

Obstetric Hemorrhage Checklist: A Stage-based Approach for Response and Treatment

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DISTRICT II

SMI Safe
Motherhood
Initiative

Before We Get Started



This webinar will be recorded



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Submit your questions throughout this session using the Q&A box



Any questions following this webinar can be sent to obgynsafety@acog.org

Welcome

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Today's Speakers



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Obstetric Hemorrhage Checklist & Quick Reference Guide

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Disclosures

- Nothing to disclose.

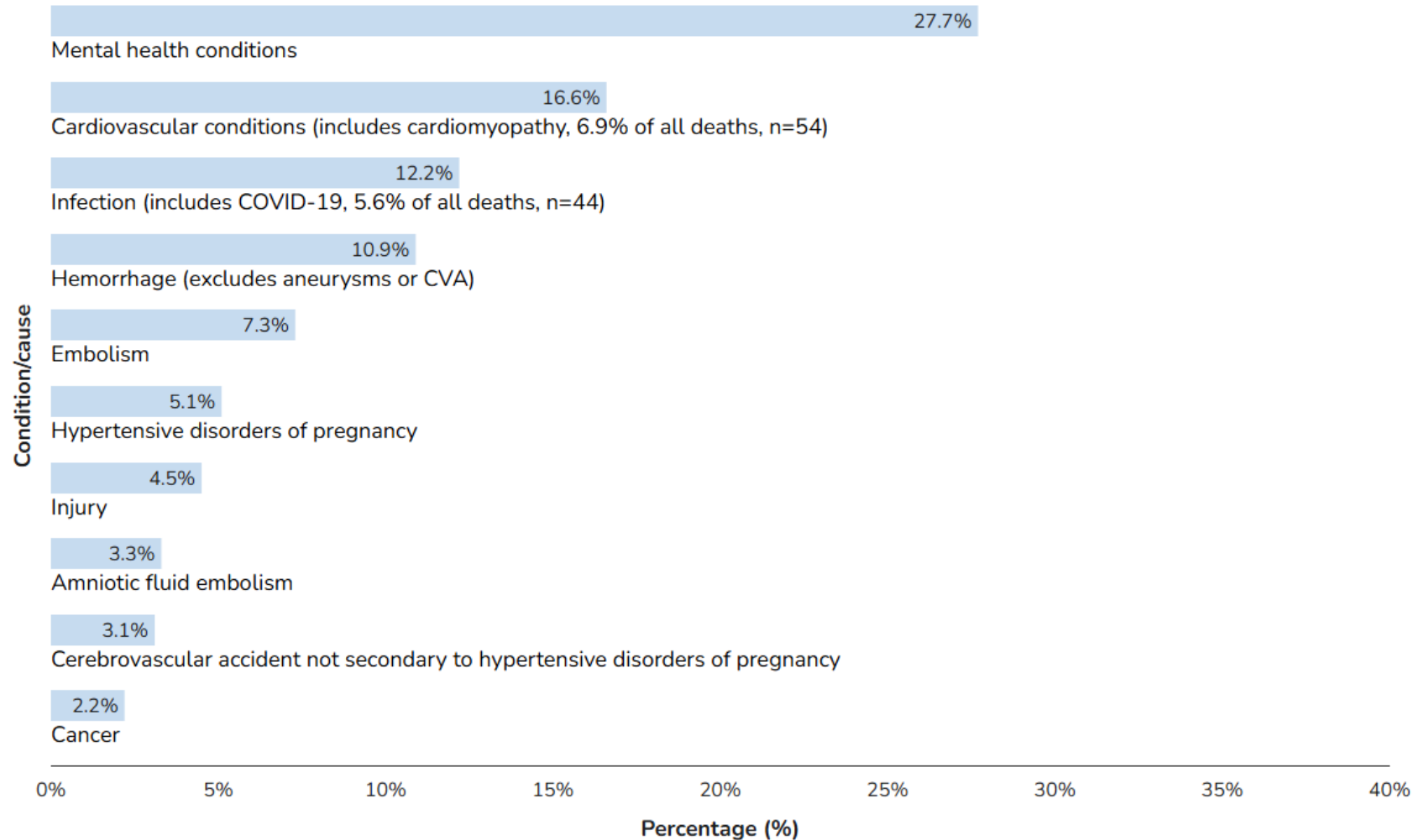
Learning Objectives

By the end of this session attendees will be able to:

