Implementation of Postpartum Hemorrhage Bundle
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Introduction

According to California Department of Public Health (CDPH, 2010), the rate of maternal deaths in the United States has nearly doubled from 1996 to 2006. The state health department contracted with the California Maternal Quality Care Collaborative (CMQCC) to examine deaths related to pregnancy.

Bingham, Lyndon, and Lagrew (2011) stated, “Beyond identifying who died, the causes of death, and where and when deaths occurred, experts on the mortality review panel determine the degree to which each death may have been preventable. They also provide their best judgment of contributing factors and quality improvement opportunities or lessons to be learned from each death” (p. 298).

Together with the root cause analysis and the consensus that obstetric hemorrhage had the highest probability of being prevented a safety bundle for obstetric hemorrhage was developed and implemented and evaluated.

Statement of the Problem

The desired outcome was for nursing staff to identify patients at risk for postpartum hemorrhage, recognize the level of hemorrhage earlier, intervene quickly, and report postpartum hemorrhages with a subsequent debrief of the incident. The intervention employed was the development and implementation of a safety bundle for obstetric hemorrhage.

“As health care quality improvement and patient safety efforts intensify, understanding the social and health care contexts surrounding women who die as a result of pregnancy is critical to instituting the systemic changes needed to decrease pregnancy-related mortality.” (Beng, Callaghan, Syverson, & Henderson, 2010, p. 1308).

Planning and Implementation

Ishikawa Diagram

Gantt Chart

Bundle Components

- Hemorrhage Cart
- Simulation Drills
- Readiness
- Recognition
- Risk Assessment
- Quantification of Blood Loss
- Blood Product Replacement
- Debriefing

Evaluation of Bundle with Simulation

<table>
<thead>
<tr>
<th>Metric</th>
<th>Met</th>
<th>Not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Properly assess hemorrhage risk</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Requests hemorrhage cart</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Proper set up of warmer for rapid blood replacement</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Quantifies blood loss</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Debrief completed</td>
<td>3</td>
<td>0</td>
</tr>
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</table>

References


Contact and Acknowledgements

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Ann Stoltz, PHD, RN, CNL Touro University California, School of Nursing Director