HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Massive Obstetric Haemorrhage Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose of this policy

The purpose of this policy is to provide safe and effective care for women who experience a massive obstetric haemorrhage. Massive obstetric haemorrhage is one of the leading causes of maternal death and practitioners should be skilled in diagnosis and treatment of this emergency. Practitioners are also referred to the management of postpartum haemorrhage policy and to the management of antepartum haemorrhage policy.
Communication and effective teamwork are crucial for a successful outcome.

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders.
- Anaesthetic staff
- Neonatal staff
- Blood bank staff

Definition

Massive obstetric haemorrhage
This is a blood loss in excess of 1000mls. 1500mls represents about 25% of the blood volume and is potentially a life threatening complication. (Draycott, Winter, Crofts & Barnfield, 2008).

Risks

The risks associated with haemorrhage include

Maternal

- Shock, DIC, renal failure
- Fluid overload and left ventricular failure from replacement of fluid
- Anaemia
- Sheehan's Syndrome (Permanent hypopituatirism)
- Reduced fertility
- Death

Foetal

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- Cerebral hypoxia
- Prematurity
- Death

Risk Assessment

Women with known antenatal risk factors should have a well-documented care plan. Practitioners should follow the guidelines as per Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000. Women at increased risk of massive haemorrhage are:

- Women with placenta praevia especially those who have a previous uterine scar
- Women who have had a haemorrhage (PPH, APH) in a previous pregnancy

Aim

When massive haemorrhage occurs, the responsibility of practitioners is to

- Identify the cause
- Stop the bleeding
- Rapid fluid resuscitation

Action

Multiple actions simultaneously

Consultant/Registrar to consider activating
Massive transfusion protocol

- Call for help: Ring 777 State **that we are activating the massive transfusion protocol. State room number.**
- If the woman has not yet delivered, please state a **CODE 2 EMERGENCY** at the same time.
- Insert two large bore intravenous cannulae (size 14 –16 gauge)
- Take blood for cross match and clotting, order at least 6 units of blood
- Alert blood bank at an early stage (ext. 9632). O Negative blood is available immediately from blood bank
  Fresh Frozen Plasma and Cryoprecipitate are available at Hutt Blood Bank. Platelets must be transported from NZBS Wellington. Therefore, if required, their early request is vital.
- Assess initial ABC, vital signs
- Assess and document amount of blood lost
- Administer O_2 via a non rebreather mask
- A compression cuff can be used to facilitate rapid administration of fluid
- Monitor urine output; insert IDC hourly measures
- Treat cause of haemorrhage

If pregnant deliver the baby (For further detail see APH policy)

- Decision of delivery method to be made by clinical judgement either operative vaginal delivery or caesarean section **Category 1** i.e. Life threatening condition.
- If the cervix is fully dilated and there is less than 1/5 head palpable abdominally and without foetal compromise may have assisted birth
- If cervix is not fully dilated Category 1 C/S (RANZCOG, 2009)
- Method of anaesthesia is decided between the anaesthetist and the obstetrician
- Paediatric RMO called for birth

If postpartum, please see PPH policy

- If bleeding due to genital trauma or retained products, take the woman to theatre for EUA and suturing
- Consider insertion of Bakri Balloon
- Consider coagulopathy if bleeding persists
- Consider uterine packing if clinically indicated
- May require surgical intervention – sooner rather than later. Such intervention includes uterine artery embolisation, B-Lynch suture, internal iliac artery legation, hysterectomy.
- Consider transfer to ICU or CCDHB

Documentation

- All drugs and IV fluids administered must be prescribed on the woman's medication chart.
- All blood administered to the woman must be documented on the medication chart
- Any response or adverse reaction to medication/blood should also be noted.
- **Accurate** fluid balance must be maintained on the fluid balance chart
- Record and document Resps, Pulse, BP and Oxygen saturation & Temperature at regular intervals
- Continuous CTG monitoring if pregnant
- An accurate description of events should be written in the body of the notes as close as possible to the time that they occur.

Associated Documents

Labour induction guidelines
Active management of the third stage of labour
Physiological management of the third stage of labour
Primary postpartum haemorrhage management and treatment
Management acute antepartum haemorrhage.

References

Draycott, T., Winter, C., Crofts, J. & Barnfield, S. (Eds.) (2008.) PROMPT. Practical Obstetric Multiprofessional Training Course Manual. United Kingdom: North Bristol NHS Trust

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The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (RANZCOG.) (2009) *Categorisation of Urgency for Caesarean section.* (**C-OBS 14)** Australia: Author

Referral Guidelines

See the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) MOH, 2012.

