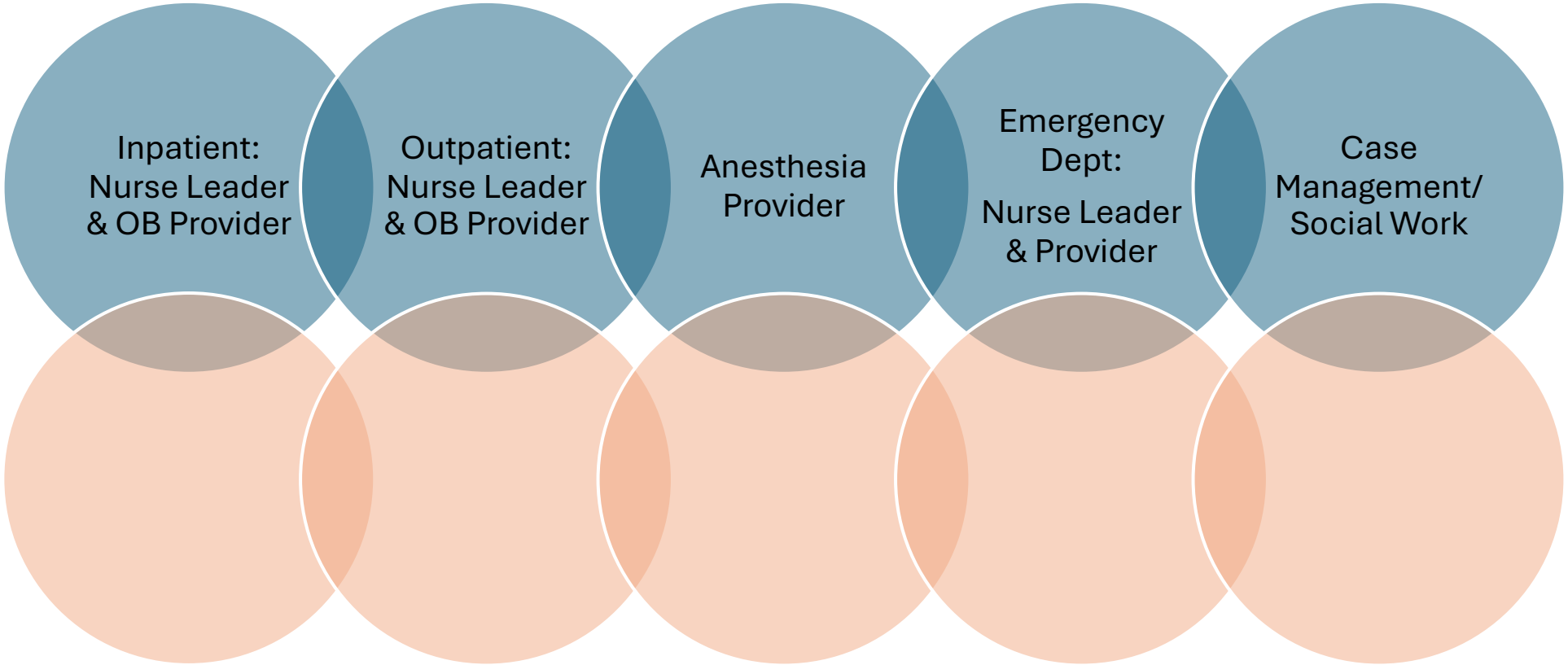
ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Obstetric Unit & Emergency Dept. Collaborations on AIM Bundles - 2024

[insert Institution's name]
AIM Implementation Team Players



AIM
ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

2024

Checklist Guidelines & Examples

- Use this as a guide in your discussions between the Obstetric Unit Leaders and Emergency Department Leaders
- We've provided direct links to resources that are well-established and ready to use
- If you prefer to customize documents you can email Kayla for editable versions (originally created for UVMMC) and/or get her assistance with customizing for your site

ED Triage Process

- **<u>Identification of pregnant or recently pregnant persons:</u>**
  - ❑ How can this be added into triage process?
  - ❑ What needs to be done in EMR to assist/document this process?
  - ❑ When to consult OB colleagues?
  - ❑ When to transfer to L/D?

Example of Triage Process - Hypertension

<u>As part of Triage 1:</u>

For female with an initial BP of 140 (systolic) OR 90 (diastolic) and is between the ages of 10-50 ask the question: **Are you pregnant or have you been in the past 6 weeks?**

The answer "yes" to this question plus an elevated BP **will trigger a BPA (Best Practice Alert)**

