

Prevention and Management of Primary Postpartum Haemorrhage

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in the care of women with Primary Postpartum Haemorrhage.

Following a comprehensive literature review a number of evidence-based recommendations for prevention and management of Primary Postpartum Haemorrhage were agreed upon.

Key Recommendations

PREPAREDNESS

1. Women who are at higher Post Partum Haemorrhage (PPH) risk should be identified and actively managed at each care opportunity. This should include screening for and management of antenatal anaemia and recognised PPH risk factors.
2. Each maternity unit should have a policy in place for identification and management of women with red cell antibodies (where specific additional blood transfusion matching is required).
3. Women who do not wish to receive blood products should be identified at their booking visit. There should be a detailed discussion and documentation of acceptable and unacceptable treatments. Advance Decision to Refuse Specified Medical Treatment should be completed and kept in the maternity chart and updated during pregnancy.
4. Women with inherited bleeding disorders should be identified at booking and referred for planning of pregnancy, intrapartum and postpartum care by experienced fetomaternal specialists, haematologists and anaesthetists.
5. Women should have a FBC at booking and at 28 weeks' gestation to screen for anaemia with the aim of treating and optimising haemoglobin before birth. Keeping in line with UK recommendations repeat blood group at 28 weeks to further screen for red cell alloantibodies should be considered.
6. Placental site should be determined at routine fetal anatomy scanning, particularly if there is a previous Caesarean Section.
7. If placenta accreta spectrum has been diagnosed, planned delivery before term in a unit with an experienced skilled multidisciplinary team of specialists and resources, is recommended.
8. Risk factor assessment for PPH should continue intrapartum and should be clearly communicated during handover of clinical care.
9. Women with retained placenta, or who require intrapartum Caesarean Section (especially in the second stage of labour) require close surveillance for PPH.
10. It is important to remain vigilant for excessive blood loss at all births because many women who suffer a PPH do so without identifiable risk factors.
11. All obstetric units should maintain a supply of O Rh D negative, Kell negative blood for emergency use.
12. Each maternity unit should develop local policies and protocols to include standards of documentation, defined roles and responsibilities, blood component and pharmaceutical location/availability, reporting and review processes.
13. Each maternity unit should identify and document the turn around times (TAT) for laboratory tests relevant to management of MOH. Near patient testing (blood gas analysis and coagulation testing), if used, should be compliant with national guidelines/standards.

14. Local hospital blood group serology testing and blood order schedules for delivery method should be developed and periodically reviewed for appropriateness. Sample acceptance and component release policies should be agreed.
15. Local simulated multidisciplinary team (including laboratory staff) drills should be used to promote learning. Each maternity unit should undertake training of all staff engaged in the management/support of PPH/MOH in compliance with their policies and local procedures. Training should include the use of multidisciplinary 'drills' on a specified periodic basis and eLearning if available.
16. Appropriately trained colleagues should provide simulation training for life threatening MOH to anaesthesiologists, obstetricians, midwives, laboratory and portering staff.
17. We recommend that a national MOH poster be adopted and personalised by each unit delivering maternity care. This poster should be prominently displayed in each labour ward/theatre.

PREVENTION

18. Delayed cord clamping is recommended for neonatal benefit. The cord should be clamped immediately if there is active maternal bleeding or a need for neonatal resuscitation.
19. Prophylactic uterotonics should be administered to all women immediately following birth to prevent PPH.
20. Administration of oxytocin at a dose of 10 IU IM or 5 IU by slow IV, is recommended following a vaginal birth.
21. While oxytocin can be administered at lower doses at elective CS and followed by low dose infusion, higher initial doses and infusions may be required for intrapartum CS especially when an oxytocin infusion has been used in labour.
22. Prophylactic oxytocin (5IU) in combination with ergometrine (500µg) [Syntometrine] IM may reduce blood loss more than oxytocin alone and may be considered as a first line prophylactic uterotonic in women at high PPH risk. We do not recommend it as a first line uterotonic in women at low risk because of a five-fold higher risk of nausea, vomiting and hypertension compared to use of oxytocin alone.
23. Carbetocin is non-inferior to oxytocin in preventing PPH following vaginal birth and elective CS. We do not recommend it as an alternative first line uterotonic because of unproven cost benefit.
24. Women requesting physiological management of the third stage of labour should be informed of the risk and benefits, especially if they have PPH risk factors. They should be supported in their choice, once fully informed, but advised that a uterotonic should be administered if excessive bleeding occurs or if the placenta has not separated after 30 minutes.
25. Preparations should be made to transfer the woman to theatre for manual removal of placenta (MROP) 30 to 60 minutes after birth and sooner if there is active bleeding.
26. We suggest that prophylactic tranexamic acid administration may be considered in women who are at high PPH risk (including combinations of risk factors).

