



Maternity Education Program

Uterine Inversion

Facilitator Resource Kit

Maternity Education Program (MEP)

The resources developed for MEP are designed for use in any Queensland Health facility that care for patients/women who are pregnant/birthing or postnatal. Each resource can be modified by the facilitator and scaled to the needs of the learner as well as the environment in which the education is being delivered, from tertiary to rural and remote facilities.



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Uterine Inversion – Facilitator Resource Kit

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Who is this resource kit for?

This resource kit provides healthcare workers with knowledge and skills on assessing and managing a uterine inversion.

Target audience

Midwifery and medical staff providing maternity care

Duration

45 mins – including simulation and debrief (15 mins for set up not included)

Group size

Suited to small groups (6 – 8)

Learning objectives

By the end of the session the learner should be able to:

- Manage the third stage of labour as per the clinical guidelines.
- Identify the clinical features concerning for uterine rupture.
- Recognise uterine inversion and act promptly.
- Recognise and respond to a clinically deteriorating patient.
- Implement emergency management of uterine inversion.

Facilitation guide

1. Provide Participant Resource Kit to the learner.
2. Utilise 2D pictures to demonstrate uterine inversion, manual replacement and hydrostatic replacement.
3. Utilise the PowerPoint (Obcast) to assist learners prior to session.
4. Allow learner to apply actions in a simulated uterine inversion case.
5. Conduct group debrief following simulation.

Supporting documents

1. Participant Resource Kit
2. 2D pictures
3. List of further readings and resources
4. Uterine inversion simulation



Overview

Uterine inversion occurs when the uterine fundus collapses into the endometrial cavity, turning the uterus partially or completely inside out. It is a rare complication of vaginal or cesarean delivery, but when it occurs, it can be a life-threatening obstetric emergency. If uterine inversion is not promptly recognized and treated, uterine inversion can lead to severe postpartum hemorrhage and shock which ultimately could result in a maternal death.¹

Uterine inversion is rare, occurring in 0.05 percent of births. Active management of the third stage of labour may reduce the incidence of uterine inversion, but mismanagement of the third stage can lead to uterine inversion. A fundal implantation of the placenta may also contribute to a uterine inversion and needs to be considered when managing the third stage of labour.

The inverted uterus usually appears as a bluish-gray mass protruding from the vagina, often with the placenta still attached. The vasovagal effects of the inversion produce vital signs that are disproportionate to the amount of bleeding, usually accompanied by lower abdominal pain. The management of a uterine inversion is to replace the uterus quickly back into position, and manual replacement is the quickest method. Once the uterus has reverted, uterotonic agents should be given to promote uterine tone and to prevent recurrence. If initial attempts to replace the uterus manually fail,

then hydrostatic pressure can be employed to assist reduction. Leave the placenta attached once the uterus has been replaced until the patient can be safely transferred to theatre. Administration of terbutaline, nitroglycerin (GTN), magnesium sulphate or general anesthesia may be required to allow the uterus to relax for manipulation. If these methods fail, the uterus will need to be replaced surgically.²

Obstetric Emergency is any clinical situation involving a maternity patient where immediate medical/ midwifery assistance is required.

¹ Puerperal uterine inversion George Macones, Vincenzo Berghella, Vanessa A Barss, Up to Date march 2020 -

[https://www.uptodate.com/contents/ puerperal-uterine-inversion](https://www.uptodate.com/contents/puerperal-uterine-inversion)

² Prevention and Management of Postpartum Hemorrhage Janice m. Anderson, Duncan Etches, American Family Physicians 2007-
<https://www.aafp.org/afp/2007/0315/p875.html>

Further readings and resources

Prevention and Management of Postpartum

Author	Royal College of Obstetricians and Gynaecologists
Link	https://bit.ly/34f3siO

Perinatal Practice Guidelines – Uterine inversion

Author	Royal College of Obstetricians and Gynaecologists
Link	https://bit.ly/2FMwFlq

Uterine Inversion

Author	Monika Thakur, Angesh Thakur Nation Centre for Biotechnology Information (NCBI)
Link	https://bit.ly/2HfWr8r

Uterine Inversion

Author	Pradeesha Hettiarachchi, Abigail Evans, O&G Magazine
Link	https://bit.ly/3kezUaw

Puerperal uterine inversion

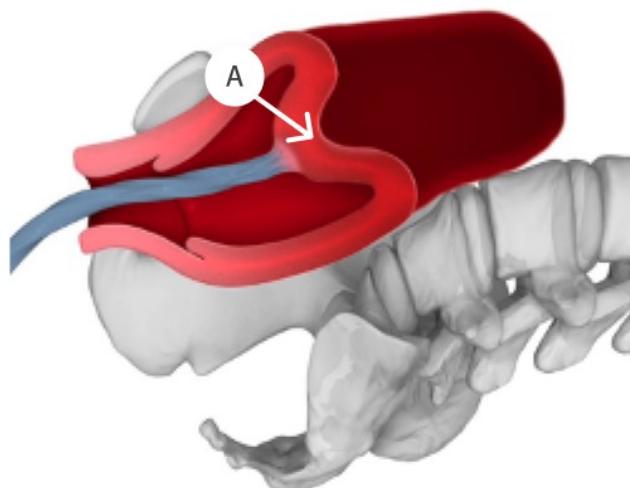
Author	Pradeesha Hettiarachchi, Abigail Evans, O&G Magazine
Link	https://bit.ly/3kiEq7S