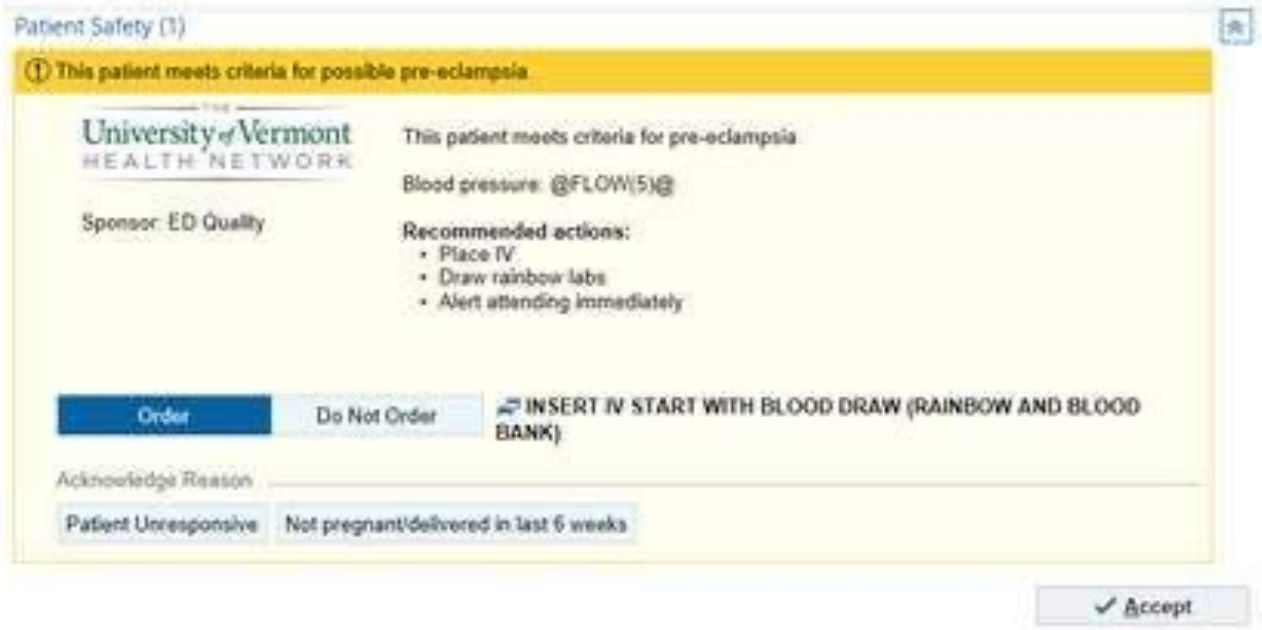
Example of Best Practice Alert - BPA

Action Items:
1. Place IV
2. Draw Rainbow labs
3. Alert Attending Immediately

The Provider eval will include asking for the following signs/symptoms but nursing should be aware of these as well:

- Epigastric pain
- Headache
- Visual Changes

The ED Provider will initiate an OB consult for further management either with in-house team or through the paging system



Example of Triage Process – Hemorrhage

Per Institutional Policy:

1. The Emergency Department triage will identify women with active, heavy, vaginal bleeding within 6 weeks of delivery.

2. The patient will be assessed and stabilized per Emergency Department protocols

3. Any patient with heavy, active, vaginal bleeding:
    - If at a site with OB services: Call OB or activate your OB Emergency team for co-management assistance.
    - For sites without OB services: call the regional transfer center for OB consultation and potential transfer

Added to PPH guidelines

Activation of Emergency Response Teams

- ❑ Identify current Code/Rapid Response/OB Emergency teams already in place
  - Are all the correct stakeholders included on these teams?
  - Is it clear to staff how to “activate” these teams?

Education of Staff and Providers

Role-specific education that includes warning signs of PPH and HTN on orientation, when changes occur, and at least every 2 years

- *Topics to include:* warning signs, acknowledging biases and not making assumptions based on other factors, QBL, treatment algorithms
- Global topics also included in the AIM bundles: Trauma-informed care, equitable care

❑ How will this be executed?

- One option is to work with Kayla to tailor modules to be site-specific

Example of ED-specific Education Modules

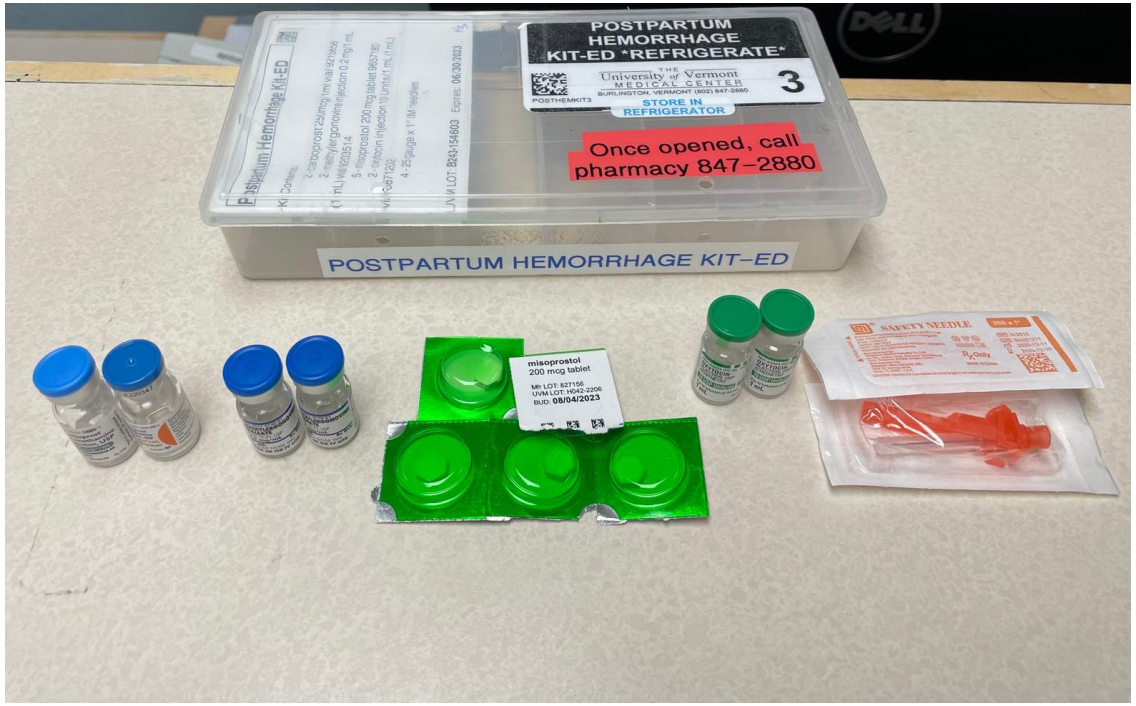
HTN: https://rise.articulate.com/share/UETquDQjtdBBP_iHWYyTUhR7CdNeLbeB

PPH: https://rise.articulate.com/share/axvexfpOuPQzRQbxRWNDcFAGyn6ieFlC

These can be tailored to each individual site to include your institution's specific practices, algorithms, documents, etc. Then can be uploaded into your learning platform to be accessed by staff and tracked for completion/compliance.

