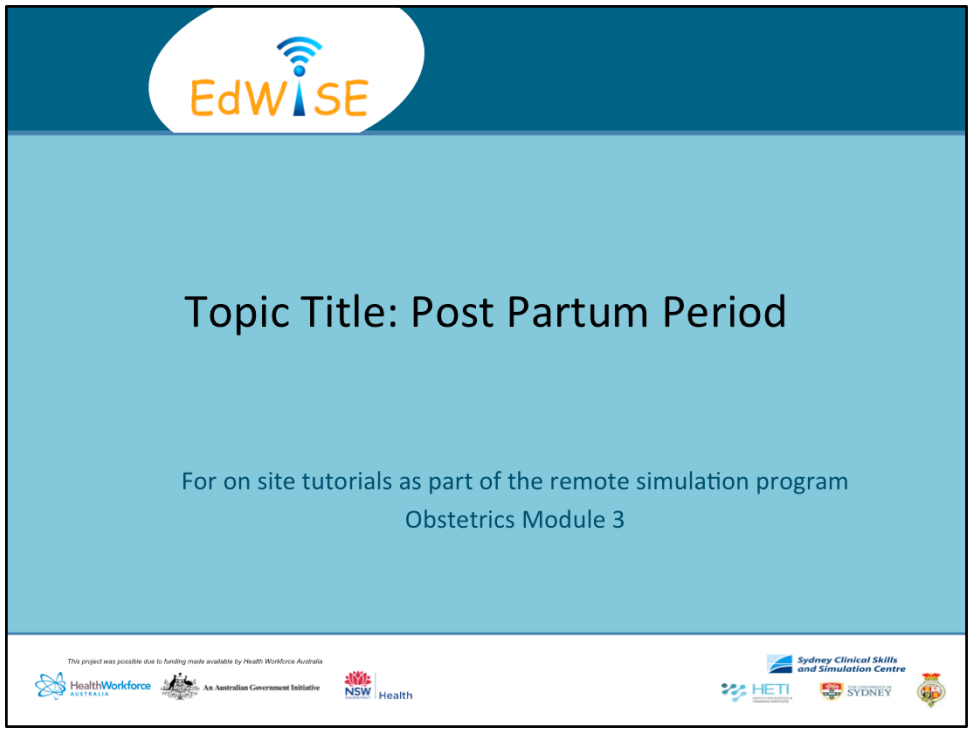
EdWiSE
Topic Title: Post Partum Period
For on site tutorials as part of the remote simulation program
Obstetrics Module 3
This project was possible due to funding made available by Health Workforce Australia
HealthWorkforce AUSTRALIA
An Australian Government Initiative
NSW Health
Sydney Clinical Skills and Simulation Centre
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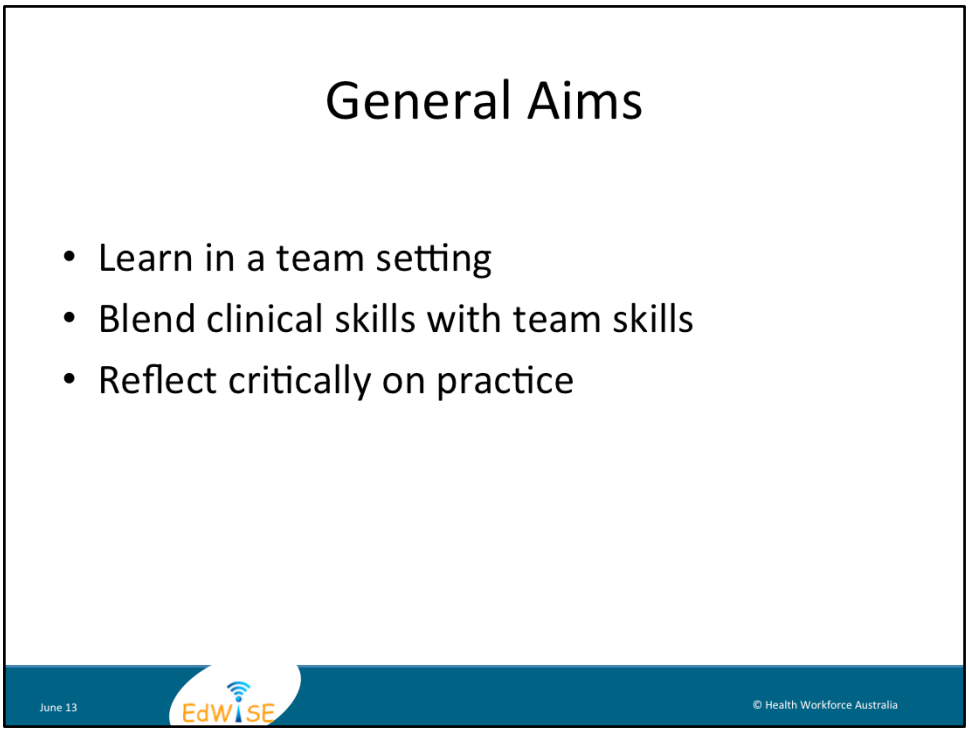
Introductions

Lets introduce ourselves!!

