**Senior**

**OBSTETRIC HAEMORRHAGE: CLINICAL GUIDELINE**
Major Obstetric Haemorrhage (MOH) Flow Chart

### Communication
- Call Coordinator, Obs SHO and middle grade
- Call Anaesthetist on call (+/- neonatologist)
- Early Consultant Obs and senior Anaesthetic input
- Call blood bank (ex 2500) Declare MOH – send FBC,Urgent X match Allocate MSW, scribe and porter

### Blood / coagulation
- 1<sup>st</sup> Obstetric Haemostatic pack : 4 x red cells
- 2<sup>nd</sup> pack: FFP, 4 x red cells and platelets
- 3<sup>rd</sup> pack FFP, 4 X red cells, platelets and Cryoprecipitate

FBC, clotting and fibrinogen levels- as guided by clinical status. Haematology advice for extensive replacement
- Remember cell salvage per abdomen
- Remember to stand blood bank down

### Resuscitation
- Oxygen, left lateral (APH), warming
- 2 large bore cannulae- take samples for FBC,URGENT X match
- Crystalloid
- (O Negative blood)

### Monitoring
- Start MEOWS
- HR, BP, RR, O2 sat, temp
- Catheterise and urine output
- ABG and lactate as per anaesthetist
- ?A-line / CVP line
- CTG once mother stable
- Uterine height / tone and vaginal blood loss

### Initial treatment
- Antenatal: consider expediting delivery
- Postnatal: rub up contraction and maintain bi-manual
- Transfer early to theatre for resuscitation +/- surgery

### Medical treatment (postpartum)
- Oxytocin (40iu/500ml saline at 125ml/hr)
- Ergometrine 500 µg IM/IV (if no raised BP)
- Carboprost 250µg IM every 15 mins (max x8)
- Misoprostol 800µg PR
- Tranexamic acid 1g IV

### Surgical treatment
- (delivery)
- Bakri balloon
- Vaginal pack
- B lynch suture
- Uterine / int. iliac ligation (not if IR)
- Hysterectomy
- Interventional radiology (IR)

### On-going care
- ? ITU /HDU
- Consider antibiotics
- Consider IV iron
- VTE prophylaxis
- De-brief family and staff

### Medical treatment (postpartum)
- Oxytocin (40iu/500ml saline at 125ml/hr)
- Ergometrine 500 µg IM/IV (if no raised BP)
- Carboprost 250µg IM every 15 mins (max x8)
- Misoprostol 800µg PR
- Tranexamic acid 1g IV

### Surgical treatment
- (delivery)
- Bakri balloon
- Vaginal pack
- B lynch suture
- Uterine / int. iliac ligation (not if IR)
- Hysterectomy
- Interventional radiology (IR)

### Documentation
- Contemporaneously during events (scribe)
- Complete MOH proforma
- Risk Management Datix
OBSTETRIC HAEMORRHAGE CLINICAL GUIDELINE

1. **Aim/Purpose of this Guideline**

1.1. This document guides obstetricians, obstetric anaesthetists, midwives, nurses and maternity support workers (MSW) on the recognition and management of Antepartum Haemorrhage, Postpartum Haemorrhage and Major Obstetric Haemorrhage (MOH), relevant at any time during pregnancy and the postpartum period. MOH management is therefore presented first before consideration of issues relating specifically to bleeding before and after delivery.

2. **The Guidance: Massive Obstetric Haemorrhage**

2.1. **Definitions**: Major Obstetric Haemorrhage is defined as blood loss >2000ml or rate of blood loss of 150ml/min, or 50% blood volume loss within 3hrs. It may result in a decrease in haemoglobin (Hb) >40g/l, or an acute transfusion requirement of >4 units. An MOH that triggers the ‘Massive Obstetric Haemorrhage’ protocol is defined as blood loss that is ‘uncontrolled’ and ‘ongoing’ with a rate of blood loss of 150mls or more per minute or >2L.

2.2. **Trigger Phrase**: The anaesthetist /obstetrician leading on the management of the major obstetric haemorrhage must communicate to all members of the clinical team involved in the care of the women that the situation has now become a ‘Massive Obstetric Haemorrhage’ (MOH). The time that the MOH was declared must be noted and documented on the proforma (Appendix 1). Any subsequent communication between the clinical team and other clinical areas e.g. portering personnel and laboratory personnel, must include the trigger phrase of ‘Massive Obstetric Haemorrhage’.

