SCENARIO

APH- Abruption

LEARNING OBJECTIVES

Effective team working and communication

Use of SBAR to communicate

Coordinating initial resuscitation and preparation for theatre

Understanding nature of Abruption, likelihood of coagulopathy

Management of Massive Obstetric Haemorrhage

EQUIPMENT LIST

Noelle/SimMOM
Fluids / giving sets
IVC/blood Bottles
PPH red box
Airway trolley
Baby Hal
Phone
Fake blood
Blood Request Forms
GA drug box
Rapid infuser
Monitor for manikin
Intra operative blood gas result

PERSONNEL

MINIMUM: 5

Obstetricians 1-2
Midwives 1-2
Anaesthetics 1-2
Paediatricians 1-2

FACULTY

MINIMUM: 4

Facilitator
Observer x2
Debrief Lead

TIME REQUIRMENTS

TOTAL 1.5hours

Set up: 30 mins
Pre Brief: 10 mins
Simulation: 20mins
Debrief: 30mins

INFORMATION TO CANDIDATE

PATIENT DETAILS

Name: Jessica Thomas
Age: 19
Weight/BMI: 60kg / 22

Phx: Cocaine use
Allergies: Nil

SCENARIO BACKGROUND

Location: Labour Ward /theatre transfer

Situation: Primip 35+1weeks
Baby Small for gestational age
32 week scan – small, normal AFI, normal dopplers
Known Transverse Lie

Presents with constant abdominal pain and APH of 1500ml
(Grandma +/- dad on their way)

Task: Assess patient

RCOG CURRICULUM MAPPING

Module: 10 Management of labour Ward
Management of Obstetric Antepartum Haemorrhage
Safe use of blood products
Maternal Collapse
Liaise with Staff

INFORMATION FOR ROLEPLAYERS

BACKGROUND

NA- patient collapsed and unwell

RESPONSES TO QUESTIONS

INFORMATION TO FACILITATOR

SCENARIO DIRECTION

Recognise large APH and hypovolemic shock, likely abruption.
Initial assessment ABCDE with fluid resuscitation on labour ward, urinary catheter
Initiation of Obstetric Haemorrhage Protocol- HELP 2222
Transfer to theatre once stable after discussions with anaesthetics/obstetricians Fetal bradycardia requiring Category 1 LSCS, maternal stability post resuscitation main goal.
Communicate with Paediatrician
ABG –Hb 60g/dl pre GA, start 2 units of blood O negative. Ensure blood bank contacted and 4 units blood enroute by labour ward runner
Safe RSI reduce induction drug dose, continued resuscitation with fluid and blood, Anticipate /check for coagulopathy and communicate with team.
Give FFP / cryopercipitate or communicate with Haematology.
Anticipate PPH- give appropriate tocolytics (oxytocinon/ergometrine/Haemobate)

SCENARIO OBSERVATIONS/ RESULTS

	BASELINE	STAGE 1 Post initial Resus on LW	STAGE 2 In OT pre GA	STAGE 3 Post GA and delivery	STAGE 4 Post blood/blood product and PPH drug administration
RR	30	26	24	15	18
chest sound	Normal	Normal	Normal	Normal	Normal
SpO2	96%	95%	98% O2	95%	97% 50% O2
HR	145	130	140	150	115
Heart sound	Normal	Normal	Normal	Normal	Normal
BP	80/60	85/65	90/60	75/50	90/60
Temp	36.5C	36C	36C	36.5C	36C
Central CRT	4secs	5secs	5secs	4secs	3secs
GCS/AVPU	P	V	V	U	U

Arterial Gas/Lactate: Hb 60g/L prior to theatre transfer

Fibrinogen result 1.6, PT 15 APPT 32, Plt 200, HB 90 during bleed in theatre

Urine Output 30mls/hr

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SCENARIO DEBRIEF

TOPICS TO DISCUSS

Effectiveness of communication and team working.
Use of SBAR.
Coordinating initial resuscitation and preparation for theatre –stabilisation prior to GA despite fetal bradycardia
Understanding pathophysiology of abruption, anticipation of coagulopathy
Management of massive obstetric haemorrhage- anticipation of PPH
Techniques for difficult delivery of transverse lie
Consultant involvement
Safe use of blood products- involve haematology

REFERENCES

RCOG Green-top Guideline Antepartum Haemorrhage No. 63 Nov 2011
RCOG Green-top Guideline Prevention and Management of Postpartum Haemorrhage 2009

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