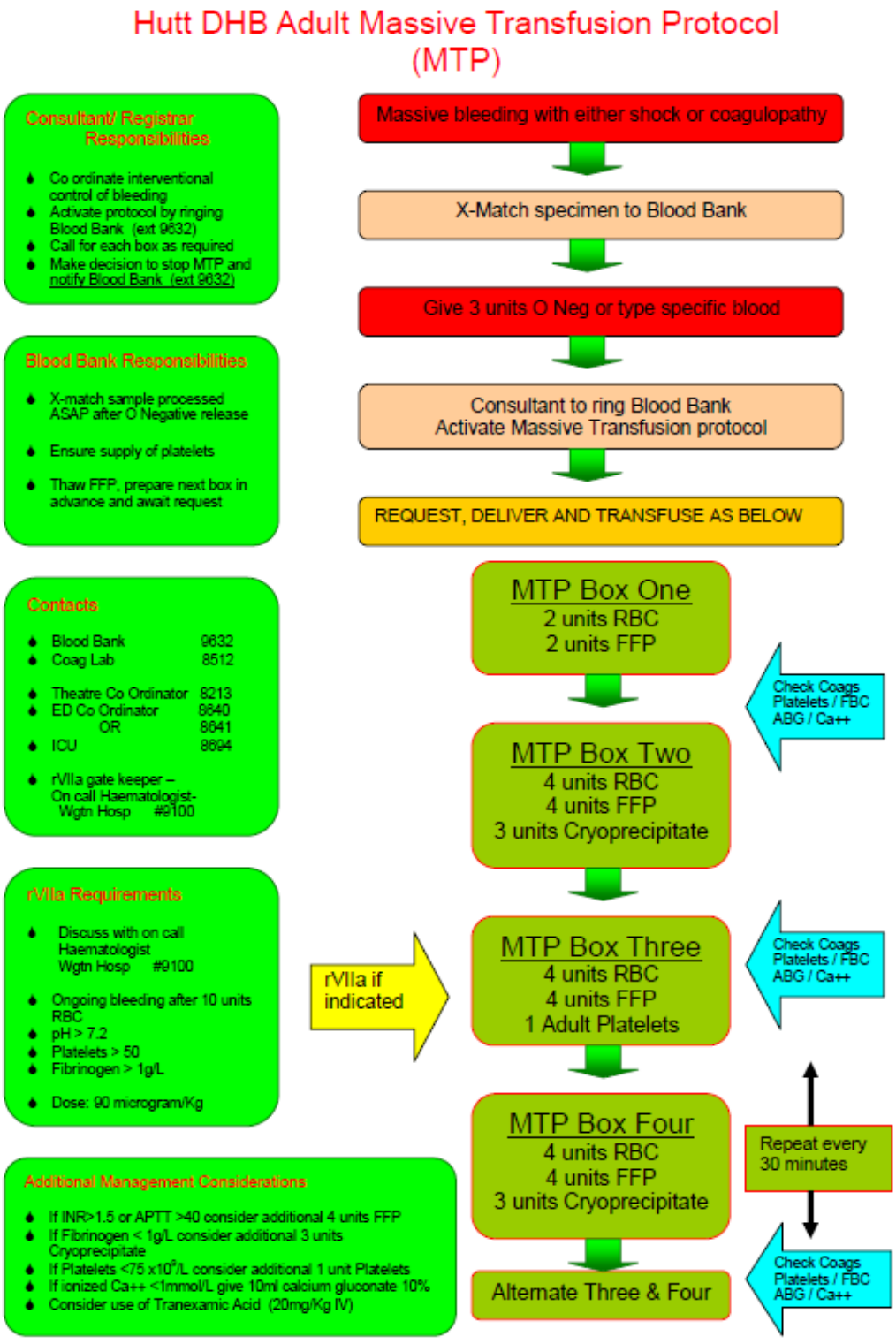
Informed Consent

The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).

APPENDIX 1: Massive obstetric haemorrhage
Initial management sheet.

Action	Time	Signature
Diagnosis and initial call for help		
Ring Emergency bell		
Emergency call made to the operator (777).		
• Alert blood bank/ haematology, O Negative or cross matched blood required		
• Orderlies called/arrived		
Documentation • Clinical notes • Fluid balance • Drug chart • Blood order form		
Initial, ABC and P, BP R, T, SPO_2,		
Insert two large bore cannulae (14- 16 gauge)		
O_2 administered via a non-rebreather mask		
Administer medications as prescribed if PPH • Oxytocin bolus IVI,IMI • Oxytocin infusion IV • Ergometrine IM • Carboprost IM (Contraindicated IV) • Misoprostol P.R.		
Blood taken for X match and clotting		
Fluid replacement commenced		
Insert IDC, hourly measures		
Measure and record blood loss		
Treat cause/ stabilise		
Continue to monitor P, BP, SPO_2,consider ECG, CVP monitoring as appropriate, Fetal heart if antepartum		
Ongoing assessment of fundal tone and lochia		
Transfer woman to theatre or ICU if required		

APPENDIX 2: Massive Transfusion Protocol Flowchart



Hutt Valley District Health Board Transfusion Committee
April 2012