2.3. **Communication pathway**:

- Call the senior midwife, resident anaesthetist, Obstetric Registrar and SHO
- Involve senior medical staff early (Senior Anaesthetists and consultant Obstetrician)
- Midwifery coordinator to nominate one person to communicate with lab staff and support services
- Nominated person to call the neonatologist if the baby is alive and undelivered
- Nominated person to call the blood bank (ext. 2500) and alert lab staff that there is a Massive Obstetric Haemorrhage
- Allocate a MSW or porter to be on standby for urgent blood samples/collection of blood
- Consider informing Intervention Radiology team (see separate guideline). This should be done at Consultant level

2.4. **Resuscitation**
• Full A to E assessment and management of Airway, Breathing, Circulation, Drugs/Disability, Exposure and Emergency Surgery
• Oxygen 100% high flow, via reservoir mask
• Full left lateral tilt for APH - Head down, legs up
• Consider warming blanket
• Site two large bore IV cannulae (at least 16 g). Take blood at the same time for urgent cross match (type specific), full blood count (FBC) and coagulation screen.
• Commence a Modified Obstetric Early Warning System (MOEWS) chart including fluid balance monitoring. If the woman is already in theatre the monitoring will be done by the anaesthetist using the appropriate anaesthetic chart and the MEOWS chart will be started when the woman is in recovery

2.5 Fluid balance

• Warm all resuscitation fluids and aim to correct hypovolaemia initially with crystalloids
• Consider permissive hypotension – systolic BP <85mmHg
• If a blood transfusion is required urgently and a delay anticipated in receiving group specific blood, consider the use of 0 Rhesus negative blood in Maternity blood fridge.
• Dextran are hazardous and should not be used in obstetric practice
• Restore normovolaemia, monitor Hb and haematocrit, use nearside patient testing (HaemaCue)
• If the MOH trigger is called, request 'Obstetric Haemostatic Pack' from lab (ext. 2500). Pack 1 contains 4 units of type specific blood. Pack 2 will automatically follow pack 1 unless blood bank is asked to stand down. Pack 2 will contain FFP and platelets (which should be given on arrival) and a further 4 units of cross matched blood. Pack 3 contains FFP, 4 X red cells, platelets and Cryoprecipitate

• Use FBC, coagulation studies, fibrinogen levels and haematology advice to guide the use of further blood products: FFP (for clotting factors), cryoprecipitate (for fibrinogen), platelets (to maintain >50x10^9/l).
• Re-infusion of blood from the cell saver can be given through a normal blood giving set. Even though a Leucodepletion filter is recommended, it may not be appropriate for acute resuscitation as this will slow the reinfusion (see Obstetric Cell Salvage guideline). Cell Saver blood must be prescribed

2.6 Monitoring

• Monitor heart rate, blood pressure, respiratory rate, oxygen saturation and temperature at 15 minute intervals
• Record MEOWS score
• Catheterise and record urine output hourly
• Blood gases and lactate as advised by anaesthetist
2.7 Clinical Management

- If antenatal: consider expediting delivery
- If postnatal: rub up contraction and commence bimanual compression. This is tiring- change clinician regularly to maintain effectiveness
- Transfer to theatre early for further resuscitation and possible surgery
- Request ODP to set up cell saver
- Start medical management (for postpartum cases):
  - Oxytocin 40iu in 500mls Normal Saline given at 125mls/per hour for 4 hrs (10iu per hour)
  - Ergometrine 500mcg IM or IV (NOT if raised BP)
  - Carboprost 250mcg given deep IM every 15 minutes up to 8 doses (NOT if asthmatic)
  - Misoprostol 800mcg PR
  - Tranexamic acid 1g IV
- Surgical manoeuvres:
  - Bakri balloon
  - Vaginal pack
  - B Lynch suture
  - Ligation of uterine and then internal iliac arteries (but not if considering Intervention Radiology)
  - Consider role of interventional radiology
  - Hysterectomy (involve second consultant in decision if time allows and additional skills required). Don’t delay decision
- Post operative care:
  - Multidisciplinary decision to determine requirements for ICU/HDU care
  - Inform blood bank of resolution of MOH
  - Consider prophylactic antibiotics
  - Blood transfusion to be avoided after acute management unless very symptomatic
  - Consider intravenous iron
  - Venous thromboprophylaxis should be commenced after haemostasis is secured due to prothrombotic state developing after massive haemorrhage
  - Debrief the woman and her partner
- Documentation:
  - Complete MOH proforma
  - Datix to Risk Management
3 The Guidance: Antepartum Haemorrhage