- Understand key definitions and components of the Obstetric Hemorrhage Checklist
- Navigate and apply the checklist during each stage of postpartum hemorrhage response
- Utilize the checklist to improve clinical decision-making and team communications

Why Obstetric Hemorrhage Matters

Underlying cause of pregnancy-related deaths, overall, 2022



We are Striving to Become High Reliability Organizations

- Currently, we do **MOST** of the right things, for **MOST** patients, **MOST** of the time.
- We want to do **ALL** the right things, for **ALL** patients, **ALL** the time

The B-17 Bomber: A Flying Fortress

The First Checklist in Aviation

Oct. 1935: Crashed on one of its initial test flights while being flown by one of the most experience test pilots

“Too much airplane for one man to fly.”



Saved by the Checklist

- 12,726 airplanes built
- Flew 1.8 million miles without an accident



Checklist

- A cognitive aid used to reduce failure by compensating for potential limits of human memory and attention.
 - Allows complex tasks to be broken down into simpler components
 - Essential steps can be listed
 - Tasks can be delegated
 - Consistency can be achieved

Key Characteristics of Effective Checklists

- Brief
- Multidisciplinary development
- Evidence based
- Requires knowledge of task (not an educational tool)
 - Make implicit steps explicit
- Understand the knowledge of users may be heterogeneous

Types of Checklists



Task list or Pre-Flight Checklist (e.g. Safe Surgery Checklist)



Troubleshooting list (for complex situations to determine the etiology of a problem)



Coordination list (for complex activities to allow for coordination of individuals or teams)



Discipline list or Emergency Checklist (to assist individuals to perform optimally in stressful situations when they may be in danger of forgetting steps or making bad decisions)



To Do List (the grocery store list)