RECOGNITION

27. Gravimetric or calibrated methods of blood loss measurement are recommended at CS, operative vaginal birth and after spontaneous vaginal birth if visual estimation of blood loss is >500 ml.
28. Cumulative measured blood loss during PPH should be recorded and communicated to the team.
29. Care providers should be vigilant for symptoms and signs of hypovolemia as these may not always correlate with blood loss and should consider the possibility of underestimated or concealed blood loss.

MANAGEMENT: STOP THE BLEEDING

30. A staged approach to PPH response is recommended with escalation of care depending on blood loss and clinical concerns.
31. We recommend that each Maternity unit implement the NPEC/NWIHP-documented pathway checklist for PPH management with local agreed modifications.

32. Standard components of initial uterine atony management should include uterine massage, insertion of an indwelling catheter and a check of the completeness of the placenta and membranes.
33. Oxytocin is recommended as the first-line PPH treatment, either as a slow IV bolus or infusion. It is preferable to administer oxytocin using a controlled infusion device.
34. We suggest that ergometrine is administered as the second line uterotonic for PPH treatment (in the absence of contra-indications) followed by either misoprostol or carboprost depending on the clinical circumstances.
35. Each obstetric unit should have a clear local policy on uterotonic use in PPH treatment, providing suggested drug sequences and dosing recommendations that may be individualised.
36. Tranexamic acid administration is recommended early during PPH treatment.
37. The most appropriate surgical intervention should be determined by the cause of PPH, the haemodynamic stability of the woman, the available surgical expertise and access to supportive services (such as imaging and interventional radiology).
38. Hysterectomy should be considered when interventions to arrest bleeding and/or resuscitation measures to compensate for bleeding are not effective. Efforts should be made to obtain a second opinion before proceeding to hysterectomy if feasible in a timely manner.

MANAGEMENT: RESUSCITATE

39. Restrictive crystalloid administration < 3.5L is suggested during severe ongoing haemorrhage.
40. The use of blood components should be guided by the clinical situation and should not be delayed while awaiting laboratory results. Access emergency/patient specific red cell support immediately and refer to the national MOH poster.
41. Platelet components should be ordered at a platelet count of $100 \times 10^9/l$. Platelet transfusion should be given when the platelet count falls $<75 \times 10^9/l$, in order to maintain a count $>50 \times 10^9/l$. Early platelet transfusion should be considered for abruption and abnormal placentation.
42. A plasma fibrinogen level of $> 2 \text{ g/l}$ should be maintained by administration of fibrinogen concentrate.
43. Empiric early fibrinogen replacement may be considered if the fibrinogen result (or Viscoelastic haemostatic assay (VHA) equivalent) is not rapidly available, especially in the setting of placental abruption/praevia or amniotic fluid embolism.
44. VHA may be considered in the management of PPH if local resources and governance structures permit.
45. Cell salvage may have a role in the management of PPH in selected cases, if local resources and governance structures permit.
46. There is no evidence favouring either general or regional anaesthesia in postpartum haemorrhage management in the operating room.

MANAGEMENT: COMMUNICATE – CODE RED OBSTETRICS

47. The major obstetric haemorrhage (MOH) protocol (articulated as CODE RED OBSTETRICS) should be activated for uncontrolled bleeding $>1500\text{ml}$ blood loss or if a clinical concern warrants it.
48. Each maternity unit should adopt the nationally agreed term 'life threatening haemorrhage: code red – obstetrics'.
49. Clear communication pathways are recommended to alert all relevant team members and a designated person should coordinate further management. The team should use the ISBAR (Identify – Situation-Background-Assessment-Recommendation) technique as a simple way to plan and structure communication.
50. The woman and her partner should be informed and supported by appropriate staff throughout the event.
51. A scribe should be assigned to document staff present and timing of interventions.
52. The emergency should be stood down when bleeding is controlled or as appropriate with clear communication to all team members including laboratory staff.

