Obstetric Hemorrhage Initiative
Hospital and Patient Stories

Story #1:

Postpartum hemorrhage is an event that can be life changing or life ending depending on the circumstances. As a large and busy center we began to notice a rise in the number of complications that can result in a massive postpartum hemorrhage event. In early 2013 we had 13 patients identified with some sort of abnormal placental implantation. We decided to join the Obstetrical Hemorrhage Initiative (OHI) in order to ensure we had the best processes in place to respond to these events.

In July of 2014 these processes were put to the test. This patient was pregnant with her second baby and had been admitted overnight for observation at 33 weeks for contractions. During the course of her stay it was noted that it appeared she had a placenta percreta and plans were made to set her up for delivery at 35 weeks. The surgeons had just seen her and were at the desk writing orders. She was being cleared for discharge, when she suddenly had a seizure and within minutes was in a pool of blood. She was immediately rushed to the operating room (OR) for an emergency cesarean section. By the time she arrived to the OR she was in full cardiac arrest. A viable female infant was delivered and sent off to the NICU. Massive Transfusion Protocol had been activated upon arrival to the OR. The trauma surgeon had been called for and was present. The patient was a full code. During the next 8 hours she would be coded three more times. She was transferred to the interventional radiology suite for embolization. Her estimated blood loss via weight and measurement was a total of 12,340 cc.

She received over 125 units of different blood products. She was finally stabilized and left with an open abdomen and sent to the surgical critical care unit. She coded one more time and was reopened and bilateral nephrostomy tubes were placed.

Over the course of the next 21 days she would return to the OR multiple times and receive more blood products. The damage to her ureters and bladder was extensive and plans were made for reconstruction at a later date. On postoperative day 22 the patient and her baby were discharged home.

The standardized processes, massive transfusion protocol and simulation drills that had been put in place from the work that we did with the OHI played a large part in allowing this patient to be alive to raise her baby.

Story #2:

We are a small hospital working to improve patient safety at our hospital. We implemented the Obstetric Hemorrhage Initiative with the FPQC, which has led to improved care for our patients experiencing postpartum hemorrhage. This is an example story highlighting our success and does not represent one specific patient.

A G3 P2 patient, assessed to be at low risk for post-partum hemorrhage, had a fast delivery. After the infant's birth, her vaginal bleeding was heavy. We identified the heavy vaginal

bleeding immediately and informed the doctor. We then activated the PPH protocol: we massaged the fundus and delivered the IV oxytocin as a bolus. Additional staff members were present to help. MD was called right back into room and ordered IM Methergine. Second IV access was established. Vital signs were monitored every 5 minutes until stable.
Retained clots were quickly identified as the source of the bleeding and we were able to successfully treat the patient with fundal massage, oxytocin bolus, followed by continuous oxytocin infusion and Methergine which prevented further interventions and any drastic changes in vital signs. The staff members worked efficiently and in a timely fashion to keep control of the situation with a great outcome.

We had a good team and leadership. The management of this postpartum hemorrhage was so seamlessly performed that the family members commented on their confidence in the care we provided. We quantified the blood loss to be over 2500mL. CBC was drawn a few hours later and another the following morning. Patient was stable and no blood transfusion was needed.