Document Title:	**MANAGEMENT OF A PATIENT REPORTING AN ANTEPARTUM HAEMORRHAGE**		
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Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	Obstetricians & Midwives
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Developed in response to:	National Guidance/Recommendations (i.e. NICE; RCOG) Intrapartum NICE Guidelines, RCOG guideline High Impact Intervention Guideline		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**			10, 11
Issuing Division/Directorate:	Women's & Children's		
Author/Contact: (Asset Administrator)	Miss A Dutta, Consultant for Obstetrics & Gynaecology		
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Angela Woolfenden	Lead Midwife for Community Services	
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Related Trust Policies (to be read in conjunction with)	(Refer to the main body of the text) 04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 04234 Guideline for the Management of a Postpartum Haemorrhage 07040 Guideline for the Management of Pregnant and Postnatal Patients Refusing Blood Products Trust Blood Transfusion Policy 09062 Mandatory training policy for Maternity Service 09095 Severely Ill Pregnant Patient 06065 Administration of antenatal prophylactic anti-D for rhesus

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/Superseded Document:**	**Issue Date:**
1.0	Nina Smethurst		July 2003
2.0	Caro Goodman		December 2007
2.1		Equality and diversity; audit and monitoring update	November 2009
3.0	Saadia Farrakh		March 2012
4.0	Madhu Joshi		16 November 2015
5.0	Anita Dutta	Full Review	24th October 2018

INDEX

1.0 Purpose

1.1 The purpose is to aid staff in the treatment of antepartum haemorrhage.

1.2 All staff must perform these guidelines in accordance with the Trust's Health and Safety Policy.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Background

3.1 Obstetric haemorrhage remains a significant cause of maternal death. Patients may be asymptomatic until significant blood loss occurs, and then deteriorate rapidly. The revealed blood loss may not reflect the severity of the haemorrhage.

4.0 Definition

4.1 Antepartum haemorrhage is defined as bleeding from or in to the genital tract, occurring from 24+0 weeks of pregnancy and prior to birth of the baby. All patients over 20 weeks should be assessed in the same manner.

5.0 Causes and classification of an APH (Antepartum Haemorrhage)

5.1 Causes of an APH can include:

- Placental abruption
- Placenta praevia
- Local causes from the cervix or vagina
- Vasa praevia
- A heavy 'show'

5.2 Classification of APH

- Spotting – staining or streaking noted on underwear
- Minor haemorrhage – blood loss less than 50 mls which has settled
- Major haemorrhage – blood loss of 50-1000 ml, with no clinical signs of shock
- Massive haemorrhage - blood loss greater than 1000ml and/or signs of shock

6.0 Procedure

6.1 Establish the severity and duration of the haemorrhage to maintain the safety of patient and fetus and in order to carry out assessment, planning and implementation of appropriate care**. ALWAYS ASSESS FOR SIGNS OF SHOCK.**

6.2 If a 'show' has been confirmed reassure the patient to prevent unnecessary admission.

6.3 If a **minor APH**, advise prompt attendance at hospital for observation.

6.4 Inform the obstetric registrar/consultant on call.

6.5 Monitor vital signs: blood pressure, pulse, respirations and temperature for indications of hypovolaemia.

6.6 Perform on admission a cardiotocograph tracing. If under 28 week's gestation, this should be discussed with the obstetric registrar/ consultant on call. Continuous monitoring may need to be considered. If below 24 weeks gestation, auscultate the fetal heart to ensure fetal well being.

6.7 Consider insertion of a 16 guage cannula to gain venous access if there is evidence of fresh blood loss or placenta praevia. Take blood samples for full blood count, group and save and Kleihauer.

6.8 Arrange/perform ultrasound for maternal and fetal wellbeing.

6.9 If placenta praevia prior to 34 weeks gestation, hospitalise for observation and admit if further episodes of bleeding.

6.10 If major placenta praevia after 34 weeks gestation manage as an inpatient.

6.11 From 38 weeks onwards consider delivery. Patients going to theatre with known placenta praevia should be delivered by the most experienced consultant obstetrician and anaesthetist on duty.

6.12 If placenta praevia is excluded a speculum examination should be performed by Obstetric registrar to exclude local causes.

6.13 A Kleihauer should be performed (refer to point 6.7) and if the patient is rhesus negative, anti-D should be requested on the group and save blood form. All rhesus negative patients should be given anti-D.
(Refer to the guideline entitled 'Administration of antenatal prophylactic anti-D for rhesus negative patients; register number 06065)

6.14 If repeated bleeding occurs following discharge from the hospital, the patient should be admitted for in patient care.