MANAGEMENT: POST EVENT CARE

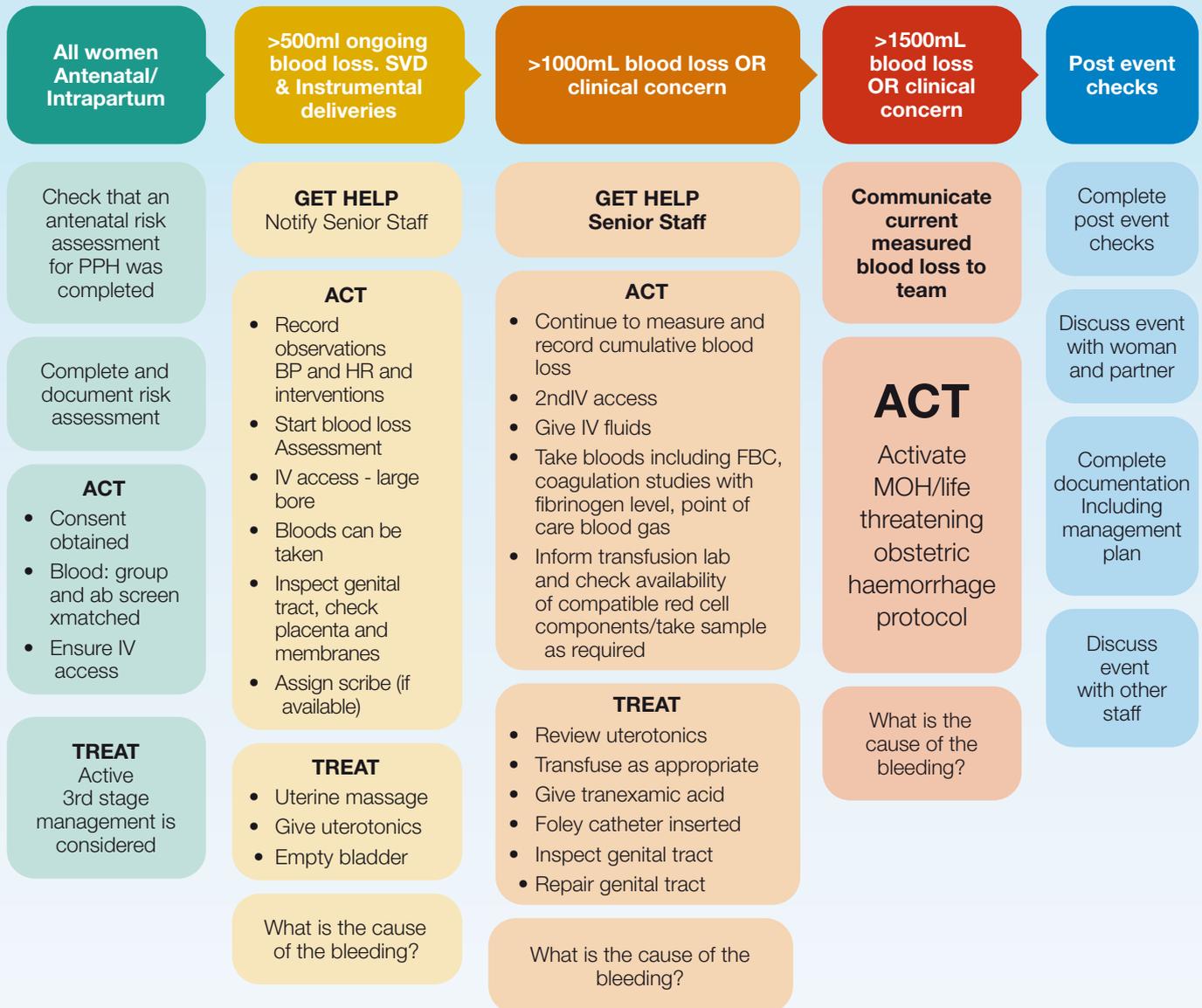
53. A restrictive transfusion policy (Hb < 7 g/dl) may be considered in stable women without severe symptoms following a postpartum haemorrhage.
54. All women should undergo a formal VTE and bleeding risk assessment after haemostasis has been secured (and repeated when the clinical situation changes). Pharmacological and/or mechanical thromboprophylaxis should be considered as appropriate. Multidisciplinary discussion may be required to determine the optimal timing of initiation of pharmacological thromboprophylaxis. Women should be informed of the signs and symptoms of a VTE, and that such an event may occur post-discharge. Women should be provided with a HSE VTE alert card before leaving hospital.
55. There should be debriefing of the staff, the woman, and her partner as soon as possible after the event. A further debrief should be offered to the woman and her partner following hospital discharge, usually around six weeks following birth.
56. Documentation of events, and completion of component traceability should be carried out if not completed contemporaneously.
57. MOH should be reported through the hospital clinical incident reporting system.
58. Serious adverse events and serious adverse reactions (SAE/SAR) associated with transfusion/life threatening haemorrhage should be reported to the National Haemovigilance Office (NHO).

