Maternity Education Program

Postpartum Haemorrhage

Facilitator Resource Kit

CSDS
Clinical Skills Development Service

Queensland Government

Maternity Education Program

The resources developed for Maternity Education Program (MEP) are designed for use in any Queensland Health facility that care for patients/ women who are pregnant/ birthing or postnatal. Each resource can be modified by the facilitator and adapted to the needs of the learner and the environment in which the education is being delivered- from tertiary to rural and remote facilities.

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Postpartum Haemorrhage – Facilitator Resource Kit

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Who is this resource kit for?

This resource kit provides healthcare workers with knowledge and skills on assessing and managing a postpartum haemorrhage.

Target audience

Midwifery and medical staff providing maternity care

Duration

45 mins - case study simulation and debrief (additional 15 minutes for set up)

Group size

Suited to small groups (6 – 8)

Learning objectives

By the end of the session the learner should be able to:

- Recognise and manage a post-partum haemorrhage.
- Identify the need for and call for help early.
- Manage the PPH using the Queensland Clinical Guideline PPH.
- Recognise and respond to the clinical deteriorating patient.

Facilitation guide

1. Provide Participant Resource Kit to the learner.
2. Utilise 2D pictures to demonstrate PPH management.
3. Utilise PowerPoint (QCG) to assist learner prior to session.
4. Provide a pre simulation briefing and deliver a PPH simulation case.
5. Utilise the debriefing guide to evaluate participants performance and provide feedback.

Supporting documents

1. Participant Resource Kit
2. 2D pictures
3. List of further readings
4. PPH Flow diagram
5. PPH drug table
6. PPH simulation

Overview

Primary postpartum haemorrhage (PPH) is the most common form of obstetric haemorrhage and is a leading cause of maternal morbidity and mortality. Obstetric haemorrhage which includes antepartum haemorrhage is still responsible for maternal deaths in Australia.

There is no single definition but primary PPH is an excessive bleeding in the first 24 hours post birth and secondary PPH after 24 hours and up to six (6) weeks postpartum. In an emergency, diagnosis most commonly occurs through estimation of blood loss and the changes in the haemodynamic state, but quick response and treatment are vital for a good outcome.

Obstetric emergency is any clinical situation involving a maternity patient where immediate medical/midwifery assistance is required.

Further Readings

Queensland Clinical Guideline (QCG) on primary postpartum haemorrhage

Statewide guideline on primary postpartum haemorrhage. The information contained in this guidelines has been prepared using a multidisciplinary approach with reference to the best information and evidence available at the time of preparation.

https://www.health.qld.gov.au/__data/assets/pdf_file/0015/140136/g-pph.pdf

Queensland Clinical Guideline on Primary postpartum haemorrhage Clinical Guideline Presentation v5.0

Presentation developed by QCG as an implementation tool and should be used in conjunction with the QCG on PPH.

https://www.health.qld.gov.au/__data/assets/pdf_file/0017/141074/ed-pph.pdf

Queensland Clinical Guideline on Oxytocin infusion: updated protocol 2017

Presentation developed by QCG as an implementation tool and should be used in conjunction with the QCG on Induction of labour and PPH.

https://www.health.qld.gov.au/__data/assets/pdf_file/0024/645333/ed-oxytocin-protocol.pdf

Royal College of Obstetricians & Gynaecologists, Postpartum haemorrhage, prevention and management (Green-top guideline no 52)

This guideline provides information about the prevention and management of postpartum haemorrhage (PPH), primarily for clinicians working in obstetric-led units in the UK; recommendations may be less appropriate for other settings where facilities, resources and routine practices differ.

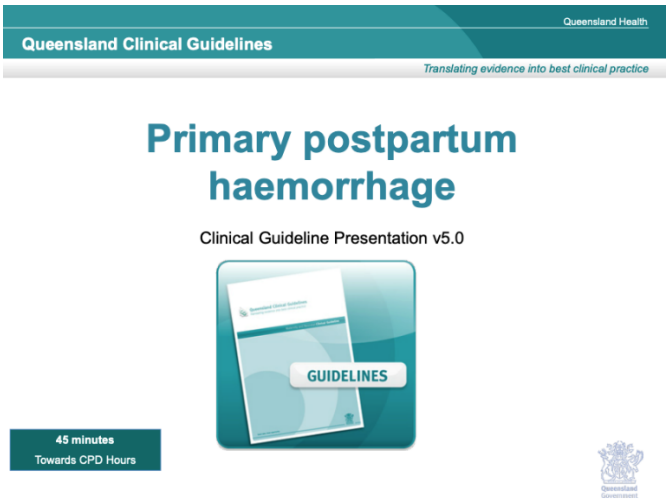
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg52/

Obstetric Emergency

Postpartum Haemorrhage

Initial response to primary postpartum haemorrhage (PPH) https://www.health.qld.gov.au/__data/assets/pdf_file/0021/144363/f-pph-response.pdf
Massive haemorrhage protocol (MHP) https://www.health.qld.gov.au/__data/assets/pdf_file/0012/142320/f-pph-mhp.pdf