6.15 In the event of **major APH**, vigilant approach to care and admission is required.

6.16 Manage as a minor APH and in addition:

- Insert 2 x size 16 cannulae to gain venous access, cross match 4 - 6 units of blood
- Send group and save serum, full blood count, urea and electrolytes and clotting screen
- Inform the consultant haematologist and blood bank and discuss management with on call obstetric registrar/consultant in case of possible blood transfusion
- Consider delivery if over 38 weeks

6.17 In the event of **massive APH**, in addition to the management of moderate APH:
(Refer to Appendix A for the flow chart for massive obstetric haemorrhage)

- Inform obstetric consultant, registrar, consultant anaesthetist, consultant haematologist and blood bank

(Refer the guideline for the Management of a Postpartum Haemorrhage'. Register number 04234)

- Assess airway, breathing, evaluate circulation, oxygen by face mask at 10-15 litres/minute
- Left lateral tilt and keep the woman warm
- Transfuse blood as soon as possible
- If cross-matched blood is still unavailable, infuse up to 3.5 litres of warmed crystalloid Hartmann's solution (2 litres) and/or colloid (1-2 litres) as rapidly as required
- Or give O negative blood or uncross-matched (own group blood). Two units of 'O' negative blood are available in the maternity unit and a further 2 units are available in the blood fridge in the general corridor. The porter should be bleeped to collect these 2 units of blood urgently from the Blood Bank in Pathology
- Maintain strict fluid balance chart
- Continuous monitoring of the fetal heart to assess fetal wellbeing
- Arrange an ultrasound scan on labour ward
- Obstetric registrar/consultant on call to decide mode of delivery

6.18 Intraoperative cell salvage is not a routine procedure within Maternity Services but is available on an individual basis.

6.19 There are occasions when patients will refuse blood products i.e. religious beliefs. (Refer to the 'Guideline for the management of pregnant and postnatal patients who refuse blood products'. Register number 07040)

6.20 Interventional radiology is available at Mid Essex Hospital Services NHS Trust. Consultant Interventional RadiologistEmail:Muhammad.Hanif@meht.nhs.uk; Bleeper:07623957819; Extension:4527 and Dr Nick Railton Email:nicl.railton@meht.nhs.uk. Bleeper: 07623956522 Extension 6393

7.0 Staffing and Training

7.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training, including the management of PPH, maternal resuscitation and early recognition of the ill patient.
(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis. Register number 09062)

7.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

8.0 Infection Prevention

8.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

8.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

9.0 Audit and Monitoring

9.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

9.2 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

9.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

9.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

9.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

9.7 Key findings and learning points will be disseminated to relevant staff.

10.0 Guideline Management

10.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

10.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

10.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

10.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

11.0 Communication

11.1 A quarterly 'maternity newsletter' is issued to all staff. The newsletter has embedded icons to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on

maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

11.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

11.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

11.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folder

12.0 References

Royal College of Obstetricians and Gynaecologists Antepartum haemorrhage. Green- top guideline No. 63

Royal College of Obstetricians and Gynaecologists Prevention and management of post partum haemorrhage. Green- top guideline No. 52.

Royal College of Obstetricians and Gynaecologists Maternal collapse in pregnancy and puerperium. Green-top guideline No. 56.

Royal College of Obstetricians and Gynaecologists Blood transfusion in Obstetrics, Green- top guideline No. 47

Royal College of Obstetricians and Gynaecologists. National collaborating centre for women's and children's health. Intrapartum care: Care of healthy women and their babies during childbirth. RCOG: London.

National Institute for Clinical Excellence. Clinical guideline [CG190] Intrapartum care: Care of healthy women and their babies during childbirth.

Royal College of Obstetricians and Gynaecologists. Green top guideline :Placenta pravia and placenta praevia accrete 27b, Vasa Preavia 27 a

Mid Essex Hospital Services NHS Trust

APH ≥ 1000mls Proforma

Or signs of cardiovascular compromise

First Name		**Surname**
NHS No	**Hospital No**	**DOB**
Date / Time of Event		**Location**

Staff Present	Name	Time Called	Arrived
Midwife 1			
Midwife 2			
Labour Ward Co-ordinator			
Obstetric Registrar			
Obstetric Consultant			
Anaesthetist			
Anaesthetic Consultant			
ODP			
Obstetric Theatre Staff			
Interventional Radiologist			
Others			
Designated lead for emergency			
Scribe			

