University Hospitals Sussex
NHS Foundation Trust

# Retained Placenta Protocol

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## 1.0 INTRODUCTION

This protocol provides evidence based guidance for all staff on the diagnosis and safe management of retained placenta. It applies to obstetric, medical and midwifery staff.

A retained placenta is diagnosed when delivery of the placenta is not completed within 30 minutes of the birth with active management or within 60 minutes of the birth with physiological management.

- Incidence: 1:100 - 200 births.
- Recurrence rate of about 8-10%
- Persistence atony is often caused by retained placental tissue or blood clots.

## 2.0 RESPONSIBILITIES

It is the responsibility of all midwifery and medical staff to:

- Access, read, understand and follow this guidance.

It is the responsibility of the division to:

- Ensure the guideline is reviewed as required in line with Trust and National recommendations.
- Ensure the guideline is accessible to all relevant staff.

## 3.0 DEFINITIONS AND ABBREVIATIONS USED WITHIN THIS PROTOCOL

| | |
|---|---|
| **MEOWS -** Modified Early Obstetric Warning Score | **MIS -** Maternity Information System eg Badgernet |

## 5.0 CAUSES

- Trapped separated or partially separated placenta.
- A full bladder
- Uterine atony
- A constriction ring
- A uterine abnormality
- A morbidly adherent placenta - in this relatively uncommon condition (1 in 1500 births), the trophoblast has invaded the decidua and myometrium to varying degrees (placenta accrete / increta) or has penetrated to the serosal coat (placenta percreta).

## 6.0 MANAGEMENT

### 6.1 IMMEDIATE MANAGEMENT IF NOT BLEEDING

- Inform the labour ward coordinator.
- If the mother or birthing parent has opted for physiological management active management is recommended when there is a failure to deliver the placenta within 60 minutes.
- Consent for the commencement of active management should be obtained.
- Catheterise the bladder with an indwelling catheter and leave in situ to monitor output.
- Advise the mother or birthing person to latch the baby on to the breast to encourage a uterine contraction. If the mother or birthing person has chosen not to breastfeed explain the benefits of breastfeeding for the mother or birthing person and baby in this situation (uterine contraction). Respect the mother or birthing person's wishes ensuring provision of informed choice.
- Support the mother or birthing person to sit upright (possibly on top of a bed pan or a walk to the toilet)
- Unclamp the umbilical cord and allow blood to drain from the maternal birthing person end.
- Once retained placenta is diagnosed at a homebirth, consider transfer via ambulance into a hospital setting for further management.
- Inform the obstetric registrar of the situation.
- Site a 16G wide-bore venflon and take blood for group and save, full blood count and U&Es.
- Consider IV infusion of crystalloid (Hartmann's or sodium chloride 0.9%).
- Monitor the pulse and BP every 15 minutes.
- Observe closely for bleeding.
- Keep the mother or birthing person nil by mouth.
- **Intravenous oxytocin infusion should not be used if there is no active bleeding.**

If the placenta remains undelivered 30 minutes after active management or 1 hour following physiological management (or sooner if there is concern about the woman or birthing person's condition) an assessment of the need to remove the placenta should be offered.

**NB: Do not pull on the cord if the placenta fails to descend with gentle traction.**

**If manual removal of the placenta is required, this must be carried out under effective regional anaesthesia (or general anaesthesia when necessary).**

### 6.2 IMMEDIATE MANAGEMENT IF ACTIVELY BLEEDING

Follow the procedures outlined above and:

- Commence an oxytocin infusion 40 units in 50mls of sodium chloride 0.9% at 12.5mls/hour via a syringe driver.
- Prepare for manual removal of placenta in theatre.
- Obstetric registrar/SHO to obtain consent for procedure.
- Request crossmatch of 2 units of blood.
- Obstetric registrar to inform anaesthetist.
- Commence PPH proforma. See Maternity obstetric haemorrhage guidance.
- Labour ward coordinator to inform theatre team.
- Maintain an accurate fluid balance on MIS (including a running blood loss total).
- Give **one dose of prophylactic intravenous** Cefuroxime IV 1.5g and Metronidazole IV 500mg (unless in the case of IgE penicillin allergy in which case use Clindamycin IV 240mg and Gentamycin IV 900mg) - Refer to Adult Antimicrobial Guide)

Further oxytocic can be considered to help contract the uterus after manual removal of the placenta if there is ongoing blood loss.

