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Quality Improvement Activity: Postpartum Hemorrhage

A G4 P3 L3 27-year-old woman was transferred to the postpartum unit 2 hours after a vaginal delivery. The patient came in for induction of labor at 39 weeks and 6 days and had an epidural at 4 cm. She had spontaneous rupture of membranes at delivery. The postpartum nurse was given report over the phone before receiving the patient and received the patient from a nurse who did not care for the patient because of patient scenarios on the labor and delivery unit. The report included a QBL of 254, fundus firm at the umbilicus, bag of Pitocin running with a second to start, foley removed prior to delivery by the provider, and blood type A+. Baby had one-minute APGAR of 8 for color and tone, and five-minute APGAR of 9 for color. The receiving nurse introduces herself to the patient and helps transfer the patient to the room, then assesses her patient and feels her fundus is slightly to the right. She encourages her patient to drink lots of water and call her in a little bit for assistance to get up to go to the restroom. The nurse gets called in to other patient rooms and does not check in with the patient for two more hours. When she checks in on her the patient is dizzy, nauseas, and says she might have peed in her pad because she feels wet down there. When the nurse checks, the pad is saturated, and the patient's uterus is boggy and distended far to the right. The nurse immediately starts fundal massage and calls for help and a straight catheter to help empty her patient's bladder. The nurse gets vital signs on her patient and counts the blood loss on her patient by measuring the pads. The straight catheter relieves the patient of 850 milliliters of urine and combined with fundal massage helps firm the uterus back to the umbilical line.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In the scenario above the patient was transferred from one unit to another during a busy and hectic time for the nurses during their shift. This should not have meant a lack of communication. Unfortunately, the report to the postpartum nurse included the removal of the foley at delivery by the provider, but not if the patient had voided or not post-delivery and catheter removal. The receiving nurse also assessed her patient and wanted her patient to void but did not check how long it had been since catheter removal and did not recheck on her patient for two hours, knowing her patient's uterus was already deviated to the right and was at risk for post-partum hemorrhage being a multipara patient. It is a common occurrence that units become busy, and report is given quick and short and not at the bedside. This is something that the patient care environment lacked because a bedside report improves outcomes and trust between the patient and the nurse. This is very unfortunate because leaving off small amounts of information can lead to large changes in patient outcome and even cause harm to patients like in the above scenario.

What circumstances led to the occurrence?

The circumstances that directly led to this occurrence was the missed communication during report of the lack of voiding after urethral catheter removal. Another circumstance that led to this postpartum hemorrhage was the postpartum nurse not checking the chart and not having the patient void right away using a straight catheter (or a bed pan) depending on the mobility of the patient after the epidural. This would have helped the uterus be able to contract without something getting in its way. With this

patient being multipara and already at higher risk of postpartum hemorrhage, having her uterus distended to the right should have been more concerning to the nurse taking care of her.

In what way could you measure the frequency of the occurrence? (interview nurses, examining charts, patient surveys, observation, etc.)

The frequency of postpartum hemorrhage can be measured by examining charts and by observation. Charts will be one of the best ways to measure the frequency of postpartum hemorrhage and degrees of postpartum hemorrhage because the interventions that must be done to stop postpartum hemorrhages have to be documented. Intervention for severe postpartum hemorrhages include medication or surgery and can even include staff briefings to stop similar situations from occurring in the future. Observing is also a good way to see frequency of postpartum hemorrhages because it will show how often and at what severity, including very minor occurrences that may be missed by looking through charts.

What evidence-based ideas do you have for implementing interventions to address the problem?

Implementing interventions to address the problem of busy floors and communication errors has been on the mind of healthcare since healthcare started. One of the biggest evidence-based solutions to giving a thorough report is having a cardex or similar report giving checklist to make sure that all areas of import are addressed and not forgotten by the nurses no matter the state of the unit giving or receiving report. This is a great way to make sure that no matter what is going on, the employees can focus on their patient and specific areas for each patient that need to be focused on. Another intervention to implement would be encouraging bedside report. Bedside report is shown to increase accuracy of information and increase respect for patients from caregivers.

How will you measure the efficacy of the interventions?

I will measure the efficacy of the report checklist and bedside report by examining charts from before implementing the interventions to after implementing the interventions. I would be looking at the combination of location of the fundus, if the fundus was firm, lochia and amount, and the frequency of postpartum hemorrhages before and after the implementation of more hemorrhage reducing information on the report checklist. I would expect that the frequency of post-partum hemorrhages would lower after the implementation of the intervention, proving its efficacy.