Emergency Management

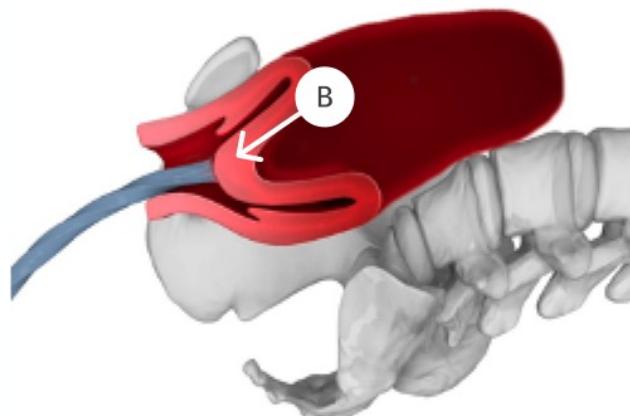
Management of uterine inversion

Degree of inversion



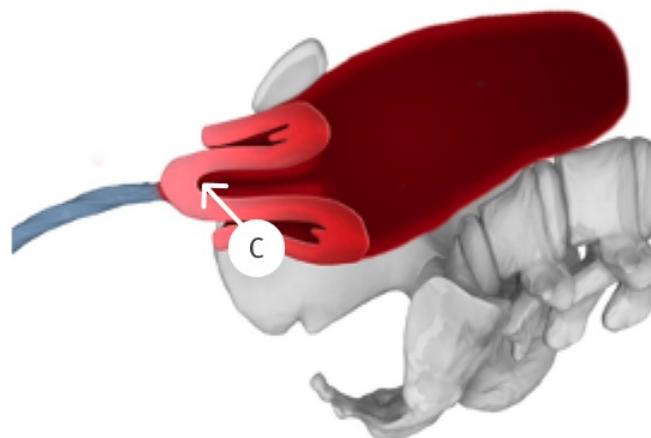
A

First degree inversion – fundus inverting into uterus, may not be obvious but a dip in the fundus maybe felt.



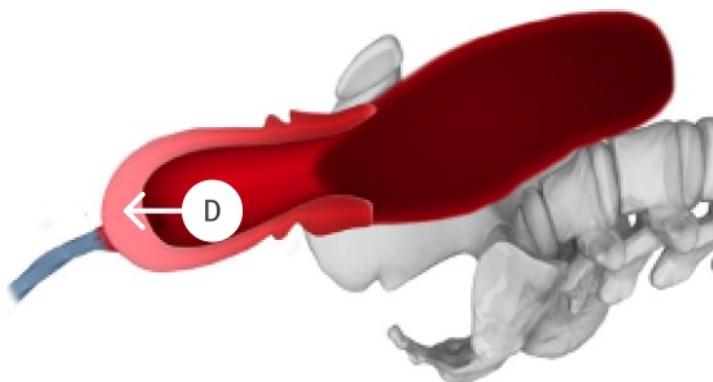
B

Second degree inversion – Fundus and placenta entering the cervix, woman maybe experiencing discomfort.



C

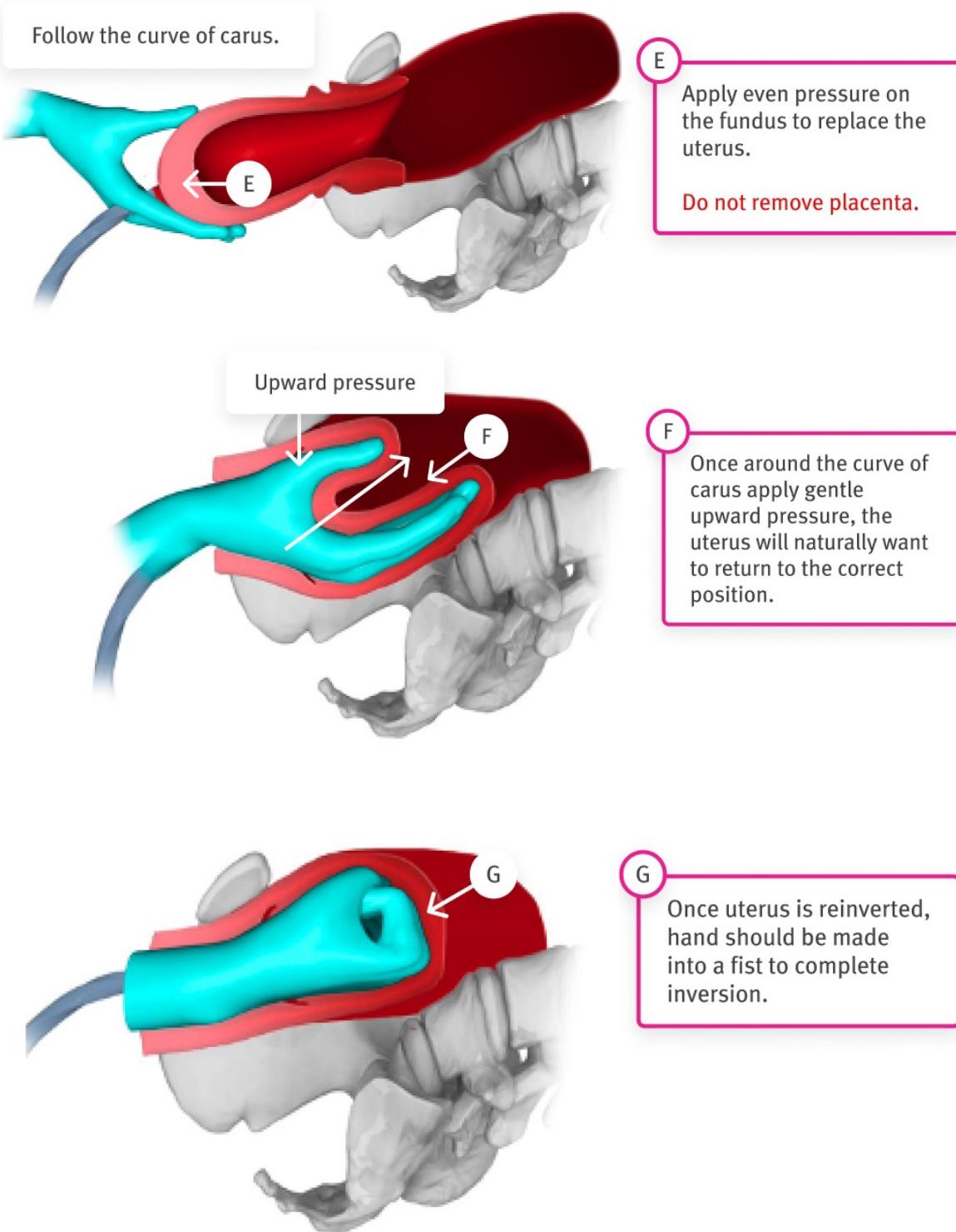
Third degree inversion – placenta surface is visible at introitus, woman probably in pain with early signs of shock.