3.1 Introduction

Severe antepartum haemorrhage (APH) occurs in 3-5% of pregnancies. The main differential diagnoses are placenta praevia, placental abruption, bleeding of unknown origin and vasa praevia. Risk factors for APH include increased maternal age and parity, multiple pregnancy, smoking and cocaine abuse. Risk factors for Placenta Praevia include previous caesarean section (10-15%), TOP & D&C, MROP and myomectomy/TCRE. Risk factors for Placental Abruption include pregnancy induced hypertension/PET, FGR, preterm rupture of membranes, fibroids, previous abruption, external trauma, substance abuse, polyhydramnios, low BMI, assisted reproductive techniques and maternal thrombophilias.

3.2 Clinical presentation: vaginal bleeding and may also include:

- Abdominal pain
- Uterine tenderness
- Increased uterine tone
- CTG abnormality
- Intra-uterine death
- Disseminated intravascular coagulation
- Maternal collapse

3.3 Complications of APH

- Anaemia
- Infection
- Maternal shock
- Renal tubular necrosis
- Consumptive coagulopathy
- Postpartum haemorrhage
- Complications of blood transfusion
- Fetal hypoxia
- Small for gestational age and fetal growth restriction
- Prematurity
- Fetal death

3.4 Clinical Management

Principles of management are described in the MOH section above. The intensity of resuscitation and monitoring will depend upon severity of bleeding and maternal condition.

- Contact obstetric middle grade and SHO
- Contact obstetric anaesthetist
- Inform duty obstetric consultant
- Assess for signs of clinical shock
- Assess for risk factors for abruption and placenta praevia
Review placental site on scan reports and avoid vaginal examination if placenta praevia is suspected (in the presence of pain/contractions a senior obstetrician may need to gently digitally assess cervix for labour or use transvaginal ultrasound if available immediately)

- Site large cannulae (two if large APH or maternal compromise)
- Blood for FBC and Group and save as minimum. Cross match and clotting studies if large APH or maternal compromise
- Assess uterine tone
- Ensure left lateral tilt at all times
- Keep woman warm
- Analgesia as required
- Kleihauer test should be performed in rhesus D-negative women
- For administration of anti-D refer to separate guideline: Anti-D Immunoglobulin (Anti-D) for the prevention of haemolytic disease of the newborn - clinical guideline
- Only when the mother is stable should the viability and condition of the fetus be assessed
- From 28 weeks CTG monitoring should continue until bleeding or significant pain relating to abruption stops. The decision for continuous monitoring at lower gestations should be made by a senior obstetrician
- Consider corticosteroids between 24 and 34+6 weeks’ gestation if preterm birth is anticipated but is not required immediately
- Tocolysis should be avoided in a major APH or there is evidence of fetal compromise
- If the mother remains unstable despite aggressive resuscitation, delivery may be required to stop the bleeding
- In cases of intra-uterine death vaginal birth is usually appropriate but anticipate PPH. An emergency caesarean section may be necessary for obstetric reasons e.g. transverse lie or if uncorrectable maternal shock
- Remember venous thromboprophylaxis as an inpatient after bleeding has completely settled
- For bleeds unrelated to placenta praevia, a speculum examination must be performed before discharge (if not performed before in this pregnancy) to exclude a non-uterine genital tract cause for bleeding (e.g. cervical cancer)

3.5 Management specific to Placenta Praevia

- Fetal compromise is rare unless heavy bleeding leads to impaired placental perfusion or unless there is a co-existent abruption. Therefore, conservative management with blood replacement and awaiting cessation of bleeding may be appropriate at preterm gestations
- Diagnosis of praevia and planning the mode of delivery may require trans vaginal ultrasound
- A senior obstetrician should be present at caesarean section
- Assessment for placenta accreta by ultrasound (and possible MRI) is necessary for cases of anterior praevia with previous caesarean section. A plan of care requires a multidisciplinary approach. Refer to the guideline ‘MOH-The role of Interventional Radiologist’ for further information