Resource Needs

- ❑ Equipment:
  - PPH: equipment and medication access
    - PPH Cart or Kit to include: scale, medication guide, uterine devices & instructions for use [Bakri or Jada]
      - *If cart won't be kept in ED determine the process for getting supplies to the ED in an Emergency*
      - *Consider at minimum having medication kit and uterine devices stocked in ED*
  - HTN: medication access
    - *Ensure all three medications for treatment of Hypertensive Crisis are available*



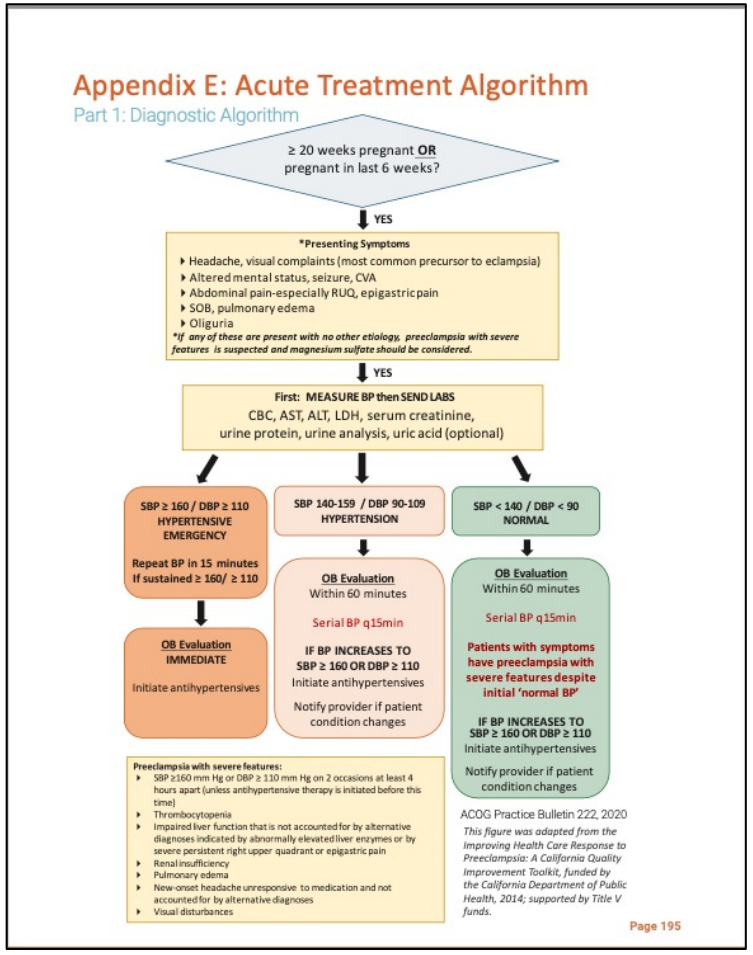
Example of ED PPH Medication Kit

Resource Needs

- ❑ Algorithms:
  - What assessment and treatment algorithms will be used and available to staff?

- ❑ Checklists:
  - What checklists are available to staff for emergencies?

Examples of Assessment Algorithms - Hypertension



Appendix E: Acute Treatment Algorithm

Part 1: Diagnostic Algorithm

≥ 20 weeks pregnant OR pregnant in last 6 weeks?

YES

*Presenting Symptoms
- Headache, visual complaints (most common precursor to eclampsia)
- Altered mental status, seizure, CVA
- Abdominal pain-especially RUQ, epigastric pain
- SOB, pulmonary edema
- Oliguria

*If any of these are present with no other etiology, preeclampsia with severe features is suspected and magnesium sulfate should be considered.

YES

First: MEASURE BP then SEND LABS
CBC, AST, ALT, LDH, serum creatinine, urine protein, urine analysis, uric acid (optional)

SBP ≥ 160 / DBP ≥ 110	SBP 140-159 / DBP 90-109	SBP < 140 / DBP < 90
HYPERTENSIVE EMERGENCY	HYPERTENSION	NORMAL
Repeat BP in 15 minutes If sustained ≥ 160/ ≥ 110	OB Evaluation Within 60 minutes	OB Evaluation Within 60 minutes
OB Evaluation IMMEDIATE	Serial BP q15min	Serial BP q15min
Initiate antihypertensives	IF BP INCREASES TO SBP ≥ 160 OR DBP ≥ 110 Initiate antihypertensives	Patients with symptoms have preeclampsia with severe features despite initial 'normal BP'
	Notify provider if patient condition changes	IF BP INCREASES TO SBP ≥ 160 OR DBP ≥ 110 Initiate antihypertensives
		Notify provider if patient condition changes

Preeclampsia with severe features:
- SBP ≥160 mm Hg or DBP ≥ 110 mm Hg on 2 occasions at least 4 hours apart (unless antihypertensive therapy is initiated before this time)
- Thrombocytopenia
- Impaired liver function that is not accounted for by alternative diagnoses indicated by abnormally elevated liver enzymes or by severe persistent right upper quadrant or epigastric pain
- Renal insufficiency
- Pulmonary edema
- New-onset headache unresponsive to medication and not accounted for by alternative diagnoses
- Visual disturbances

ACOG Practice Bulletin 222, 2020

This figure was adapted from the Improving Health Care Response to Preeclampsia: A California Quality Improvement Toolkit, funded by the California Department of Public Health, 2014; supported by Title V funds.

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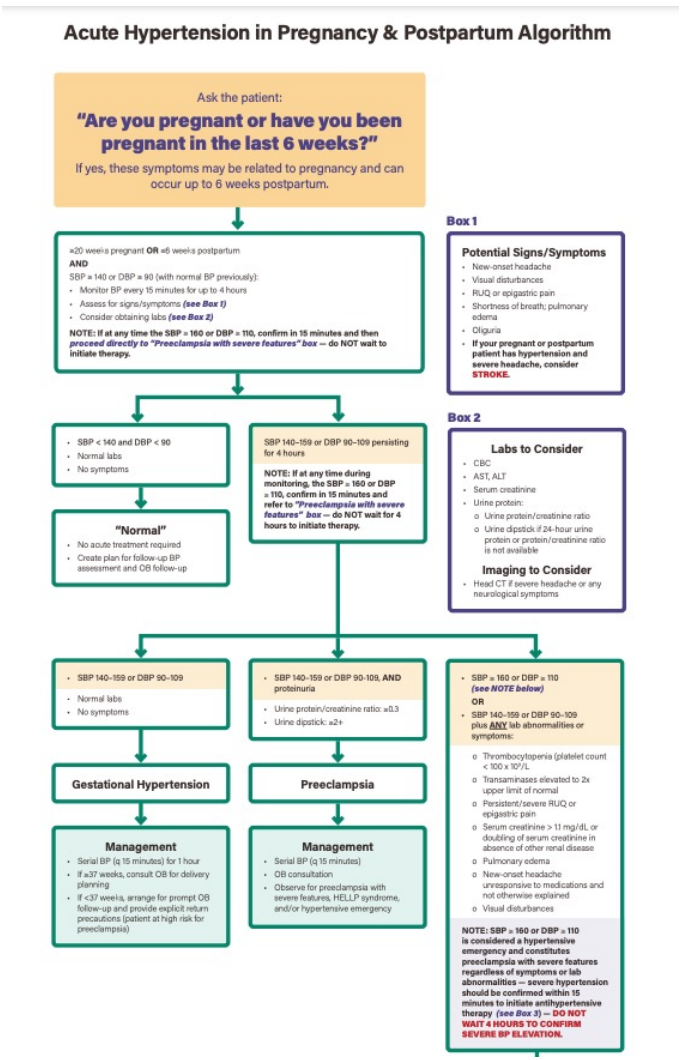


Acute Hypertension in Pregnancy & Postpartum Algorithm

Ask the patient:
"Are you pregnant or have you been pregnant in the last 6 weeks?"
If yes, these symptoms may be related to pregnancy and can occur up to 6 weeks postpartum.