Things to Highlight

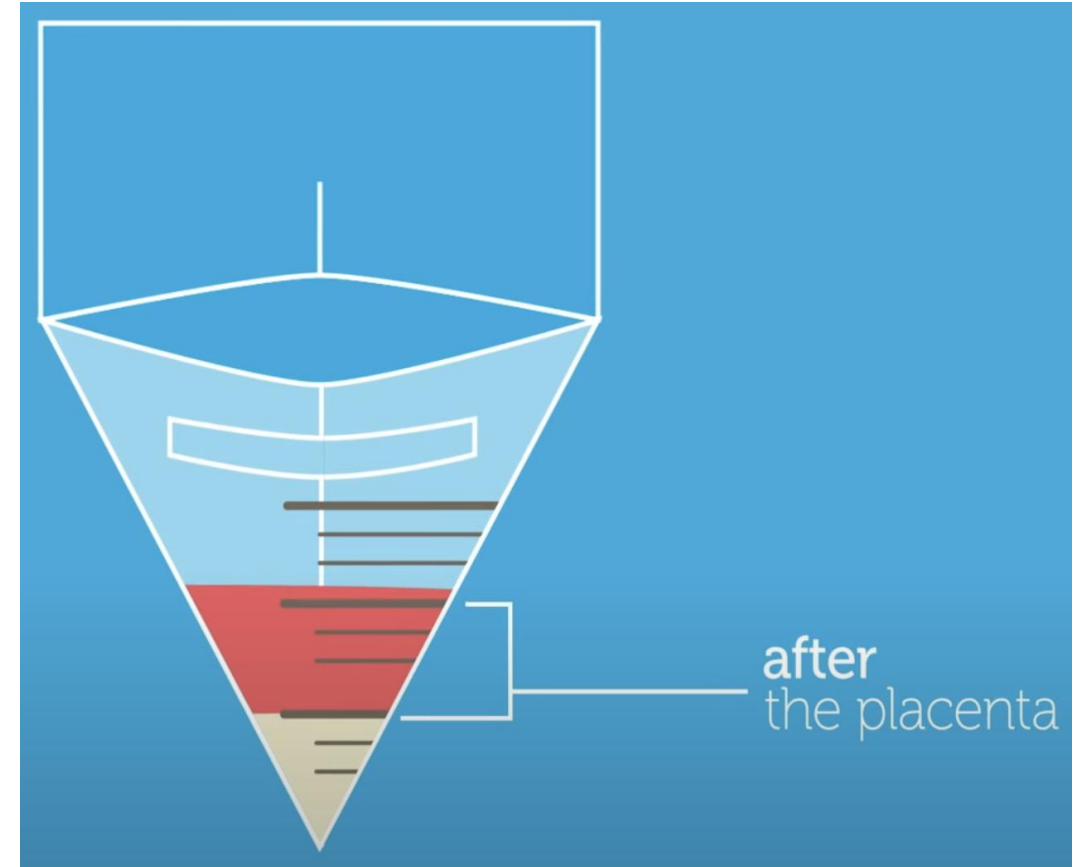
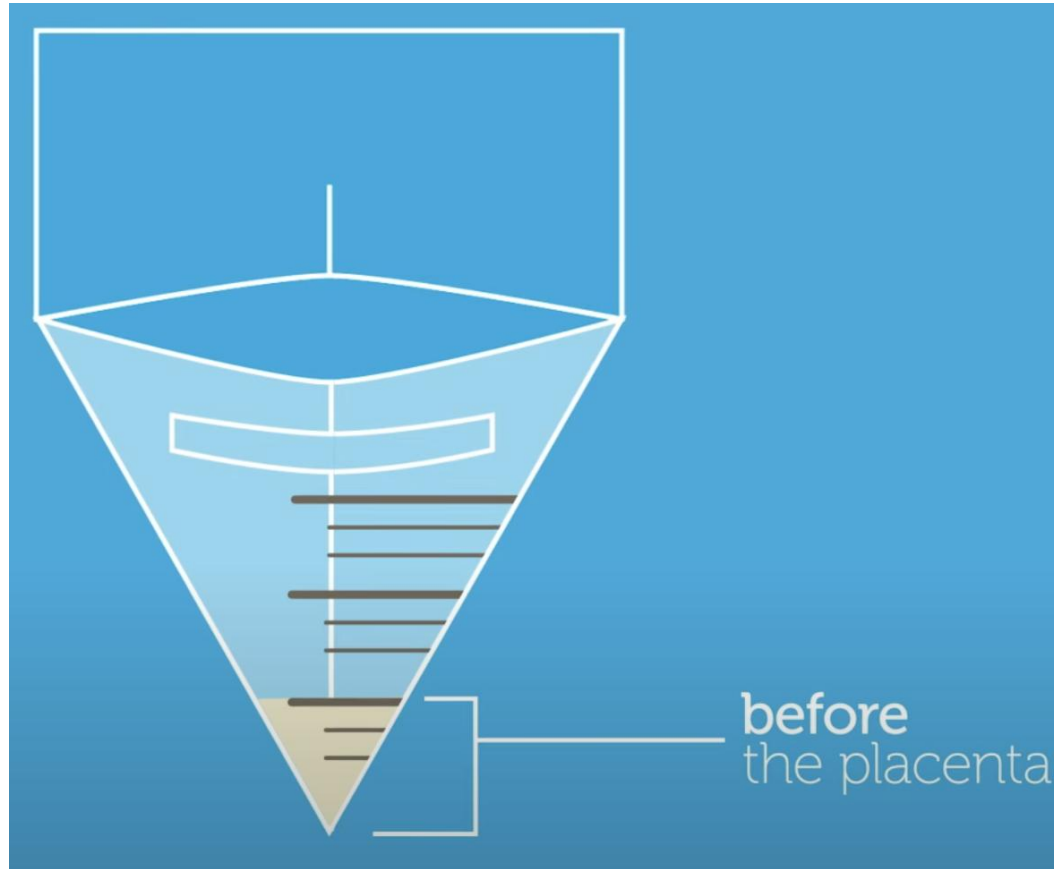
- The team used closed loop communication
- Staff were thinking out loud and making suggestions
- The nurse made the Code PPH call without waiting to be asked
- Arriving team was given an SBAR
- Ongoing monitoring of the estimated blood loss

Checklist could have been used better to determine stage of hemorrhage.

Other Items to Remember

- Hemorrhage risk assessment
 - On admission
 - Prior to delivery (especially prior to unscheduled cesarean delivery)
 - Postpartum
- Utilizing the graduated under-buttock drape to quantify blood loss
- Debriefing with the team
- Debriefing with the patient

Calculating Quantitative Blood Loss Using the Under-Buttock Drape



Don't forget to record the fluid (which is mostly not blood) in the pocket before the delivery of the placenta!

