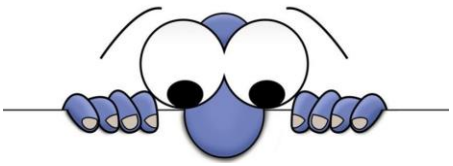
April 29th, 2022

The Baby Buzz

NEW Emergency Code:

CODE TRANSFUSION

Code Transfusion is the activation of the ***Massive Hemorrhage Protocol (MHP).***



KHSC MHP Bedside Clinical Checklist for the TEAM CONTACT

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To activate a Code Transfusion:

- ❑ Call 4444
- ❑ Provide the following information
  - ❑ Patient Location
  - ❑ Team contact's name
  - ❑ The patient's CR number
  - ❑ If the patient is in the OR or Connell 5 or going to the OR
  - ❑ Weight (for pediatric patients)
  - ❑ Biological Sex
  - ❑ Age
  - ❑ Type of Hemorrhage
  - ❑ History of antiplatelets or anticoagulants in the last 7 days

After the first blood pack arrives:

- ❑ Locate and carry the Code Transfusion phone (will be in the first pack)
- ❑ Ensure all necessary blood testing has been done (a pack of tubes will be sent with the first pack in a bag that has a red MHP sticker on it)
- ❑ Communicate directly with the Transfusion Medicine Laboratory (TML) (x4188) regarding additional blood products and lab results
- ❑ Direct the porter to the Core Lab to drop off samples or to the blood bank to pick up the next pack
- ❑ If there is a change in location or Team Contact notify the TML and hand over any remaining blood products and the Code Transfusion phone

Once MHP has been terminated:

- ❑ Inform the TML the MHP has been terminated
- ❑ Return all unused blood products in appropriate containers and Code Transfusion phone to the TML via the porter immediately
- ❑ Inform the porter the MHP has been terminated so they can resume other tasks

MRP determines the need to activate the MHP. MRP assigned a Team Contact

Team Contact- lead ensuring coordinated blood product delivery

Switchboard (4444) is called and announcement is made overhead

This checklist will be located on both units **(ie: Beside the phone in both ORs).** Blood bank will have the exact same sheet so the same information is being communicated between both areas. Familiarize yourself with the steps!

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CMQCC **Peri-Partum Bleeding Algorithm: Checklist Format** Revision 21/08/24

Stage 0: All Births – Prevention & Recognition of OB Hemorrhage
Prenatal Assessment & Planning

☐ Identify and prepare patients with special considerations: Placenta Previa/Accreta, Bleeding Disorder, or those who Decline Blood Products
☐ Screen and prevent anemia: if oral iron fails, initiate IV Iron Sucrose as per established protocol to achieve hemoglobin over 110 g/L at delivery.

Admission Assessment & Planning		Ongoing Risk Assessment
Verify Group & Screen from prenatal record If no Group & Screen in this pregnancy, ☐ Order Group & Screen If patient has red cell antibodies, (not passive anti-D from RHIG), ☐ Order Group & Screen Patients at high risk for hemorrhage or transfusion, ☐ Order Group & Screen & Crossmatch (2 units)	☐ Evaluate for Risk Factors on admission, throughout labor, and postpartum. (At every handoff) If medium risk: ☐ Order Group & Screen ☐ Review Hemorrhage Protocol If high risk: (in addition to above) ☐ Order Group & Screen & Crossmatch (2 units) ☐ Notify OB Anesthesia ☐ set up cell saver on CS Identify women who may decline transfusion ☐ Notify OB provider for plan of care ☐ Early consult - OB anesthesia, cell saver, blood conservation RN ☐ Review Consent Form	☐ Evaluate for development of additional risk factors in labor: • Prolonged 2nd Stage labor • Prolonged oxytocin use • Active bleeding • Chorioamnionitis • Magnesium sulfate treatment ☐ Increase Risk level convert to Group & Screen or Group & Screen & Crossmatch (2 units) ☐ Treat multiple risk factors as High Risk ☐ consider early uterotonics, set up cell saver on CS ☐ consider preemptive tranexamic acid for some high risk patients ☐ Monitor women postpartum for increased bleeding and hemodynamic instability

