Obstetric Hemorrhage

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women’s Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

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

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For more information visit the Council’s website at www.safehealthcareforeverywoman.org

READINESS
Every unit
■ Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions 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 (formal, 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