AUDIT, EVALUATE, ASSIMILATE

59. Each maternity unit should have processes in place for auditing clinical practice and agreed data set, providing feedback to team members.
60. Cases of MOH should be reviewed at local serious incident management team (SIMT) meetings (or similar risk management team meetings), hospital transfusion committee (HTC) and overarching transfusion committees (OTCs) to evaluate the effectiveness of care, treatment and services provided. Systems learning should be identified, and change effected through communication and education.

Algorithm

Staged approach to prevention and management of PPH



ALERT : Consider the possibility of underestimated or concealed blood loss

Please note that the nature of PPH is such that depending on the clinical circumstances, staffing, etc these stages are not prescriptive and some interventions (e.g. blood testing or establishing adequate IV access) may occur at an earlier stage. This algorithm is designed to aid recognition, guide management with the aim of reducing the incidence of progression to LTH/MOH.





Prevention and Management of Postpartum Haemorrhage Checklist*

MRN:

Most recent

Hb

Plt

Date:

STAGE 0: PPH Risk Assessment Complete for all women on admission (including LSCS Labour)		
Check Antenatal Risk Assessment	TIME:	ACT
Retained products of conception/Placenta		Woman group & ab screen Yes No
Induction of labour/Augmentation of labour		Woman xmatched Yes No
Placenta Previa/Accreta/Abruption		IV access required? Yes No
Chorioamnionitis		Consent obtained Yes No
Labour Delivery (Please make an on going assessment of the following risk factors throughout labour and delivery)		TREAT
Sepsis/Pyrexia in labour		Planned active 3rd stage management? Yes No
Prolonged 1st of labour > 12 hours active		PLAN TO MEASURE AND RECORD ALL BLOOD LOSS
Prolonged 2nd stage of labour >4hours		
> 12 hours of Syntocinon		
Operative Vaginal Delivery		
Emergency Caesarean Section		
Baby >4.5kg		Please make an on going assessment of risk factors throughout labour and delivery

STAGE 1: >500ml ongoing blood loss. SVD & Instrumental deliveries			
GET HELP	TIME:	ACT	TIME:
Notify Midwife/Obstetrician		Check placenta and membranes	
ACT		Inspect genital tract	
Assign scribe (if available)		TREAT	
Measure Blood Loss (cumulative measurement)		Uterine Massage	
Record observations HR + BP)		Empty bladder	
IV access – large bore		Give uterotonics	
Blood can be taken		Bimanual uterine compression	
What is the cause of the bleeding? Tone Trauma Tissue Thrombin. (please circle cause/s)			

**ALERT : Consider the possibility of underestimated or concealed blood loss
Communicate current measured blood loss to team**

STAGE 2: >1000mL blood loss OR clinical concern

e.g. abruption or concealed bleeding OR abnormal vital signs RR>30, HR ≥ 120, BP ≤ 90/40mmHg, SpO2<95%. Progress here from stage 1 if SVD/Instrumental delivery. Restart here after stage 0 if LSCS.

