



Open RN Virtual Reality Scenario Plan

OB - CARING FOR A POSTPARTUM CLIENT AFTER EMERGENT C SECTION DELIVERY - LEVEL 4

Scenario Overview

Carmen Garza-Valdez is a 32-year old female who presented to the hospital yesterday at 0820 by EMS following a motor vehicle accident. The patient suffered blunt force trauma from a frontal impact, requiring extrication on scene. A primary cesarean section was performed at 0913 following initial assessments due to a placental abruption. The baby was admitted to the NICU following delivery and was diagnosed with hypoxic ischemic encephalopathy.

Carmen recently put her call light on with questions about her incision. Students will implement postpartum orders and communicate therapeutically with Carmen while addressing her questions and concerns. A simulated EHR with tabbed chart content is available on the WOW cart to augment the reality of the scenario.

Technician prompts are provided for an optional additional feature of a patient who only speaks Spanish.



Estimated Scenario Time: 60 minutes - Estimated Debriefing Time: 60 minutes

Learning Objectives

1. Maintain a safe, effective health care environment
2. Perform proficient comprehensive assessments
3. Provide patient centered care by utilizing the nursing process
4. Relate patients' health status to assessment findings, medications, laboratory and diagnostic test results, medical and nursing interventions
5. Provide patient education regarding postpartum and newborn topics
6. Model effective communication strategies for clients based on clients' age, developmental level, disability and/or culture and team characteristics.



Curriculum Alignment

WTCS Nursing Program Outcomes

- Integrate professional nursing identity reflecting integrity, responsibility, and nursing standards
- Communicate comprehensive information using multiple sources in nursing practice
- Integrate theoretical knowledge to support decision making
- Integrate the nursing process into patient care across diverse populations
- Function as a healthcare team member to provide safe and effective care

Nursing Fundamentals Course Competencies

- Maintain a safe, effective care environment for adults of all ages
- Adapt nursing practice to meet the needs of diverse patients in a variety of settings
- Use appropriate communication techniques
- Use the nursing process
- Provide nursing care for patients with comfort alterations

Nursing Pharmacology Course Competencies

- Apply components of the nursing process to the administration of medications

Nursing Skills Course Competencies

- Perform general survey and focused assessments
- Analyze vital signs

Nursing Health Promotions Course Competencies

- Use principles of teaching/learning when reinforcing teaching plans
- Apply principles of family dynamics to nursing care
- Apply principles of evidence-based practice when using the nursing process for high risk perinatal patients
- Plan nutritional interventions for patients to promote/maintain health for patients with high risk perinatal conditions
- Integrate pharmacological therapy in the care of patients with high risk perinatal conditions
- Select teaching/learning topics to promote self care for the patient with high risk perinatal conditions
- Consider patient diversity across the lifespan when applying principles of patient-centered care

Nursing Complex Health Alterations II

- Evaluate nursing care for the high-risk perinatal patient
- Evaluate nursing care for a high-risk newborn



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Scenario Setup

Scene

Postpartum room

Patient Information

- 32 year-old female
- Patient identification armband present
- Patient Name: Carmen Garza-Valdez
- DOB: 07/18/19XX
- Age: 32
- Height: 168 cm (66 inches)
- Weight: 76.4 kg (168 lbs)
- Allergies: NKDA
- Code Status: Full code
- Primary Language: English (Spanish if interpreter is available)

Initial Sim Manager Settings

See the [Acadicus Sim Manager Tutorial](#) for more information. Use default settings plus the following:

- Vitals: BP 138/82, HR 88 RR 18, O2 98% on room air, T 98.6F, Pain: 5/10
- Animation: Talking; Anxious; Position: Fowler's 45
- General Apparel and Equipment: Patient Gown with a blood spot present from incision site; Blanket On; Side Rails Raised, Bed Lowered and Locked
- Circulatory: Regular rhythm, Heart sounds normal, 2+ pulses, 2+ capillary refill
- Respiratory: Normal breathing, Lung sounds clear
- Digestion and Abdomen: Normal defaults
- Skin and Subcutaneous Tissue: Cesarean incision with 3cm dehiscence and small amount of bleeding present
- Nervous and Musculoskeletal: Normal defaults
- Cognition: Alert