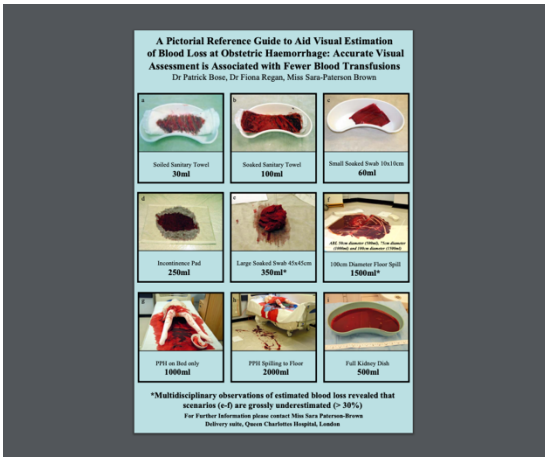
Postpartum Haemorrhage PowerPoint Presentation



Scan me on your phone

https://www.health.qld.gov.au/__data/assets/pdf_file/0017/141074/ed-pph.pdf

Blood estimation pictures



Scan me on your phone

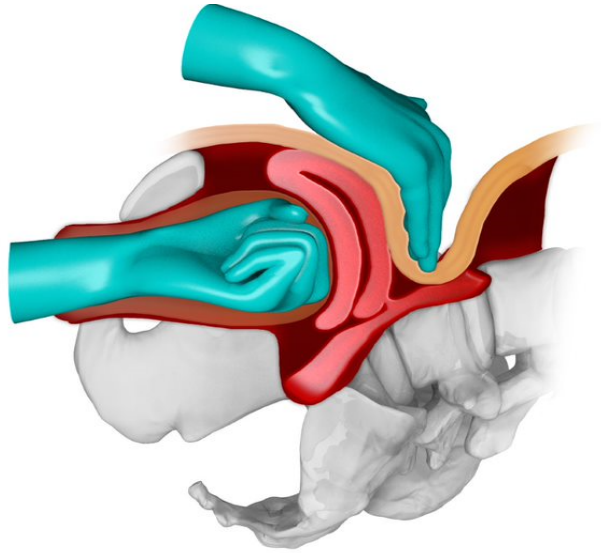
https://crana.org.au/uploads/pdfs/Guide_to_Aid_Visual_Estimation_of_Blood_Loss_at_Obstetric_Haemorrhage.pdf

Drugs and Blood Products Kit

Drug/ Product	Dose/Route	Reconstitution	Maximum	Comments
Carboprost	250 micrograms IM 	Nil	May repeat after 15 minutes to maximum total dose of 2 mg (8 doses)	Manufacturer does not recommend intramyometrial —use at clinician's discretion Commence cardiac monitoring and oxygen therapy prior to administration Contraindicated in patients with asthma
	500 micrograms intramyometrial	Nil	Unknown/repeat not recommended	
Cryoprecipitate	Dose in response to fibrinogen level One adult standard dose IV is equivalent to 10 whole blood or five apheresis units. 	Stored frozen Defrost over 30 minutes before administration	Unknown	Derived from whole blood or collected via apheresis Australian Red Cross states one standard adult dose provides 3–4 g of fibrinogen; clinical experience suggests 2–3 g or less
Ergometrine	250 micrograms IV over 1–2 minutes 	Dilute 250 microgram up to 5 mL with 0.9% sodium chloride (50 micrograms per mL)	May repeat every 2 – 3 minutes to maximum total dose of 250 micrograms –1 mg	Administer with an anti-emetic Contraindicated with retained placenta, pre-eclampsia May cause severe hypertension
	250 micrograms IM	Nil	May repeat after 5 minutes to maximum total dose of 500 micrograms –1 mg	
Fibrinogen concentrate	Dose in response to fibrinogen level If fibrinogen level unknown, then 50–70 mg/kg body weight IV at a rate not exceeding 5 mL per minute. 	Reconstitute with 50 mL of sterile water Swirl gently to ensure fully dissolved Do not shake vial	Unknown	Dosing based on product information for congenital fibrinogen deficiency Administer via infusion device/pump Dose per vial approximately 1 g 4 g increases fibrinogen by approximately 1 g/L

Misoprostol	800–1000 micrograms per rectum (PR) 	Nil	Repeat dose not recommended	Use when oxytocin and ergometrine are not successful Due to slow onset of action, consider early administration Associated with postpartum fever
Oxytocin	5 international units IM	Nil	May repeat after 5 minutes to maximum total dose of 10 international units	Instead of Ergometrine if BP is elevated Ensure placenta is expelled
	5 international units IV over 1–2 minutes	Nil		
	5–10 international units per hour IV via infusion pump 	Oxytocin 30 international units in 500 mL crystalloid or 0.9% sodium chloride Infuse at 83–167 mL/hour		
Syntometrine (500 mcg ergometrine 5 IU oxytocin)	1ml IM if Oxytocin only has been given for 3rd stage management 	Nil	X1 Dose	Avoid if allergic to components Do not use in: hypertension, pre-eclampsia, heart, liver or renal issues, narrowed or blocked blood vessels, severe infection
Tranexamic Acid	1 gram IV over 10 minutes 	Nil	If bleeding persists after 30 minutes or stops and restarts within 24 hours of the first dose, a second dose may be administered	Rapid administration may cause hypotension, dizziness Use infusion device/pump

Bimanual compression



Bimanual compression

The accoucheurs dominant hand enters the vagina, once in place makes a fist, the outside hand presses down on the fundus and compresses the uterus between the external and internal hand.