GET HELP	TIME:	
MW in charge		Hb
Obstetrician		Coag
Anaesthetist		PT
Other staff		APTT
		Fibrinogen
ACT	TIME:	TREAT
Measure and record cumulative blood loss		Review uterotonics
Record observations (HR + BP)		Give tranexamic (1g IV, if no Cl's)
2nd IV access and fluids		Transfuse as appropriate
Take bloods		Uterine Compression
Lab tests FBC, Coag, Xmatch, U&E, FIB		Foley catheter inserted
Inform transfusion lab and check availability of compatible RCC take sample as required		Inspect genital tract
		Repair genital tract
		Check placenta and membranes

What is the cause of the bleeding? Tone | Trauma | Tissue | Thrombin. (please circle cause/s)

ALERT : Consider the possibility of underestimated or concealed blood loss
Communicate current measured blood loss to team

STAGE 3: >1500ml blood loss OR clinical concern
IF BLEEDING ONGOING TRANSFER PATIENT TO THEATRE

STATE I am activating the Life Threatening Haemorrhage Protocol, CODE RED OBSTETRICS

ACT	TIME:	TREAT	TIME:
Activate the MOH/ life threatening haemorrhage protocol		Review uterotonics	
Identify Emergency Coordinator Identify Communication Lead		Consider repeat tranexamic acid	
Inform consultant obstetrician and anaesthetist		Consider advanced surgical techniques	
Resuscitate			
Order blood components as per the MOH poster			

ONCE BLEEDING STOPPED ENSURE PPH CHECKLIST IS COMPLETED AND MANAGEMENT PLAN WRITTEN IN NOTES

What is the cause of the bleeding? Tone | Trauma | Tissue | Thrombin. (please circle cause/s)

Adapted with permission from California Maternal Quality Care Collaborative and OBS Cymru



