Safety Action Series

Practicing for Patients: Obstetric Drill Program for Postpartum Hemorrhage
Speakers

Tamika C. Auguste MD FACOG
Director, OB/GYN Simulation
MedStar Health
Associate Professor, Obstetrics & Gynecology
Georgetown University School of Medicine

Shad Deering, MD, Colonel (retired), FACOG
Baylor College of Medicine
Director of Medical Simulation,
CHRISTUS Healthcare
Disclosures

- Tamika C. Auguste, MD, FACOG has no real or perceived conflicts of interest.
- Shad Deering, COL, MD, FACOG has no real or perceived conflicts of interest.
Objectives

- Provide an in-depth overview of the Practicing for Patients Manual and its accompanying resources
- Take a look at the processes, methods, and tools that were used to develop this program
- Identify ways to customize this program for effective use within your organization
- Discuss upcoming opportunities to attend additional trainings
Overview

• Postpartum hemorrhage care requires a multidisciplinary team approach for optimal outcomes

• In-Situ simulation can improve teamwork and performance and identify facilities/system issues before patients are negatively affected

• The Council on Patient Safety in Women’s Health Care has created a national multidisciplinary program to help hospitals run in-situ postpartum hemorrhage simulations that is directly connected to the AIM safety bundle
Program Components

1. Comprehensive Online Instruction Manual
   • Preparation and scheduling
     • Simulator options
   • Standardized simulation scenarios
   • Team debriefing and review forms
   • Video examples of simulations/ debriefing

2. Implementation Training
   • Online and in-person options available
Program Creation

- Program created with input from multiple organizations in order to have a true interdisciplinary focus

- Endorsed by the Council on Patient Safety in Women’s Healthcare

Acknowledgements

The Council on Patient Safety in Women’s Health Care would like to thank the volunteer members of the workgroup that worked to assemble the Practicing for Patients: Obstetric Drill Program Manual for Postpartum Hemorrhage.

Thad Anderson  
American Academy of Pediatrics

Tamika Auguste, MD, FACOG*  
American College of Obstetricians and Gynecologists

Eric Carlson, DO, MPH, FACOOG*  
American College of Osteopathic Obstetricians and Gynecologists

Shad Deering, COL (retired), MD, FACOG  
American College of Obstetricians and Gynecologists

Deborah Kilday, MSN, RNT  
Premier, Inc.

Emily Marko, MD, FACOG  
Virginia Commonwealth University School of Medicine

Ross McQuivey, MD, FACOG†  
Clinical Innovations

Lucie Moravia, DO, MPH, FACOG  
WellSpan Health

Loral Patchen, PhD, CNM  
American College of Nurse-Midwives

Joseph Pellegrini, PhD, CRNA*  
American Association of Nurse Anesthetists

Jeff Quinlan, MD, FAAFP  
American Academy of Family Physicians

Elizabeth Rochin, PhD, RN, NE – BC  
Association of Women’s Health, Obstetric and Neonatal Nurses

James Ruiter, MD, MCFP†  
Salus Global

Jennifer Tessmer-Tuck, MD, FACOG*  
Society of OB/GYN Hospitalists

Paloma Toledo, MD*  
American Society of Anesthesiologists

* Denotes representative is a voting member of the Council on Patient Safety in Women’s Healthcare

† Denotes representative is a current member of the Forum on Patient Safety in Women’s Healthcare
PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS
Every unit
- Hemorrhage cart with supplies, checklist, and instruction cards for intravascular balloons and compression stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION
Every patient
- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (oral, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE
Every hemorrhage
- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING
Every unit
- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

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Practice is essential to optimizing outcomes in obstetrics. Team practice encourages members of the team to work together, communicate, and anticipate the actions of other team members to achieve a common goal. While members of the labor and delivery team may practice and train as individuals, they rarely practice together to prepare for obstetric emergencies.

*Practicing for Patients* was designed to help labor and delivery units effectively conduct team-based training for simulated medical emergencies on their actual unit. Each of our program manuals offers extensive tools and resources that units can utilize to conduct team-based simulations for specific clinical conditions in order to reduce maternal mortality and morbidity.