Assets in VR Room

- WOW cart
- Vital signs equipment and monitor on
- IV in place (saline lock)
- Oxygenation devices available (nasal cannula, non-rebreather mask, etc.)
- Postpartum hemorrhage kit
- Available on Postpartum Floor • IV start kit • 18 gauge angiocath • 1 liter bag lactated Ringers & 0.9% Normal Saline • IV tubing • Urinary catheter kit with urimeter • Flashlight
- NALS resuscitation chart
- Postpartum hemorrhage cart

Medications in WOW cart

- See MAR

EMR Chart Forms

- [Provider Orders](#)
- [MAR](#)
- [Lab Results](#)
- [Diagnostic Reports](#)
- [Prenatal Record](#)
- [OB/GYN History](#)
- [Motor and Sensory Checks](#) (optional)
- Patient Education Handouts (optional): [Breastfeeding](#) - [Postpartum Care](#) - [Postpartum Warning Signs](#) - [Hypoxic Ischemic Encephalopathy](#) - [Hypoxic Ischemic Encephalopathy \(Spanish version\)](#)

State 1

Carmen is admitted to the postpartum unit. Students perform an initial assessment then implement postpartum orders.

Events	Expected Student Behaviors	Suggested Facilitator Prompts/Questions
State 1 Scenario Settings Scenario time: 0820 • HR 88 • BP 132/82 • RR 18 • Temp 98.6 F or 37 C • Lung Sounds – clear • Bowel sounds active • Heart sounds normal S1S2 no murmur Technician Prompts Patient is excited but tired after surgery. She has a lot of questions about the welfare of her baby and her cesarean incision. If students do not use appropriate therapeutic communication, Carmen becomes increasingly anxious about the baby. If students do not perform a focused skin assessment Carmen becomes increasingly worried about infection. English Version of patient questions/responses: • “Hello, I put my call light on because I have some concerns about my incision.”	• Perform hand hygiene • Introduce themselves to the patient • Critical behavior: Verify patient identity • Obtain and interpret vital signs • Communicate therapeutically about client's concerns • Perform focused assessments • Review client chart as it relates to client care • Review, prioritize and appropriately implement provider orders • Safely administer medications as indicated • Provide patient education • Notify provider of any abnormal findings using SBAR format	Suggested Facilitator Questions Based on NCSBN CJMM: Recognizing Cues: • What do you know about this patient? • How does the patient feel now? What is a priority to them? • What significant clinical cues did you recognize that require nurse follow-up? • What do your assessment findings mean in terms of physiological significance? • Is there any additional information you need to collect? Why? Analyze Cues: • What problem is most likely? • What problem is most important to manage first? • Is the patient at risk for developing any complications? Prioritize Hypotheses and Generate Solutions: • What are the priority nursing problems for this patient at this time? • Should any assessment findings be communicated to the provider? • Are any new provider orders anticipated/desired? • Create a SMART outcome (specific, measurable, achievable, realistic, with a timeline) for this patient.

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- "How is my baby doing?"
- "I don't understand what is wrong with my daughter. Will she live a normal life?"
- "How will I be able to take care of a daughter with special needs, my family and still work?"
- "I need to make sure that I get everything done while I am here. I work a lot and I don't have maternity leave."
- "When can I breastfeed her?"
- "Why is there blood on my incision?"
- "Am I going to get an infection?"
- "My arm really hurts."
- "When can I go home?"
- "They can make my followup appointments whenever they want, it doesn't matter."

Spanish version of the patient questions/responses above:

- "Hola, encendí mi luz de llamada porque tengo algunas preocupaciones sobre mi incisión."
- "¿Cómo está mi bebé?"
- "No entiendo qué le pasa a mi hija. ¿Vivirá una vida normal?"
- "¿Cómo podré cuidar de una hija con necesidades especiales, a mi familia y seguir trabajando?"
- "Necesito asegurarme de hacer todo mientras estoy aquí. Trabajo mucho y no tengo licencia de maternidad."
- "¿Cuándo podré darle pecho?"
- "¿Por qué hay sangre en mi incisión?"
- "¿Voy a contraer una infección?"
- "Mi brazo me duele mucho."
- "¿Cuándo podré ir a casa?"
- "Pueden programar mis citas de seguimiento cuando quieran, no importa."

