and wants to breastfeed baby. Baby is born and she is cuddling on chest. Partner is keen to weigh baby so he can inform all the relatives.	<u>General approach:</u> very unobtrusive, protecting bonding and atmosphere. <u>Information to gather:</u> quietly monitoring blood loss, mother and baby condition. Observe baby colour (especially mucous membranes), activity and respiratory pattern. Observe mother's behavior. <u>Advice and actions:</u> Protect the space for the new family, encourage skin to skin contact mother and baby, keep baby warm and mother comfortable. Explain to partner that weighing can wait as bonding, skin to skin and breastfeeding are more important.		Mother and baby's condition remain good. Baby warm, breathing regularly and good HR. No further blood loss from mother.	Mother and partner on couch, mother cradling baby.

	Breast feeding: maintain skin to skin contact, support woman to breastfeed, explain how helps with 3rd stage and benefits establishment of breast feeding			Mother and baby naked with baby at mothers chest breastfeeding.
	Cutting cord: wait for cessation of pulse. Offer woman/partner to clamp cord. Place baby clamp at umbilical end and metal clamp some distance from. Assist woman/partner to cut between clamps.			Midwife, mother and partner can feel for pulse in cord, clamp and cut cord
	Placenta: encourage woman to void, watch for signs of separation (small gush blood, lengthening of cord, contraction). Encourage woman to squat over bowel for placenta (no pulling on cord or palpation of uterus). Placenta born into bowl. Monitor blood loss.	Woman feels contraction.	Blood collected in bowl with placenta and measures 150mL	Small gush blood, woman squat over bowl while holding baby, placenta comes out
	Observations: take when appropriate, BP, Pulse, temp, fundus, comment on blood loss (nature and amount)		BP: 123/72, HR 82, Temp 36.5, blood loss moderate rubra, fundus firm and central, woman has voided in toilet.	a/a for observations
	Check placenta: offer to do in front of parents and explain findings to them, check complete no missing cotyledons, check membranes for	Yes, want to see placenta	Placenta: complete, membranes complete, no calcification, cord central insertion, 3 vessels (2 arteries one vein)	Placenta and bowl

	completeness (non ragged), check condition (calcification), check insertion of cord site, check cord 3 vessels (2 arteries and 1 vein) Offer refreshments and shower etc when appropriate. Documentation			

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