LEARNING OBJECTIVES

Recognise and define severe PPH
Multidisciplinary Team Work and Communication
Coordinate transfer to theatre
Surgical Management of retained placenta

EQUIPMENT LIST

SimMom/Noelle + Placenta
Bed/trolley, phone
Maternal monitoring
O2 Facemask
IV Fluids/Blood
Foley’s catheter
Consent form
IVC packs/IV
Giving sets/blood bottles/request slips/tourniquets
PPH Box- oxytocinon/ergometrine/misoprostol/haemobate

PERSONNEL

MINIMUM: 5
ROLES:
Partner
HCA
Anaesthetist
Obstetric Registrar

FACULTY

MINIMUM: 3
Facilitator
Observer
Debrief Lead

TIME REQUIREMENTS

TOTAL 1.5 hours
Set up: 30 mins
Pre Brief: 10 mins
Simulation: 20 mins
Debrief: 30 mins
INFORMATION TO CANDIDATE

PATIENT DETAILS
Name: Susan Harper  Phx: Mild Asthma
Age: 31yrs  Allergies: Penicillin
Weight/BMI: 81kg/39  Rh +ve

SCENARIO BACKGROUND
Location: Labour Ward
Situation:
You are the ST4 on labour ward. The midwife has called you into room 3. She is worried about the amount of bleeding from her patient Susan Harper.
Task: Please assess the patient

RCOG CURRICULUM MAPPING
Module 10: Management of labour Ward
  Safe use of blood products
  Liaise with Staff
Module 11: Management of delivery
  Retained placenta
Module 12: Postpartum problems (The Puerperium)
  Primary postpartum haemorrhage
  Management of massive obstetric haemorrhage
  Acute Maternal Collapse
INFORMATION FOR ROLEPLAYERS

Midwife

BACKGROUND

Midwife gives SBAR handover to the trainee:

S- Susan had a normal delivery 35mins ago. She is now actively bleeding and the placenta is still insitu.
B- Susan is now P2 after a SVD, she has a BMI 39 and mild asthma. She takes PRN salbutamol. She is allergic to penicillin. Her perineum is intact and the EBL at delivery was 500mls. The baby weighed 3.2kgs.
A- There is now about 1000mls of fresh loss on the bed, she looks pale; her uterus is above the umbilicus. Her BP is 95/60 her pulse 110 O2 sats 99% RR16. I have attempted to the deliver the placenta with CCT and emptied her bladder.
R- I think Rebecca is having a PPH and a retained placenta. I need you assistance to manage.

RESPONSES TO QUESTIONS

As above
INFORMATION TO FACILITATOR

SCENARIO DIRECTION

Communication:
Recognise major PPH and call for Help: Emergency buzzer/delegates 2222 call.
Brief introduction to patient/partner
Requests use of scribe

Resuscitation:
Initiates resuscitation measures- coordinates/delegates following tasks
  - Lies patient flat
  - Airways: checks patent, assesses conscious level
  - Breathing: applies 02 Facemask
  - Circulation: Requests Monitoring
    - IV access x2 18G
    - Requests blood FBC/Crossmatch
    - Fluid resuscitation crystalloid/colloid < 3.5L
    - Keeps patient warm
  
4U/Clotting/U&E
  - Monitoring: Requests 15mins Observations
  - Management: Inserts urinary catheter with hourly urometer

Patient is still actively bleeding
Examination of patient – retained placenta
Decision to transfer to OT communicates this effectively to team with degree of urgency
  - if remain in room midwife prompt to transfer to OT
Reassess in OT
Initiates Massive Obstetric Haemorrhage Protocol
Commence O-ve blood transfusion
Inform blood bank/haematology

PLTS/FFP/Cryoprecipitate- on haematologist advice
Anaesthetist to determine – general anaesthesia
Aseptic Technique
Manual Removal of placenta- inserting dominant hand into the cavity indentify plane between placenta and uterine wall, separate and remove whilst placing other hand on abdomen to prevent inversion
  - Transfuse 2UNITS RBC

Bimanual compression

Bleeding significantly slowed

Uterotonics-
  - oxytocinon 5 units IV, ergometrine 0.5mg IM
  - carboprost
  - misoprostol 1000mg PR
  - prompt for contraindications

oxytocinon 40 units IV infusion over 4 hours
contraindicated ASTHMA
Post Haemorrhage instructions:

- Obstetric HDU >12hrs
- MEWS: 0-1hr 15mins, 1-2 hr 30mins, hourly for 6 hours
- Hourly urinary out put >30mls
- LMWH – if PLTs normal when bleeding stable
- Documentation
- Debrief

### SCENARIO OBSERVATIONS/ RESULTS

<table>
<thead>
<tr>
<th></th>
<th>BASELINE Pre Review</th>
<th>STAGE 1 Prior to fluids</th>
<th>STAGE 2 In OT</th>
<th>STAGE 3 MRP</th>
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<tbody>
<tr>
<td>RR</td>
<td>16</td>
<td>18</td>
<td>25</td>
<td>14</td>
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<td>SpO2</td>
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<td>36.6C</td>
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<tr>
<td>Central CRT</td>
<td>2secs</td>
<td>4secs</td>
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<td>GCS/AVPU</td>
<td>A</td>
<td>A</td>
<td>V</td>
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<tr>
<td>EBL</td>
<td>1500mls</td>
<td>1800mls</td>
<td>2100mls</td>
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Urometer insertion: 70mls

Arterial Gas/Lactate: Hb 65g/L

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SCENARIO DEBRIEF

TOPICS TO DISCUSS

Effectiveness of communication and team working.
Use of SBAR.
Coordinating initial resuscitation and preparation for theatre – stabilisation prior to GA
Uterotonics and asthma
Management of massive obstetric haemorrhage
Consultant involvement
Safe use of blood products- involve haematology

REFERENCES

RCOG Green-top Guideline Prevention and Management of Postpartum Haemorrhage 2009