This procedure needs to be maintained until the woman is in OT and ready for ongoing management.

B-Lynch Suture

Surgical management

The B-Lynch suture acts as a brace suture. The principle is to compress the uterus by pulling drop on the suture pulling it taught to achieve or aid compression. It is simple and effective. Refer to page 35 QCG Primary Postpartum Haemorrhage

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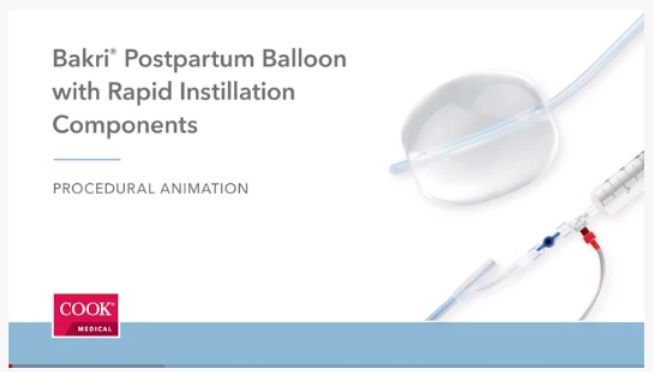
Bakri Postpartum Balloon



Bakri Postpartum Balloon w/Rapid Instillation Animation Demonstration

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https://www.cookmedical.com/products/wh_sosr_webds/#

Simulation Event

This section contains the following documents:

1. Pre-simulation briefing poster
2. Immersive in-situ scenario
3. Physical resources
4. Human resources
5. Simulated patient script information
6. Handover card
7. Additional information
8. Stage 1 – Initial assessment
9. Stage 2 – Ongoing management
10. Stage 3 – Resolution

Pre-simulation Briefing

Establishing a safe container for learning in simulation.

1 Clarify objectives, roles and expectations

- Introductions.
- Learning objectives.
- Assessment (formative vs summative).
- Facilitators and learners' roles.
- Active participants vs observers.

2 Maintain confidentiality and respect

- Transparency on who will observe.
- Individual performances.
- Maintain curiosity.

3 Establish a fiction contract

Seek a voluntary commitment between the learner and facilitator.

- Ask for buy-in.
- Acknowledge limitations.

4 Conduct a familiarisation

- Manikin/simulated patient.
- Simulated environment.
- Calling for help.

5 Address simulation safety

Identify risks.

- Medications and equipment.
- Electrical or physical hazards.
- Simulated and real patients.

Note: Adjust the pre-simulation briefing to match the demands of the simulation event, contexts or the changing of participant composition.

Adapted from Rudolph, J., Raemer, D. and Simon, R. (2014). Establishing a Safe Container for Learning in Simulation. Simulation in Healthcare: Journal of the Society for Simulation in Healthcare, 9(6), pp.339-349.

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Scenario

Type	Immersive in-situ scenario
Target audience	Obstetric medical staff and midwives
Overview	Birth suite woman post birth: Situation: IOL with prolonged 2nd stage of 2-hours. Progressed to a normal birth with a shoulder dystocia which was resolved with multiple steps. It is now 15 minutes since the birth and you are ready to manage the 3rd stage. Placenta and membranes are still in situ. Oxytocin has been given 5 minutes ago. Background: 35 year old G1P0. 40/40 gestation. GDM diet controlled BGLs normal. Had an epidural and oxytocin infusion for labour and birth. Hb 126 @ 36/40 O Pos GBS Negative All other serology NAD Allergies – Nil Nil medical history NOTE: Baby required resuscitation and is now stable- not the focus of scenario. Assessment: Mother appears hemodynamically stable PV loss current 200mls. Baby skin to skin with mother and stable. 3rd stage appears to be ready for delivery. Fundus firm at umbilicus, lengthening of the cord and PV loss. Recommendations: • Commence CCT • Following the delivery of the 3rd stage heavy PV loss leads to a PPH of a total of 2 litres.
Learning objectives	By the end of the scenario the learners should be able to: • Recognise and manage a post-partum haemorrhage. • Identify the need for and call for help early • Manage the PPH using the Queensland Clinical Guideline PPH • Recognise and respond to the clinical deteriorating patient
Duration	Pre-brief: 10 minutes

	Orientation: 5 minutes Simulation: 15 mins Debrief: 15 mins Total: 45 mins (allow further 15 minutes for set up)

Physical resources

Room set up	Standard birth suite set up
Simulator/s	Simulated patient or Manikin (including software)
Simulator/s setup	**If using a simulated patient:** • A hospital gown on, semi-recumbent in bed with a post birth abdomen – with baby skin to skin with umbilical cord out of vagina with approx. 200mls blood on bed. • Placenta attached to umbilical cord placed in a plastic bag with clots and blood in the bag. • Behind placenta a urine bag containing 2L of blood. **If using a manikin:** • A hospital gown on, semi-recumbent in bed post with a post birth abdomen – with baby skin to skin umbilical cord out of vagina with approx. 200mls blood on bed. • Placenta attached to umbilical cord placed in a plastic bag with clots and blood in the bag. • Behind placenta a urine bag containing 2L of blood.
Clinical equipment	• Standard birth suite room • Epidural attached to patient and pump • Oxytocin infusion/ mainline fluids
Access	1 x IVC setups with IV stickers attached
Other	PHR chart & relevant paperwork for emergency management

Human resources

Faculty	X 2 facilitators (Obstetric reg/ consultant and midwife with debriefing experience) to take roles of scenario commander (primary debriefer) and co-debriefer.