≥20 weeks pregnant OR ≥6 weeks postpartum
AND
SBP ≥ 140 or DBP ≥ 90 (with normal BP previously):
- Monitor BP every 15 minutes for up to 4 hours
- Assess for signs/symptoms *(see Box 1)*
- Consider obtaining labs *(see Box 2)*

NOTE: If at any time the SBP ≥ 160 or DBP ≥ 110, confirm in 15 minutes and then *proceed directly to "Preeclampsia with severe features" box* — do NOT wait to initiate therapy.

- SBP < 140 and DBP < 90
- Normal labs
- No symptoms

"Normal"
- No acute treatment required
- Create plan for follow-up BP assessment and OB follow-up

SBP 140–159 or DBP 90–109 persisting for 4 hours

NOTE: If at any time during monitoring, the SBP ≥ 160 or DBP ≥ 110, confirm in 15 minutes and refer to *"Preeclampsia with severe features" box* — do NOT wait for 4 hours to initiate therapy.

Box 1

Potential Signs/Symptoms
- New-onset headache
- Visual disturbances
- RUQ or epigastric pain
- Shortness of breath; pulmonary edema
- Oliguria
- **If your pregnant or postpartum patient has hypertension and severe headache, consider STROKE.**

Box 2

Labs to Consider
- CBC
- AST, ALT
- Serum creatinine
- Urine protein:
  - Urine protein/creatinine ratio
  - Urine dipstick if 24-hour urine protein or protein/creatinine ratio is not available

Imaging to Consider
- Head CT if severe headache or any neurological symptoms

- SBP 140–159 or DBP 90–109
- Normal labs
- No symptoms

Gestational Hypertension

Management
- Serial BP (q 15 minutes) for 1 hour
- If ≥37 weeks, consult OB for delivery planning
- If <37 weeks, arrange for prompt OB follow-up and provide explicit return precautions (patient at high risk for preeclampsia)

- SBP 140–159 or DBP 90–109, AND proteinuria
- Urine protein/creatinine ratio: ≥0.3
- Urine dipstick: ≥2+

Preeclampsia

Management
- Serial BP (q 15 minutes)
- OB consultation
- Observe for preeclampsia with severe features, HELLP syndrome, and/or hypertensive emergency

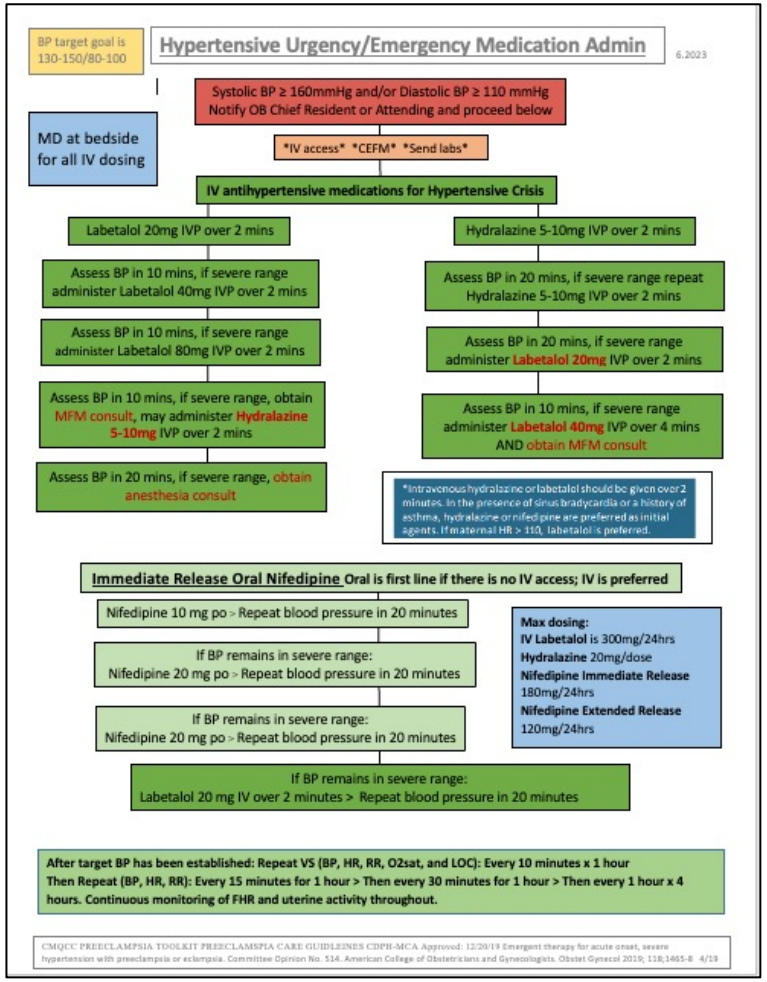
- SBP ≥ 160 or DBP ≥ 110 *(see NOTE below)*
  OR
- SBP 140–159 or DBP 90–109 plus ANY lab abnormalities or symptoms:
  - Thrombocytopenia (platelet count < 100 x 10^9/L
  - Transaminases elevated to 2x upper limit of normal
  - Persistent/severe RUQ or epigastric pain
  - Serum creatinine > 1.1 mg/dL or doubling of serum creatinine in absence of other renal disease
  - Pulmonary edema
  - New-onset headache unresponsive to medications and not otherwise explained
  - Visual disturbances