**Program Manuals**

- Postpartum Hemorrhage Manual
Obstetric Drill Program Manual
Postpartum Hemorrhage

V1 Released May 2019
PRACTICING FOR PATIENTS POSTPARTUM HEMORRHAGE

Supporting Resources

- Patient Safety Bundle: Obstetric Hemorrhage
- Modifiable Presentation for Leadership: PPH
- Modifiable Presentation for Staff: PPH
- In-Situ Drill Preparation Checklist: PPH
- Team Review and Debriefing Form: PPH Management
- Teamwork and Communication: PPH Events
- In-Situ Drill Facility Protocol Change Form
- In-Situ Drill Feedback Form
- Catalog of Video Examples
- Obstetric Simulator Options
- Scenario Training Aids for PPH: Blood Products
- Scenario Training Aids for PPH: Vital Signs
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Modifiable Presentation for Leadership: PPH

In-Situ Obstetric Simulation Program for Postpartum Hemorrhage

Why do In-Situ Simulation?
- Maternal morbidity and mortality in the United States continue to increase
- Teamwork and communication errors are common reasons for poor outcomes and not taught well by lectures
- Simulations on the delivery unit can identify facilities and systems issues before they cause problems in real life

Current Status
- It takes a team to care for patients on labor and delivery
- Members of the team are trained differently
- The basic concepts of care are the same, but the approaches are often different
- The team is expected to come together and perform well even if they have not had time to "practice" together

In-Situ Obstetric Simulation Training
- Allows actual teams to train together and practice clinical skills as well as communication and teamwork
- Permits hospitals to practice and refine their protocols
- Identifies systems/facilities issues
- Tests new wards / protocols

Program Components
1. Comprehensive Instruction manual
   - Preparation and scheduling
   - Simulator options
   - Standardized simulation scenarios
   - Team debriefing and review forms
   - Video examples of simulations / debriefing
2. Implementation Training course
   - Online and in person options available

Leadership Support Needed to Implement Practicing for Patients
- Visible leadership support
- Funding for simulation equipment
- Designated point of contact on the labor and delivery unit
- Buy-in from the labor and delivery care team
Building the Implementation Team

For simulation drills to be successful, there must be a interprofessional ownership. Obstetric simulation efforts will require cooperation from and collaboration amongst departmental leadership, physicians, nursing staff, anesthesia, neonatal intensivists, ancillary staff, and opinion leaders. We recommend identifying the following members to form the core implementation team:

- Physician Lead
- Nursing Lead
- Support Staff Lead (pharmacy, blood bank)
- Change Leaders (those who can make the change and/or influence staff)

Initial Team Composition:
- Physician Lead
- Nursing Lead
- Support Staff Lead
- Frontline Influencers (opinion leaders/individuals who are highly respected and revered at the institution)
**PREPARATION**
- Identify a date and time to conduct simulation
- Identify the specific individuals for participation:
  - Assign facilitator(s)
  - Assign debriefer(s)
  - Obstetrics/Gynecology Department Staff
  - Obstetric Nurses
  - Rapid Response Team (if applicable)
  - Anesthesia Staff
  - NICU/Pediatrics
  - Ancillary services:
    - Laboratory
    - Blood bank
    - Simulation technician (if applicable)
- 2-4 weeks prior: confirm participation of identified departments and individuals
  - 1 week prior: schedule meeting with participants to discuss logistics/case flow/debrief flow
  - 1 day prior: call/assign ancillary staff of potential call days before drill
  - 1 day prior: assign participants into groups and develop alternate schedule (if applicable)
- 1 day prior: set up simulator and ensure all equipment and training aids available

**DAY OF SIMULATION**
- Run simulation drill(s)
- Conduct debrief
- Debriefers schedule post-drill meeting with Obstetrics/Gynecology leadership
- Debriefers complete and return:
  - Facility Protocol Change Form
  - In-situ Drill Feedback Form

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Standardization of health care processes and reduction in variation has been shown to improve patient outcomes and quality of care. The Council on Patient Safety in Women’s Health Care strives to create patient safety strategies to help facilitate the standardization process. This best practice advisory effort, initially pediatric-specific, will grow as advances continue. The information contained herein is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Although the content of this document is intended to be comprehensive and representative of good practices, it is not intended to be a substitute for clinical expertise and judgment.

The Council on Patient Safety in Women’s Health Care is a broad consensus of organizations across the spectrum of women’s health and the promotion of safe health care for every woman.

For more information visit the Council website at www.safetyinwomenshealth.org

September 2018
Obstetric Simulator Options

GAUMARD SCIENTIFIC
Victoria

LAERDAL
SIM Mom

OPERATIVE EXPERIENCE
C-Celia

OB Susie
Prompt Flex

SIMULAIDS
SMART Mom

Real Mom

Mama Natalie

The simulators listed are provided as suggestions and are neither endorsed nor sanctioned by ACOG or the Council on Patient Safety in Women’s Health Care.