Simulation Coordinators	**If using a manikin** – Sim Co X 1 for set up and control manikin software during scenario.
Confederates	• **If using a simulated patient –** simulated patient x1. • Midwife as support person and confederate to push placenta out and release blood loss. • Facilitator to provide handover.
Other	Midwife x1 is present in the simulation room to receive the handover. The other midwives and doctors are outside the room, to be called in as needed.

Simulated patient script information

You are Pamela. you're having your first (1st) baby. You had an induction of labour over the past 24 hours, you have been contracting since last night and you are exhausted. You have been in birth suite for several hours, but the epidural had worked really well.

You are a little worried because the baby is not interested in breast feeding.

The baby is breathing normally.

You can feel your tummy tightening again, you just want it all over with!

Handover card

Handover from midwife caring for Maria to next shift.

I	Introduction	This is Pam, this is … <staff name>
S	Situation	Has just given birth 15 mins ago following an IOL, labour assisted with Synto. and epidural. Significant shoulder dystocia at delivery. 3rd stage placenta and membranes are still in situ oxytocin has been given 10 minutes ago.
B	Background	G2P0 induction of labour at 38+1 weeks. GDM on insulin BGL NAD. 2-hour second stage with a significant shoulder dystocia requiring multiple manoeuvres. Bloods NAD.
A	Assessment	Placenta & membranes are still in situ EBL 200mls.
R	Recommendation	Can you manage the 3rd stage while I write my notes? I think it's ready to be delivered there are signs of separation.

Additional information

Name	Pamela Little
Age	35 years old
Sex	Female
Weight	86 kg

Allergies	Nil known
Medications	Nil
Medical/Surgical	Nil
History	Nil
Social History/Employment	Admin officer QLD Health
Partner's name	Brad

Pregnancy history	G1P0
Blood Group	O Pos antibodies Neg
Hb	126 – 36 weeks
Serology	Neg
Rubella	Immune
GBS	Unknown
	GDM in this pregnancy

State 1: Initial assessment				
Vital signs		**Script**	**Details**	**Expected actions**
RR	16	As per handover card.	Primary assessment. Provide handover. Confederate: will do anything they ask but do not initiate any actions unless the group struggles.	☐ Establishes rapport with woman ☐ Listens/asks for history ☐ Perform maternal assessment i.e. obs. ☐ Check fundus ☐ Check – 3rd stage ☐ Check bladder empty ☐ Assess baby ☐ Asks Pam how she is feeling ☐ Check for signs of placental separation
SPO2	100%			
BP	125/70			
HR	80			
Temp	36.9°C			
Consciousness Sedation score	Alert but sleepy			
FH	N/A			
PV loss	200mls			
BGL	N/A			
Fundus	Firm			

State 2: On going management				
Vital signs		**Script**	**Details**	**Expected actions**
RR	22	Fundus firm and central with signs of separation – placenta delivers by CCT. Fundus is soft and boggy but firmer now I am rubbing it. Complaining of pain with person rubbing her fundus. A bit dizzy asking for water.	Allow placenta to deliver with CCT. Following delivery of placenta follow with large clots of blood and continuous trickle. Some blood loss as you start rubbing and then allow a large amount of loss 700ml- 1000mls. Slow down bleeding if clinical scenario is managed well, keep bleeding if slow or inadequate management. Keep bleeding until IDC inserted and urine has drained out.	☐ Rubbing fundus ☐ Call for help ☐ Maternal obs – 5 minutely there after ☐ Handover to attendees ☐ 4 'Ts' ☐ IDC ☐ IV access x2 ☐ IV fluids with pressure bag ☐ Drugs ☐ Syntocinon ☐ Syntometrine ☐ Ergometrine ☐ Misoprostil ☐ Carboprost ☐ Elevate legs ↓ B/P ☐ Bi manual compression
SPO2	97%			
BP	100/45			
HR	98			
Temp	36.3°C			
Consciousness Sedation score	Sleepy			
FH	N/A			
PV loss	+100mls			
BSL	N/A			
Fundus	Boggy & non central			

State 2: On going management						
5-min OBS.						
Vital signs						
Time	PPH	5 mins	10 mins	15 mins	20 mins	
RR		22	24	20		
SPO²		98%	96%	98%		
O_2 Flow		R/A	10L	R/A		
BP/ART		100/60	80/40	100/60		
HR		110	122	110		
TEMP		37°C	37.4°C	37.6°C		
GCS Consciousness		Tired but alert	Light heading sleeping wakes to voice	Tired but conscious		
PV Loss		400mls	1500mls	2000mls		
Uterus		Boggy non central	Central firm when rubbed	Bi manual		
Q-MEWT		3	9 MERT call	3		

