CMQCC

Obstetric Hemorrhage Emergency Management Plan: Table Chart Format

version 2.0

Meds/Procedures **Blood Bank Assessments Every woman in labor/giving birth** Stage 0 **Active Management** • If Medium Risk: T & Scr Assess every woman 3rd Stage: Stage 0 focuses for risk factors for • If High Risk: T&C 2 U Oxytocin IV infusion or on risk hemorrhage • If Positive Antibody assessment and Measure cumulative 10u IM Screen (prenatal or active quantitative blood Fundal Massagecurrent, exclude low level management of vigorous, 15 seconds min. loss on every birth anti-D from the third stage. RhoGam):T&C 2 U Blood loss: > 500ml vaginal or >1000 ml Cesarean, or Stage 1 VS changes (by >15% or HR ≥110, BP ≤85/45, O2 sat <95%) • IV Access: at least 18gauge • T&C 2 Units PRBCs Activate OB Hemorrhage Protocol Increase IV fluid (LR) and (if not already done) Stage 1 is short: and Checklist Oxytocin rate, and repeat activate Notify Charge nurse, fundal massage hemorrhage OB/CNM, Anesthesia • Methergine 0.2mg IM (if protocol, initiate VS, O2 Sat q5' not hypertensive) preparations and May repeat if good Record cumulative give Methergine response to first dose, BUT blood loss q5-15' IM. otherwise move on to 2nd Weigh bloody materials level uterotonic drug (see Careful inspection with below) good exposure of Empty bladder: straight cath vaginal walls, cervix, or place foley with urimeter uterine cavity, placenta Stage 2 Continued bleeding with total blood loss under 1500ml 2nd Level Uterotonic Drugs: OB back to bedside (if Notify Blood Bank of not already there) • Hemabate 250 mcg IM or **OB Hemorrhage** • Extra help: 2nd OB, • Misoprostol 800 mcg SL Bring 2 Units PRBCs Stage 2 is 2nd IV Access (at least Rapid Response Team to bedside, transfuse focused on (per hospital), assign 18gauge) per clinical signs - do sequentially Bimanual massage not wait for lab values advancing Vaginal Birth: (typical order) VS & cumulative Use blood warmer for through blood loss q 5-10 min Move to OR transfusion medications and Weigh bloody materials · Repair any tears Consider thawing 2 FFP procedures, • D&C: r/o retained placenta Complete evaluation (takes 35+min), use if mobilizing help of vaginal wall, cervix, Place intrauterine balloon transfusing > 2u PRBCs and Blood Bank placenta, uterine cavity Selective Embolization Determine availability of support, and Send additional labs, (Interventional Radiology) additional RBCs and keeping ahead including DIC panel Cesarean Birth: (still intra-op) other Coag products with volume and • If in Postpartum: Move (typical order) blood products. · Inspect broad lig, posterior to L&D/OR uterus and retained Evaluate for special placenta cases: • B-Lynch Suture -Uterine Inversion -Amn. Fluid Embolism • Place intrauterine balloon Total blood loss over 1500ml, or >2 units PRBCs given Stage 3 or VS unstable or suspicion of DIC Mobilize team Activate Massive Transfuse Aggressively Massive Hemorrhage Pack Stage 3 is -Advanced GYN **Hemorrhage Protocol** Near 1:1 PRBC:FFP focused on the surgeon Laparotomy: -2nd Anesthesia Provider Massive 1 PLT apheresis pack -B-Lynch Suture Transfusion -OR staff per 4-6 units PRBCs -Uterine Artery Ligation -Adult Intensivist protocol and -Hysterectomy Unresponsive invasive surgical Patient support Repeat labs including Coagulopathy: approaches for coags and ABG's After 8-10 units PRBCs -Fluid warmer control of and full coagulation factor Central line -Upper body warming device bleeding. replacement: may consult Social Worker/ family -Sequential compression re rFactor VIIa risk/benefit

support