V1 September 2018
# Obstetric Simulator Options

<table>
<thead>
<tr>
<th>DRILL CAPABILITIES</th>
<th>Gaumard Scientific</th>
<th>Laerdal</th>
<th>Operative Experience</th>
<th>Simulaids</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Victoria</td>
<td>Noelle</td>
<td>OB Susie</td>
<td>SIM Mom</td>
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<td>Postpartum Hemorrhage</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<td>Spontaneous Vaginal Delivery</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Operative Vaginal Delivery</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Breech Vaginal Delivery</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Shoulder Dystocia</td>
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<td>X</td>
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<td>X</td>
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<tr>
<td>Umbilical Cord Prolapse</td>
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<td>X</td>
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<td>Eclampsia</td>
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<td>COST</td>
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<tr>
<td>$500 to $20,000</td>
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<tr>
<td>$10,000 to $50,000</td>
</tr>
<tr>
<td>&gt; $20,000</td>
</tr>
</tbody>
</table>

The simulators listed are provided as suggestions and are neither endorsed nor sanctioned by ACOG or the Council on Patient Safety in Women’s Health Care.

V1 September 2018
Team Review and Debriefing

General Team Review

Debriefing Instructions

Simulation Scenarios

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General Simulation Instructions

Case 1: Postpartum Hemorrhage Secondary to Uterine Atony

Case 2: Postpartum Hemorrhage Secondary to Uterine Atony Requiring Intrauterine Tamponade with a Balloon or Uterine Packing

Case 3: Postpartum Hemorrhage Secondary to Retained Products of Conception and is Responsive to a Single Medication
Case 1: Postpartum Hemorrhage Secondary to Uterine Atony

Learning Objectives
By the end of this scenario, each care team member should be able to successfully do the following:
- Recognize risk factors for postpartum hemorrhage.
- Identify postpartum hemorrhage due to uterine atony and be able to treat with appropriate medical management.
- Demonstrate teamwork and communication skills during a simulated postpartum hemorrhage.

Planned Completion Points
To successfully complete this scenario, the care team should successfully do the following:
- Recognize uterine atony as the etiology for postpartum hemorrhage.
- Perform uterine massage.
- Administer two different uterotonic medications.
- Call for blood (e.g.: 2 units of PRBCs).
- OR
  - If 10 minutes has elapsed after recognition of hemorrhage and the team has not corrected the hemorrhage or called for blood.

Expected Duration
Approximately 60 minutes (30 minutes for simulation / 30 minutes for debriefing).

Case Scenario
- Patient: Maria Smith
  Mrs. Maria Smith is a 38-year-old G3P0013 who was admitted in active labor at 39+3 weeks and had a spontaneous vaginal delivery 30 minutes ago. Her delivery was uncomplicated. She had a first-degree laceration that did not require repair. She is approximately 30 minutes postpartum and has just called out because she feels dizzy and has more bleeding.

- Patient Information
  - She has no significant past medical history.
  - She has no known drug allergies.
  - Her pregnancy was uncomplicated except for an elevated 1-hour glucose screen with a normal 3-hour glucose tolerance test.

- Laboratory Data (On Admission):
  - Hemoglobin: 12.2
  - Hematocrit: 36.6
  - WBC: 12,000
  - Platelets: 218,000

- Delivery Information
  - Measurement of cumulative blood loss (as quantitative as possible) from the delivery was 300cc.
  - The placenta was inspected at the time of delivery and appeared to be intact per the delivery note.
  - There was only a first-degree laceration that did not require repair.
  - The infant weighed 4120 grams.
  - The patient has an IV line in place with oxytocin running.

- Family Member/Patient Instructions
  - Standardized Patient: If a person is playing the role of the patient during the scenario, she should emphasize that this is much more bleeding than the last delivery. As the bleeding continues the patient can also state that she is feeling faint and dizzy.
  - Family Member/Friend: If someone plays the role of the patient’s family member or friend, he or she may be the patient’s partner, mom, other relative, or friend. This person should continue to ask questions during the scenario including things like, “Why is she bleeding so much?” or “She looks like she is kind of pale.”
  - As the patient’s vital signs continue to decline, this person should occasionally ask, “Is she going to die?” This person should be aware of any mention of going to the OR and asks for clarification as to why that is necessary. This person should continue to voice that the patient wants to have more children and should initially refuse to, but reluctantly, leave the patient’s bedside when/if asked to.