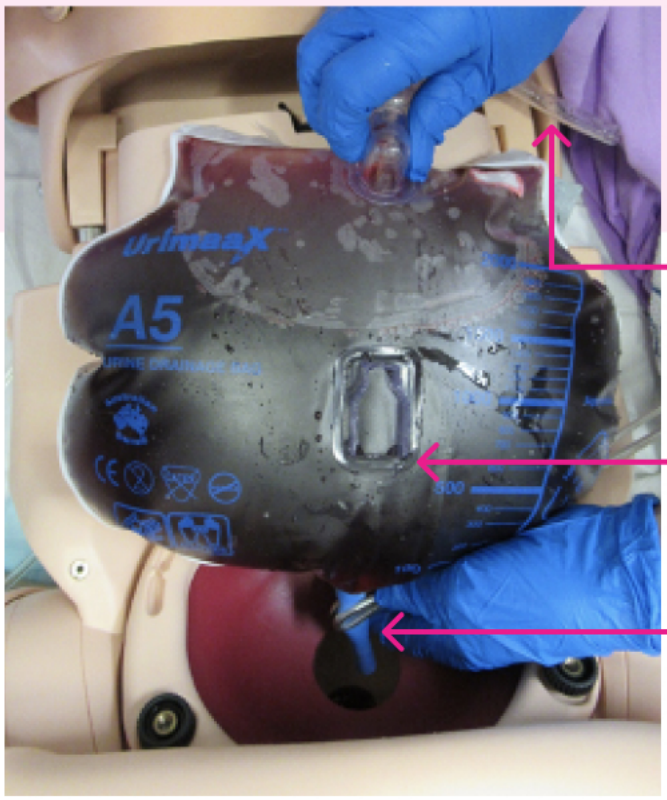
State 3: Resolution				
Vital signs		**Script**	**Details**	**Expected actions**
RR	16	Still a bit lightheaded would like something to eat and drink.	Once IDC inserted and bladder is empty blood loss can slow and fundus remains firm without rubbing.	☐ Look for teamwork and summarising of actions taken ☐ Explanation to Pam of what happened and why ☐ Debrief to family ☐ Documentation of events ☐ Plan of care now recovered
SPO2	97%			
BP	110/55			
HR	105			
Temp	37.1°C			
Consciousness Sedation score	Alert			
FH	N/A			
PV loss	2000mls			
Fundus	Firm			
RR	16			

Supporting Resources

This section contains the following supporting documents that will be essential to the successful delivery of this learning package:

1. Manikin set-up guide
2. Laboratory reports
3. CTG on admission
4. Current CTG. 2nd stage pushing
5. Simulation debriefing poster
6. Debriefing guide

More resources can be downloaded from our website csds.qld.edu.au/mep.