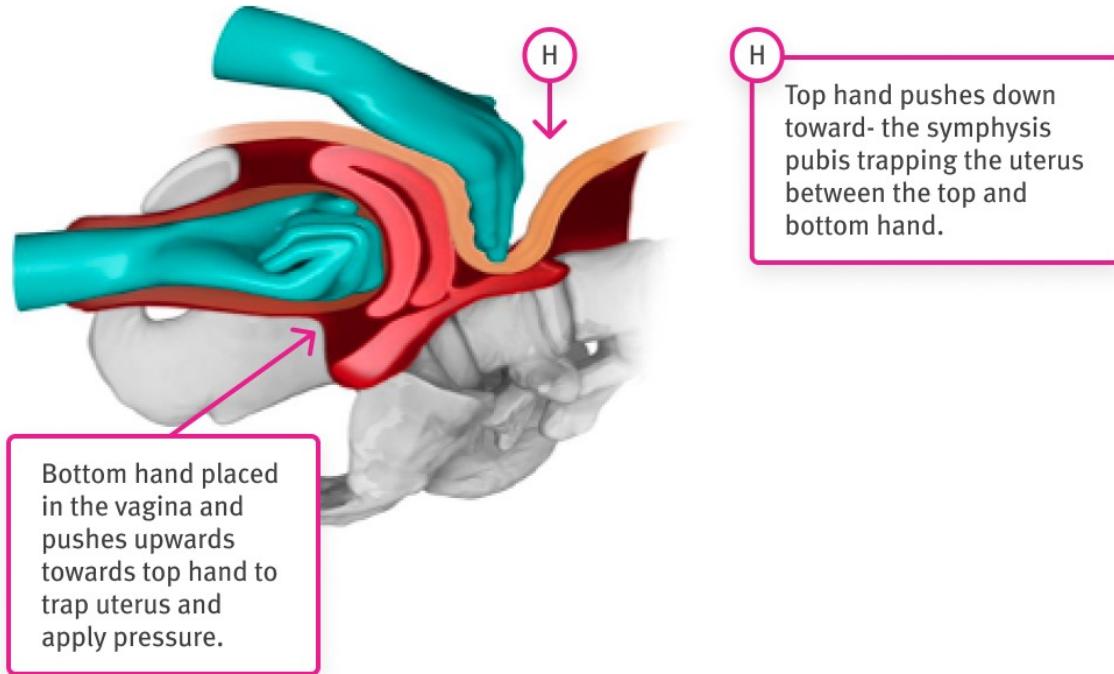
D

Fourth degree inversion – uterus completely inverted outside of vagina with placenta still attached, woman in pain and most likely shocked.

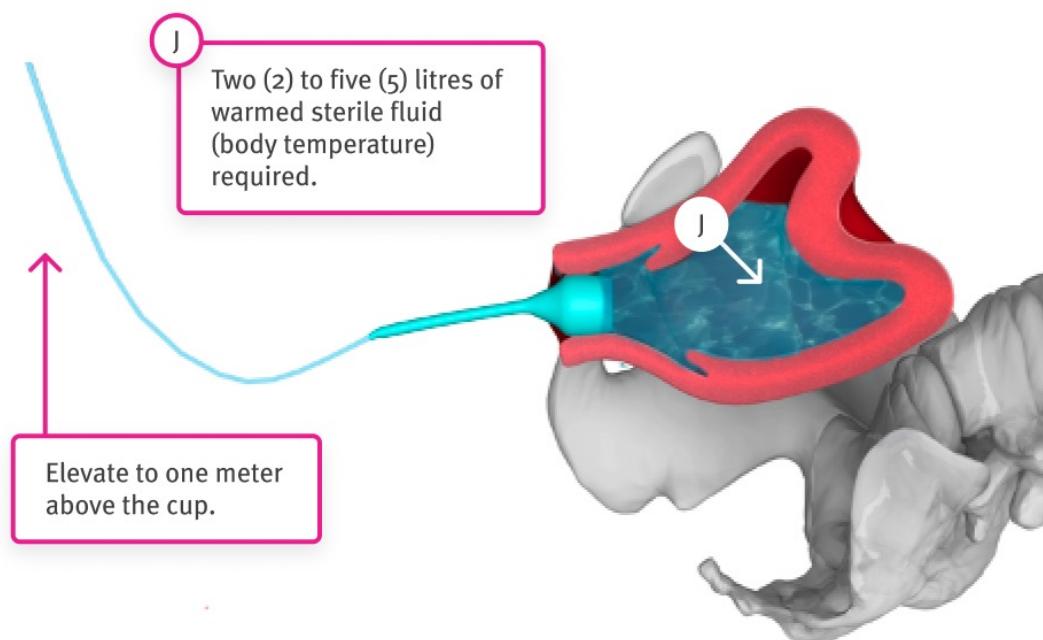
Manual replacement of the uterus



Bimanual compression applied to prevent bleeding when transporting to theatre.



Hydrostatic pressure (O'Sullivan technique)



Hydrostatic pressure (O'Sullivan technique) is the reduction of an acute uterine inversion. It is an option if all other interventions have failed and surgical intervention is not possible or delayed. The woman is placed in Reversed Trendelenburg position (see below).

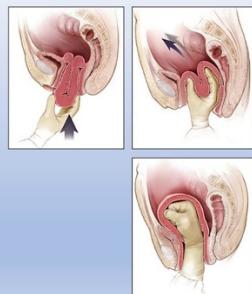


A bag of warmed fluid (body temperature) is hung at least one meter above the woman and is allowed to flow by gravity or with light pressure through tubing (suction tubing) connected to a silastic ventouse cup or a neonatal mask in the vagina; the seal between the cup/ mask and the vagina prevents significant leakage. The resulting intravaginal hydrostatic pressure may force the inverted fundus back to its normal position. Two to five litres of fluid may be needed to achieve this procedure.

Uterine Inversion – Obcast video

Uterine Inversion

- Replace fundus, then bimanual compression



Scan me on your phone

<https://bit.ly/3o3LLut>

How to Manage Uterine Inversion – Merck Manuals



Scan me on your phone

<https://bit.ly/3jgggcR>



Simulation Event

This section contains the following documents:

1. Pre-simulation briefing poster
2. Immersive in-situ scenario
3. Physical resources
4. Human resources
5. Simulated patient script information
6. Handover card
7. Additional information
8. Stage 1 – Initial assessment
9. Stage 2 – Ongoing management
10. Stage 3 – Resolution

Pre-simulation Briefing

Establishing a safe container for learning in simulation.



