OBSTETRIC EMERGENCIES

POSTPARTUM HAEMORRHAGE (PPH)

A PPH is defined as vaginal bleeding in excess of 500mL after childbirth or sufficient blood loss to compromise the client. It is the leading cause of maternal mortality worldwide with the majority of morbidity and mortality occurring within 24 hours of childbirth.

This policy is to be read in-conjunction with the Community Midwifery Program's Medication Protocol and Standing Orders and CMP Active Management of the Third Stage of Labour

Applies to:

All Midwives working for the Community Midwifery Program

Clients at risk of PPH:

All CMP clients must receive from their Midwife a copy of the CMP informed choice pamphlet "The birth or delivery of your placenta (afterbirth)" prior to 36 weeks gestation. Documented discussion must also occur, surrounding possible risk factors and recommendations / maternal choice. In line with the ANMC Consultation and Referral Guidelines, any client with the following risk factors needs to be referred to an obstetrician.

Antenatal risk factors:

- Grand multipara: parity 5 or more
- Previous history of PPH
- Raised BMI >35
- Maternal anaemia (undiagnosed or untreated)
- APH
- Previous Macrosomic baby ≥4.5 kg
- Polyhydramnios
- Fibroids
- Induction/augmentation of labour (IOL)

Note: PPH may occur when there are no risk factors identified

Where Intrapartum risk factors for increased risk are identified, a plan must be made with the obstetrician at the supporting hospital at that time.

Intrapartum risk factors:

- Spurious labour or prolonged latent phase of labour
- Fetal macrosomia > 4.5 kg
- Precipitate or in coordinate labour
- Pyrexia in labour
- Prolonged active first stage of labour > 12 hours
- Prolonged 2nd stage > 3 hours
- Maternal fatigue or exhaustion (dehydration and ketosis)
- Prolonged physiological third stage of labour > 60 minutes
- Prolonged actively managed third stage > 30 mins

Potential Consequences of a PPH:

- Hypovolaemic shock
- Anaemia
- Blood transfusion
- Coagulopathy – thrombosis, DIC
- Lactation difficulties
- Operative procedures including Hysterectomy
- Maternal death

Primary cause of PPH

- Tone (70%), atonic uterus, distended uterus, uterine muscle exhaustion.
- Trauma (19%), cervical, vaginal, or perineum
- Tissue (10%), retained products of conception
- Thrombin (1%), blood clotting disorders

Management:

Early management for delay in labour (see CMP Guideline Labour Dystocia during the First Stage and Labour Dystocia during the Second Stage)

Prophylaxis of PPH (active management of the 3rd stage) in clients identified with risk factors

- Recommend active management of the third stage if risk factors have been identified

- Ensure that the support midwife is in attendance prior to expulsive phase of second stage
- Check and prepare oxytocics for active management of haemorrhage and equipment for intravenous rehydration and volume expansion (1000mL Hartmann's solution).
- Administer 1mL Syntometrine IMI following birth of baby if consent has been obtained.

Management of the PPH:

Explain procedure and ongoing care to client:

- Rub up the fundus to stimulate uterine contractions if actively bleeding prior to placenta being delivered (tone)
- Administer 1mL Syntometrine IMI (if prophylactic dose was not administered)
- Attempt to deliver placenta by Controlled Cord Traction (CCT)
- Empty bladder via catheter (in/out)
- Administer 1mL Syntometrine IMI as second dose if blood loss does not settle.
- Insert a large bore IV cannula, preferably 16 gauge. Insert 2nd cannula if necessary/possible. Take bloods for full blood picture (purple tube), group & save (pink tube).
- Continue to rub up fundus to stimulate uterine contractions
- Once the placenta has delivered, check placenta and membranes for completeness (tissue)

  Check for vaginal trauma and apply pressure to bleeding tissue and suture immediately if able.