3.6 Management specific to Placental Abruption

- Fetal compromise is rare unless heavy bleeding leads to impaired placental perfusion or unless there is a co-existent abruption. Therefore, conservative management with blood replacement and awaiting cessation of bleeding may be appropriate at preterm gestations
- Abruption is a clinical diagnosis and neither ultrasound nor kleihauer exclude the diagnosis
- Maternal compromise may be disproportionate to the revealed bleeding so care is needed to avoid inadequate fluid replacement
- Regular clotting studies may be required to exclude or treat disseminated intravascular coagulation
- Assess for pre-eclampsia or fetal growth restriction that may co-exist and further compromise fetal well being

3.7 Management specific to Vasa Praevia

- Commercial tests distinguishing maternal from fetal blood are not validated or locally available and the diagnosis relies on clinical awareness based upon the history and signs of acute fetal compromise disproportionate to the degree of bleeding and maternal condition
- Category 1 caesarean section will usually be required with early cord clamping

4 The Guidance: Postpartum Haemorrhage

4.1 Introduction

Primary Post-Partum Haemorrhage (PPH) is the loss of 500ml or more from the genital tract within 24 hours of the birth. Any blood loss that causes deterioration in a woman’s condition may be considered a PPH. Secondary PPH is defined as abnormal or excessive bleeding from the birth canal between 24 hours and 12 weeks postnatally. PPH can be minor 500-1000ml or major > 1000ml

4.2 Risk factors

Women with risk factors should be advised to deliver in an obstetric unit where further emergency treatment options are available. If a woman has risk factors for PPH these should be highlighted in her notes and a plan of care discussed with the woman covering the Third Stage of labour. The woman should be advised early IV access in labour, full blood count, group and save and Active Management of the Third Stage.

Antenatal Risk Factors:
- Previous PPH or retained placenta
- Maternal Hb level below 85g/L at onset of labour
- BMI >35
- Grandmultiparity (P4 or more)
- APH
- Over distension of the uterus (multiple pregnancy, macrosomia, polyhydramnios)
- Existing uterine abnormalities
- Low-lying placenta
- Maternal age 40 years and above
• Pre-existing bleeding disorders
• Hypertension
• Therapeutic anticoagulants

Intrapartum Risk Factors

• Induction
• Augmentation
• Prolonged 1st and 2nd stage and retained placenta
• Precipitate labour
• Pyrexia in labour
• Operative birth or caesarean section

4.3 Management of Post Partum Haemorrhage

Principles of management are described in the MOH section above. The intensity of resuscitation and monitoring will depend upon severity of bleeding and maternal condition

In the Community setting the staff will call Paramedics and arrange Emergency transfer to Acute Unit. Community midwives and subsequently the Paramedics will initiate and undertake the following actions listed up to the point where certain drugs are not carried as stock in the community setting.

In the Hospital Setting staff will call for help: coordinator, scribe, runners, obstetric middle grade, SHO and anaesthetist.

• Lie the woman flat
• Administer facial oxygen with non rebreathre mask and monitor oxygen saturation levels
• Continually assess Airway, Breathing, Circulation
• Massage the uterus and commence bimanual compression. This is tiring- change clinician regularly to maintain effectiveness
• Assess cause of blood loss remembering the four T’s:
  o Tone- palpate uterus and use uterotonics
  o Tissue- examine placenta and membranes and consider theatre for examination under anaesthetic (EUA). Remember that clot alone in the cavity may impair contractility
  o Trauma- systematically examine the lower genital tract and repair a tear. EUA may be required to identify and access a cervical or forniceal tear
  o Thrombin- assess for bruising, puncture site ooze and evaluate repeated blood results
  o Consider rare causes such as uterine rupture or inversion, broad ligament haematoma and extra genital bleeding (e.g. splenic, liver capsule or adrenal)
  o Secondary PPH is usually due to retained products and/or
• Empty the bladder inserting a size 12ch Foleys Indwelling Catheter
• IV access with one (consider two) wide bore cannulae
• Take blood for FBC and Group and save as minimum. Cross match and clotting studies if large PPH or maternal compromise
• Intravenous fluids Hartmanns 1000ml stat
• Screen for and treat potential infection. Remember Sepsis 6
• Administer Uterotonic Drugs:
  o repeat bolus oxytocic: Ergometrine 500mcgs (IM or IV with caution) or Syntometrine 1 ampule IM or Syntocinon 5 units IM (if hypertensive)
  o Syntocinon 40iu in N/Saline 0.9% 500ml @125ml/hr IV
  o Misoprostol 800-1000 mcg PR
  o Carboprost 250mcg IM at 15 minute intervals up to a maximum of 8 doses (caution asthma)
  o Tranexamic acid 1g IV (not a uterotonic)
• **Early decision for EUA if bleeding on going and inform consultant obstetrician. See MOH section for surgical options**
• Remember venous thromboprophylaxis as an inpatient after bleeding has completely settled