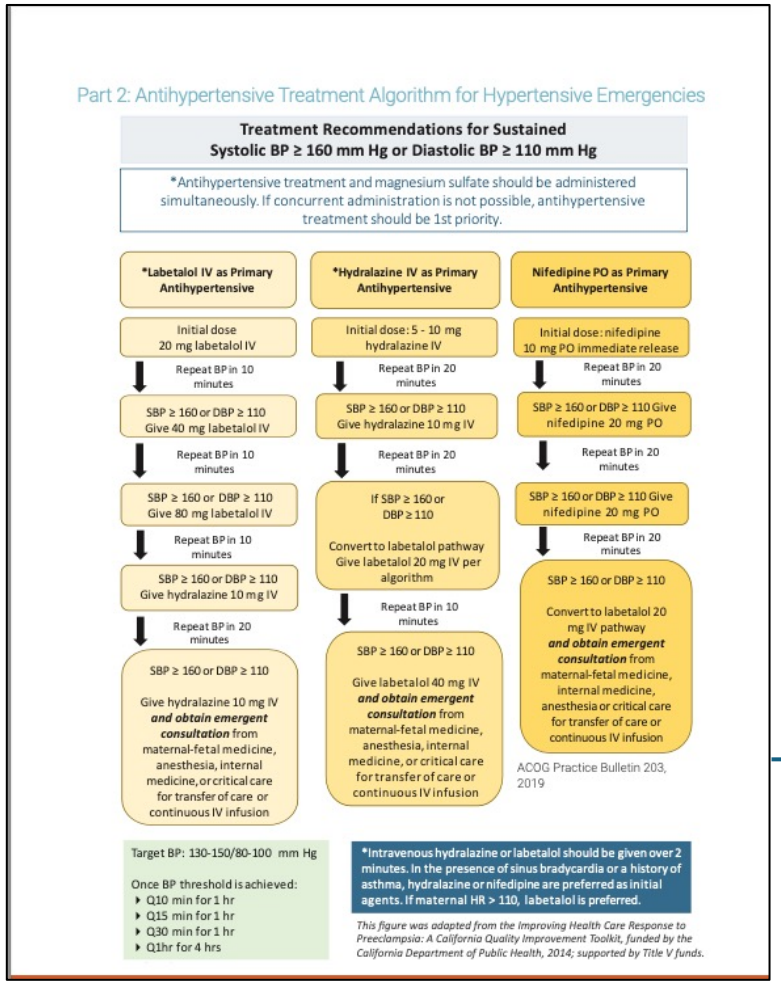
NOTE: SBP ≥ 160 or DBP ≥ 110 is considered a hypertensive emergency and constitutes preeclampsia with severe features regardless of symptoms or lab abnormalities — severe hypertension should be confirmed within 15 minutes to initiate antihypertensive therapy *(see Box 3)* — DO NOT WAIT 4 HOURS TO CONFIRM SEVERE BP ELEVATION.

These can be tailored to each individual site to include your institution's specific practices, or you can use already-established resources.

https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/programs/ob-emergencies/hypertension_algorithm.pdf

Examples of Medication Algorithms - Hypertension

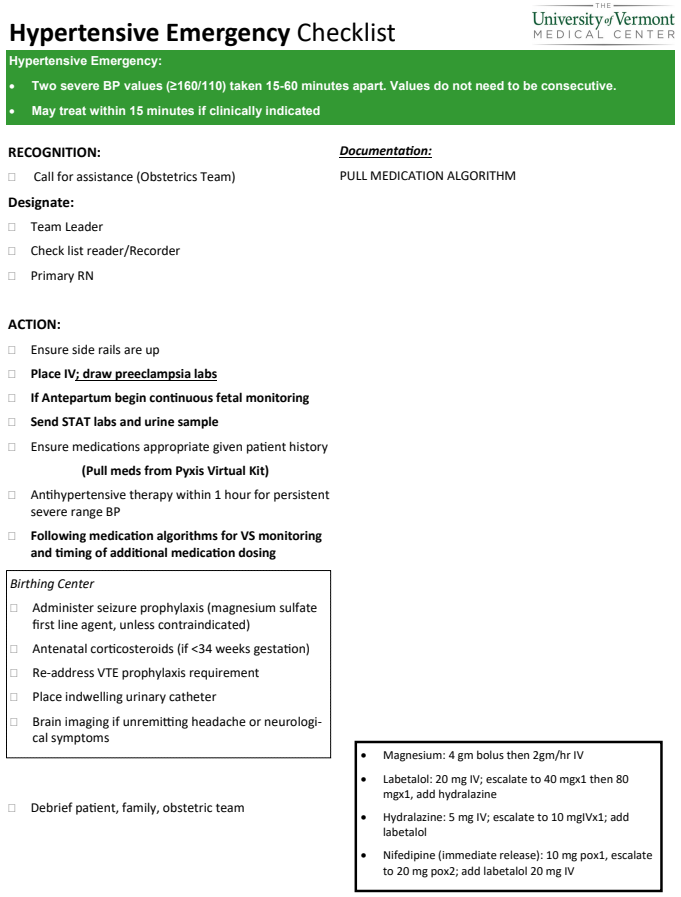




These can be tailored to each individual site to include your institution's specific practices, or you can use already-established resources.

https://www.cmqcc.org/sites/default/files/HDP_FINAL_Appendix_E_2022.pdf

Examples of Checklists - Hypertension



Hypertensive Emergency Checklist

University of Vermont Medical Center

Hypertensive Emergency:

- **Two severe BP values (≥160/110) taken 15-60 minutes apart. Values do not need to be consecutive.**
- **May treat within 15 minutes if clinically indicated**

RECOGNITION:

- ☐ Call for assistance (Obstetrics Team)

Designate:

- ☐ Team Leader
- ☐ Check list reader/Recorder
- ☐ Primary RN

ACTION:

- ☐ Ensure side rails are up
- ☐ **Place IV; draw preeclampsia labs**
- ☐ **If Antepartum begin continuous fetal monitoring**
- ☐ **Send STAT labs and urine sample**
- ☐ Ensure medications appropriate given patient history

(Pull meds from Pyxis Virtual Kit)

- ☐ Antihypertensive therapy within 1 hour for persistent severe range BP
- ☐ **Following medication algorithms for VS monitoring and timing of additional medication dosing**