(May use an interpreter to relay student responses to the client.)

- What interventions are indicated to achieve the desired outcomes?
- Prioritize the provider orders. What should be accomplished first for safe and effective care?

Taking Action/Implementing Interventions

- What intervention(s) is/are needed immediately?
- What intervention(s) can be safely delegated? (CNA/LPN)
- What should be taught to the patient/family to promote health?
- What information should be included in an SBAR report to interprofessional team members or during the shift handoff report?

Suggested Facilitator Questions:

What assessments are expected to be performed on a postpartum client?

- VS: BP (including MAP), HR, RR, Temp, Pulse Ox
- Lungs
- Cardiac
- BUBBLE LE
 - B: breast
 - U(terus): fundus for position and tone
 - B: Bladder: Voiding? Last void? Burning, frequency?
 - B: Bowel bowel sounds, passing flatus? Bowel movement? Consistency of bowel movement
 - L: Lochia: Color, amount, consistency (clots)?
 - E: Perineum laceration/episiotomy: bruising, swelling, approximation, bleeding, hematoma (REEDA: redness, ecchymosis, edema, discharge, approximation)? Hemorrhoids?
 - L: Lower extremities: for warmth, redness, swelling, pain
 - E: emotional status



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Suggested Debriefing Questions

1. Encourage students to vent their emotional reactions: "How do you feel this scenario went?"
2. Use group discussion to facilitate the development of clinical judgment:
 - a. **Effective Noticing**
 - i. **Focused observation:** What did you first notice about the client? What clinically significant cues did you recognize when you initially assess the client?
 - ii. **Recognizing deviations:** How was what you noticed different than expected?
 - iii. **Seeking appropriate information:** What additional information did you need to know?
 - b. **Effective Interpreting**
 - i. **Prioritizing data:** What is the significance of the data you collected/noticed? What was this client's most important need? What priority nursing problems did you identify?
 - ii. **Making sense of the data:** What issues are beginning to emerge? What evidence did you use to make a decision?
 - c. **Effective Responding**
 - i. What actions, if any, can be delegated to other health care team members?
 - ii. What information should be communicated to the client?
 - iii. What information should be communicated to the provider or other team members?
 - iv. What nursing interventions should be implemented for this client?
 - v. How should the client's response to interventions be monitored?
 - vi. What nursing skills did you perform?
 - d. **Effective Reflecting**
 - i. Analyze your clinical performance. What decisions did you make? Why were those decisions made at that time? Were there alternative actions that should have been taken?
 - ii. Were the nursing skills you performed accurate and efficient?
 - iii. Identify strengths and weaknesses that occurred personally and among team members during this scenario. How do you plan on eliminating weaknesses to promote quality improvement?
3. Summarize/Identify Take away Points: "In this scenario you care for a patient with atypical chest pain."
 - a. **Thinking-In-Action:** What were the critical decision points during this scenario?
 - b. **Thinking-On-Action:** What would you do differently if you could repeat this scenario? Name 3 things you learned from this scenario that you will include in your future nursing practice.
 - c. **Thinking-Beyond-Action:** How would you respond if Maria lost consciousness and became pulseless during this scenario? What nursing interventions would receive priority?

Survey

Please share this hyperlink with students or print this page and provide it to them:

Please complete a brief (2-3 minute) survey regarding your experience with this VR simulation. There are two options:

1. Copy and paste the following survey link into your browser: <https://forms.gle/fM2HfhzyQ6qma2Mi8>
2. Scan the QR code with your smartphone to access the survey





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Suggested Scenario Rubric *(based on Lasater's Clinical Judgment Rubric)*

Adapted from Tanner (2006), Lasater (2007), and Lasater (2011)

Student Name:

Date:

	4 (Exemplary)	3 (Accomplished)	2 (Developing)	1 (Beginner)
Effective Noticing Performs focused observation Recognizes deviation from expected patterns Seeks appropriate information	Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing the client and from interacting with the client and family.	Regularly observes/monitors a variety of data, including both subjective and objective; most useful information is noticed but may miss the most subtle signs. Recognizes the most obvious patterns and deviations in data and uses these to continually assess. Actively seeks subjective information about the client's situation from the client and the family to support planning interventions; occasionally does not pursue important leads.	Attempts to monitor a variety of subjective and objective data, but is overwhelmed by the array of data; focuses on the most important data, missing some important information. Identifies obvious patterns and deviations, missing some important information; unsure how to continue the assessment. Makes limited efforts to seek additional information from the client/family; often seems not to know what information to seek and/or pursues unrelated information	Confused by the clinical situation and the amount/type of data; observation is not organized and important data is missed and/or assessment errors are made. Focuses on one thing at a time and misses most patterns/deviations from expectations; misses opportunities to refine the assessment. Is ineffective in seeking information; relies mostly on objective data; has difficulty interacting with the client and family and fails to collect important subjective data.
Effective Interpreting Prioritizes Data Makes Sense of Data	Focuses on the most relevant and important data useful for explaining the client's condition. Even when facing complex, conflicting, or confusing data, is able to (1) note and make sense of patterns in the client's data, (2) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (3) develop plans for interventions that can be justified in terms of their likelihood of success.	Generally focuses on the most important data and seeks further relevant information, but also may try to attend to less pertinent data. In most situations, interprets the client's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or complicated cases where it is appropriate to seek the guidance of a specialist or more experienced nurse.	Makes an effort to prioritize data and focus on the most important, but also attends to less relevant/useful data. In simple or common/familiar situations, is able to compare the client's data patterns with those known and develop/explain intervention plans; has difficulty, however, with even moderately difficult data/situations that are within the expectations for students and inappropriately requires advice or assistance.	Has difficulty focusing and appears to not know which data are most important to the diagnosis; attempts to attend to all available data. Even in simple or familiar/common situations, has difficulty interpreting or making sense of data; has trouble distinguishing among competing explanations and appropriate interventions, requiring assistance both in diagnosing the problem and in developing the intervention.
Effective Responding Demonstrates a calm, confident manner Clearly communicates Performs well-planned interventions with flexibility Being Skillful	Assumes responsibility; delegates team assignments, assesses the client, and reassures them and their families. Communicates effectively; explains interventions; calms/reassures the clients and families; directs and involves team members, explaining and giving directions; checks for understanding. Tailors interventions for the individual client; monitors client progress closely and adjusts treatment as indicated by the client response. Shows mastery of necessary nursing skills.	Generally displays leadership and confidence, and is able to control/calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to clients, gives clear directions to the team; could be more effective in establishing rapport. Develops interventions based on relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in most nursing skills; could improve speed or accuracy.	Is tentative in the leader role; reassures clients/families in routine and relatively simple situations, but becomes stressed and disorganized easily. Shows some communication ability (e.g., giving directions); communication with clients/families/team members is only partly successful; displays caring but not competence. Develops interventions based on the most obvious data; monitors progress, but is unable to make adjustments based on the patient response. Is hesitant or ineffective in using nursing skills.	Except in simple and routine situations, is stressed and disorganized, lacks control, making clients and families anxious/less able to cooperate. Has difficulty communicating; explanations are confusing, directions are unclear or contradictory, and clients/families are made confused/anxious, not reassured. Focuses on developing a single intervention addressing a likely solution, but it may be vague, confusing, and/or incomplete; some monitoring may occur. Is unable to select and/or perform nursing skills.
Effective Reflecting Evaluation/Self Analysis Commitment to Improvement	Independently evaluates/analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths/weaknesses and develops specific plans to eliminate weaknesses.	Evaluates/analyzes personal clinical performance with minimal prompting, primarily major events/decisions; key decision points are identified and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths/weaknesses; could be more systematic in evaluating weaknesses.	Even when prompted, briefly verbalizes the most obvious evaluations; has difficulty imagining alternative choices; is self-protective in evaluating personal choices. Demonstrates awareness of the need for ongoing improvement and makes some effort to learn from experience and improve performance but tends to states the obvious and needs external evaluation.	Even prompted evaluations are brief, cursory, and not used to improve performance; justifies personal decisions/choices without evaluating them. Appears uninterested in improving performance or unable to do so; rarely reflects; is uncritical of himself or overcritical (given level of development); is unable to see flaws or need for improvement.



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References

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Scenario Author: Jamie Howell, MSN, RN, CHSE, Western Technical College

Remixed from OB-Active Labor and OB- Postpartum Vaginal Delivery (Routine)

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