Clarify objectives, roles and expectations

1

- Introductions.
- Learning objectives.
- Assessment (formative vs summative).
- Facilitators and learners' roles.
- Active participants vs observers.

2

Maintain confidentiality and respect

- Transparency on who will observe.
- Individual performances.
- Maintain curiosity.



3

Establish a fiction contract

Seek a voluntary commitment between the learner and facilitator.

- Ask for buy-in.
- Acknowledge limitations.

4

Conduct a familiarisation

- Manikin/simulated patient.
- Simulated environment.
- Calling for help.

5

Address simulation safety

Identify risks.

- Medications and equipment.
- Electrical or physical hazards.
- Simulated and real patients.

Note: Adjust the pre-simulation briefing to match the demands of the simulation event, contexts or the changing of participant composition.

Adapted from Rudolph, J., Raemer, D. and Simon, R. (2014). Establishing a Safe Container for Learning in Simulation. *Simulation in Healthcare: Journal of the Society for Simulation in Healthcare*, 9(6), pp.339-349.

Scenario

Type	Immersive in-situ scenario
Target audience	Obstetric medical staff and midwives
Overview	<p>Birth suite standard set up</p> <p>Situation: Presented in spontaneous labour at 39+1/40, started labour 6 hours ago and is now in advanced labour. VE. 1 hour ago, 6cm dilated.</p> <p>Background:</p> <ul style="list-style-type: none"> • 30-year-old G2P1. 39+1/40 gestation, previous birth 2 years ago vacuum delivery with a retained placenta requiring a MROP in OT. • Low risk pregnancy • Hb 118 @ 36/40 • AB Pos • GBS Negative • All other serology NAD • Allergies – Nil • Medical history – Nil • USS 20 weeks – NAD <p>Assessment:</p> <ul style="list-style-type: none"> • In advanced labour with urges to push, early signs on second stage. • Routine labour care. <p>Recommendations:</p> <ul style="list-style-type: none"> • Prepare for birth, discuss third stage management. • Observe CTG.
Learning objectives	<p>Participants are required to:</p> <ul style="list-style-type: none"> • Manage the third stage of labour as per the clinical guidelines. • Identify early the difficult with the placenta delivery. • Recognise uterine inversion and act promptly. • Recognise and respond to a clinically deteriorating patient. • Implement emergency management of uterine inversion to include:

	<ul style="list-style-type: none"> ○ drug therapy ○ preparation for OT ○ manage shock ○ attempt replacement by manual or hydrostatic method 	
Duration	<p>Pre-brief: 10 minutes Orientation: 5 minutes Simulation: 15 mins Debrief: 15 mins</p>	<p>Total: 45 mins Allow 15 minutes for set up</p>

Physical resources

Room set up	Standard birth suite room
Simulator/s	Simulated patient with a pregnant abdomen <i>or</i> Manikin (including software)
Simulator/s setup	<p>If working with a simulated patient - simulated patient sitting in bed wearing a hospital nightie with:</p> <ul style="list-style-type: none"> ● Pregnant abdomen at term in labour with CTG on. ● Part task trainer in between legs with fetal head just visible. ● Fetus in trainer OA position, +1cm station (so head is just visible in distance). ● Heavy show on pad. ● Using N₂O² for pain relief. <p>If using a manikin - full manikin semi recumbent in bed with pregnant abdomen wearing a hospital nightie and birthing perineum with:</p> <ul style="list-style-type: none"> ● Pregnant abdomen at term in labour, CTG on. ● Baby in situ, fetal head just visible. ● Fetus in trainer OA position +1cm station (so head just visible in distance). ● Heavy show on pad. ● Using N₂O₂ for pain relief.
Clinical equipment	Standard birth suite room set up
Access	IVC x1
Other	Pregnancy Health Record, chart and relevant paperwork for emergency management

Human resources

Faculty	x2 Facilitators (Obstetric Reg/Consultant and midwife with debriefing experience) to take on roles of scenario lead and primary debriefer
Simulation Coordinators	If using a manikin – x1 SimCo for manikin set up and control of software during scenario
Confederates	Working with a simulated patient: <ul style="list-style-type: none"> • Simulated patient x1 • Confederate x1 to push fetus out – and play the part of patient support person. • Facilitator to provide handover
Other	Midwife x1 is present in the simulation room to receive the handover. The other midwives and doctors are outside the room, to be called in as needed.

Simulated patient script information

You are Jemma, a 30-year-old woman having your second baby. Your baby is due in six days, you started contracting in the night not too badly to start with but becoming painful about 2am. Your other child is two years old, born by suction cup and your placenta would not come out, so you had to have it removed in theatre.

You are contracting 4:10 last 60 sec. The contractions are strong and painful. You have just commenced N²O² which is helping, but you are getting some pressure with the occasional urge to push.

Act as if you are ‘transitional’, moving around on the bed unable to keep still.

Give the staff five minutes to get themselves ready for the birth. Once the support person gives you the signal, start pushing and progress to a normal birth. Baby is born in good condition.

After 5 minutes complain you can feel a contraction again. On commencement of controlled cord traction (CCT) no problems are identified initially but over approximately two minutes you have increased pain in your sides, you start to complain of feeling hot, sweaty, dizzy and the pain is worsening and you are unable to tolerate what the midwife is doing. If the staff change over, continue to be in pain until staff realise what is happening. Feel nauseated due to reduced B/P. Allow the staff to replace the uterus but be restless as this occurs. Complain of discomfort but just talk when asked questions during the procedure (do not over act).

Once the uterus is replaced start to feel less pain, except for the fact bimanual compression is required prior to going to OT and this is uncomfortable. You are conscious throughout the whole event.

Handover card

I	Introduction	This is Jemma, this is ... <staff name>
S	Situation	Jemma presented in spontaneous labour at 39+1/40. Labour started 6 hours ago and she is now in advanced labour, last VE 1 hour ago 6cm.
B	Background	30-year-old G2P1. 39+1/40 gestation, previous birth 2 years ago Vacuum delivery with a retained placenta MROP in OT. <ul style="list-style-type: none"> • Low risk pregnancy • Hb 118 @ 36/40 • AB Pos • GBS Negative • All other serology NAD • Allergies – Nil • Medical history - Nil • USS 20 weeks – NAD
A	Assessment	<ul style="list-style-type: none"> • In advanced labour with urges to push, signs on 2nd stage, nil visible but heavy show present. • Routine labour care. • IVC – in-situ due to previous MROP – Bloods to lab for G&H.
R	Recommendation	<ul style="list-style-type: none"> • Prepare for birth, discuss 3rd stage management. • CTG reattached as there have been a couple of variable decelerations heard on the Doppler after the VE.