Birthing Center

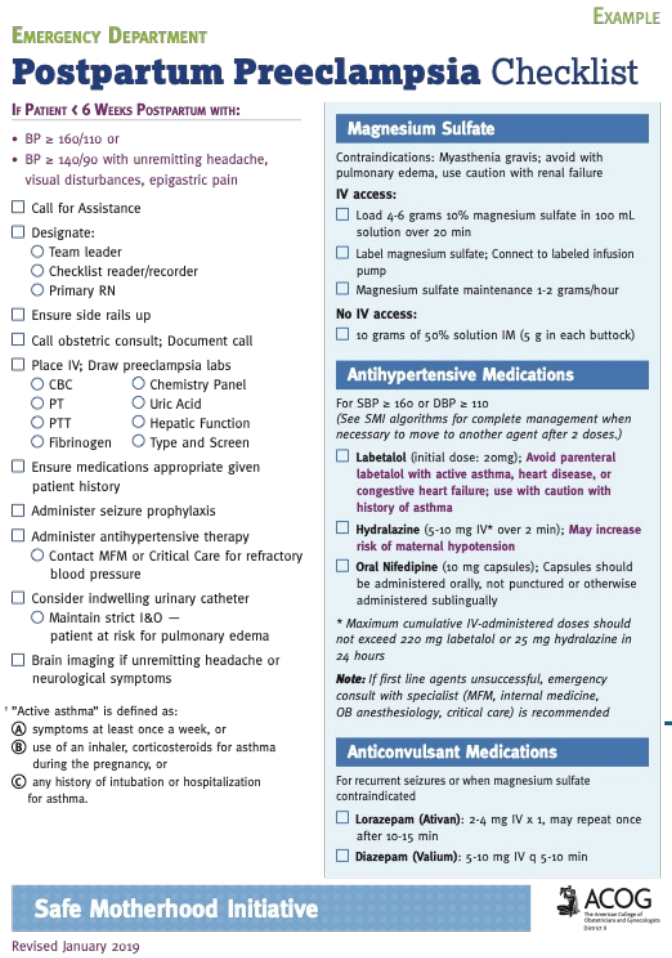
- ☐ Administer seizure prophylaxis (magnesium sulfate first line agent, unless contraindicated)
- ☐ Antenatal corticosteroids (if <34 weeks gestation)
- ☐ Re-address VTE prophylaxis requirement
- ☐ Place indwelling urinary catheter
- ☐ Brain imaging if unremitting headache or neurological symptoms

Documentation:

PULL MEDICATION ALGORITHM

- ☐ Debrief patient, family, obstetric team

- Magnesium: 4 gm bolus then 2gm/hr IV
- Labetalol: 20 mg IV; escalate to 40 mgx1 then 80 mgx1, add hydralazine
- Hydralazine: 5 mg IV; escalate to 10 mgIVx1; add labetalol
- Nifedipine (immediate release): 10 mg pox1, escalate to 20 mg pox2; add labetalol 20 mg IV



EXAMPLE

EMERGENCY DEPARTMENT

Postpartum Preeclampsia Checklist

IF PATIENT < 6 WEEKS POSTPARTUM WITH:

- BP ≥ 160/110 or
- BP ≥ 140/90 with unremitting headache, visual disturbances, epigastric pain

☐ Call for Assistance

☐ Designate:
- ○ Team leader
- ○ Checklist reader/recorder
- ○ Primary RN

☐ Ensure side rails up

☐ Call obstetric consult; Document call

☐ Place IV; Draw preeclampsia labs
- ○ CBC
- ○ PT
- ○ PTT
- ○ Fibrinogen
- ○ Chemistry Panel
- ○ Uric Acid
- ○ Hepatic Function
- ○ Type and Screen

☐ Ensure medications appropriate given patient history

☐ Administer seizure prophylaxis

☐ Administer antihypertensive therapy
- ○ Contact MFM or Critical Care for refractory blood pressure

☐ Consider indwelling urinary catheter
- ○ Maintain strict I&O — patient at risk for pulmonary edema

☐ Brain imaging if unremitting headache or neurological symptoms

† "Active asthma" is defined as:
- Ⓐ symptoms at least once a week, or
- Ⓑ use of an inhaler, corticosteroids for asthma during the pregnancy, or
- Ⓒ any history of intubation or hospitalization for asthma.

Magnesium Sulfate

Contraindications: Myasthenia gravis; avoid with pulmonary edema, use caution with renal failure

IV access:

☐ Load 4-6 grams 10% magnesium sulfate in 100 mL solution over 20 min

☐ Label magnesium sulfate; Connect to labeled infusion pump

☐ Magnesium sulfate maintenance 1-2 grams/hour

No IV access:

☐ 10 grams of 50% solution IM (5 g in each buttock)

Antihypertensive Medications

For SBP ≥ 160 or DBP ≥ 110
(See SMI algorithms for complete management when necessary to move to another agent after 2 doses.)

☐ **Labetalol** (initial dose: 20mg); **Avoid parenteral labetalol with active asthma, heart disease, or congestive heart failure; use with caution with history of asthma**

☐ **Hydralazine** (5-10 mg IV* over 2 min); **May increase risk of maternal hypotension**

☐ **Oral Nifedipine** (10 mg capsules); Capsules should be administered orally, not punctured or otherwise administered sublingually

** Maximum cumulative IV-administered doses should not exceed 220 mg labetalol or 25 mg hydralazine in 24 hours*

***Note:** If first line agents unsuccessful, emergency consult with specialist (MFM, internal medicine, OB anesthesiology, critical care) is recommended*

Anticonvulsant Medications

For recurrent seizures or when magnesium sulfate contraindicated

☐ **Lorazepam (Ativan)**: 2-4 mg IV x 1, may repeat once after 10-15 min

☐ **Diazepam (Valium)**: 5-10 mg IV q 5-10 min

Safe Motherhood Initiative

ACOG

Revised January 2019

These can be tailored to each individual site to include your institution's specific practices, or you can use already-established resources.

https://www.acog.org/-/media/project/acog/acogorg/files/forms/districts/smi-hypertension-bundle-postpartum-preeclampsia-checklist.pdf

