Mid Essex Hospital Services NHS
NHS Trust

GUIDELINE FOR THE MANAGEMENT OF RETAINED PLACENTA	**CLINICAL GUIDELINES** **Register no 04245** **Status: Public**

Developed in response to:	Intrapartum NICE Guidelines RCOG guideline
Contributes to CQC Outcome	4

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Version Number	3.0
Issuing Directorate	Obstetrics and Gynaecology
Approved by	Documents Ratification Approval Group
Approved on	26th April 2012
Trust Executive Sign Off Date	May 2012
Next Review Date	March 2015
Author/Contact for Information	Stacey Bryan, Obstetric Senior House Officer
Policy to be followed by (target staff)	**Midwives, Obstetricians, Paediatricians**
Distribution Method	Intranet & Website Notified on Staff Focus
Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 04234 Guideline for the management of postpartum haemorrhage 06045 Antibiotic policy for Adults and Children 09062 Mandatory training policy for Maternity Service (incorporating training needs analysis) 09095 Severely Ill Pregnant Patient

Review No	Reviewed by	Review Date
1.0	Julie Bishop	October 2005
2.0	Dr Gajjar	January 2009

It is staffs responsibility to access the most up to date version of this document which will always be the version on the intranet

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1.0 Purpose of Guideline

1.1 The purpose of the guideline is to facilitate the management of retained placenta including the use of intraumbilical injection of syntocinon.

1.2 Although a retained placenta puts the woman at risk of haemorrhage, fatalities from it are very rare in the UK (estimated at 1 in 30,000 retained placentas) so long as there are the appropriate facilities available to perform manual removal safely and effectively.

1.3 There may be some psychological trauma associated with this procedure so soon after childbirth in addition to the health risks of the procedure itself, namely haemorrhage, infection and genital tract trauma.

2.0 Equality and Diversity

2.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Definition

3.1 The placenta is defined as “retained” when it has not been delivered within 30 minutes of birth, when the third stage is actively managed and longer than one hour when physiologically managed, without signs of postpartum haemorrhage (PPH) or maternal collapse.

4.0 Causes and Complications of Retained Placenta

4.1 These include “trapped” placenta, uterine atony, uterine abnormality, constriction ring-reforming cervix, full bladder, morbid adherence of the placenta: placenta acreta, placenta increta, placenta percreta.

4.2 Complications of manual removal of placenta (MROP) include perforation of uterus, retained parts, infection and anaesthetic risks

4.3 Complications of retained placenta include shock, postpartum haemorrhage, puerperal sepsis, sub-involution, hysterectomy and death if left untreated

5.0 Management of Retained Placenta

5.1 If the placenta is undelivered after 30 minutes consider:

- Emptying bladder
- Breastfeeding or nipple stimulation
- Change of position - encourage an upright position
  (Refer to appendix A)

5.2 An intravenous infusion of oxytocin **should not** be used to assist the delivery of the placenta unless there is bleeding.

5.3 For patients with a retained placenta, an oxytocin injection into the umbilical vein administering 20 IU (international units) of oxytocin in 20 ml (millilitres) of normal saline 0.9% is recommended, followed by proximal clamping of the cord.

5.4 This can either be done by direct injection into the umbilical vein or by insertion of an umbilical catheter into the vein by the obstetric registrar or consultant.

5.5 If the placenta is still retained 30 minutes after the oxytocin injection or sooner if there is concern about the patient's condition, the patient should be informed of the need to remove the placenta.

5.6 Patients should be informed that this assessment can be painful and they should be advised to have analgesia or anaesthesia for this assessment.

5.7 If a patient reports inadequate pain relief during the assessment, the healthcare professional must immediately stop the examination and address this need.

5.8 If a manual removal of the placenta is required, this must be carried out under effective regional anaesthesia (or general anaesthesia when necessary).

5.9 The delivery midwife should document the third stage completion time and completeness of the placenta.

5.10 If bleeding occurs immediately:

- Inform the senior midwife, obstetric registrar and anaesthetic registrar
- Insert a large bore (16 gauge) intravenous (IV) cannula
- Insert a Foleys indwelling urinary catheter
- Commence an oxytocin infusion of 40 IU in Hartmanns 500 mls commenced at a rate of 125 mls/hour
- Measure and accurately record blood loss per vaginum
- Prepare and transfer the patient to the obstetric theatre for the manual removal of placenta (MROP)
- Refer to postpartum haemorrhage (PPH) guideline (Register number 04234)

5.11 Manual Removal of placenta:

- The on call consultant should be informed before the patient goes to the obstetric theatre, that the procedure is due to take place
- Consultant presence should be stipulated if there is any suspicion of placenta accreta or an anterior low placenta with previous history of a caesarean section
- Prophylactic antibiotics should be given in conjunction with the Trust's antibiotic guideline for Adults and Children; register number 06045.
- The surgeon should ensure the complete removal of the placenta
- If placenta is thought to be adherent, immediately seek the opinion of the senior obstetrician

- Beware of the risk of uterine perforation

- If there is a constriction ring preventing the insertion of the examining hand into the uterus, stopping the syntocinon infusion may allow the uterus to relax and make the procedure easier. Uterine relaxants (tocolysis) can be used

- Restart the syntocinon infusion regime as soon as possible after that and continue the post procedure to prevent PPH

5.12 Future pregnancy

- Patients are advised to deliver in an obstetric unit if there has been a history of a retained placenta requiring MROP in a previous pregnancy

- Retained placenta is also a risk factor for PPH in any future pregnancy

6.0 Staffing and Training

6.1 All midwifery and obstetric staff must attend yearly statutory training which includes skills and drills training.

6.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

7.0 Infection Prevention

7.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

7.2 All staff should ensure that they follow Trust guidelines on infection control, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. obtaining blood samples, insertion of an IDC (Indwelling Catheter), vaginal examinations and conducting deliveries.

8.0 Audit and Monitoring

8.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy, the Maternity annual audit work plan and the NHSLA/CNST requirements. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

8.2 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

8.3 The audit report will be reported to the monthly Maternity Directorate Governance Meeting (MDGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

8.4 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

8.5 Key findings and learning points will be disseminated to relevant staff.

9.0 Guideline Management

9.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

9.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

9.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

9.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

10.0 Communication

10.1 A quarterly 'maternity newsletter' is issued to all staff with embedded icons to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

10.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

10.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

10.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

11.0 References

Nardin JM, Weeks A, Carolli G. (2011) Umbilical vein injection for management of retained placenta Cochrane database of systematic reviews (5):CD001337

NICE clinical guidance 55 – Intrapartum care Sept 2007

Appendix A

Retained placenta Flow Chart