

Emergency Scenarios with Case Review

Hemorrhage

This emergency scenario is about patient with hemorrhage following an abortion, and is set up for role-play and case review with your staff.

- 1) The person facilitating scenarios can print out the pages below.
- 2) Cut up the “role” pages, and assign several roles, distributing them to appropriate participants in clinic.

Patient who is having hemorrhage during a procedure

Boyfriend of patient

Another patient in clinic

Medical Assistant

Nurse

Doctor or Clinician

Clinician or additional nurse

2nd Clinic Assistant

Manager or Administrator

- 3) If your staff is smaller, you can cut optional roles. Any additional staff can be asked to observe and discuss.
- 4) Following role-play, gather the staff to review questions for debriefing and teaching.
- 5) Repeat scenario for further practice as time allows.
- 6) Record date of scenario and topic on your emergency scenario log (as appropriate)

(8 roles)

Sasha (patient): You are age 35, G5P4, and you have just had an uncomplicated 10 week aspiration abortion.

You are in the exam room and lying down on the exam table. Your partner, Jonas, is with you. Tell him that you don't feel good, because you feel dizzy. You try to get up off the exam table, and lay back down because you feel very weak. Tell the medical assistant you are bleeding, and a collection of blood is developing on the exam table and floor. Don't act improved until you have been given IV fluids, medicines, 2nd IV line started and oxygen. You will continue to have significant bleeding until you are on the way to the hospital. Here are your vitals, each 5 minutes.

1st set Vital signs: 120 / 80, pulse 75: continued heavy bleeding

2nd set vital signs: 110 / 70, pulse 80, continued heavy bleeding

3rd set vital signs: 100 / 60, pulse 100, continued heavy bleeding

4th set vital signs: 90/ 60, pulse 120, continued bleeding

If someone mentions checking orthostatic vitals, you can tell them "my diastolic BP drops 20 points, and pulse increases 30 points with standing"

Manager or Administrator: You are in the front office.

Hopefully you will hear a page or emergency alarm, or someone will find you because there has been an emergency in one of the rooms. Go and see what is needed. You may need to find someone to relieve the nurse in the recovery room or find the doctor. You will need to oversee patient transport to the hospital ER after she is stabilized, and assigning someone to go with her.

Medical Assistant helping abortion patient Sasha. You are in the exam room.

You are helping Sasha in the exam room. (Look over her chart.) She has just had an aspiration abortion and she is still on the exam table. The doctor has left the room. When she tries to get up from the exam table, you will see a lot of blood on the floor. You will need to call for help and also assist her. Then do whatever is designated to you.

Clinic or Recovery Room Nurse.

You are taking care of another patient who has just had an abortion. She is weak and you are taking her vital signs and checking her oxygen level. There will be an emergency in another room. If someone comes to relieve you; only then can you leave the room. You may have a medical assistant with you; so you could send her to find another licensed person like the NP doing family planning. You will have the responsibility once you get to the room of starting an IV if needed, and helping with any meds. You may also need to help the doctor record

Jonas. Patient's boyfriend

You are in the exam room with your girlfriend Sasha, who has just had a 10-week abortion. You are attempting to help her get off the exam table, but she tells you she feels weak and you notice she is bleeding heavily. You should act scared and not be very helpful. You should get more worried over time.

Doctor or Clinician:

You are in the break room between procedures, getting your afternoon espresso (you wish).

You have just left the exam room after completing a 10 week seemingly uncomplicated aspiration abortion on Sasha, a 35 year old G5P4 woman. There will be an emergency in that exam room. Do not go to the room until you are paged or until someone finds you in the break room. You will be in charge of the medical team managing the emergency. You will need to direct the team in how to care for the patient, and delegate roles. It will take a while to stabilize the patient, and require transport to the ER.

2nd Medical Assistant: You are in the Lab

You are a medical assistant working in the lab, and today is procedure day. There will be an emergency in one of the rooms. Wait till you are assigned. You may help to get transport arranged, help communicate with the hospital, or make sure the patient's records are together.