Quantitative Blood Loss



Quantification of Blood Loss: AWHONN Practice Brief Number 13
Association of Women’s Health, Obstetric and Neonatal Nurses
Journal of Obstetric, Gynecologic & Neonatal Nursing, Volume 50, Issue
4, 503 - 505

OB HEMORRHAGE REPORT Measuring Blood Loss

Patient Addressograph

Item (Hospital Specific)	Approx Dry Weight (grams)	“Wet” weight (grams)	Wet weight minus Dry weight = Milliliters (ml) of fluid/blood (may have multiple items)	Total per category
Blue Chux	35			
Kendall Curity Maternity Pads®	14			
Maxithins®	11			
Cloth soaker pad	465			
Dry lap sponge (large)	22	“Soaked” lap = 80 gms → “Partially wet” lap = 50gms →	Approx. 60ml blood Approx. 30ml blood	
Dry lap sponge (small)	14			
Graduated container volume	Estimated amniotic fluid volume _____ Irrigation fluid volume _____ Non Blood SubTotal _____		Container #1 _____ Container #2 + _____ Less non-Blood- _____	
TOTAL ESTIMATED BLOOD LOSS (ml)				

EXAMPLE

Item	Approx Dry Weight (gms)	“Wet” weight (grams)	Wet weight minus Dry weight = Milliliters of fluid/blood	Total per category
Blue Chux	35	135 (- 35 =)	100 ml	100 ml
Kendall Curity Maternity Pads®	14			
Maxithins®	11	26 + 31 = 57 (- 22 =)	35 ml	35 ml
Cloth soaker pad	465			
Dry lap sponge (large)	22	“Soaked” lap = 80 gms → “Partially wet” lap = 50gms →	Approx. 60ml blood x 15 = 900ml Approx. 30ml blood x 20 = 600ml	1500 ml
Dry lap sponge (small)	SAMPLE			
Graduated container volume	Container volume minus estimated amniotic fluid volume		Container #1 _____ Container #2 _____ Container #3 _____	
TOTAL ESTIMATED BLOOD LOSS (ml)				1635 ml

Background and Purpose



Developed by the Safe Motherhood Initiative (SMI) and updated by District II in collaboration with Quality in Action, the ACOG Foundation's patient safety organization, and ACOG subject matter experts.



First ACOG stage-based hemorrhage management protocol developed for national implementation.



Practical bedside resource that supports the rapid recognition and management of postpartum hemorrhage.



Provide clinicians with a standardized framework for hemorrhage recognition, escalation of care, team communication, and recovery.



Key Features include stage-based management guidance, team roles and communication prompts, and post-event debriefing considerations.

Obstetric Hemorrhage Checklist



Obstetric Hemorrhage Checklist

Pit + 2 TRIGGER:

Use this checklist if starting a second non-prophylactic hemorrhage treatment or a second additional dose of medication

RECOGNITION

☐ Call for assistance (eg, obstetric hemorrhage team, including anesthesiology)

Designate: ☐ Team leader ☐ Recorder ☐ Primary RN
☐ Runner ☐ Second RN ☐ Infant care provider

ANNOUNCE & REVIEW

- ☐ SBAR (prior events)
- ☐ Vital signs (VS)*
- ☐ Cumulative blood loss*
- ☐ Potential etiologies
- ☐ Stage
- ☐ Previous interventions
- ☐ Contraindications to uterotonics
- ☐ Interventions already undertaken

*Repeat at every stage

HEMORRHAGE ETIOLOGIES

- Tone (ie, atony)
- Trauma (ie, laceration)
- Tissue (ie, retained products)
- Thrombin (ie, coagulation dysfunction)

STAGE 1 INTERVENTIONS

Implement Stage 1 for any of the following

- Blood loss >1,000 mL delivery with normal VS and lab values – or –
- If using a second non-prophylactic treatment for hemorrhage, eg, misoprostol, tranexamic acid (TXA), hemorrhage control devices

- ☐ 16G or 18G IV access
- ☐ Increase IV fluid (crystalloid without oxytocin)
- ☐ Urinary catheter
- ☐ Fundal massage
- ☐ Confirm active type and screen
- ☐ Consider cross-match of 2 units of RBCs
- ☐ Prepare OR if indicated (optimize visualization, examination)

