Guideline for the Management of a Retained Placenta

Author/Owner	**Practice Educator Midwife**	
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1.0 Introduction

The third stage of labour is the time from the birth of the baby to the expulsion of the placenta and membranes. Women in labour must be involved in decisions pertaining to their care and where applicable should be offered a choice of either active or physiological management of the third stage.

Active management of the third stage involves the following components:

- Routine use of uterotonics drugs
- Deferred clamping and cutting of the cord
- Controlled Cord Traction (CCT)

Physiological management of the third stage includes the following components:

- No routine use of uterotonic drugs
- No clamping of the cord until pulsation has ceased
- Delivery of the placenta by maternal effort only (no cord traction).

The third stage of labour is diagnosed as prolonged if not completed within:
30 minutes of the birth of the baby with active management
and 60 minutes with physiological management (NICE 2015).

2.0 Objective

To ensure women with a retained placenta receive appropriate and timely management in order to minimise the risks of haemorrhage and infection in the postnatal period.

3.0 Scope

This guideline applies to all medical and midwifery staff working within maternity services.

4.0 Main body of the document

4.1 Treatment of women with a retained placenta in the immediate postnatal period

If the woman has had physiological management:

- Active management is indicated when there is a failure to deliver the placenta within 60 minutes
- Maternal consent for the commencement of active management should be obtained.
- A further 30 minutes of active management is then advocated if the woman is clinically stable and there is no vaginal bleeding

If the placenta and membranes fail to deliver spontaneously following active management:

- Perform intermittent catheterisation if full bladder suspected
- Avoid excessive controlled cord traction
- If the placenta fails to deliver after 30 minutes, obstetric review by the registrar is required
- Consider intervention earlier if the woman's condition is of concern
- Gain IV access and take blood for FBC and G&S
- Intravenous infusion of oxytocin should not be routinely used to assist the delivery of the placenta but should be used if the woman is bleeding excessively
- If there is concern about the woman's condition, perform a vaginal examination with consent to determine if a manual removal is required. If the woman reports inadequate pain relief during any assessment the healthcare professional must immediately stop the examination and address this need

- Do not perform uterine exploration or manual removal without an anaesthetic
- Perform clinical observations of blood pressure, pulse and respirations at 15 minute intervals and record on the partogram
- Assess the amount of bleeding. Be aware of possible concealed bleeding, therefore note fundal height

NB: A retained placenta in a woman with a previous Caesarean section should be treated with caution due to the risk of placenta accreta

4.2 Management of a woman requiring a manual removal of placenta

Manual removal of the placenta must be carried out under regional/general anaesthesia:

- Prepare for theatre
  - Obstetric registrar to obtain consent
  - Ensure Ranitidine has been given within the last 6 hours
  - Administer oral Sodium citrate 30mls prior to transfer to theatre if requested by anaesthetist
- Inform the anaesthetist and the theatre team
- Prior to anaesthetic, ensure that placenta is not in the vagina or cervical canal
- During the procedure the Consultant Obstetrician should attend if a placenta accreta is suspected or a major post partum haemorrhage occurs
- Inspect the placenta and membranes on removal and record assessment on the partogram
- Any cervical, vaginal or uterine trauma must be repaired in theatre under anaesthesia once the placenta is delivered

Midwives role in theatre:

- Support the woman
- Ensure notes are complete

4.3 Antibiotic Prophylaxis for procedure

The recommended prophylactic antibiotics are:

<u>First line</u>

Cefuroxime IV 1.5g single dose and Metronidazole I/V 500mg single dose

<u>Women with a penicillin allergy</u>

Non-life threatening – Cefuroxime 1.5g IV single dose and Metronidazole 500mg IV single dose

Life threatening allergy – Gentamicin 120mg IV single dose and Clindamycin 600mg IV single dose

<u>Women with a history of MRSA</u>

Teicoplanin I/V 600mg single dose and Gentamicin 2mg/kg single dose and Metronidazole 500mg I/V single dose

4.4 Post-operative care

The woman will be cared for in the theatre recovery area. The operating department care plan will be completed by the recovery nurse. Continuous one to one clinical observation of the woman is maintained by the recovery nurse/anaesthetist until the woman has regained airway control, cardio-respiratory stability and is able to communicate. A midwife is available to offer emotional support to the woman if required.

The following will occur for women following manual removal of placenta:

- An IV infusion of Syntocinon will be maintained for a minimum of 4-6 hours

- The woman's post – operative clinical observations will be documented on the Modified Obstetric Early Warning Score Chart and the medical team should be alerted as indicated by the score chart.
- The frequency of observations should be as follows (as a minimum):
  - Every half hour for 2 hours (this may be extended until the woman is stable)
  - Then hourly for four hours
  - Then four hourly for 24 hours
- Temperature should be recorded as a minimum every four hours
- Ensure adequate pain relief
- Monitor blood loss
- Antibiotics should be stopped after removal of placenta if there are no other risk factors
- Offer debrief and explanation of management of care

5.0 Roles and responsibilities

Midwives

To manage the delivery of the placenta and membranes in line with maternity guidelines
To ensure the timely intervention and management of a retained placenta and membranes

Obstetricians

To risk assess and formulate a management plan in cases of retained placenta and membranes which may include surgical intervention

Anaesthetists

To provide adequate anaesthesia for any surgical intervention for retained placenta and membranes
To give prophylactic antibiotics in line with this guidance.

6.0 Associated documents and references

Barnsley Hospital NHS Foundation Trust/Rotherham Hospital NHS Foundation Trust. Antimicrobial Policy for Adults (2017) Surgical Prophylaxis (Obstetrics and Gynaecology)

National Institute for Health and Care Excellence (NICE). Clinical Guideline 190. Intrapartum care: care of healthy women and their babies during childbirth (2017) [online] http://www.guidance.nice.org.uk/cg190

7.0 Training and resources

This section should clearly identify any training requirements for specific staff groups

8.0 Monitoring and audit

Any adverse incidents relating to the guideline for the management of a Retained Placenta will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the Management of a Retained Placenta will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1 Glossary of terms
FBC – Full blood count
G&S – group and save
HDU – High Dependency Unit
ICU – Intensive Care Unit
IV – Intravenous

Appendix 2 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	
Reviewed at Women's Business and Governance meeting	
Approved by CBU 3 Overarching Governance Meeting	
Approved at Trust Clinical Guidelines Group	
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	**Guideline for the Management of a Retained Placenta**
Document author (Job title and team)	Lead Consultant Obstetrician
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	
Approval recommended by (meeting and dates):	**WB&G 18/11/22** **CBU3 B&G 21/12/22**
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Key words for search criteria on intranet (max 10 words)	EUA, manual removal, MROP, RPOC
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Molly Claydon** **Designation: Governance Support Co-ordinator**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 business and governance
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