Additional information

Name	Jemma Hurd
Age	30 years old
Sex	Female
Weight	82 kg
Allergies	Nil known
Medications	Nil
Medical/Surgical	Previous MROP following last birth no complications EBL = 400mls
Social History/Employment	Teacher
Partner's name	Wade
Pregnancy history	G2P1
Blood Group	AB Pos antibodies Neg
Hb	118 – 36 weeks
Serology	Neg
Rubella	Immune
GBS	Unknown
USS 20 weeks	20 weeks – Anterior/ Fundal placenta non praevia

State 1: Initial assessment				
Vital signs		Script	Details	Expected actions
RR	16	Jemma: Transitional so unable to stay still, moving around with the CTG on. Using N ² O ² for pain relief and has the occasional urge to push.	I Introduction This is Jemma this is ... <staff name>	<input type="checkbox"/> Introduce self, obtains history <input type="checkbox"/> Take maternal Obs. <input type="checkbox"/> Perform abdominal palpation <input type="checkbox"/> Review CTG <input type="checkbox"/> Prepare for birth <input type="checkbox"/> Discuss 3 rd stage management <input type="checkbox"/> Discuss retained placenta and why it happened <input type="checkbox"/> Call for a 2 nd midwife for the birth <input type="checkbox"/> Ask 2 nd midwife to check resus. gear
SPO ²	98%		S Situation Presented in spontaneous labour at 39+1/40, started labour 6 hours ago now in advanced labour, last VE 1 hour ago 6cm.	
BP	110/70			
HR	104			
Temp	37.2°C			
Consciousness sedation score	Alert		B Background 30-year-old G2P1. 39+1/40 gestation previous birth 2 years ago Vacuum delivery with a retained placenta MROP in OT. Low risk pregnancy.	
FH	130 some variable decelerations but typical 2 nd stage CTG		<ul style="list-style-type: none">• Hb 118 @ 36/40• AB Pos• GBS Negative• All other serology NAD• Allergies – Nil• Medical history - Nil• USS 20 weeks – NAD.	
PV loss	Bloody mucous show			
BGL	N/A			
RR	16			

State 1: Initial assessment			
Vital signs	Script	Details	Expected actions
		<p>A Assessment</p> <ul style="list-style-type: none">• Advanced labour with urges to push.• Nil visible.• Routine labour care.• IVC – in-situ due to previous MROP – Blood to lab for G&H. <p>R Recommendation</p> <ul style="list-style-type: none">• Prepare for the birth, discuss 3rd stage management.• CTG reattached due to a couple of variable decelerations heard on the Doppler after the VE.	

State 2: Ongoing management				
Vital signs		Script	Details	Expected actions
RR	24	Jemma: After a few minutes complain of contraction pain again. Start to push the placenta and uterus down as midwife applies CCT.	<ul style="list-style-type: none"> • Uterus firm and central. • Slight trickle of blood. • Contractions felt. <p>Starts to apply CCT. Appears the placenta is delivering but as it becomes visual it is still attached to the uterus.</p>	<input type="checkbox"/> Start to manage 3 rd stage <input type="checkbox"/> Recognise the uterine inversion <input type="checkbox"/> Declare emergency <input type="checkbox"/> Call for help <input type="checkbox"/> DRABC <input type="checkbox"/> Facial O ² – 15 L via rebreather <input type="checkbox"/> Commence IV fluids <input type="checkbox"/> 2 nd IV line <input type="checkbox"/> Call consultant <input type="checkbox"/> Document actions <input type="checkbox"/> Prepare Oxytocin 30U/ 500mls <input type="checkbox"/> Collect Tocolytic drugs <ul style="list-style-type: none"> ○ Terbutaline ○ GTN
SPO ₂	97%			
BP	100/60			
HR	108			
Temp	NR			
Consciousness sedation score	Alert	As placenta becomes visible then Jemma complains of acute pain in each side and across her abdomen. Pain becomes more intense starting to show signs of shock:	Becomes shocked – vomiting. Just rousable but in pain.	
PV loss	Post birth blood loss approx. 100mls with gush	<ul style="list-style-type: none"> • Pale • Sweaty • Tachycardia • ↓ BP • Nauseated • Restless 		
BSL	N/A			
RR	24			

QMEWT Observations (5-minute OBS)

State 2: Vital Signs									
Time	Uterine Inversion	5 mins	10 mins	Uterus re-inverted	15 mins	20 mins			
RR		28	24		18	16			
SPO ₂		94%	96%		97%	98%			
O ₂ Flow		15L	15L		2L NP	0L			
BP/ART		80/50	75/40		100/70	110/75			
HR		110	120		100	106			
TEMP		N/R	N/R		37°C	N/R			
GCS Consciousness		Rousable in acute pain	Rousable in acute pain		Awake less pain	Awake discomfort			
PV Loss		50mls	50mls		75mls	min			
Q- MEWT Score		No total as no Temp.	No total as no Temp.		1	No total as no Temp.			

State 3: Resolution				
Vital signs		Script	Details	Expected actions
RR	See QMEWT table for OBS.	Jemma: Feeling better now that the uterus has been replaced, discomfort from bimanual compression.	Recognises the uterus is inverted. Commences manual replacement OR Hydrostatic replacement. Prepares for transfer to OT for MROP.	<input type="checkbox"/> Do manual replacement OR hydrostatic replacement <input type="checkbox"/> Recap on management <input type="checkbox"/> Continue 5 minute obs. <input type="checkbox"/> Call OT to prepare for CAT 1 situation <input type="checkbox"/> Reassure the patient and tell her what has happened <input type="checkbox"/> Make a plan of care <input type="checkbox"/> Transfer to OT <input type="checkbox"/> Briefly discuss with Jemma if able – debrief at a later time after emergency.
SPO ²				
BP				
HR				
Temp				
Consciousness sedation score				
PV loss				
BSL				



Supporting Resources

This section contains the following supporting documents that will be essential in the delivery of this learning package:

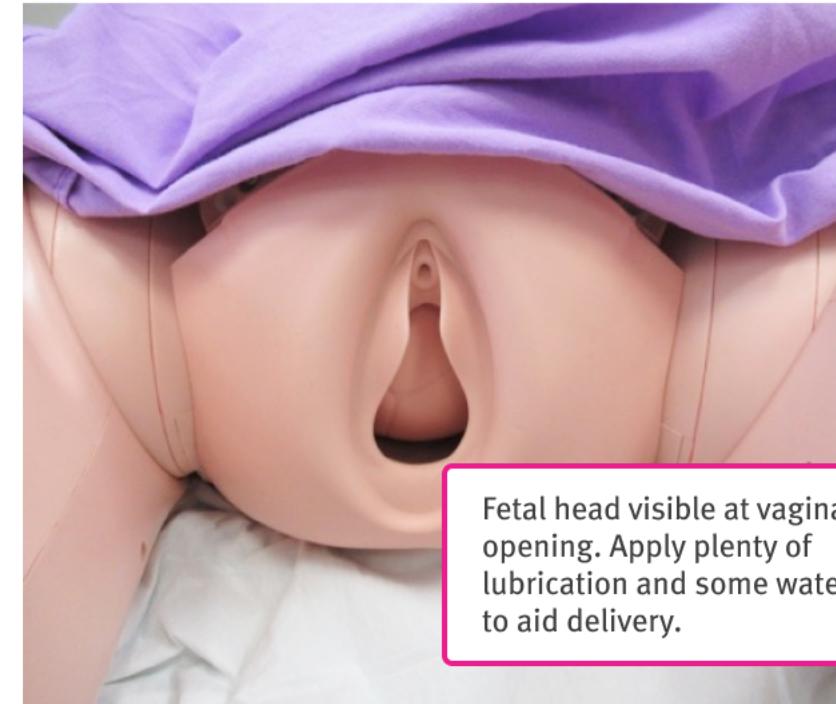
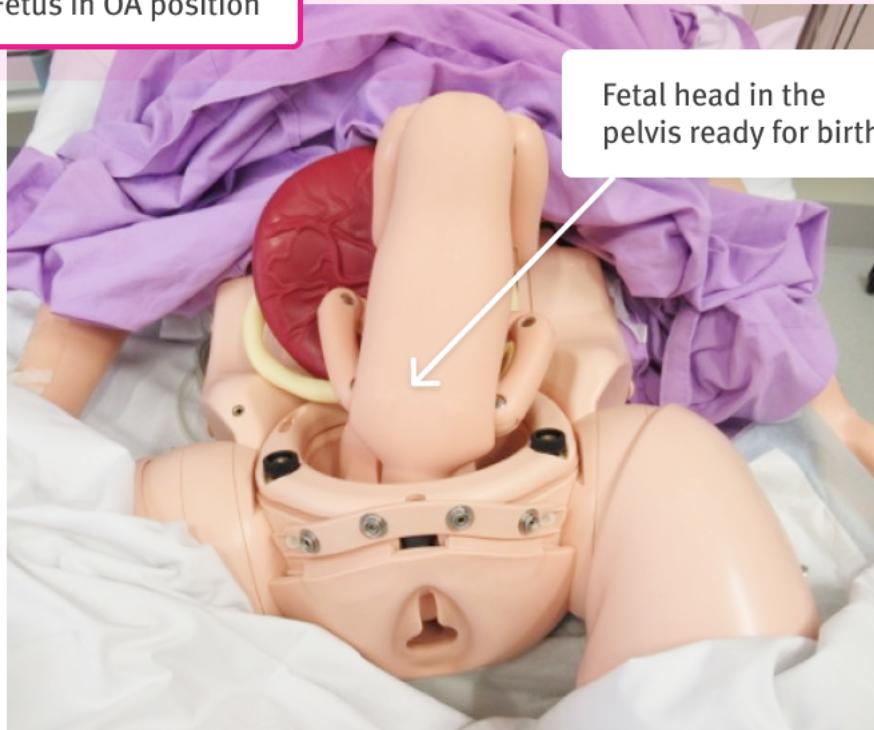
1. Ultrasound scan report
2. Manikin set-up guide
3. Laboratory reports
4. CTG on admission
5. Current CTG - 2nd stage pushing
6. Simulation debriefing poster
7. Debriefing guide

More resources can be downloaded from our website.



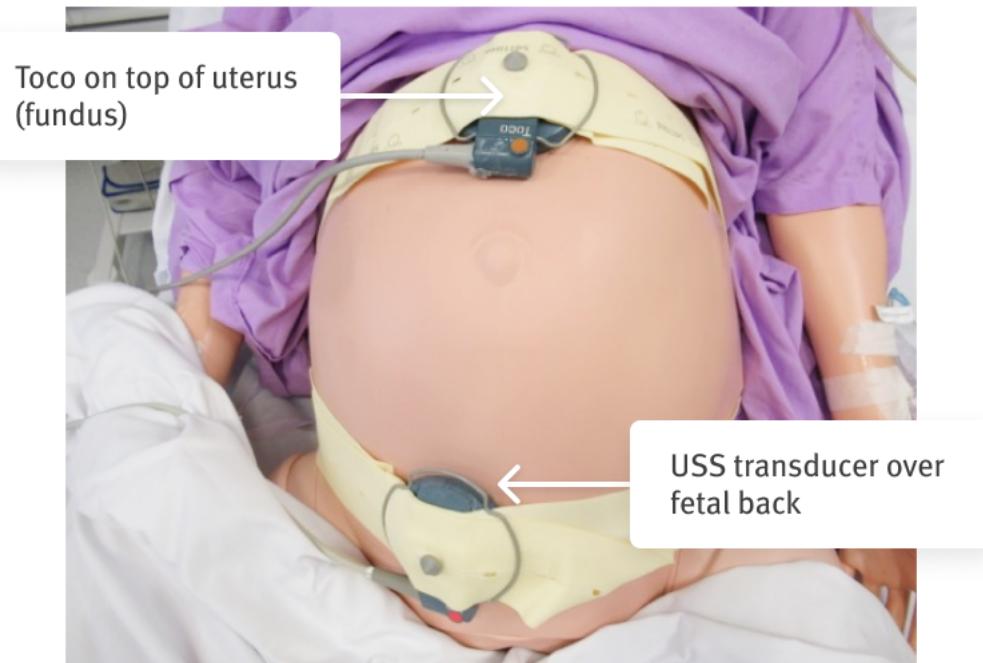
Fetal placement

Fetus in OA position





CTG placement



36 week Routine**DATE:****PATIENT:****DOB:****LABORATORY REPORT****PAGE: 1****REF:**