Medications

- ☐ Increase oxytocin
- ☐ Methylergonovine
- ☐ Carboprost tromethamine
- ☐ Misoprostol
- ☐ TXA

Mechanical Interventions

- ☐ Vacuum-induced hemorrhage device
- ☐ Balloon tamponade
- ☐ Packing

ACHIEVE HEMOSTASIS OR ESCALATE TO NEXT STAGE

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STAGE 2 INTERVENTIONS

ANNOUNCE & REVIEW

☐ Vital signs ☐ Cumulative blood loss

Escalate to Stage 2 for any of the following

- Blood loss >1,000 mL but <1,500 mL
- Using >2 uterotonic medications -and- normal VS (no vasopressor support) and labs

If abnormal labs, VS, or >1,500-mL blood loss, immediately complete Stage 2 and Stage 3

- ☐ Mobilize additional help, (eg, OB RRT)
- ☐ Move hemorrhage cart near patient
- ☐ Place second IV (16G–18G)
- ☐ Stage 1 mechanical interventions
- ☐ Repeat or additional medications
- ☐ Focused ultrasound for OB hemorrhage
- ☐ Prepare to move to OR
- ☐ Draw STAT labs (CBC, coags, fibrinogen)
- ☐ Consider ROTEM or TEG if available
- ☐ Obtain and transfuse 2 units of RBCs
- ☐ Consider FFP (ie, thaw 2 units of FFP) or fibrinogen substitute

Consider Surgical Interventions

- ☐ Compression/B-Lynch suture in setting of cesarean delivery (only if manual compression effective)
- ☐ Uterine artery ligation or embolization
- ☐ Consider D&C, hysterectomy

ACHIEVE HEMOSTASIS OR ESCALATE TO NEXT STAGE



STAGE 3 INTERVENTIONS

ANNOUNCE & REVIEW

☐ Vital signs ☐ Cumulative blood loss

Escalate to Stage 3 for any of the following

- Bleeding (EBL/QBL) >1,500 mL
- Bleeding and 2 units of RBCs given
- At risk for occult bleeding/coagulopathy
- Abnormal VS, labs, oliguria

- ☐ Move to OR
- ☐ Call specialty teams, eg, surgical backup team, or consider patient transfer
- ☐ Initiate MTP – if clinical coagulopathy, add cryoprecipitate, consult for additional agents
- ☐ Repeat labs for coags, fibrinogen, ABG
- ☐ Repeat or additional medications
- ☐ Stage 1 mechanical interventions
- ☐ Calcium replacement

Consider Surgical Interventions

- ☐ Aortic compression
- ☐ Packing
- ☐ Stage 2 surgical interventions

ACHIEVE HEMOSTASIS OR ESCALATE TO NEXT STAGE



STAGE 4 INTERVENTIONS

ANNOUNCE & REVIEW

☐ Vital signs ☐ Cumulative blood loss

Escalate to Stage 4 with cardiovascular collapse – massive hemorrhage, profound hypovolemic shock, or amniotic fluid embolism

- ☐ Call add'l resources, eg, ECMO team
- ☐ ACLS algorithm
- ☐ Immediate surgical intervention – hysterectomy
- ☐ Simultaneous aggressive massive transfusion

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Obstetric Hemorrhage Quick Reference Guide

Obstetric Hemorrhage Checklist

Quick Reference Guide

KEY CHECKLIST SUCCESS POINTS

- Use this checklist if starting a second non-prophylactic treatment for hemorrhage.
- Teams should practice using the checklist during obstetric hemorrhage simulations and adapt it to their setting. A maternal early warning system (MEWS) may also help identify hemorrhage.
- This checklist has been created for vaginal births. It may be helpful to adapt the checklist for cesarean deliveries.

HEMORRHAGE DEFINITION AND PROTOCOL USE

- **Third-Stage Labor Management/Stage 0:** Consider second hemorrhage prophylaxis agent for medium- or high-risk hemorrhage patients.
- **Blood loss >500 mL in a vaginal delivery is abnormal** and should be investigated and managed as outlined in Stage 1.
- **OB Hemorrhage** = cumulative blood loss $\geq 1,000$ mL or ANY blood loss and signs or symptoms of hypovolemia within 24 hours.
- **Complete all steps in prior stages plus the current stage, regardless of the stage in which the patient presents.**