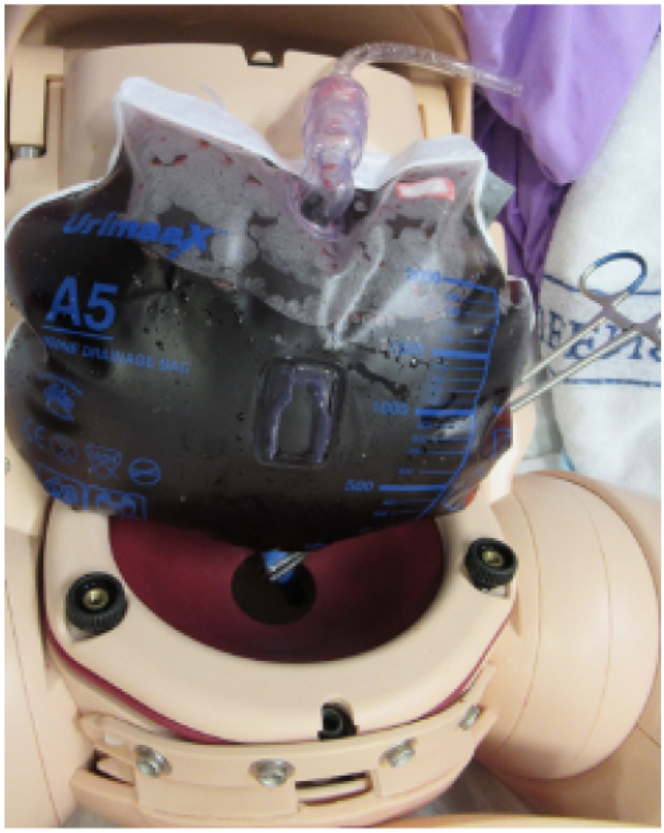


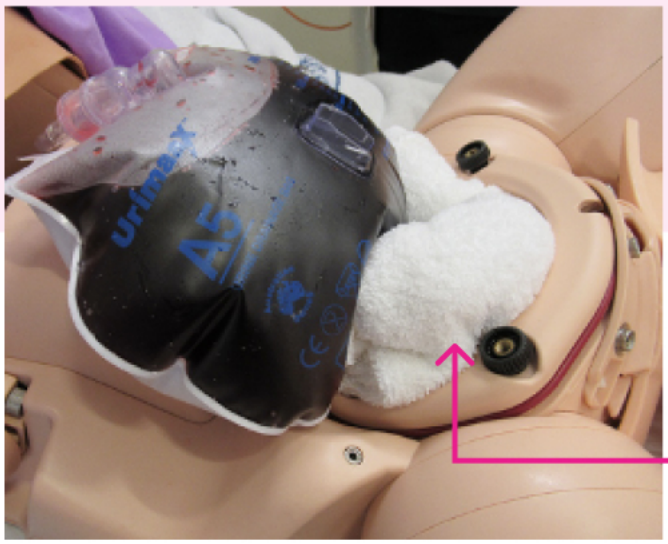
1. Blood bag

Excess tubing cut off approx. 10cm from non-return value

2L urine bag with 2L of blood mix

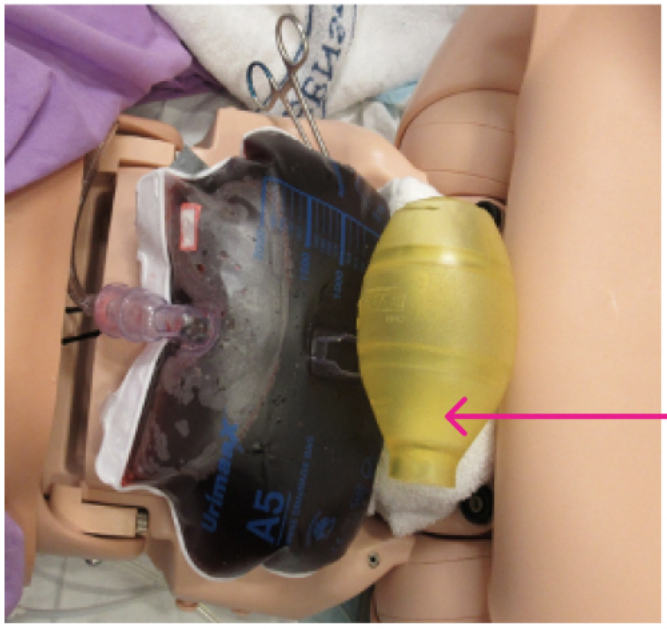
Supplied clamp removed from blue tubing replaced with sponger holders





