



CLINICAL PRACTICE GUIDELINE

Guideline coverage includes NICU KEMH, NICU PMH and NETS WA

Postnatal Midwifery Care: Maternal Secondary Postpartum Haemorrhage (PPH) on Ward 6B

This document should be read in conjunction with the [Disclaimer](#)

This guideline is specifically for mothers who are visiting and/or rooming in on 6B.

Secondary Postpartum Haemorrhage is defined as abnormal or excessive bleeding from the birth canal between 24 hours and 6 weeks following the birth. A secondary PPH occurs in 2% of postpartum women. Occurrence of secondary PPH is associated with a high maternal morbidity with approximately 85% requiring hospital admission. Approximately 15% of these women will require a blood transfusion and there is a 1% incidence of hysterectomy.

Risk Factors

Women at increased risk of a secondary PPH are those who have experienced:

- Primary postpartum haemorrhage.
- Manual removal of placenta.
- Intrauterine infection.

Aetiology

In approximately one third of women the cause is unknown. The most common causes are:

- Sub involution of the uterus.
- Retained products in the uterus associated with bleeding early in the postpartum period.
- Endometriosis associated with bleeding later in the postpartum period.

Initial Management

1. **Initial Assessment:** Assess the patient, call for help, commence resuscitation (DRSABCD). Assess blood loss and vital signs (pulse, respirations, oxygen saturation, blood pressure). Supply oxygen if required. If significant blood loss with haemodynamic compromise i.e. symptoms of pallor, rapid pulse, decrease in blood pressure, collapse or significant ongoing bleeding Dial 55 Code Blue.
2. **Massage the fundus** (place your hand at umbilical level and apply pressure towards the mother's feet until the uterus contracts and feels firm under your fingers) and evacuate any vaginal clots. Continue to apply pressure to fundus while bleeding continues. Elevate feet, but not pelvis.(as this can allow the uterus to fill with blood and conceal bleeding).





3. Obtain management advice from the KEMH Obstetric Senior Registrar on page 3299 or via switch board. Give ISOBAR handover including mother's obstetric history and PPH status.
4. Obtain phone order KEMH Obstetric Senior Registrar for Uterotonic agents and administer, **i.e. Oxytocin 10 I.U. intramuscular injection (All medications must be prescribed by a medical officer)**. Oxytocin is kept in 6B drug fridge in a Red labelled box
5. Insert 2 large bore intravenous cannula (18 G) and commence IV fluid replacement normal saline or volume expander (Hartman's) 1000 mL/hr.
6. Intravenous Oxytocin infusion of 40 I.U. in 500 mL of normal saline at 125 mL per hour may be ordered by KEMH Obstetric Registrar.
7. Insert IDC as full bladder will prevent the uterus from contracting (located in adult resus trolley).
8. Bimanual Compression may be required if ongoing uncontrollable bleeding. This should only be performed by staff competent in the procedure.
9. Keep all soiled perineal pads to estimate blood loss.
10. Ensure the next of kin are notified.
11. Arrange transfer by ambulance to KEMH Emergency Dept. as directed by the Obstetric Senior Registrar on page 3299.

References

1. King Edward Memorial Hospital. (May 2016). "Postpartum Haemorrhage". Clinical Guidelines, Section B: Obstetric and Midwifery Guidelines 9.1.4
2. King Edward Memorial Hospital. (2011). "Emergency procedures, basic life support-adult". Clinical Guidelines, Section A: Advanced life support 11.3.
3. Princess Margaret Hospital. (2011). "Code Blue (55) and Emergency Resuscitation". Paediatric Practice Manual, Section 4 Resuscitation Procedures 4.1.

Related WNHS policies, procedures and guidelines

WNHS O&M Clinical Guidelines – [Secondary Postpartum Haemorrhage](#)

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