Examples of Medication Charts – Hemorrhage

Appendix R: Medications for Postpartum Hemorrhage

Medications for Postpartum Hemorrhage

Drug	Dose	Route	Frequency	Side Effects	Contraindications	Special Storage Considerations
Oxytocin (Pitocin™) 10 units/mL	10-40 units per 500-1000 mL, rate titrated to uterine tone	IV infusion	Continuous	Usually none Nausea, vomiting, hyponatremia ("water intoxication") with prolonged IV admin. ↓ BP and ↑ HR with high doses, especially IV push	Hypersensitivity to drug	None
Methyler-gonovine (Methergine®) 0.2 mg/mL	0.2 mg	IM (not given IV)	-q2-4 hours -If no response after first dose, it is unlikely that additional doses will be of benefit	Nausea, vomiting, severe hypertension, especially with rapid administration or in patients with HTN	Hypertension, Preeclampsia, Heart disease Hypersensitivity to drug **Caution** if multiple doses of ephedrine have been used, may exaggerate hypertensive response w/ possible cerebral hemorrhage	Refrigerate Protect from light
Carboprost (Hemabate®) (15-methyl PG F2a) 250 mcg/mL	250 mcg	IM or intra-myometrial (not given IV)	-q15-90 min -If no response after 3 doses, it is unlikely that additional doses will be of benefit	Nausea, vomiting, diarrhea, fever (transient), headache, chills, shivering, hypertension, bronchospasm	Caution in women with hepatic disease, asthma, hypertension, active cardiac or pulmonary disease Hypersensitivity to drug	Refrigerate
Misoprostol (Cytotec®) 100 or 200 mcg tablets	600-800 mcg	SL or PO	One time	Nausea, vomiting, diarrhea, shivering, fever (transient), headache	Rare Known allergy to prostaglandin Hypersensitivity to drug	None
Tranexamic Acid (TXA)	1 gram	IV infusion (over 10 min)	-One dose within 3 hrs of hemorrhage recognition -A 2nd dose may be administered if bleeding continues after 30 min or if bleeding stops and then restarts within 24 hrs of completing the 1st dose	Nausea, vomiting, diarrhea, hypotension if given too rapidly	A known thromboembolic event in pregnancy History of coagulopathy Active intravascular clotting	None

Improving Health Care Response to Obstetric Hemorrhage, a CMQCC Quality Improvement Toolkit, 2022

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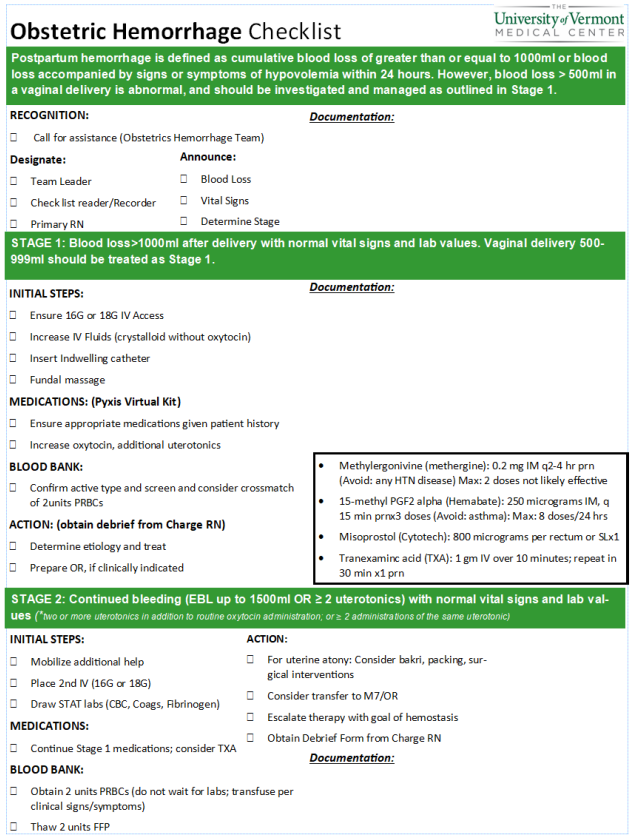
These can be tailored to each individual site to include your institution's specific practices, or you can use already-established resources.

https://www.cmqcc.org/content/ob-hemorrhage-toolkit-v30-appendix-r-medications-postpartum-hemorrhage

Examples of Checklists - Hemorrhage



Obstetric Hemorrhage Checklist

University of Vermont MEDICAL CENTER

Postpartum hemorrhage is defined as cumulative blood loss of greater than or equal to 1000ml or blood loss accompanied by signs or symptoms of hypovolemia within 24 hours. However, blood loss > 500ml in a vaginal delivery is abnormal, and should be investigated and managed as outlined in Stage 1.

RECOGNITION: ***Documentation:***

☐ Call for assistance (Obstetrics Hemorrhage Team)

Designate:
☐ Team Leader
☐ Check list reader/Recorder
☐ Primary RN

Announce:
☐ Blood Loss
☐ Vital Signs
☐ Determine Stage

STAGE 1: Blood loss>1000ml after delivery with normal vital signs and lab values. Vaginal delivery 500-999ml should be treated as Stage 1.

Documentation:

INITIAL STEPS:
☐ Ensure 16G or 18G IV Access
☐ Increase IV Fluids (crystalloid without oxytocin)
☐ Insert Indwelling catheter
☐ Fundal massage

MEDICATIONS: (Pyxis Virtual Kit)
☐ Ensure appropriate medications given patient history
☐ Increase oxytocin, additional uterotonics

BLOOD BANK:
☐ Confirm active type and screen and consider crossmatch of 2units PRBCs

ACTION: (obtain debrief from Charge RN)
☐ Determine etiology and treat
☐ Prepare OR, if clinically indicated

- Methylergonivine (methergine): 0.2 mg IM q2-4 hr prn (Avoid: any HTN disease) Max: 2 doses not likely effective
- 15-methyl PGF2 alpha (Hemabate): 250 micrograms IM, q 15 min prnx3 doses (Avoid: asthma): Max: 8 doses/24 hrs
- Misoprostol (Cytotech): 800 micrograms per rectum or SLx1
- Tranexamic acid (TXA): 1 gm IV over 10 minutes; repeat in 30 min x1 prn

STAGE 2: Continued bleeding (EBL up to 1500ml OR ≥ 2 uterotonics) with normal vital signs and lab values (*two or more uterotonics in addition to routine oxytocin administration; or ≥ 2 administrations of the same uterotonic)

INITIAL STEPS:
☐ Mobilize additional help
☐ Place 2nd IV (16G or 18G)
☐ Draw STAT labs (CBC, Coags, Fibrinogen)