RECOGNITION

- Calling for assistance (eg, obstetric hemorrhage team)
- Designating appropriate roles and responsibilities
 - ☐ Checklist reader
 - ☐ Team leader
 - ☐ Primary nurse
- Contraindications to any of the medications used
- Announcing and reviewing repeatedly throughout the event
 - ☐ SBAR to inform arriving staff
 - ☐ Post-event debrief



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- ☐ Vital signs (VS)
- ☐ Interventions already performed
- ☐ Cumulative blood loss

- Partner, communicate, and huddle with obstetrician-gynecologists, midwives, pediatricians/neonatology, and the patient and patient's support person(s)

POST-HEMORRHAGE MANAGEMENT

Actions and Interventions

Day of Event

- Determine the disposition of the patient
 - Detailed sign-out/huddle with teams
 - Discuss care needs, lactation, anticoagulation, etc.
- Debrief
 - Debrief with the whole obstetric care team
 - Debrief with patient and family; consider post-delivery support and counseling separate from inpatient debriefing and counseling
- Document

Next Day

- Debrief again with family
- Debrief with patient (unlikely to remember first day)
- Consider post-delivery support and counseling needs separate from inpatient debriefing and counseling for family
- Consider counseling for colleagues



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STAGE-BASED STAT LABS

- | STAGE | STAT LABS |
|---------|--|
| STAGE 1 | • Confirm blood type and screen |
| STAGE 2 | • CBC including platelets
• CMP
• Coag panel including fibrinogen
• ABG |
| STAGE 3 | • Repeat Stage 2 labs |



CONCEALED HEMORRHAGE

- Signs and symptoms
 - Abnormal or changes in vital signs
 - No evidence of vaginal bleeding
- Focused ultrasound for OB hemorrhage
 - Consider ED collaboration for focused hemorrhage ultrasound training, eg, "FAST scan"



BLOOD PRODUCT RATIOS

- For MTPs, a fixed initial transfusion ratio of 1:1:1 should be used, designed to mimic replacement of whole blood. Reaffirmed 2024.



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MEDICATION DOSING

- **Oxytocin:** 10–40 units per 500–1,000 mL solution
- **Methylergonovine:** 0.2 mg IM (may be repeated but no earlier than 2 hours from last dose)
- **Carboprost tromethamine:** 250 micrograms IM (may repeat q15 min, maximum eight doses)
- **Misoprostol:**
 - 800–1,000 micrograms PR -or-
 - 600 micrograms PO -or-
 - 800 micrograms SL/buccal (one-time dose)
- **Tranexamic Acid (TXA):** 1 g over 10 minutes (add 1-g vial to 100 mL NS and give over 10 minutes; may repeat once after 30 minutes)

Obstetric Hemorrhage Protocol

Stage 1

Implement Stage 1 for any of the following

- Blood loss >1,000 mL after vaginal delivery with normal vital signs (VS) and lab values – or –
- If using a second non-prophylactic treatment for hemorrhage, eg, misoprostol, TXA, hemorrhage control devices

Follow Checklist Items

Achieve Hemostasis or Escalate to Next Stage

Stage 2

Escalate to Stage 2 for any of the following

- Blood loss >1,000 mL but <1,500 mL
 - Using >2 uterotonic medications –and– normal VS (no vasopressor support) and lab values
- If abnormal labs, VS, or >1,500-mL blood loss, immediately complete Stage 2 and Stage 3**

Follow Checklist Items

Achieve Hemostasis or Escalate to Next Stage

Stage 3

Escalate to Stage 3 for any of the following:

- Continued bleeding (EBL/QBL) >1,500 mL
- Continued bleeding and 2 units of RBCs given
- At risk for occult bleeding/coagulopathy
- Any patient with abnormal VS, labs, oliguria

Follow Checklist Items

Achieve Hemostasis or Escalate to Next Stage

Stage 4

Escalate to Stage 4 with cardiovascular collapse: Massive hemorrhage, profound hypovolemic shock, or amniotic fluid embolism

Achieve Hemostasis



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Trigger to Initiate

- Trigger to initiate to ensure the checklist gets used- at the right time, every time.
 - Early recognition and rapid response
 - Reduces delay in critical interventions
 - Improves team coordination
 - Standardizes escalation of care



Obstetric Hemorrhage Checklist

Pit + 2 TRIGGER:

Use this checklist if starting a second non-prophylactic hemorrhage treatment or a second additional dose of medication