Names of Staff Present

MEASURED CUMULATIVE BLOOD LOSS

Time	Blood Loss (ml)	Running total

Total Measured Blood Loss: ____ ml

BLOOD & BLOOD PRODUCTS TRANSFUSED **TIME**

Remember to discuss the event with the woman and her partner

RECORD OF UTEROTONICS USED – TO PREVENT BLEEDING

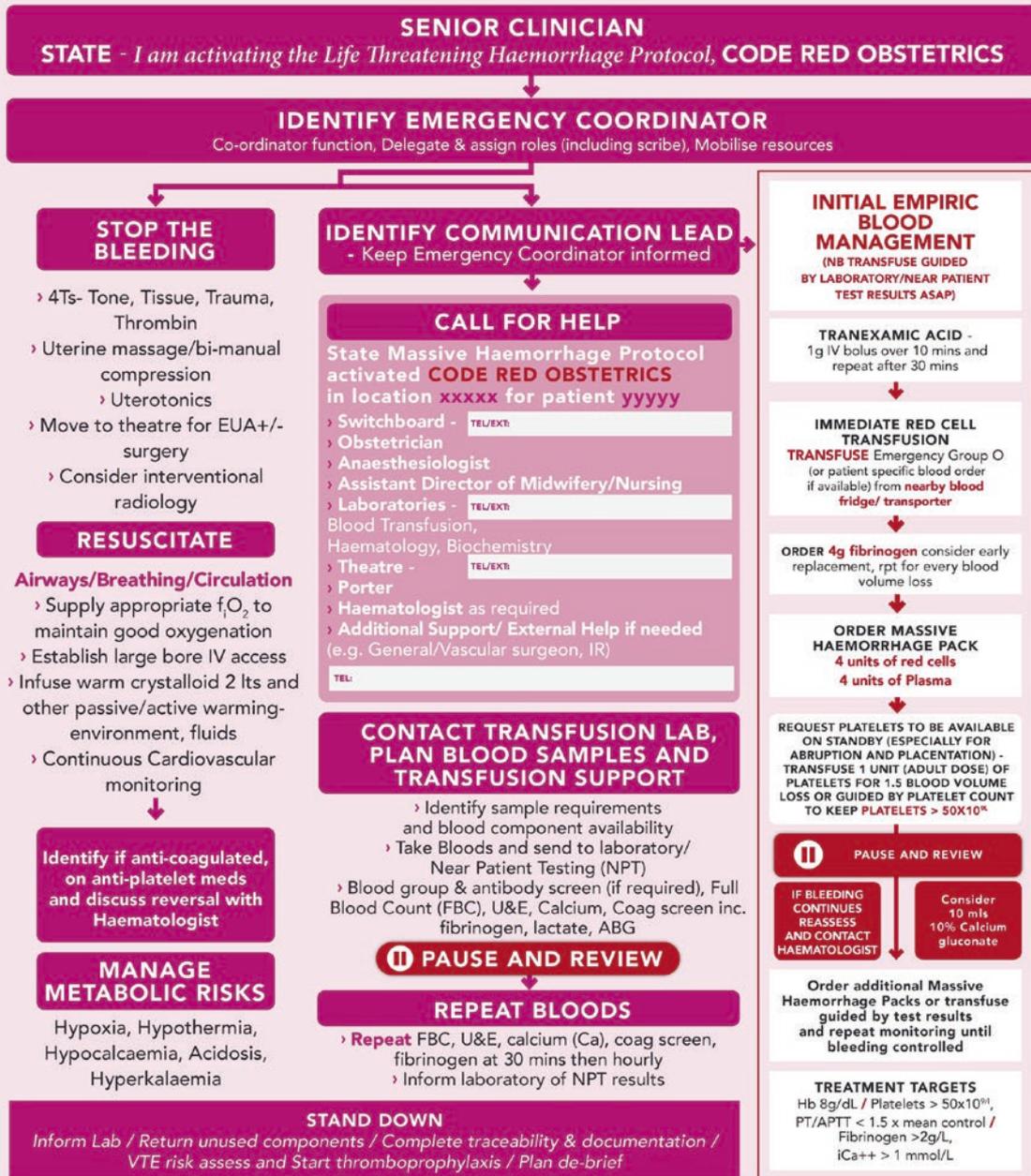
Drug	Dose	Time

RECORD OF UTEROTONICS USED – TO TREAT BLEEDING

Notes

Post Partum Life-Threatening Haemorrhage Protocol

POST PARTUM LIFE THREATENING HAEMORRHAGE PROTOCOL
CLINICAL CONCERN FOR LIFE THREATENING BLEEDING –
UNCONTROLLED BLOOD LOSS >1500ML (CAVE CONCEALED LOSS)



NEAREST EMERGENCY GROUP O	BLOOD FRIDGE/ TRANSPORTER	RED CELL COMPONENTS	PLATELETS	PLASMA	FIBRINOGEN	TRANEXAMIC ACID (TXA)	PROTHROMBIN COMPLEX CONCENTRATE	IDARUCIZUMAB (PRAXBIND)
Location		Time to availability Patient's own group	Location	Location	Location	Location	Location	Location
Minimum contents		Cross matched	Time to availability	Time to availability	Time to availability	Time to availability	Time to availability	Time to availability

Supplied as Available For Anticoagulated Patient

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Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this guideline include:

1. Proportion of women having an antenatal Hb at 28 weeks and appropriate response to antenatal anaemia
2. Proportion of women who have had red cell antibody screen at 28 weeks
3. Proportion of women with previous CS having location of placenta documented
4. Proportion of women having consent to blood transfusion documented
5. Proportion of MOH events compliant with best practice
6. Proportion of women who have had antenatal PPH risk assessment documented
7. Proportion of women who received AMTL
8. Proportion of women receiving VTE risk assessment
9. Proportion of staff training for checklist/algorithm, drills completed
10. Drills completed and staff attending the drill

Recommended reading:

1. HSE Nomenclature for Clinical Audit – <https://www.hse.ie/eng/about/who/nqpsd/ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf>
2. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines at <https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/>
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5. Gallos ID, Papadopoulou A, Man R, al. et. Uterotonic agents for preventing postpartum haemorrhage: a network meta-analysis. *Cochrane Database Syst Rev.* 2018;12:CD011689 <https://pubmed.ncbi.nlm.nih.gov/29693726/>
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9. OB Hemorrhage Toolkit V3.0 | California Maternal Quality Care Collaborative. <https://www.cmqcc.org/resources-tool-kits/toolkits/ob-hemorrhage-toolkit>
10. Shahid S, Thomas S. Situation, Background, Assessment, Recommendation (SBAR) Communication Tool for Handoff in Health Care – A Narrative Review. *Saf Heal* 2018 41. 2018;4(1):1-9. <https://safetyinhealth.biomedcentral.com/articles/10.1186/s40886-018-0073-1>

Authors

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<https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/>

<https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/>