### 6.3 RETAINED PLACENTA IN BIRTHS UNDER 24 WEEKS GESTATION

- Administer 10units oxytocin IM (5iu IV if access in place and actively bleeding NICE 2023) following the birth of baby unless the delivery of the placenta is imminent.
- If the placenta is not delivered within the next 30 minutes contact the on-call obstetric team for review.
- Carboprost (eg Hemabate) 250 micrograms IM can be used if deemed appropriate by an obstetrician.
- Surgical intervention should be undertaken if the placenta is not delivered within 2 hours (max) after the birth of baby, unless there is a clinical indication to intervene sooner.

The timing and urgency of any intervention should be guided by the clinical picture at all times in liaison with the senior obstetrician on-call.

## 7.0 POST PROCEDURE OBSERVATIONS AND CARE

Please follow recovery care guidance. Observations should include:

- Level of consciousness (using AVPU as per MEOWS chart)
- Blood pressure
- Respiratory rate
- Oxygen saturation by pulse oximetry
- Verbal pain and nausea score
- Uterine fundus height
- Vaginal bleeding
- Overall appearance (well or unwell)

Ensure this is recorded on the correct type of MEOWS observation form on MIS that includes consciousness.

Please note some pulse oximeters can underestimate or overestimate oxygen saturation levels, especially if the saturation level is borderline. Overestimation has been reported in people with dark skin so hypoxaemia may not be detected. (NICE 2024)

These observations, if stable, can then be recorded ½ hourly for 1 hour and then hourly until fit for discharge from recovery.

Once fit for discharge from the recovery care 4 hourly observations should be recorded for the next 12 -24 hours as indicated.

- Maintain fluid balance.
- Maintain an oxytocin infusion for 4 hours post manual removal of placenta (patient to remain on labour ward until this is completed).
- Promote mother or birthing person and baby contact at the earliest opportunity, preferably skin to skin when safe to do so and assist the mother or birthing person to breastfeed if they have chosen this method of feeding.
- The mother or birthing person should remain on labour ward until their condition is stable.
- They should have a full obstetric review prior to transfer to the postnatal ward.

## MONITORING

| Issue being monitored | Monitoring method | Responsibility | Frequency | Reviewed by and actions arising followed up by |
|---|---|---|---|---|
| Retained placenta that resulted in PPH >1500mls | Case review | Patient Safety | As indicated by DATIX | Clinical Governance Lead |

## ADDITONAL GUIDANCE / INFORMATION

NICE 2023 NG235 Intapartum Care

PROMPT Course Manual Third Edition

## SEE ALSO / LINKED DOCUMENTS

Obstetric Haemorrhage

Care in Labour

## CLINICAL PROTOCOL GOVERNANCE AND APPROVAL

| | |
|---|---|
| **OWNER** | S. Adamson, F. Usifo |
| **AUTHOR/FURTHER INFORMATION** | D. Utting, Consultant Obstetrician<br>A. Davey, Consultant Obstetrician |
| **PROTOCOL VERSION** | v1.0 |
| **RELATED POLICIES** | N/a |
| **RELATED DOCUMENTS** | Maternity clinical document:<br>Obstetric Haemorrhage<br>Care in Labour |
| **STANDARDS** | NICE 2023 NG235 Intapartum Care |
| **SUPERSEDED DOCUMENTS** | CG1146 Retained Placenta<br>MP052 Retained Placenta |
| **REVIEW DUE** | 21st August 2027 |

### Approval

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|---|---|---|
| Joint Obstetric Guideline Group | **Date approved:** | 15th May 2024 |
| W&C Clinical Effectiveness Group | **Date approved:** | 20th June 2022 |

### Consultation

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| Medicines Governance Group | **Date approved:** | 12th March 2024 |
| Antimicrobial Stewardship Group | **Date approved** | 11th March 2024 |

### Ratification

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| Clinical Document Approval Group | **Date approved:** | 21st August 2024 |

## PROTOCOL VERSION CONTROL LOG

| Version | Date | Author(s) | Comment |
|---|---|---|---|
| 1.0 | April 2024 | D. Utting, Consultant Obstetrician<br>A. Davey, Consultant Obstetrician | New Trust wide protocol replacing:<br>• CG1146 Retained Placenta<br>• MP052 Retained Placenta |

***Protocol which includes any prescribing must include approval from UHSussex Medicines Governance Committee (MGC)***