Midwifery Emergency Skills Program (MESP) Team Action Checklist

Post Partum Hemorrhage

→ **Check each action performed by either 1st or 2nd attendant**

Primary attendant: ____________

2nd attendant: ____________

Checked by: ____________

Placenta NOT delivered – NOT bleeding

- ☐ Assess for signs of separation: lengthening of cord, small gush of blood, uterine contraction
- ☐ Attempt to deliver the placenta – if AMTSL – CCT with suprapubic support + pushing effort
- ☐ Attempt to deliver the placenta – if PMTSL – NO CCT by gravity, nipple stim, pushing effort
- ☐ Communicate with client and team
- ☐ Follow cord to assess if placenta is at os
- ☐ Administer oxytocin 10 iu IM – or -
- ☐ Establish IV with 20 units of oxytocin and run at 125 ml/ hr.
- ☐ Call for help – EMS and Hospital -**SBAR**
- ☐ Monitor vital signs, uterine tone and size, blood loss and LOC
- ☐ Drain cord & Instill 30 ml N/S with 800 micrograms misoprostol through feeding tube UV, clamp, wait 15 mins
- ☐ Catheterize bladder with indwelling foley
- ☐ Consider second large bore IV line NS or LR & Labs
- ☐ Arrange to transfer for manual removal while waiting for resolution. Be prepared to convert management in event of PPH with placenta not delivered.

Placenta NOT delivered - PPH

- ☐ Communicate with client and team
- ☐ Quantify blood loss.
- ☐ Call 911 / hospital if at home; for OB if in hospital
- ☐ Bleeding ++→Manual Removal w pain mgmnt if available
- ☐ Bimanual Comp + remove clots - if man removal not done or after manual removal as needed
- ☐ ABCs. / CABs / OTIS
  - o Oxygen by face mask
  - o IV w 16 / 18 G, 1 L LR or NS bolus
  - o Q 5 min Vital signs, uterine tone. blood loss, LOC.
- ☐ Administer 20 u oxytocin in 1 L RL or NS – Oxy: 10 IU IM while establishing Ivor /3IU IV push
- ☐ Administer TXA 1 gm in 10mL iv over 30-40 secs
- ☐ Prep for OR
- ☐ Move forward with PPH management after placental delivered as below.
- ☐ Consult for antimicrobial therapy if manual removal required.

Placenta delivered – PPH

- ☐ **Communicate** with client and team – assess + communicate VS, LOC, blood loss
- ☐ Call - 911 & hospital – Charge RN OB Anaesthesia,
- ☐ **TONE** immediately assess uterine tone**, size,** and **Massage uterus** keep hand on uterus**.**
- ☐ Quantify blood loss
- ☐ **Oxytocin** IV 3IU IV push; or 10IU IM ; or 4 IU in 100 mL over 4 min or 20-40 in 1Litre RL/NS and running quickly
- ☐ **Tranexamic Acid** (TXA) 1 G diluted in10mL over 30-60 seconds
- ☐ **Resuscitate:** ABCs / CABs / Obs Shock Index
    - O^2 by face mask 15 l/min
    - Monitor vital signs q 5min, quantify blood loss, assess LOC and uterine tone and size.
    - IV 16 or 18 G 1000mL RL / NS- IV run wide open – initiate SHOCK protocol
- ☐ **Bimanual uterine massage** & **remove clots**
- ☐ Still bleeding @ 4 min after oxy- **Ergot 0.25 mg IM** note cautions **or** Hemabate 0.25 mg IM (2nd choice) Note cautions
- ☐ Adjunct - Misoprostol 200-400 mcg PO or SL – if injectable uterotonics ineffective
- ☐ ASAP labs: CBC, Coag, and Cross match x 4 units (may have to wait for hospital)
- ☐ Empty bladder with indwelling catheter +monitor renal output
- ☐ **Tissue:** ASAP Inspect placenta/ assess for retained clots
    - Manually remove clots or placental fragments
- ☐ **Trauma** Evaluate from labia to the cervix with adequate light and visualization.
    - Secure hemostasis
- ☐ Consider Bakri balloon to replace bimanual compression (assess time/distance + capacity)
- ☐ **Thrombin-** Bedside clot test – COAGs (Pt PTT, INR Fibrinogen) with lab investigations.
- ☐ Prepare for Operating Room
- ☐ Consider need for transfusion
- ☐ Transport with chart, placenta and ALL blood soaked pads to weigh blood loss
- ☐ **SBAR** Consult asap / Transfer Care
- ☐ Document & Debrief