- Answers to Common Questions for this Scenario
  - The patient does not have a history of asthma or hypertension in this case.
  - The patient does not have any known allergies to medications.
  - If asked additional questions, try to redirect and not answer specifics so as not to introduce things that might complicate the scenario (i.e. don’t say that she has a relative with an unknown bleeding disorder).
Case 1: Case Flow/Algorithm with Branch Point and Completion Criteria

Simulation facilitator will introduce the scenario to the team outside the room and then bring OB Nurse to the patient’s room to review the patient scenario. The OB Nurse should then enter the room, assess the patient and then call for assistance.

The patient should be examined by the team and initial management of the hemorrhage started (funiculal massage, examination for lacerations, retained products of conception, etc.).

When asked or the provider does the appropriate exams, inform the team of the following:

- No evidence of additional lacerations
- No evidence of retained products of conception
- The uterus continues to be boggy
- Initial vital signs should also be available

The patient will continue to hemorrhage, and the uterus will remain atonic. Vital signs should change approximately every 2 minutes and get worse as bleeding continues (can use monitors or vital sign cards). Team should be calling for blood.

OB provider may order labs; however, no additional labs are available during the simulation. The team should progress with treatment based on deteriorating vital signs.

Providers should recognize hemorrhage and call for additional help and administer medications (may also use Intrauterine balloon tamponade or pack uterus).

Scenario ends when the team has done the following:

- Performed uterine massage
- Examined for lacerations
- Evaluated for retained products of conception
- Administered two medications to correct uterine atony (correct dose and route)
- Called for blood

OR

The team fails to correct the hemorrhage within 10 minutes or fails to call for blood.

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Catalog of Video Examples

Scenario: Postpartum Hemorrhage with Retained Products
Mrs. Jennifer Patton is a 32-year-old GSP0040 with a history significant for 4 surgical terminations is admitted in active labor at 41+2wks and had a spontaneous vaginal delivery 30 minutes ago.

The placenta took about 20 min to deliver and required a bit more traction than normal. After the delivery of the placenta the patient continues to have bleeding that is more than normal. The patient had no lacerations.

The patient has just called out because she feels dizzy and has noticed more bleeding.

Scenario: Postpartum Hemorrhage Requiring Uterine Tamponade
Mrs. Patty Noble is a 42-year-old GSP4014 who was admitted in active labor at 38+2wks and just had a spontaneous vaginal delivery 30 minutes ago. The delivery was uncomplicated and the patient had no lacerations.

The patient has just called out because she feels dizzy and has noticed more bleeding.

Scenario: Postpartum Hemorrhage Requiring Uterotonics
Mrs. Marla Smith is a 38-year-old G3P2012 who was admitted in active labor at 39+3wks and just had a spontaneous vaginal delivery 30 minutes ago. The delivery was uncomplicated and the patient only had a first degree laceration that did not require repair.

The patient has just called out because she feels dizzy and has more bleeding.
Scenario Training Aids for PPH: Blood Products
Scenario Training Aids for PPH: Vital Signs

- **QBL: 500 cc**
- **QBL: 750 cc**
- **QBL: 1000 cc**
- **QBL: 1500 cc**
- **QBL: 2000 cc**
Logistics
Preparation and Scheduling
Collecting Equipment and Tools
Frequency of Training
Staffing Roles and Responsibilities
Simulation Facilitators and Technicians
Nurses
Family Members
Debriefers
Providers
Equipment Options
Fidelity
Low-Tech
High-Tech
Choice of Mannequin
Team Review and Debriefing
General Team Review
Debriefing Instructions
Simulation Scenarios

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V1 May 2019
# Team Review and Debriefing Form: Postpartum Hemorrhage

## READINESS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Opportunity for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage cart stocked with all needed supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemorrhage medications immediately available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency response team established</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massive transfusion protocol available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency blood release protocol available</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## RECOGNITION & PREVENTION

Review risk factors for hemorrhage in this patient: (list factors)