MEDICATIONS:
☐ Continue Stage 1 medications; consider TXA

BLOOD BANK:
☐ Obtain 2 units PRBCs (do not wait for labs; transfuse per clinical signs/symptoms)
☐ Thaw 2 units FFP

ACTION:
☐ For uterine atony: Consider bakri, packing, surgical interventions
☐ Consider transfer to M7/OR
☐ Escalate therapy with goal of hemostasis
☐ Obtain Debrief Form from Charge RN

Documentation:

Appendix B: Obstetric Hemorrhage Care Guidelines: Checklist Format

Prenatal Assessment & Planning
☐ Evaluate for risk factors prenatally and **identify/prepare for patients with special considerations:** Placenta previa/accreta, bleeding disorder, or those who decline blood products
☐ **Screen and aggressively treat severe anemia:** if oral iron fails, initiate "IV Iron Protocol" to reach optimal Hgb/Hct, especially for at risk patients
☐ Provide counseling/education
☐ Consider site of delivery
☐ Plan for blood salvage if appropriate
Admission Assessment & Planning
Admission Hemorrhage Risk Factor Assessment
☐ Evaluate for risk factors on admission
☐ Verify type & antibody screen from prenatal record
☐ If not available: Order type and screen (lab will notify if 2nd specimen needed for confirmation)
☐ Send specimen to blood bank as indicated by institutional practices. ***Blood bank recommendations should be highly localized.*** *Many institutions no longer hold a specimen in the blood bank; others utilize automated technology to type and screen all obstetric patients.*
☐ If prenatal or current antibody screen positive (not low-level anti-D from RhoGam)
☐ Type and crossmatch 2 units PRBCs
☐ Identify patients who may decline blood products
☐ Notify OB provider for plan of care
☐ Early consult with OB anesthesia
☐ Review consent form
☐ Ensure readiness

These can be tailored to each individual site to include your institution's specific practices, or you can use already-established resources.

→ https://www.cmqcc.org/content/ob-hemorrhage-toolkit-v30-appendix-b-obstetric-hemorrhage-care-guidelines-checklist-format

In-situ drills

- How can these two topics be added into Professional development days as multi-disciplinary drills?

- What structure needs to be in place to coordinate 1 annual drill that tests systems [call system, blood bank, etc.]

Examples of Obstetric Drill in ED

Will add resource when completed

Integration into Guideline/Policy

- ❑ How does the above actions integrate into your guidelines?

Examples of Obstetric Policies

Documents Status: **Approved**

IDENT	NOBG65
Type of Document	Guideline
Applicability Type	Cross-Organizational
Title of Owner	Nursing Dir: Women's Care & Peds
Title of Approving Official	Chief Nursing Officer
Date Effective	1/20/2021
Date of Next Review	1/20/2022

THE University of Vermont MEDICAL CENTER

TITLE: Obstetric Hemorrhage Guideline

PURPOSE: Obstetric hemorrhage is a leading cause of maternal morbidity and mortality in the United States. The overall rate of postpartum hemorrhage increased 26% between 1994 and 2006, primarily driven by a 50% increase in cases of uterine atony (CMQCC, 2015). Rapid recognition and treatment are necessary to prevent progression of hemorrhage as women can lose large volumes of blood very quickly due to the physiologic changes of pregnancy. A systematic approach and standardized protocol leads to improved outcomes as a result of early recognition, effective communication, and appropriate application of interventions.

POLICY STATEMENT: The UVMMC OB Hemorrhage guideline includes readiness, recognition, response, and reporting for obstetric hemorrhage within our institution. Activation of appropriate resources and personnel may be necessary for patients within the Birthing Center, Mother Baby Unit, or other areas of the institution.

Readiness:
- System Level: Use of Simulation/Drills and Standardized Hemorrhage Carts.
- Patient Level: Use of admission and ongoing risk assessment for all OB patients.

Recognition:
- Prevention with active management of the third stage, & early recognition of hemorrhage, assessment of blood loss every delivery, quantitative assessment when indicated, use of huddles in high risk patients

Response:
- Standardized approach for each stage of hemorrhage including activation of additional resources, checklists, and personnel. Support for patient, families, staff during and after event.

Reporting:
- Use of SAFE system for reporting of events, multidisciplinary review of severe cases at QAI; education every 2 years and M&M as indicated

PERSONNEL: All providers (RN, physician, CNM) oriented to the Birthing Center, and Mother/Baby Unit including anesthesiology, providers (physician, nurse anesthetists, anesthesia assistants); & Emergency Department providers (RN, physician, physician assistants) and blood bank personnel involved in massive transfusion requests (MTP activation). Pharmacy will review and sign off on this guideline.

Readiness:

(1) A Hemorrhage cart is immediately available on McClure 7 (Birthing) and Baird 7 (Ante/Postpartum) units (contents; Appendix A). Providers should know where carts are located; the RN that opens the cart restocks immediately after use; the labor and delivery assistants will be responsible for checking and restocking monthly (if not used and for expired materials. Bakri balloons and sutures are immediately available in the OR and OB Hemorrhage Cart, drawer 3. The Emergency Department protocol will STAT page McClure 7 in the rare event of a postpartum hemorrhage and the cart can be brought to the ED by the responding OBGYN team. Medications are available in the Emergency Kit in Pyxis on McClure 7, Baird 7, and the anesthesiology medication cart. The Hemorrhage cart will contain guidelines by hemorrhage stage, instruction cards for balloon and compression sutures, how to access blood products instructions, and the checklist for treatment and debrief (see Appendix B).

(2) Immediate access to medications are in the Pyxis or refrigerator (if indicated) as an emergency kit. McClure 7, Baird 7, and the operating room have access to these medications. When the emergency department calls the team for postpartum hemorrhage, those medications (and the cart) will be brought by the responding OBGYN team (available 24/7/365).

(3) The Postpartum Hemorrhage response team includes the OBGYN resident, the attending provider, the attending physician (if not the provider), the emergency OBGYN attending (708 beeper, available 24/7/365 in house) if the

Email Kayla for editable version of guidelines utilized by UVMMC to adapt to your site

Please do not reinvent the wheel.

Email Kayla @ Kayla.Panko@uvmhealth.org to receive editable versions or to have her edit documents to customize to your site if needed.

Kayla is available to join meetings to answer questions, help clarify the asks, or offer support in other ways.

Share your progress and/or needs with the AIM team. We are here to support you in this work.