Post Partum Haemorrhage

IAOC Simulation

Name:	Sonya Abbott	**Observation at start**		**CRT:**	3s
D.O.B.	03/06 (26Y)	**RR:**	25	**Temp:**	36.2
Address:	(Insert local address)	**ETCO2**	-	**BM:**	5.6
		Sats:	98%	**Weight:**	88Kg
Hospital ID:	3142685521	**Heart Rate:**	105	**Allergy**	NKDA
Ward:	Labour ward	**BP:**	108/65		

Background to scenario	Specific set up
A 26 year old patient with a previous history of PPH, is induced due to gestational diabetes at 38 weeks. She has an instrumental delivery in the labour room followed by a PPH	Simulated patient or mannequin in labour room Cannulated, no fluid attached Just delivered, blood seen at perineum Obstetrician working to control bleeding
Required embedded faculty/actors	**Required participants**
Midwife/Obstetrician	Anaesthetist (obstetric and senior for support) Optional – Midwife, obstetrician

Past Medical History

26 year old, history of childhood asthma, otherwise well. G2P1 – PPH in last pregnancy, received blood transfusion
Gestational diabetes (controlled with diet), induced at 38 weeks – On oxytocin infusion (follow local protocol)
No airway concerns
Blood tests: Hb 105, WCC 11.5, Plt 186

Drugs Home	Drugs Hospital
Pregnancy vitamins	Paracetamol/Codeine/Diamorphine (IM) – according to local protocol for analgesia Oxytocin – induction (according to local protocol)

Brief to participants

The emergency buzzer has just gone off in a labour room where a patient has just delivered vaginally

Scenario Direction	
Stage 1, 0– 5 minutes	
A	Patent
B	RR 18 Sats 98%
C	(EBL 500ml) (Not shocked, anxious) HR 80-100, BP 110/65 CRT 2s, cool peripheries
DE	Alert, Bleeding due to tone and trauma
Rx	History and assessment of patient Resuscitation: IV access, venepuncture (G&S, FBC, Clotting including fibrinogen, POC testing), IV fluids Treat cause: Atony – oxytocin, ergometrine, carboprost (childhood asthma), tranexamic acid, calcium MDT approach
Stage 2, 5–10 minutes	
A	Patent, becoming drowsy
B	RR 20 Sats 95%
C	EBL 1000ml, shocked – HR >120 BP < 90/50, CRT 4s, Cold peripheries
DE	Becoming drowsy, continued bleeding
Rx	Regular monitoring including urine output Resuscitation: 2 large bore IV access, Transfusion (consideration of MOH, follow local protocols), active warming Consideration of transfer to theatre – the scenario can end here if adequate learning achieved
Stage 3, 10– 15 minutes	
A	Progress to chosen technique of anaesthesia, GA maybe indicated, intubate
B	Ventilate with chosen technique
C	HR > 140 BP remains low. Arterial monitoring may be indicated, CVC if access is difficult/ionotropes required
DE	Continued bleeding
Rx	Surgical and medical methods to manage PPH Appropriate escalation, communication with the MDT, timekeeping, consideration of scribing Consideration of post operative high dependency destination

Guidelines

- F Plaat, BA MBBS FRCA, A Shonfeld, MBBS FRCA, Major obstetric haemorrhage, *BJA Education*, Volume 15, Issue 4, August 2015, Pages 190–193, https://doi.org/10.1093/bjaceaccp/mku049
- Mavrides E, Allard S, Chandraharan E, Collins P, Green L, Hunt BJ, Riris S, Thomson AJ on behalfof the Royal College of Obstetricians and Gynaecologists. Prevention and management of postpartum haemorrhage.BJOG 2016;124:e106–e149.

Guidance for Patient Role

Opening lines/questions/cues/key responses	Concerns
What is happening to me? Will I be ok? What will happen to baby if I go to theatre?	Anxious, overwhelmed Actions Increasingly drowsy
Partner Worried about partners health, insist on concerns being listened to	

Guidance for Obstetrician	Guidance for midwife
In labour room as conducted the instrumental delivery To increase challenge in scenario – can become task focussed on suturing in room, and lose perspective of difficulty and EBL requiring Stop the Line and reassess	Act as advocate for patient, ensure concerns are addressed Can support resuscitation efforts, also helps with newborn

Guidance for Role e.g. ITU/Anaesthetic Senior

Expectations
Appropriate means of being contacted
Appropriate handover
Actions
Offer appropriate support for grade of anaesthetist

Session Objectives	
Clinical	Management of PPH
Non-technical skills	
Teamworking	Coordinating team activity, exchanging information with MDT, using assertiveness, appropriate delegation and supporting colleagues
Task management	Planning and preparing, prioritising, identifying and utilising resources appropriately
Situational awareness	Gathering information on entering, recognising critical incident, anticipating events
Decision making	Identifying options for management, balancing risks, continuous re-evaluation