### 4.4 Documentation

• Commence full MEOWS assessment including fluid balance, initially at 5 minute intervals then as per MEOWS score.
• Complete documentation, PPH proforma and arrange debrief for woman, her family and staff involved
• Datix to Risk Management
### 5. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Application of this guideline in Antepartum, Postpartum and Major Obstetric Haemorrhage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Maternity Risk Forum</td>
</tr>
<tr>
<td>Tool</td>
<td>Are appropriate interventions undertaken and accordance with the guideline</td>
</tr>
<tr>
<td>Frequency</td>
<td>Individual cases identified via Risk Management and Maternity Forum</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>A formal report of the results will be received at the Maternity Forum / Clinical Audit Forum.</td>
</tr>
</tbody>
</table>
| Acting on recommendations and Lead(s) | Any deficiencies identified will be discussed at the Maternity Risk Management Forum / Clinical Audit Forum and an action plan developed  
Action leads will be identified and a time frame for the action to be completed  
The action plan will be monitored by the Maternity Risk Management Forum / Clinical Audit Forum |
| Change in practice and lessons to be shared | Required changes to practice will be identified and actioned within a time frame agreed on the action plan  
A lead member of the forum will be identified to take each change forward where appropriate  
The results of the audits will be distributed to all staff through the Risk Management or Practice Development Newsletter and Maternity Forum. |

### 6. Equality and Diversity

**4.1.** This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

**4.2. Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
# Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>OBSTETRIC HAEMORRHAGE CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>17th February 2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>17th February 2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>17th February 2020</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Mr Rob Holmes, Obstetric Consultant</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252730</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guidance is for obstetricians, obstetric anesthetists, midwives, nurses and maternity support workers and gives guidance on the management of Obstetric Haemorrhage.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Massive Obstetric Haemorrhage, post-partum haemorrhage, PPH, ante partum haemorrhage, APH, praevia, abruption, vasa praevia, accrete, maternal collapse, bleeding, MOH, FFP, Bakri, embolization, cell salvage, oxytocin, platelets, Ergometrine, Miso prostol, Carboprost, interventional radiologist, B Lynch</td>
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<tr>
<td>Target Audience</td>
<td>RCHT</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>2nd February 2017</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Major Obstetric Haemorrhage (MoH) Clinical Guideline for the Management and Post Partum Haemorrhage (PPH) - Clinical Guideline for the management of</td>
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<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Maternity Guidelines Group Obs and Gynae Directorate Meeting Divisional Board</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Head of Midwifery</td>
</tr>
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</table>
Related Documents:

- RCOG: Antepartum Haemorrhage (Green-top Guideline No. 63, 2011)
- RCOG: Placenta Praevia, Placenta Praevia Accreta and Vasa Praevia: Diagnosis and Management (Green-top Guideline No. 27, 2011)
- BJA-CEACCP: Massive haemorrhage in pregnancy volume 5 number 6 (2005)
- The Scottish obstetric guidelines and audit project; The Management of PPH (Updated March 2002)
- Frca.co.uk (Emergency treatment of obstetric haemorrhage) Blood transfusion and the anaesthetist: management of massive haemorrhage. AAGBI (Oct 2010)

Training Need Identified?