## RESPONSE

<table>
<thead>
<tr>
<th>ASSESSMENT/ACTION</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Done</td>
</tr>
<tr>
<td>Provider/Team recognizes PPH in timely manner</td>
<td></td>
</tr>
<tr>
<td>Team calls for hemorrage cart</td>
<td></td>
</tr>
<tr>
<td>Provider/Team calls for additional assistance</td>
<td></td>
</tr>
<tr>
<td>Team inspects for lacerations</td>
<td></td>
</tr>
<tr>
<td>Provider checks for retained products of conception</td>
<td></td>
</tr>
<tr>
<td>Team diagnoses etiology of hemorrhage accurately</td>
<td></td>
</tr>
<tr>
<td>Team administers uterotonics</td>
<td></td>
</tr>
<tr>
<td>Team communicates about ongoing blood loss</td>
<td></td>
</tr>
<tr>
<td>Team places second IV</td>
<td></td>
</tr>
<tr>
<td>Team orders labs (CBC, PVR, PTT)</td>
<td></td>
</tr>
<tr>
<td>Team considers placements of Foley catheter to monitor urine output</td>
<td></td>
</tr>
<tr>
<td>Team considers administering TKA</td>
<td></td>
</tr>
<tr>
<td>Team places uterine balloon or uterine packing</td>
<td></td>
</tr>
<tr>
<td>Team recognizes need for operative management of PPH in timely manner</td>
<td></td>
</tr>
<tr>
<td>Team counsels the patient/family on the need for operative management, including potential need for hysterectomy</td>
<td></td>
</tr>
<tr>
<td>Team considers transfer to other facility</td>
<td></td>
</tr>
</tbody>
</table>

## TEAMWORK & COMMUNICATION REVIEW

<table>
<thead>
<tr>
<th>How Well Did the Team:</th>
<th>Unacceptable</th>
<th>Poor</th>
<th>Average</th>
<th>Good</th>
<th>Perfect</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORIENT NEW MEMBERS (OR) during the scenario as they arrived?</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
</tr>
<tr>
<td>Call for ADDITIONAL ASSISTANCE in a timely manner?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure CLOSED LOOP COMMUNICATION?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Maintain SITUATIONAL AWARENESS?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize PATIENT FRIENDLY LANGUAGE AND TONE?</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Please rate the following:

| OVERALL TEAM COMMUNICATION during the simulation | | | | |
| OVERALL TEAM PERFORMANCE during the simulation | | | | |

Additional notes: Summarize and review any lessons learned:

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Common medications for postpartum hemorrhage (including contraindications)

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxytocin</td>
<td>10-40 units per 500-1000 ml, as continuous infusion or IM 10 units</td>
<td>Hypersensitivity to oxytocin (rare)</td>
</tr>
<tr>
<td>Methylenedioxymethamphetamine (Methambup)</td>
<td>0.3-2 mg IM or IV, intraarterially</td>
<td>Hypersensitivity, pruritus, rash, asthma, Raynaud’s syndrome</td>
</tr>
<tr>
<td>Prostaglandin F2 alpha (Estrameter)</td>
<td>2.5 mg IM, 1 mg IM or IV, intraarterially or subcutaneously</td>
<td>Asthma, renal disorders, pulmonary hypertension</td>
</tr>
<tr>
<td>Misoprostol (Cytotec, PGE 13)</td>
<td>600 ug - 1,000 mg oral per rectum x1 dose or sublingual x1 dose</td>
<td>Known hypersensitivity to NSAMS, asthma, GI bleeding</td>
</tr>
<tr>
<td>Tranexamic acid (TXA)</td>
<td>1 gram IV over 10 minutes, 2nd dose can be given if continued bleeding with 30 mina</td>
<td>Subarachnoid hemorrhage, acute intravascular clotting, hypersensitivity to TXA</td>
</tr>
</tbody>
</table>

- Emphasize that treatment of the patient is directed by symptoms and vital signs and should not be delayed while waiting for laboratory values.
- Additional treatment options: i.e., intrauterine balloon tamponade/dermatome packing should be pursued if initial interventions failed.
- Review transfusion management and local massive transfusion protocols.
- If medical management is not successful, then operative management should be pursued.
- It is important to counsel and keep the patient and family informed during the hemorrhage.
Teamwork and communication are essential to quality healthcare and patient safety. TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among healthcare professionals.

**KEY TeamSTEPPS® CONCEPTS AND TOOLS RELATED TO POSTPARTUM HEMORRHAGE EVENTS**

**READYNESS**
- **Brief:** a short planning session prior to an event or shift. Ex: patient has risk factors for PPH, let’s be prepared with equipment/medications.
- **Huddle:** a quick meeting to share information and regain situation awareness. Ex: team discusses causes for PPH, uterotonics given, plans for going to the OR.