Provisional Diagnosis

Resuscitation required	No ☐	Yes ☐	*Details*			
Code Red	No ☐	Yes ☐	*Time Initiated*			
Code Yellow	No ☐	Yes ☐	*Time Initiated*			
Placenta	*Complete* ☐	*Incomplete* ☐	*Retained* ☐			
				Time	**By Whom**	
Uterine Compression:	No ☐	Yes ☐				
IV Access:	No ☐	Yes ☐				
Indwelling Urinary Catheter:	No ☐	Yes ☐				
Hourly Urine:	No ☐	Yes ☐				

Initial Observations

BP	**P**	**T**	**Resps**	**O2 SATS**	**Est Blood Loss**
Capillary Refill		MEOW Score		ECG	
Pulse Oximeter					

MEOWS Chart Commenced	Yes ☐	Fluid Balance Commenced	Yes ☐	
Baby Delivered	Time			
Method of Delivery	SVD	Forceps	Ventouse	Kiwi
	ELSCS	EMLSCS	Live Birth	Stillbirth

Drugs Admin (Not listed in order of administration)

					Time	By Whom
Syntometrine (1 amp) 1st dose		No ☐	Yes ☐			
Syntometrine (1 amp) 2nd dose		No ☐	Yes ☐			
Ergometrine (0.5mgs)		No ☐	Yes ☐			
IV Syntocinon (5iu)		No ☐	Yes ☐			
IVI Syntocinon (40 units)		No ☐	Yes ☐			
Carboprost/Haemabate 0.25mg (at 15 min intervals/max 8 doses)	1	No ☐	Yes ☐			
	2	No ☐	Yes ☐			
	3	No ☐	Yes ☐			
	4	No ☐	Yes ☐			
	5	No ☐	Yes ☐			
	6	No ☐	Yes ☐			
	7	No ☐	Yes ☐			
	8	No ☐	Yes ☐			
Misoprostil 800mg PR		No ☐	Yes ☐			

Bloods / Test

	Time Taken and Sent	By Whom
FBC		
G+S		
Haemacue		
Cross Match		
U & E's		
LFT's		
Clotting		

Fluids

		Time Given & by Whom	Running Total Including Volumes
Fluid resuscitation commenced			
Hartmanns (crystalloid)	Bag 1 (1000mls)		
	Bag 2 (1000mls)		
Volpex (colloid)	Bag 1 (1000mls)		
	Bag 2 (1000mls)		
Normal Saline	Bag 1		
	Bag 2		
Blood Products			
O Negative Bloods	1st Unit		
	2nd Unit		
Cross Matched	1st Unit		
	2nd Unit		

Bloods	3rd Unit		
	4th Unit		
	5th Unit		
	6th Unit		
	7th Unit		
	8th Unit		

		Time Given & by Whom	Running Total Including Volumes
FFP	1st Bag		
	2nd Bag		
Factor 8			
Cryoprecipitate 10 Units			
Platelet Concentrate			
Haematologist Informed			
Declined blood products			

Transfer to Theatre			
		Time	By Whom
Arrival in Obstetric Theatre			
Type of Procedure	EAU		
	Return to theatre		
	Repair of Vaginal / Uterine tears		
	Management of Uterine Atony		
	Removal of Placenta / Retained Products		

Communication		
Partner Informed		
HoM Informed		
SOM Informed		
Debrief Counselling of women and partner		

Transfer from Obstetric Theatre			
To Recovery			
To Labour Ward			
To ITU	ITU Informed		
	Date/Time to ITU		

If Blood Loss > 2000mls			
		Date	Person Responsible
Notes Photocopies			
Risk Management MW Informed			
HOM Informed			

DATIX Completed		
Concise (Level 1) report completed & emailed to risk midwife + HoM		

Appendix B

Mid Essex Hospital Services NHS Trust
Women's, Children's and Sexual Health Directorate

CODE RED

There are two types of emergencies (code RED) that require urgent 'crash call' responses using the new 4444 emergency call number.

Initiating an emergency

- Co-ordinator/senior staff member to initiate code
- Dial 4444
- Specify code **RED**
  (Refer to below criteria)
- Give location to switchboard (i.e. maternity obstetric theatre/delivery room)

Code RED for obstetric emergencies

- Grade 1 emergency section
- Major / massive haemorrhage
- Maternity fitting

Code RED switchboard will fast bleep the following:

- Labour ward co-ordinator (#6555 2017)
- On call obstetric registrar
- On call obstetric SHO
- On call anaesthetist
- On call anaesthetic assistant
- On call paediatric registrar
- On call paediatric SHO
- Theatre scrub team

****** In the event of a cardiac arrest you will still need to dial 2222******