RECOGNITION

☐ Call for assistance (eg, obstetric hemorrhage team, including anesthesiology)

Designate:

☐ Team leader

☐ Recorder

☐ Primary RN

☐ Runner

☐ Second RN

☐ Infant care provider

ANNOUNCE & REVIEW

☐ SBAR (prior events)

☐ Stage

☐ Vital signs (VS)*

☐ Previous interventions

☐ Cumulative blood loss*

☐ Contraindications to uterotonics

☐ Potential etiologies

☐ Interventions already undertaken

HEMORRHAGE ETIOLOGIES

- **Tone** (ie, atony)
- **Trauma** (ie, laceration)
- **Tissue** (ie, retained products)
- **Thrombin** (ie, coagulation dysfunction)

**Repeat at every stage*

Stage 1

- Key updates:
 - All medication dosing moved to QRG
 - Mechanical interventions moved to Stage 1
 - 4 Ts moved to QRG
 - Each stage has an escalation trigger to move to the next stage



STAGE 1 INTERVENTIONS

Implement Stage 1 for any of the following

- Blood loss >1,000 mL delivery with normal VS and lab values – **or** –
- If using a second non-prophylactic treatment for hemorrhage, eg, misoprostol, tranexamic acid (TXA), hemorrhage control devices

☐ 16G or 18G IV access	☐ Confirm active type and screen
☐ Increase IV fluid (crystalloid without oxytocin)	☐ Consider cross-match of 2 units of RBCs
☐ Urinary catheter	☐ Prepare OR if indicated (optimize visualization, examination)
☐ Fundal massage	

Medications

☐ Increase oxytocin	☐ Carboprost tromethamine
☐ Methylergonovine	☐ Misoprostol
	☐ TXA

Mechanical Interventions

☐ Vacuum-induced hemorrhage device	☐ Balloon tamponade
	☐ Packing

ACHIEVE HEMOSTASIS OR ESCALATE TO NEXT STAGE

Stage 2

- Key updates:
 - Blood loss greater than 1,000 but < 1,500 cc, 2 or more uterotonics- consider moving to OR
 - Continuation of stage 1 mechanical interventions and stage 1 medications on interval
 - Surgical interventions remain in stage 2

STAGE 2 INTERVENTIONS		ANNOUNCE & REVIEW	
		☐ Vital signs	☐ Cumulative blood loss
Escalate to Stage 2 for any of the following			
• Blood loss >1,000 mL but <1,500 mL • Using >2 uterotonic medications -and- normal VS (no vasopressor support) and labs			
<i>If abnormal labs, VS, or >1,500-mL blood loss, immediately complete Stage 2 and Stage 3</i>			
☐ Mobilize additional help, (eg, OB RRT)	☐ Prepare to move to OR		
☐ Move hemorrhage cart near patient	☐ Draw STAT labs (CBC, coags, fibrinogen)		
☐ Place second IV (16G–18G)	☐ Consider ROTEM or TEG if available		
☐ Stage 1 mechanical interventions	☐ Obtain and transfuse 2 units of RBCs		
☐ Repeat or additional medications	☐ Consider FFP (ie, thaw 2 units of FFP) or		
☐ Focused ultrasound for OB hemorrhage	fibrinogen substitute		
Consider Surgical Interventions			
☐ Compression/B-Lynch suture in setting of cesarean delivery (only if manual compression effective)	☐ Uterine artery ligation or embolization		
	☐ Consider D&C, hysterectomy		
ACHIEVE HEMOSTASIS OR ESCALATE TO NEXT STAGE			

Stage 3

- Key updates:
 - Calcium replacement
 - Packing for transport
 - Aortic compression

⚠ STAGE 3 INTERVENTIONS		ANNOUNCE & REVIEW	
		☐ Vital signs	☐ Cumulative blood loss
Escalate to Stage 3 for any of the following			
• Bleeding (EBL/QBL) >1,500 mL • Bleeding and 2 units of RBCs given		• At risk for occult bleeding/coagulopathy • Abnormal VS, labs, oliguria	
☐ Move to OR		☐ Repeat labs for coags, fibrinogen, ABG	
☐ Call specialty teams, eg, surgical backup team, or consider patient transfer		☐ Repeat or additional medications	
☐ Initiate MTP – if clinical coagulopathy, add cryoprecipitate, consult for additional agents		☐ Stage 1 mechanical interventions	
		☐ Calcium replacement	
Consider Surgical Interventions		☐ Packing	
☐ Aortic compression		☐ Stage 2 surgical interventions	
ACHIEVE HEMOSTASIS OR ESCALATE TO NEXT STAGE			