**RECOGNITION & PREVENTION**
- **Situation Awareness:** state of mindfulness and knowing external factors that may affect care.
- **Cross Monitoring:** watching each other’s back and speaking up if you notice something.

**RESPONSE**
- **SBAR:** brief summary of Situation-Background-Assessment-Recommendation that is critical information provided to team members as they arrive to an event. Ex: "We are having a postpartum hemorrhage with uterine atony. Patient is a 42yrs GSPS s/p NSWD 1 hour ago, OBL is 1200cc, BP 95/60. I have given oxytocin and called for mepergmine."
- **Call-Out:** critical information that is relayed clear, concise and timely to team. Ex: "The patient’s blood pressure has dropped to 90/60 and she is tachycardic to 120 bpm."
- "The blood bank has been called and is activating the massive transfusion protocol."

**Check Back:** closed-loop communication to ensure that information conveyed by the sender is understood by the receiver and acknowledged. Ex: Doctor “Give 0.2mg Methergine IM” Nurse “0.2mg Methergine IM given”

**Psychological Safety:** team members are encouraged to speak up for patient safety.

**Role Clarity:** assign specific tasks to team members.

**Shared Mental Model:** team members have a common goal which is communicated.

**Handoff:** transfer of information during transitions in care.

**Debrief:** a nonjudgmental team meeting after an event discussing lessons learned and reinforcing positive behaviors, essential to process improvement. Ex: all team members after PPH, what went well, what should we change.
In-Situ Drills Facility Protocol Change Form

Date of In-situ Drill: __/__/____

**IDENTIFIED ISSUES**


**POTENTIAL SOLUTIONS**


Individual Assigned to Complete this Project: _____________________________

Date Solution Implemented: __/__/____

Date of Repeat Drill to Evaluate Solution(s): __/__/____

Note: Publicize finding, publicize solution with dates

For more information visit the Council’s website at www.councilonpatientsafety.org
Training Opportunity: Postgraduate Course

Supporting Simulation Training for Obstetric Patient Safety, New York, NY

December 15, 2019

Click Here to Register for the Course

Course Description

This 1-day course utilizes a strong simulation focus and multiple learning modalities to prepare individuals to lead trainings at their institutions. It will be held at the state-of-the-art Mary & Michael Jaharis Simulation Center at the Columbia University Irving Medical Center and hosted by leaders in simulation science. Participants in this course can expect to increase their knowledge of best simulation and staff training practices to support the implementation and sustainability of the Alliance for Innovation on Maternal Health (AIM) Obstetric Hemorrhage Bundle in their organizations and the complementary Practicing for Patients manual.

Course Objectives

Attendees at this course will learn steps to establish in-situ drill training at their institutions, including:
- How to generate institutional buy-in and pull together a multi-disciplinary team
- How to facilitate a postpartum hemorrhage drill and run effective debriefs
- How to identify opportunities for improvement
- How to implement institutional change

It is strongly suggested that attendees also attend Quality and Safety for Leaders in Women’s Health Care as a prerequisite (December 13 and 14, 2019 or previous offerings). If participants have not attended the course and wish to participate in this course, permission must be obtained. Please contact Jordan Jackson at jackson@acog.org with any permission requests.

Course Director: Dena Goffman, MD, FACOG
Q&A Session

Press *1 to ask a question

*Please note: this teleconference is being recorded. Comments from speakers and participants will be live on the website shortly.*

You will enter the question queue
Your line will be unmuted by the operator for your turn

*A recording of this presentation will be made available on our website:*  
www.safehealthcareforeverywoman.org
Announcing the 3rd Cycle of the Council’s National Improvement Video Challenge

- **How to Participate:**
  Develop a short (3 - 5 minute) video showcasing how a Council bundle has been utilized within your institution.

- **Deadline:**
  October 18, 2019

- **Awards:**
  Monetary awards are given to the top 3 entries for each cycle. Winning videos will be featured on the Council’s website.

[Click For More Information!]
Next Safety Action Series

Reproductive Psychiatry:
Navigating Treatment Options in Maternal Mental Health

June 19, 2019
12 pm Eastern

Claire Brandon, MD
Board Certified Psychiatrist
Consultation Liaison Psychiatry
New York City, New York

Randi Delirod, MA, LMSW
Behavioral Health Clinician
Mental Health Service Corps
New York City, New York

Click Here to Register