Admission Hemorrhage Risk Factor Evaluation

Low (No blood bank testing) Verify Group & Screen done during pregnancy	Medium (Group & Screen)	High (Group & Screen & Crossmatch)
No previous uterine incision	Prior cesarean birth(s) or uterine surgery	Placenta previa, low lying placenta
Singleton pregnancy	Multiple gestation	Suspected Placenta accrete or percreta
≤ 4 previous vaginal births	> 4 previous vaginal births	Hemoglobin <100 g/L AND other risk factors
No known bleeding disorder	Chorioamnionitis	Platelets < 100 x10⁹/L or falling on serial B/W
No history of PPH	History of previous PPH	Active bleeding (greater than show) on admit
Hemoglobin 110 g/L or higher	Large uterine fibroids	Known coagulopathy, fetal demise, physician concern
	Hemoglobin 100-109 g/L	

All Births – Prophylactic Oxytocin, Quantitative Evaluation of Blood Loss, & Close Monitoring

Active Management of Third Stage
☐ Oxytocin infusion: vaginal birth 10 units IM followed by 20-units oxytocin/1000 mL solution at 125ml/hr unless directed otherwise by OB C/S 1-2.5 units slow IV by anesthesia plus infusion OR carbetocin 100mcg IV.
Ongoing Quantitative Evaluation of Blood Loss
☐ Using formal methods, such as graduated containers, visual comparisons and Ongoing Evaluations of Vital Signs

If: Cumulative Blood Loss > 500ml vaginal birth or > 1000ml C/S with continued bleeding -OR- Increased bleeding during recovery or postpartum proceed to STAGE 1

As you progress through the stages 1-3, ensure checkboxes from previous stages are being completed concurrently

Look familiar? Well I hope so! These are located in each labour room, laminated, on a hook attached to the FHS monitor

Stage 3 of the Peri-partum Bleeding Algorithm is when the MHP is activated.

STAGE 3: Peri-partum Bleeding Algorithm
Cumulative blood loss > 1500mL, > 2 units PRBCs given, Vital Signs unstable or suspicion for coagulopathy
Vital Signs/Symptoms: HR >120 thready, BP ↓↓, respiratory rate ↑↑, urine output ↓↓, confusion, shortness of breath, chest pain
****Vital signs may be relatively normal if appropriate resuscitation has occurred****

MOBILIZE

Nurse or Physician:
☐ Activate Massive Hemorrhage Protocol

PHONE#:_____

Charge Nurse or designee:
☐ Call "4444" for Code Transfusion Overhead

☐ Code to Trigger to Notify:
- 2nd on-call gynecology surgeon (if not already contacted in stage 2)
- 2nd on-call OB/GYN resident
- Perfusionist
  - ☐ Notify additional Gyne surgeon
  - ☐ Notify adult intensivist
  - ☐ Consider Anesthesia to call-in AA/second anesthesiologist as requested
  - ☐ Call-in OR staff
  - ☐ Consider calling IVR as requested
  - ☐ Ensure hemorrhage cart available at the patient's location
  - ☐ Reassign staff as needed
  - ☐ Call-in supervisor, CNS, or manager
  - ☐ Continue OB Hemorrhage Record (In OR, anesthesiologist will assess and document VS)
  - ☐ If transfer considered, notify ICU

Blood Bank:
☐ Keep 1 MHP pack ahead at all times

The MHP is activated

Charge, or the Team Contact calls switchboard to call the code overhead

Activating the code will trigger switchboard to notify specific individuals (ie: 2nd on-call OB/GYN resident)

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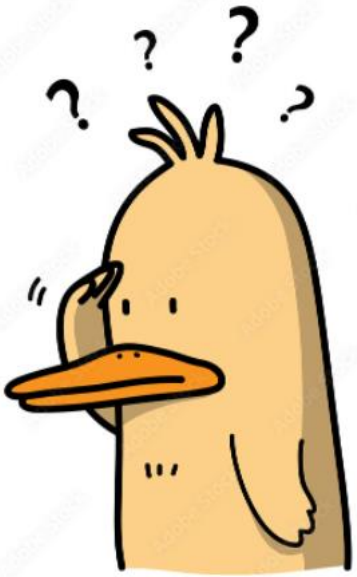
Go-Live May 2nd, 2022

What do I do when I hear the Code overhead?



Code Transfusion can be called anywhere in the hospital. But we will mostly see it in the OR, emerge, or Connell 5. When a **Code Transfusion** is called overhead, you are not to call blood bank **for one (1) hour** as they are dealing with a **critical situation** and all hands needs to be on deck to ensure the blood is processed and transported in a timely manner.

Unless you need something from blood bank that is an emergency, do not call them when you hear the Code called overhead.

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