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Retained Placenta: Management of 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

The purpose of this guideline is to recognise and appropriately manage a retained placenta and to prevent a potential or actual postpartum haemorrhage.

Scope

- All obstetric and midwifery staff employed by the Directorate of Surgical, Women's and Children's health service, Hutt Valley DHB
- All LMC access agreement holders.
- Anaesthetic staff
- Neonatal staff

Definitions

A placenta is defined as 'retained' after 30 minutes using active management of third stage (NICE, 2007, WHO, 2009) or 60 minutes following physiological management of third stage (NICE, 2007).

- *Partially separated placenta*: the placenta has partially separated from the uterus preventing the uterus from completely contracting.
- *Trapped placenta*: the placenta has separated completely from the uterus but remains trapped behind a partially closed cervix
- *Placenta adherens*: inadequate contractions to separate the placenta
- *Placenta accreta*: placenta pathologically invading the myometrium.
(Weeks, A, 2012).

Risk Factors

- Previous retained placenta
- Preterm birth
- Previous curettage
- Induced or augmented labour
- Pre-eclampsia
- Previous caesarean section
- Delivery in a semi recumbent position (rather than standing or squatting.)

If a placenta accreta/ percreta diagnosed by scan in the antenatal period plan of care clearly documented, transfer of care to tertiary unit may be appropriate.

Management of Retained Placenta

For **physiological management of third stage**: Observe for signs of placental separation (refer management of third stage policy). Encourage the woman to breastfeed if she is able as this will stimulate a natural release of oxytocin. If the placenta has not birthed after 60 minutes following the birth of the baby, then revert to active management of labour. Give 10 international units of oxytocin IM and apply controlled cord traction. (NICE, 2007). This is an immediate transfer of clinical responsibility (Code 6004) (Ministry of Health, 2012). **If the woman's condition deteriorates at any stage, begin active management earlier and call for help.**

For **active management of third stage**, if the placenta has not birthed after 30 minutes it is retained. This is an immediate transfer of clinical responsibility (Code 6004) (Ministry of Health, 2012). **Consult earlier if the woman's condition deteriorates. If the woman proceeds to have a postpartum haemorrhage, follow the PPH policy.**

- assess the mother vaginally to assess the adherence of the placenta and if adherent repeat oxytocic dose,
- Maternal observations: BP, Pulse, Temp, Resps and O2 Saturations as clinically indicated and document on the MEWS chart.
- Note taken of vaginal blood loss
- Place an Indwelling urinary catheter in her bladder
- Take bloods for Group and screen and FBC and send to lab
- Insert times 2 large bore cannula at least size 16.
- Prepare for theatre as per usual including the woman's informed consent.
- Transfer to theatre for manual removal (RANZCOG, 2011).
- Depending on the woman's clinical situation, the call to theatre by the obstetrician will be a Code 4 in an emergency or the usual route to theatre.
- Use of antibiotics following manual removal. Consider a stat dose of cefuroxime 1.5gm (WHO, 2009).
- Document all procedures and actions in the clinical records.

Due to the risk of postpartum haemorrhage, the woman's condition must be monitored. This includes regular observations of blood pressure, pulse, respirations, and assessment of blood loss.

For women birthing at home

Depending on location of birth, if after 40 minutes the placenta has not delivered, preparations for transfer to hospital should be considered (or earlier, if maternal deterioration). The midwife is to ring delivery suite on emergency number 5709562, if condition warrants it, with details of the birth and reason for transfer so that a consultation with the on-call obstetrician can be arranged on arrival. Midwives should follow the process for emergency transport as per *Guidelines for consultation with Obstetric and related Medical Services (Referral Guidelines)*. It is recommended the midwife travel with the woman in the ambulance during the transfer and the woman has an IV insitu.

References

Bullarbo, M., Bokström, H., Lilja, H., Almström, E., Lassenius, N., Hansson, A. & Ekerhovd, E. (2012). Nitroglycerin for management of retained placenta: A multicenter study. *Obstetrics and Gynecology International*

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National Institute for Health and Clinical Excellence (2007). Intrapartum care. Care of healthy women and their babies during childbirth. *NICE clinical guideline*. Developed by the National Collaborating Centre for Women's and Children's health.

Ministry of Health (2012) *Guidelines for consultation with Obstetric and related Medical Services (Referral Guidelines)*.

Weeks, A. (2012). Diagnosis and management of retained placenta after vaginal birth. *Up to date*. Retrieved 17.08.2012 <http://www.uptodate.com/contents/diagnosis-and-management-of-retained-placenta-after-vaginal-birth>

World Health Organisation (2009). WHO guidelines for the management of postpartum haemorrhage and retained placenta. Retrieved 17/08/2012 http://whqlibdoc.who.int/publications/2009/9789241598514_eng.pdf

Related Policies

Management of physiological third stage

Active management of third stage

Management of postpartum haemorrhage

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).