2. Blood bag support

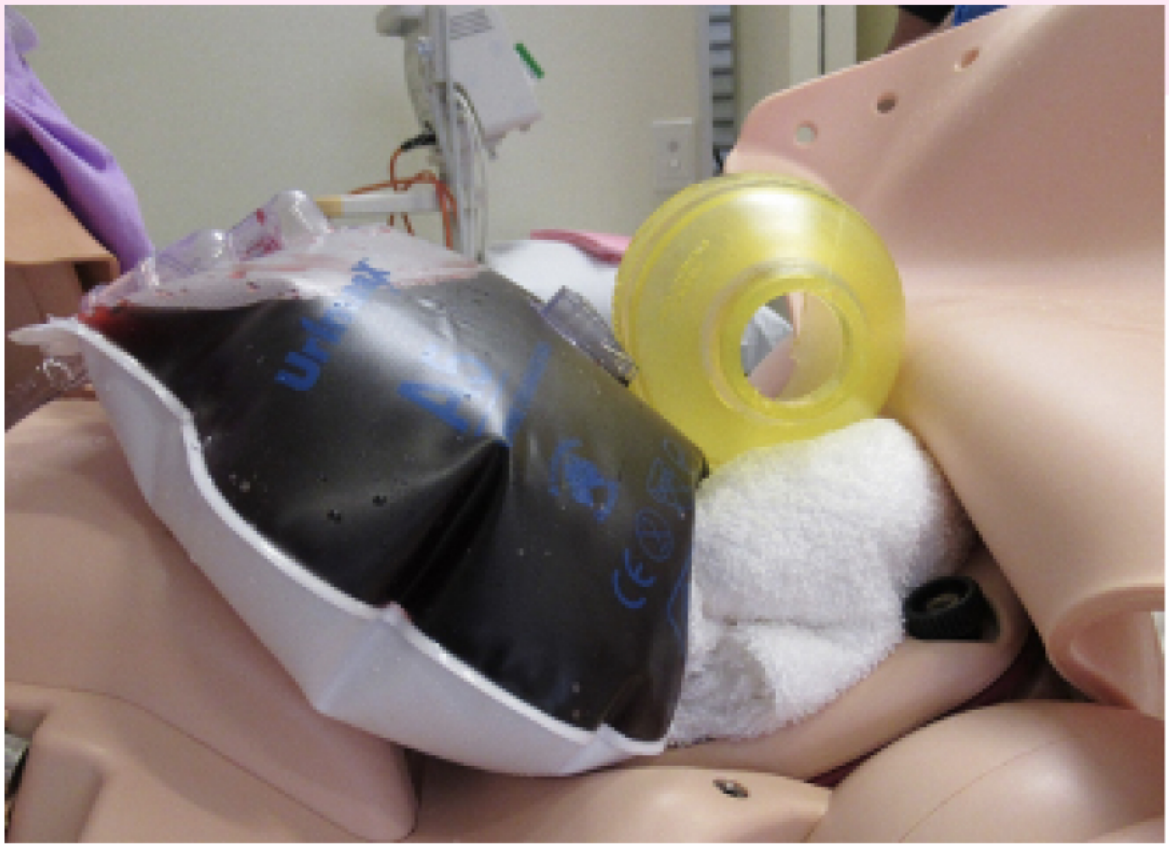
Support 2L bag with a towel

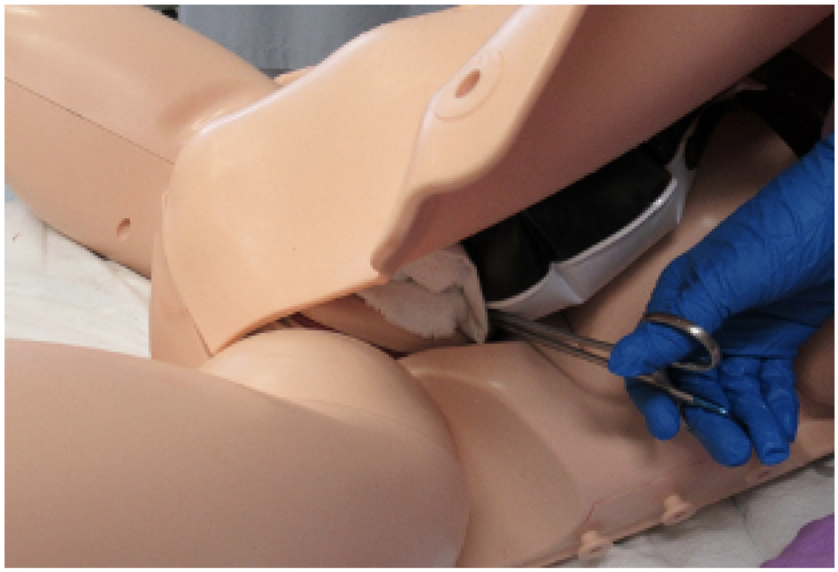


3. Simulated post delivered uterus

Neonatal BVM used as a palpable uterus or anything else available

4. Side view





Sponge holder accessible for support person to release to allow blood flow

36 week Routine
DATE:
PATIENT:
DOB:

LABORATORY REPORT
PAGE: 1
REF:

Test	Result	Reference	Comment
Haemoglobin	126 g/dL	13.7-17.7g/dL	
WCC	11.0 L	3.9-10.6 x 109/L	
Platelets	186 L	150-440 x 109/L	
Haematocrit	0.35	0.39 – 0.52	
RCC	3.85 L	4.50 – 6.0x10^{12}/L	
MCV	90 fL	80 – 100 fL	
Neutrophils	(83%) 9.15	2.0 – 8.0x10^{9}/L	
Lymphocytes	(10%) 1.15	1.0 – 4.0x10^{9}/L	
Monocytes	(6%) 0.65	0.1 – 1.0x10^{9}/L	
Eosinophils	(0%) 0.01	<0.60x10^{9}/L	
Basophils	(0%) 0.03	<0.20x10^{9}/L	

36 week Routine
DATE:
PATIENT:
DOB:

LABORATORY REPORT
PAGE: 2
REF:

Test	Result	Comment
Group and Antibody Screen		
Group	O Rh (D) Positive	
Antibody	Negative	
		Nil
Expires in 7 days		

15 minutes (urgent) post-birth
DATE:
PATIENT:
DOB:

LABORATORY REPORT
PAGE: 1
REF:

Test	Result	Reference	Comment
Haemoglobin	100 g/dL	13.7-17.7g/dL	
WCC	23.5H	3.9-10.6 x 109/L	
Platelets	170 L	150-440 x 109/L	
Haematocrit	0.35	0.39 – 0.52	
RCC	3.75 L	4.50 – 6.0x10^{12}/L	
MCV	88 fL	80 – 100 fL	
Neutrophils	20.33	2.0 – 8.0x10^{9}/L	
Lymphocytes	1.66	1.0 – 4.0x10^{9}/L	
Monocytes	1.43	0.1 – 1.0x10^{9}/L	
Eosinophils	0.00	<0.60x10^{9}/L	
Basophils	0.02	<0.20x10^{9}/L	

4 hour post-birth
DATE:
PATIENT:
DOB:

LABORATORY REPORT
PAGE: 1
REF:

Test	Result	Reference	Comment
Haemoglobin	85g/dL	13.7-17.7g/dL	
WCC	29.2 H	3.9-10.6 x 109/L	
Platelets	166 L	150-440 x 109/L	
Haematocrit	0.25	0.39 – 0.52	
RCC	2.58 L	4.50 – $6.0x10^{12}$/L	
MCV	95 fL	80 – 100 fL	
Neutrophils	27.24	2.0 – $8.0x10^{9}$/L	
Lymphocytes	1.23	1.0 – $4.0x10^{9}$/L	
Monocytes	0.67	0.1 – $1.0x10^{9}$/L	
Eosinophils	0.00	<$0.60x10^{9}$/L	
Basophils	0.03	<$0.20x10^{9}$/L	

Simulation Debriefing

Establishing a safe container for learning in simulation.