Test	Result	Comment
Group and Antibody Screen		
Group	AB Rh (D) Positive	
Antibody	Negative	
		Nil
Expires in 7 days		

36 week Routine**DATE:****PATIENT:****DOB:****LABORATORY REPORT****PAGE: 1****REF:**

Test	Result	Reference	Comment
Haemoglobin	118 g/dL	13.7-17.7g/dL	
WCC	16.0	3.9-10.6 x 10 ⁹ /L	
Platelets	126	150-440 x 10 ⁹ /L	
Haematocrit	0.40	0.39 – 0.52	
RCC	4.95	4.50 – 6.0x10 ¹² /L	
MCV	93 fL	80 – 100 fL	
Neutrophils	(83%) 9.15	2.0 – 8.0x10 ⁹ /L	
Lymphocytes	(10%) 1.18	1.0 – 4.0x10 ⁹ /L	
Monocytes	(6%) 0.62	0.1 – 1.0x10 ⁹ /L	
Eosinophils	(0%) 0.01	<0.60x10 ⁹ /L	
Basophils	(0%) 0.03	<0.20x10 ⁹ /L	

36 week Emergency Admission**DATE:****PATIENT:****DOB:****LABORATORY REPORT****PAGE: 1****REF:**

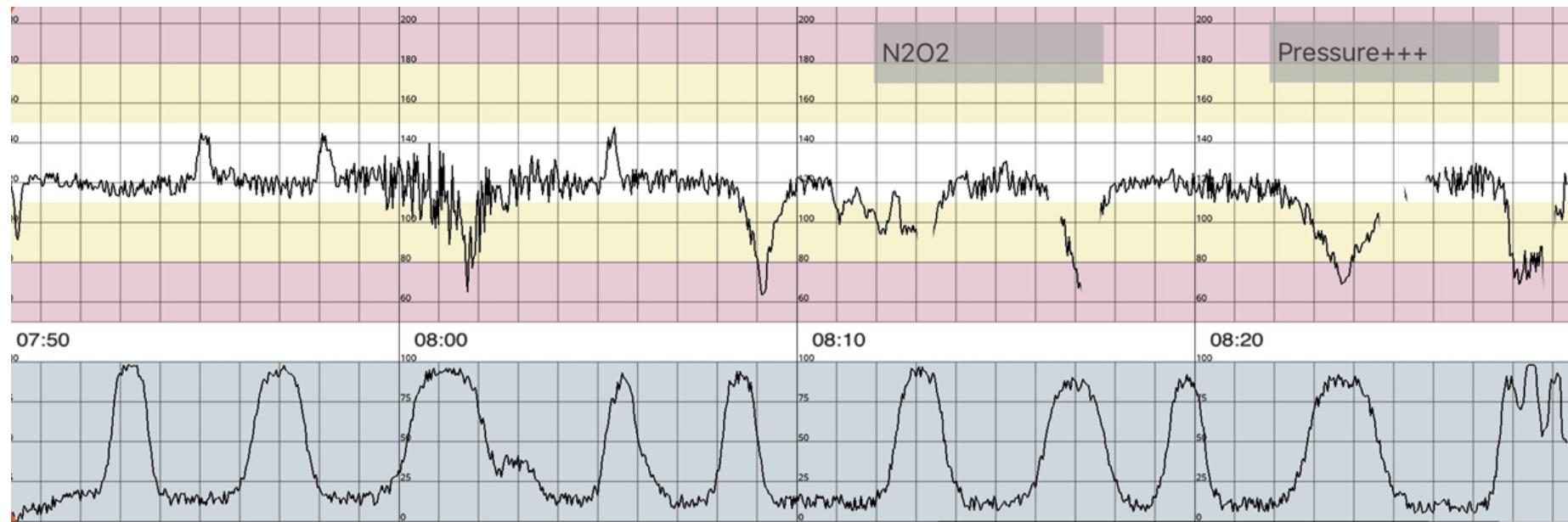
Test	Result	Reference	Test	Result	Reference
Sodium	138 mmol/L	135-145 mmol/L	Urate		
Potassium	4.2 mmol/L	3.5-5.2 mmol/L	Protein (total)	64 g/L	60-83 g/L
Chloride	104 mmol/L	95-110 mmol/L	Albumin	35 g/L	35-50 g/L
Bicarb.	28 mmol/L	18-26 mmol/L	Bilirubin (total)	20 umol/L	<20 umol/L
Anion Gap	8 mmol/L	4-13 mmol/L	Bilirubin (conj)	<4 umol/L	<4 umol/L
Glucose	4.0 mmol/L	3.0-7.8 mmol/L	Gamma GT	8 umol/L	<55 u/L
Urea	6.2 mmol/L	2.1-7.1 mmol/L	AST	32 U/L	<35
Creatinine	42 umol/L	32-73 umol/L	ALT	40 U/L	<45
Urea/Creat	63	40-100	ALP	100 U/L	56 - 119
eEFG	>90 ml/min	>60 ml/min	Calcium	2.28 mmol/L	2.10-2.60 mmol/L
Phosphate	1.01 mmol/L	0.75-1.50 mmol/L	Corr ca	2.47 mmol/L	2.10-2.60 mmol/L
Magnesium	0.76 mmol/L	0.70-1.10 mmol/L	OSM (calc)	283 mmol/L	270-290 mmol/L