Included in annual obstetric emergencies day

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job)</th>
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<tr>
<td>April 2008</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Dr Catherine Ralph Consultant</td>
</tr>
<tr>
<td>January 2011</td>
<td>V1.1</td>
<td>Inclusion of massive obstetric haemorrhage trigger phrase</td>
<td>Dr Catherine Ralph Consultant Obstetric</td>
</tr>
<tr>
<td>April 2012</td>
<td>V1.2</td>
<td>Compliance monitoring tool added</td>
<td>Dr Catherine Ralph Consultant Obstetric</td>
</tr>
<tr>
<td>September 2012</td>
<td>V1.3</td>
<td>Changes to compliance monitoring only</td>
<td>Jan Clarkson Maternity Risk Manager</td>
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<tr>
<td>Date</td>
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<td>Details</td>
<td>Author</td>
</tr>
<tr>
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<tr>
<td>June 2013</td>
<td>V1.4</td>
<td>If a blood transfusion is required and a delay is anticipated in receiving group specific blood, use 0 Rhesus negative blood.</td>
<td>Jan Clarkson Maternity Risk Manager</td>
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<tr>
<td>October 2013</td>
<td>V1.5</td>
<td>Added: If bleeding continues: (Request Obstetric Haemostatic Pack from lab) pack 1 contains 6 units of cross matched blood, pack 2 will automatically follow pack 1 unless blood bank is asked to stand down, and that will contain FFP and platelets (which should be given on arrival) and a further 6 units of cross matched blood. Alteration: Fresh Frozen Plasma (FFP) is only produced upon request or routinely with second pack. Changed blood g/dl to g/l.</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
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</table>
| 6th March 2014 | V1.6    | Added drug doses of uterotonics:  
- Oxytocin 40iu in 500mls Normal Saline given at 125mls/per hour for 4 hrs (10iu per hour).  
- Ergometrine 500mcg, given IM or IV (NOT if raised BP).  
- Carbutoprost 250mcg given deep IM every 15 minutes up to 8 doses (NOT if asthmatic).  
- Misoprostol 800mcg PR or PV, (avoid PV if using cell salvage).  

Changed: 4gd/l to 40g/l in line with current Hb levels                                                                                   | Dr Catherine Ralph Consultant Anaesthetist |
Flow chart added and minor changes and merging of Major Obstetric Haemorrhage (MoH) Clinical guideline and Post Partum Haemorrhage and addition of Antepartum Haemorrhage section Pack 3 added in line with recommendation from Dr Stephen Bassey

Mr Rob Holmes. Consultant Obstetrician
Dr Catherine ralph, Consultant Anaesthetist
Dr Stephen Bassey, Consultant Transfusion Scientist

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

Name of Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): Major/Massive Obstetric Haemorrhage (MOH) - Clinical Guideline For Management

<table>
<thead>
<tr>
<th>Directorate and service area: Obs &amp; Gynaec Directorate</th>
<th>Is this a new or existing Policy?</th>
<th>Existing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of individual completing assessment: Rob Holmes</td>
<td>Telephone: 01872-250000</td>
<td></td>
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</tbody>
</table>

1. Policy Aim*
   Who is the strategy / policy / proposal / service function aimed at?
   To give guidance to obstetricians, obstetric anaesthetists, midwives, nurses and maternity support workers on the management of Antepartum Haemorrhage, Postpartum Haemorrhage and Major Obstetric Haemorrhage.

2. Policy Objectives*
   To ensure timely recognition and management of Antepartum Haemorrhage, Postpartum Haemorrhage and Major Obstetric Haemorrhage.

3. Policy – intended Outcomes*
   Safe outcome for pregnant or newly delivered women.

4. *How will you measure the outcome?
   Compliance Monitoring Tool

5. Who is intended to benefit from the policy?
   Pregnant and newly delivered women.

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?
   No

   b) If yes, have these *groups been consulted?
   N/A

   C). Please list any groups who have been consulted about this procedure.
   N/A

7. The Impact
   Please complete the following table.

<table>
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<th>Equality Strands:</th>
<th>Yes</th>
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<th>Rationale for Assessment / Existing Evidence</th>
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<tr>
<td>Age</td>
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<td>All Pregnant Women</td>
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Are there concerns that the policy could have differential impact on:

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<th>Equality Strands:</th>
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<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tr>
<td>Age</td>
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<td></td>
<td>All Pregnant Women</td>
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<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<td>All Pregnant Women</td>
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<td>Race / Ethnic communities /groups</td>
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<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
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<td>Religion / other beliefs</td>
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<td>Marriage and civil partnership</td>
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<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes  No  X

9. If you are not recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director
Dr Catherine Ralph

Date of completion and submission 6th March 2014

Names and signatures of members carrying out the Screening Assessment
1. Rob Holmes
2. 