1 Reaction phase - "vent"

- How was that?
- How are you feeling?
- Any other initial reactions?
- Learners may reveal key areas that are important to them.

2 Description phase

- Medical summary of the case.
- Can be shorten if it appears there is shared understanding of the case.

3 Analysis phase

Select which strategy is suited.

- Learner Self-Assessment - learner generates objectives

  What went well/what would you change?
  What well/did not go well and why?

- Focused Facilitation - analyse performance related to objective

4 Summary phase

- Discuss take-home learning points
- Learner guided approach or
- Facilitator guided approach

Adapted from Eppich, W. and Cheng, A., 2015. Promoting Excellence and Reflective Learning in Simulation (PEARLS). Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare, 10(2), pp.106-115.

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Debriefing guide

Scenario objectives	Participants are required to: ☐ Recognise and manage a post-partum haemorrhage. ☐ Identify the need for and call for help early. ☐ Manage the PPH using the Queensland Clinical Guideline PPH. ☐ Recognise and respond to the clinical deteriorating patient.
Vent phase	Example questions: • Initial thoughts of how the simulation went? • Acknowledge emotions (note body language and tone of participants).
What happened (phases)?	Example questions: • Tell us about your patient and what were your initial priorities? • What led to your decision to escalate management? • What clinical signs and symptoms led you to become concerned?
What was done well and why?	Example questions: • What could have been better at each phase?
Relevance to experience	Example questions: • How would you transfer knowledge from today into your workplace?
What has been learned?	Example questions: • What actions will you take to enhance your skills and knowledge post simulation?
Transfer to clinical settings	Example questions: • What will you take away from this session? • Can you give an example of how you could apply new skills or knowledge gained during this session in your clinical setting?
Key moments	• Recognition of PPH (potential / actual). • Performing fundal rub / bimanual compression. • Having key team members present. • Preparing and plan for ongoing management – Massive Transfusion Protocol.

Acronyms and Abbreviations

Term	Definition
CCT	Controlled cord traction
CSDS	Clinical Skills Development Service
GBS	Group B streptococcus
Hb	Haemoglobin
IOL	Induction of labour
IVC	Intravenous cannula
MHP	Massive haemorrhage protocol
MTP	Massive transfusion protocol
NAD	Nothing abnormal detected
Obs.	Observations
OT	Operating theatre
PHR	Pregnancy Health Record
PPH	Postpartum haemorrhage
PV	Per vagina
QCG	Queensland Clinical Guideline
RCOG	Royal College of Obstetricians & Gynaecologists

Appendix

This section contains the following supporting documents that will be essential in the delivery of this learning package:

A. Pre-simulation briefing blank template
B. Simulation debrief blank template

Pre-simulation Briefing Notes

Establishing a safe container for learning in simulation.

1 Clarify objectives, roles and expectations

- Introductions.
- Learning objectives.
- Assessment (formative vs summative).
- Facilitators and learners' roles.
- Active participants vs observers.

2 Maintain confidentiality and respect

- Transparency on who will observe.
- Individual performances.
- Maintain curiosity.

3 Establish a fiction contract

Seek a voluntary commitment between the learner and facilitator.

- Ask for buy-in.
- Acknowledge limitations.

4 Conduct a familiarisation

- Manikin/simulated patient.
- Simulated environment.
- Calling for help.

5 Address simulation safety

Identify risks.

- Medications and equipment.
- Electrical or physical hazards.
- Simulated and real patients.

Simulation Debriefing Notes

Establishing a safe container for learning in simulation.

Crisis Resource Management Principles

1. Know your environment
2. Anticipate and plan
3. Call for help early
4. Take a leadership role
5. Communicate effectively
6. Allocate attention wisely & use all available information.
7. Distribute the workload & use all available resources.

1

Reaction phase - “vent”

- How was that?
- How are you feeling?
- Any other initial reactions?
- Learners may reveal key areas that are important to them.

2

Description phase

- Clinical summary of the case.
- Can be shortened if it appears there is shared understanding of the case.

3

Analysis phase

Select which strategy is suited.

- Learner Self-Assessment - learner generates objectives

  What went well/what would you change? What well/did not go well and why?

- Focused Facilitation - analyse performance related to objective

4

Summary phase

- Discuss take-home learning points
- Learner guided approach or
- Facilitator guided approach

References

This resource kit has been inspired by the Optimus BONUS project of the Children's Health Queensland's "Simulation Training Optimising Resuscitation for Kids" (STORK) service. To find out more about STORK and their Optimus project, visit their website.

1. Children's Health Queensland. 2020. Queensland Paediatric Emergency Care Education | CHQ. [online] Available at: ‹https://www.childrens.health.qld.gov.au/research/education/queensland-paediatric-emergency-care-education/› [Accessed 24 July 2020].

2. Queensland Clinical Guidelines Maternity and Neonatal Clinic al Guidelines Postpartum Haemorrhage, April 2019, P 8.

3. The Royal Australian and New Zealand College of Obstetrics and Gynaecologists Management of Postpartum Haemorrhage (PPH), 2017, P 3.

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Postpartum Haemorrhage – Facilitator Resource Kit

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