Ms. Joni: another post-AB patient. You are in the recovery room.

You are Ms. Joni, age 23 and you are recovering from an abortion. Act very out of it, and complain of pain and faintness on one occasion. The nurse or an assistant should be help you by evaluating you and taking your vital signs – which will be normal.

Scenario Review: Hemorrhage

- 1. Did the right people get involved on time? How did it go overall? Anything you would change?**

- 2. What criteria would you use to observe this patient vs. transfer this patient?**

Observe if vital signs stable, no orthostasis, bleeding slows, and she is stable over 2 hours if suspected mild perforation.

Transfer for unstable vital signs, continued bleeding, significant suspected trauma or worsening pain or vitals after trauma.

- 3. Was stabilization record kept? Was copy sent with the patient? Was a member of our staff sent with the patient to the ER?**

The most up to date record including stabilization steps and ER / OB contact should be included with copy of records. Use the stabilization record (should be on clipboard on your ER cart, and copies in Emergency Cart folder on share drive).

It is our policy to send someone from the clinic to the ER with the client to help advocate and communicate with ER staff.

- 4. When would you put in a second line? Why use large bore IV lines in this case?**

A hemorrhaging patient (with ongoing heavy bleeding), can lose blood volume fast. As her blood volume drops, her blood pressure will follow, although this sign can be delayed in young healthy people. It can become much harder to place IV lines with low blood volume. To be prepared, it is best to place large bore (18 or 20 gauge), so saline can run in quickly. A second IV line is placed in this circumstance as a back up in case her hemorrhage continues to worsen and she needs even more volume to keep up.

- 5. Who puts in IV lines at your facility, and how well does each of them know how each IV set is put together and the options?**

Please use this opportunity to review with each person who puts in IV lines, as well as practicing putting each set together. Make sure staff placing IV lines knows the equipment cold. Please be sure this becomes part of the sign-off process for each new recovery room nurse or clinician.

6. What are the signs of hemorrhage and shock?

Ongoing bleeding (consider doubling clot size to estimate blood loss, but remember blood loss can be occult (collecting in the abdomen or the vagina)

Dizziness, fainting or pallor.

High pulse, low blood pressure (suggests shock)

Orthostatic changes: A patient is having 'orthostatic symptoms' when they feel dizzy when they stand up (due to brief decreased blood flow and lack of volume to compensate with standing).

Orthostatic vital signs help evaluate of a patient's volume status. This is measured by checking pulse and BP in lying, sitting, and standing positions (2 min apart). Don't delay starting an IV while checking the results.

Objectively, they are 'orthostatic' if there is an increase in pulse of 20 beats/min or a fall in diastolic BP of ~15 with sitting or standing. This suggests the patient needs more aggressive IV fluid / transport.

7. What are some causes of hemorrhage after abortion?

Remember "4 T's" cause hemorrhage.

Tone (atony or poor uterine tone)

Trauma (like a laceration or perforation).

Tissue (retained POC or clot)

Thrombin (bleeding problems, DIC)

8. Primary steps for treating hemorrhage? How often did you check vitals? Was there delay was there between treatments?

Bimanual massage

Uterotonic medications:

Methergine (PO, IM, or intracervical)

Vasopressin (intracervically)

Misoprostol (rectally)

Oxytocin (IM or in IV Fluid)

IV Fluid (isotonic = normal saline or LR)

Reexamine patient for clot or trauma

Repeat basic vital signs (BP and pulse) each 3-5 minutes until stable.

Consider reaspiration

Consider Pressure (to trauma) or Tamponade (Foley cannula in uterus)

Transfer if unstable

9. How often do patient's that hemorrhage, have risk factors? Are there risk factors for hemorrhage among abortion patients?

Hemorrhage common so we should be prepared. Furthermore, abortion patients rarely have risk factors (less than half the time), so always be prepared. Risk factors include previous hemorrhage (or uterine atony), advanced gestational age, or bleeding problems.