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Sarah-Jane Pedler
Date: 17th February 2017
## Major/massive obstetric Haemorrhage Summary Proforma

<table>
<thead>
<tr>
<th>Date and time of MOH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of delivery</td>
<td>RCHT / Penrice / Helston / Home / St Mary’s</td>
</tr>
<tr>
<td>Mode of delivery</td>
<td>NVD / Kiwi Ventouse / Forceps / LSCS / Vaginal Breech</td>
</tr>
<tr>
<td>Date and Time of delivery</td>
<td></td>
</tr>
<tr>
<td>Total blood loss</td>
<td></td>
</tr>
<tr>
<td>Time transfer to RCHT (if community site)</td>
<td></td>
</tr>
<tr>
<td>Primary source of bleeding - Uterine atony / retained placenta / genital tract trauma / Other (please state………………………………………….</td>
<td></td>
</tr>
<tr>
<td>Secondary source of bleeding - Uterine atony / retained placenta / genital tract trauma / Other (please state………………………………………….</td>
<td></td>
</tr>
</tbody>
</table>

### Communication

<table>
<thead>
<tr>
<th>Name</th>
<th>Time called /Time arrived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery suite coordinator</td>
<td>/</td>
</tr>
<tr>
<td>Obstetric Registrar</td>
<td>/</td>
</tr>
<tr>
<td>Obstetric SHO</td>
<td>/</td>
</tr>
<tr>
<td>Resident Anaesthetist</td>
<td>/</td>
</tr>
<tr>
<td>Consultant Obstetrician</td>
<td>/</td>
</tr>
<tr>
<td>Senior Anaesthetist</td>
<td>/</td>
</tr>
<tr>
<td>ODP</td>
<td>/</td>
</tr>
<tr>
<td>Blood bank informed</td>
<td>/</td>
</tr>
<tr>
<td>MSW/Porter on standby for urgent samples/blood collection</td>
<td>/</td>
</tr>
</tbody>
</table>

**‘Massive Obstetric Haemorrhage’ trigger phrase.**

<table>
<thead>
<tr>
<th>Yes/NA</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric haemostatic pack Requested by</td>
<td>Yes/NA</td>
</tr>
<tr>
<td>Interventional radiologist</td>
<td></td>
</tr>
</tbody>
</table>
Other personnel involved:

<table>
<thead>
<tr>
<th>Yes/NA</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Facial oxygen
MEOWS chart/observations
Intravenous access – 2 large bore cannulae
FBC, clotting, G&S or cross match & sent
Fundal massage
Urethral catheter
Drugs
Bimanual compression
In to theatre (management to continue on green op sheet)

Use MEOWS chart for observations and, fluid input and output

<table>
<thead>
<tr>
<th>Product</th>
<th>Total Volume Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Saline</td>
<td></td>
</tr>
<tr>
<td>Hartmann’s</td>
<td></td>
</tr>
<tr>
<td>Gelofusine</td>
<td></td>
</tr>
<tr>
<td>Blood – cross-matched</td>
<td></td>
</tr>
<tr>
<td>Blood – O Rh - ve</td>
<td></td>
</tr>
<tr>
<td>Other i.e. Fresh Frozen Plasma(FFP) /Cryo/ Platelets</td>
<td></td>
</tr>
</tbody>
</table>

Summary Uterotonics used

<table>
<thead>
<tr>
<th>Product</th>
<th>Dose and Route of administration</th>
<th>Number of times given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syntrometrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syntocinon/Ergometrine bolus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syntocinon infusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemabate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misoprostol</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Serial Haemoglobin (Hb) & Clotting Results

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hb</td>
</tr>
<tr>
<td></td>
<td>WBC</td>
</tr>
<tr>
<td></td>
<td>Platelets</td>
</tr>
<tr>
<td></td>
<td>Hct</td>
</tr>
<tr>
<td></td>
<td>INR</td>
</tr>
<tr>
<td></td>
<td>APPT</td>
</tr>
<tr>
<td></td>
<td>Fibrinogen</td>
</tr>
</tbody>
</table>