Section	Resource	Description	Link
Readiness			
Readiness	ACOG Committee Opinion No. 590 *ACOG, 2014*	Patient care emergencies may occur at any time in any setting, particularly the inpatient setting. It is important that obstetrician-gynecologists prepare themselves by assessing potential emergencies, establishing early warning systems, designating specialized first responders, conducting emergency drills, and debriefing staff after actual events to identify strengths and opportunities for improvement. Having such systems in place may reduce or prevent the severity of medical emergencies.	
Readiness	OB Hemorrhage Toolkit V 3.0 *CMQCC, 2022*	The Improving Health Care Response to Obstetric Hemorrhage toolkit was developed by the Obstetric Hemorrhage Task Force to assist obstetric providers, clinical staff, hospitals and healthcare organizations with timely recognition and response to hemorrhage. Obstetric hemorrhage remains a leading and preventable cause of maternal mortality and severe maternal morbidity, a life-threatening complication during pregnancy.	
Readiness	Obstetric Care Consensus No 5 Summary: Severe Maternal Morbidity: Screening And Review *ACOG, 2016*	This document builds upon recommendations from peer organizations and outlines a process for identifying maternal cases that should be reviewed. Severe maternal morbidity is associated with a high rate of preventability, similar to that of maternal mortality. It also can be considered a near miss for maternal mortality because without identification and treatment, in some cases, these conditions would lead to maternal death. Identifying severe morbidity is, therefore, important for preventing such injuries that lead to mortality and for highlighting opportunities to avoid repeat injuries. The two-step screen and review process described in this document is intended to efficiently detect severe maternal morbidity in women and to ensure that each case undergoes a review to determine whether there were opportunities for improvement in care. Like cases of maternal mortality, cases of severe maternal morbidity merit quality review. In the absence of consensus on a comprehensive list of conditions that represent severe maternal morbidity, institutions and systems should either adopt an existing screening criteria or create their own list of outcomes that merit review.	

Section	Resource	Description	Link
Readiness	Consensus Bundle on Obstetric Hemorrhage *Anesthesia and Analgesia, 2015*	Hemorrhage is the most frequent cause of severe maternal morbidity and preventable maternal mortality and therefore is an ideal topic for the initial national maternity patient safety bundle. These safety bundles outline critical clinical practices that should be implemented in every maternity unit. They are developed by multidisciplinary work groups of the National Partnership for Maternal Safety under the guidance of the Council on Patient Safety in Women's Health Care. The safety bundle is organized into four domains: Readiness, Recognition and Prevention, Response, and Reporting and System Learning. Although the bundle components may be adapted to meet the resources available in individual facilities, standardization within an institution is strongly encouraged. References contain sample resources and "Potential Best Practices" to assist with implementation.	
Readiness	TeamSTEPPS 2.0 *AHRQ, 2019*	The Agency for Healthcare Research and Quality (AHRQ) and the Department of Defense (DoD) have developed TeamSTEPPS®, a teamwork system that offers a powerful solution to improving collaboration and communication within your institution. Teamwork has been found to be one of the key initiatives within patient safety that can transform the culture within health care. Patient safety experts agree that communication and other teamwork skills are essential to the delivery of quality health care and to preventing and mitigating medical errors and patient injury and harm.	
Readiness	Management of Major Obstetric Hemorrhage *Indian Journal of Anesthesia, 2018*	One of the most important causes of maternal mortality is major obstetric hemorrhage. Major hemorrhage can occur in patients either during the antepartum period, during delivery, or in the postpartum period. Early recognition and a multidisciplinary team approach in the management are the cornerstones of improving the outcome of such cases. The management consists of fluid resuscitation, administration of blood and blood products, conservative measures such as uterine cavity tamponade and sutures, and finally hysterectomy. Blood transfusion strategies have changed over the last decade with emphasis on use of fresh frozen plasma, platelets, and fibrinogen. Point-of-care testing for treating coagulopathies promptly and interventional radiological procedures have further revolutionized the management of such cases.	

Section	Resource	Description	Link
Readiness	Development of an Obstetric Hemorrhage Response Intervention: The Postpartum Hemorrhage Cart and Medication Kit *The Joint Commission Journal on Quality and Patient Safety, 2022*	Postpartum hemorrhage (PPH) is the leading cause of maternal morbidity in the United States, and timely treatment is imperative. Delay in treatment of PPH can lead to significant blood loss and increased morbidity and mortality. Supplies and medications essential for treating PPH are typically not located in close proximity to the hemorrhaging patient, leading to inefficiency and delay in timely response to hemorrhage.	
Readiness	Safety Program for Perinatal Care: Experiences From the Frontline *AHRQ, 2017*	This report features five case studies that describe the implementation of the AHRQ Safety Program for Perinatal Care in labor and delivery (L&D) units at University of Arkansas for Medical Sciences, Onslow Memorial Hospital, Winnie Palmer Hospital for Women & Babies, Carle Foundation Hospital, and WakeMed Health & Hospitals System. Although all L&D units shared the same framework for safety improvements, each embarked on a unique implementation path that was best suited to its local needs and resources. The national implementation team has captured these experiences through visits to these organizations and interviews with unit staff and leadership.	
Recognition			
Recognition	Obstetric Hemorrhage Outcomes by Intrapartum Risk Stratification at a Single Tertiary Care Center *Cureus, 2019*	Postpartum hemorrhage is a leading cause of maternal mortality worldwide. Performance of a postpartum hemorrhage risk assessment prior to delivery has been recommended to identify patients at higher risk for hemorrhage to support advanced planning for optimal response. The objective of this quality improvement initiative is to evaluate the transfusion and hemorrhage rates for patients at low, moderate, and high risk for postpartum hemorrhage by utilizing standardized risk assessment.	
Recognition	AWHONN Practice Brief: Quantification of Blood Loss *AWHONN, 2021*	Inaccurate evaluation of blood loss can lead to delays in response and management of postpartum. Visual estimation of blood loss (EBL) has long been established as an inaccurate measure that can potentially lead to delays in timely recognition and response to obstetric. Visual estimation increases the likelihood to underestimate blood loss when volumes are high and to overestimate blood loss when volumes are low. Delays in recognition and management result in costly treatment for women having postpartum hemorrhage	