18-20 USS report – Posterior/Fundal placental position



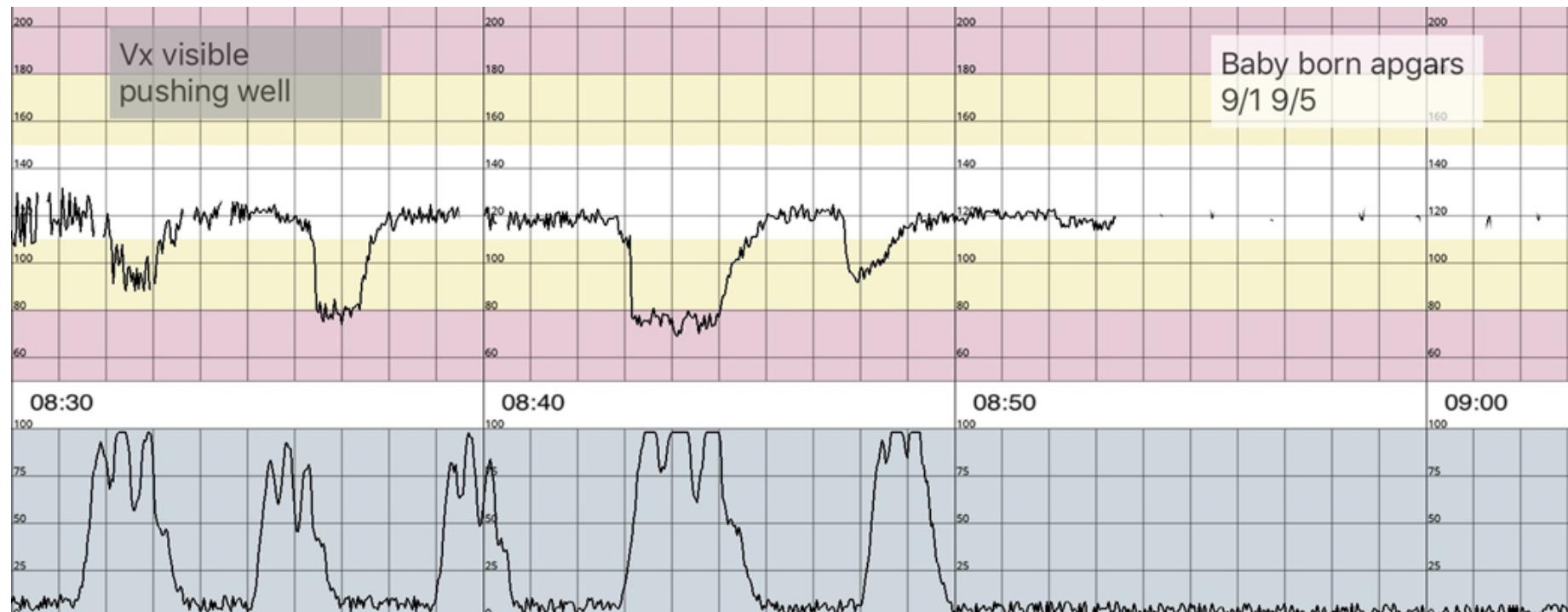
CTG during transition and 2nd stage

CTG 2 – Current



CTG during 2nd stage

CTG 2 – Current



Simulation Debriefing

Establishing a safe container for learning in simulation.



Reaction phase - “vent”

1

- How was that?
- How are you feeling?
- Any other initial reactions?
- Learners may reveal key areas that are important to them.



Description phase

2

- Clinical summary of the case.
- Can be shortened if it appears there is shared understanding of the case.

Analysis phase

3

Select which strategy is suited:

- Learner self-assessment - learner generates objectives
What went well/what would you change?
What well/did not go well and why?
- Focused facilitation - analyse performance related to objective

Summary phase

4

- Discuss take-home learning points
- Learner guided approach or
- Facilitator guided approach

Adapted from Eppich, W. and Cheng, A., 2015. Promoting Excellence and Reflective Learning in Simulation (PEARLS). *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*, 10(2), pp.106-115.

Debriefing guide

Scenario objectives	<p>Participants are required to:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Manage the third stage of labour as per the clinical guidelines. <input type="checkbox"/> Identify early the difficult with placental delivery. <input type="checkbox"/> Recognise uterine inversion and acts promptly. <input type="checkbox"/> Recognise and respond to the clinically deteriorating patient. <input type="checkbox"/> Implement emergency management of uterine inversion to include: <ul style="list-style-type: none"> • drug therapy • preparation for OT • manage shock • attempt replacement by manual or hydrostatic method
Vent phase	<p>Example questions:</p> <ul style="list-style-type: none"> • Initial thoughts of how the simulation went? • Acknowledge emotions (note body language and tone of participants)
What happened (phases)?	<p>Example questions:</p> <ul style="list-style-type: none"> • Tell us about your patient and what were your initial priorities? • What led to your decision to escalate management? • What clinical signs and symptoms led you to become concerned?
What was done well and why?	<p>Example question:</p> <p>What could have been better at each phase?</p>
Relevance to experience	<p>Example question:</p> <p>How would you transfer knowledge from today into your workplace?</p>
What has been learned?	<p>Example question:</p> <p>What actions will you take to enhance your skills and knowledge post simulation?</p>
Transfer to clinical settings	<p>Example questions:</p> <ul style="list-style-type: none"> • What will you take away from this session?

	<ul style="list-style-type: none">• Can you give an example of how you could apply new skills or knowledge gained during this session in your clinical setting?
Key moments	<ul style="list-style-type: none">• Recognition of deterioration and shock.• Recognition of uterine inversion.• Calling for HELP early.• Manual or hydrostatic replacement.• Calling for appropriate team members.• Preparing and planning for ongoing management.

Acronyms and Abbreviations

Term	Definition
BP	Blood pressure
CAT 1	Category 1
CCT	Controlled Cord Traction
CTG	Cardiotocograph
DRABC	Danger: Response: Airway: Breathing: Circulation
FH	Fetal heart
GBS	Group B streptococcus
G&H	Group & Hold
GTN	Glycerine Trinitrate
Hb	Haemoglobin
IVC	Intravenous Cannula
MROP	Manual Removal of Placenta
NAD	Nothing abnormal detected
NCHI	Nation Centre for Biotechnology Information
NR	Not Recorded
N ² O ²	Nitrous Oxide/Oxygen
OA	Occipital Anterior
Obs.	Observations
OT	Operating Theatre
PHR	Pregnancy health record
RCOG	Royal College of Obstetricians & Gynaecologists
SVD	Spontaneous Vaginal Delivery
USS	Ultrasound scan
VE	Vaginal Examination

References

This resource kit is inspired by the Optimus BONUS project of the Children's Health Queensland's "Simulation Training Optimising Resuscitation for Kids" service. To know more information about STORK and their Optimus project, visit their website at <https://bit.ly/3km1wcZ>.

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Uterine Inversion – Facilitator Resource Kit

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