Aortic Compression



- Greatest utility in scenarios where transferring patient to the surgical options
- Visualize reduction in vaginal bleeding and increase in blood pressure



- Can compress less than 60 minutes without major metabolic change
- Contraindication is presence of viable living fetus

Stage 4

- Key Updates:
 - Removed post-hemorrhage management and moved to QRG
 - ACLS algorithm
 - Mobilize surgical resources
 - Aggressive MTP resuscitation

⚠ STAGE 4 INTERVENTIONS		ANNOUNCE & REVIEW	
		☐ Vital signs	☐ Cumulative blood loss
Escalate to Stage 4 with cardiovascular collapse – massive hemorrhage, profound hypovolemic shock, or amniotic fluid embolism			
☐ Call add'l resources, eg, ECMO team		☐ Immediate surgical intervention – hysterectomy	
☐ ACLS algorithm		☐ Simultaneous aggressive massive transfusion	
ACHIEVE HEMOSTASIS			

Case Study

- 34 yo P0010 at 38w 5d presents with contractions and SROM (clear fluid). On exam: 4 cm/50%/-3 station
 - Epidural placed
 - 30 min later: 8-minute prolonged deceleration
 - On exam: FD/+2 station
 - BP 73/42, HR 120s
 - FHR returned to baseline with recurrent late decelerations, contractions q 1-2 minutes
 - Begins pushing

Case Study (continued)

- Vacuum assisted vaginal delivery. Apgars 2/6/9
 - Placenta delivered spontaneously with second degree perineal laceration
 - Large gush of blood with placenta—but improves
 - Fundus firm
 - Ongoing continued bleeding (intermittent)
 - Vagina and cervix inspected. No lacerations
 - Fundal massage performed. Methylergonovine and TXA given
 - JADA placed
 - Moved to the PACU for better monitoring
 - Difficulty placing second IV

Case Study: Follow up and discussion

- Hemorrhage thought to likely be the result of placental abruption
- Interview with the nurse found:
 - She offered to summon help soon after delivery of the placenta
 - She suggested requesting blood products
 - The delivering clinician responded that it was not necessary.
 - Clinician was focused on repairing perineal laceration.
- No ongoing QBL
- No determination of stage of hemorrhage
 - Patient was in Stage 3
- Delay in calling for help
- Delay in calling for massive transfusion protocol

How an Obstetric Hemorrhage Checklist Might Have Helped

- If used as per a unit policy/protocol, it might have:
 - Empowered the nurse to summon help based on clinical criteria
 - Prompted ongoing QBL, monitoring of vital signs and determination of stage of hemorrhage
 - Resulted in earlier summoning of assistance
 - Helped shake the clinician out of their anchoring bias that the most pressing issue was the need to repair the perineal laceration
 - Resulted in earlier activation of the massive transfusion protocol

Key Takeaways

- Checklists reduce errors, improve communication, and support high-reliability care.
- Early activation and accurate QBL assessment drive timely intervention.
- Stage-based management provides clear escalation pathways and treatment guidance.
- Closed-loop communication and multidisciplinary teamwork are essential.
- Standardized tools help mitigate delays, cognitive bias, and variation in care.

Access These Resources Today!

Available on the ACOG website and through the SMI App.



Obstetric Hemorrhage

Obstetric Hemorrhage Bundle

- [Slide Set](#)
- [Checklist](#)
- [Checklist Quick Reference Guide](#)

Respectful Care Resources

- [City Birth Trauma Scale](#)
- [Share Approach](#)
- [Respectful Care at Birth](#)

Download the SMI App

The Safe Motherhood Initiative (SMI) app is available in the [App Store](#) and [Google Play](#).

The app is free of charge, and gives users access to the latest clinical information the Safe Motherhood Initiative has created to date. You will also be able to access up-to-date information on meetings and receive notifications.

Get the App

[For Apple](#) [For Android](#)

This app was created in collaboration with Fountainhead Mobile Solutions.

Questions?

Please enter your questions in the Q&A box at the bottom of your screen.