In the event that:

- **The blood loss does not settle with the above measures and/or the estimated blood loss is approaching 500mL OR**
- **The placenta does not deliver within 30 minutes (active management) or 60 minutes (physiological management):**

Call 000 and ask for a priority 1 ambulance

- Consult with Senior Registrar or Consultant Obstetrician at the supporting hospital to inform them of woman's condition, management and reason for immediate transfer. Obtain verbal orders (ensure phone is placed on speaker phone so support midwife can also hear verbal order).
- Continue to rub up the fundus to stimulate uterine contractions

- If the uterus remains atonic and bleeding persists, administer 1000 micrograms (5X200 microgram tablets) of Misoprostol rectally. (**Do not administer Misoprostol to any woman who has a history of asthma.)**
- Following a verbal order commence infusion of Compound Sodium Lactate 1000ml (Hartmann's)
- Insert an indwelling catheter on free drainage
- Administer 1mL Ergometrine 250mcgs IMI
- Following a verbal order, if bleeding persists, commence infusion of 40IU Syntocinon in 500mL CSL (Hartmann's) run at 125mL/hr (42 drops/min) increase to 250mL / hour if ongoing bleeding and decrease by 40mL / hour every 30 minutes providing the uterus remains contracted and the blood loss minimal.
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- Monitor maternal BP, pulse rate, respirations and conscious state, blood loss and fundus 5 minutely.
- Keep the woman warm
- If bleeding continues to persist, finally apply bimanual compression to the uterus and transfer immediately on arrival of ambulance

Transfer:

- Consultation/referral and consider transfer if EBL >600mL.
- Transfer must occur if Estimated Blood Loss (EBL) ≥ 1000mL
- Transfer must occur if client symptomatic (hypotensive– systolic <80mmHg, tachycardic - pulse rate > 110 bpm, tachypnoeic – respiration rate >30 per minute, feeling faint, confused) regardless of total EBL
- Ongoing assessment of blood loss – consider weighing blood soaked materials to make accurate assessment.

Documentation:

- Document all actions and observations and total EBL
- Ensure all medications given are clearly documented on the medication chart (CMP MR 08B)
- On arrival at the supporting hospital present a clear verbal and written clinical handover (complete and present postpartum transfer form -CMP MR 08E and medication chart CMP MR 08B)
- Complete an electronic DatixCIMS

CAUTION

Caution should be given when using Syntometrine/Ergometrine with women who have had a raised BP during labour (≥140/90). These oxytocics should only be used after

consultation with an Obstetrician for these clients *(under normal circumstances these women would not be birthing at home).*

REFERENCES / STANDARDs

1. World Health Organization. **WHO recommendations for the prevention and treatment of postpartum haemorrhage.** Geneva, Switzerland: WHO Press; 2012. Available from: http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502_eng.pdf.
2. Women and Newborn Health service, KEMH Clinical Guideline, Section B: Obstetrics and Midwifery guidelines, 9 complications of the postnatal period, 9.1 postpartum haemorrhage (PPH), 9.1.1 Primary Post Partum Haemorrhage. http://wnhs.hdwa.health.wa.gov.au/__data/assets/pdf_file/0017/119312/PPH_27.7.2015.pdf
3. Royal College of Obstetricians and Gynaecologists. 2009. Green Top Guideline, No. 52. Prevention and management of Postpartum Haemorrhage.
4. CMP informed choice pamphlet "The birth or delivery of your placenta (afterbirth)"
5. ANMC National Guidelines for Consultation and Referral 2008
6. CMP guideline Active management of the third stage

National Standards – 1- Care Provided by the Clinical Workforce is Guided by Current Best Practice

Legislation - Nil
Related Guidelines / Policies – Antenatal care: The Initial Visit
Other related documents – Midwifery care when a Client Makes a Decision that Is Incompatible with the CMP Midwifery Standard of Practice

RESPONSIBILITY	
Policy Sponsor	Nursing & Midwifery Director OGCCU
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Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.