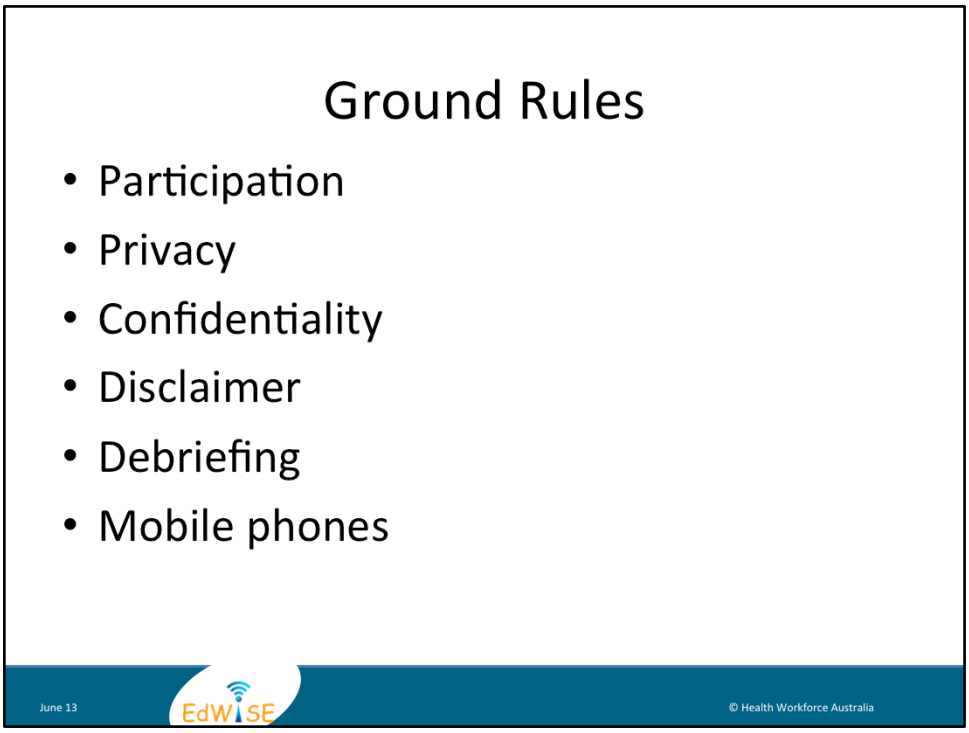
Very quick round the room to assess stage of professional development for each participant.



These aims are the same for all sessions – please do not modify

Speakers' notes

- This session, and package as a whole, involves learning together. Learning with the teams that you work with helps that team to function more efficiently and effectively. It allows you to learn from each other, explore different perspectives and to understand the importance of all members of the team.
- We are targeting higher level learning – applied skills and performance in contextualised events. This is through team discussion and also through working through simulated scenarios as a team. It also allows you to put into practice knowledge attained from the eLearning and other solo learning environments.
- To review and reflect upon our own practice and current best practice standards. During our feedback sessions we will facilitate this but we would also encourage you to reflect on your practice and experience after these sessions.



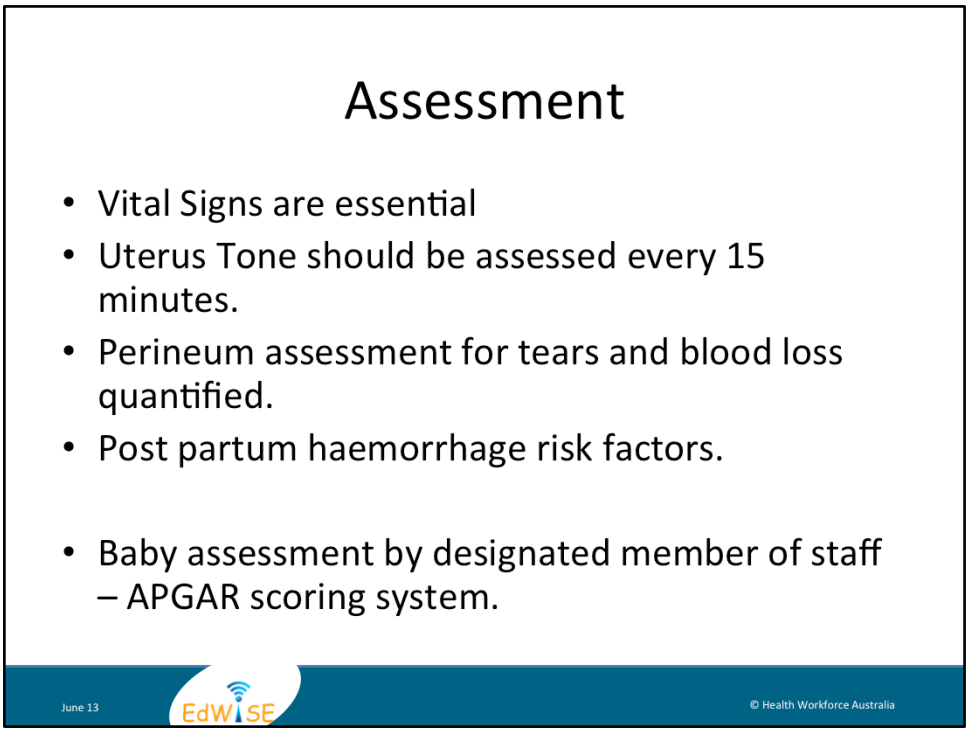
These aims are the same for all sessions – please do not modify

Speakers notes

- Challenge of video conferencing tips: don't change your seat, speak up nice & clearly
- Details collected and de-identified for reporting purposes
- Signed form, don't speak outside about how people performed as not necessarily indicative of real life. This is a chance to try new things, don't tell anyone about the scenarios as they are used again on subsequent courses.
- We try to use best evidence practice and strive to include as up-to-date material as possible. Please do refer to your local policies, guidelines and protocols.
- Debriefing is a chance to reflect upon what we did and how that translates to the workplace. Please use this time to explore the complexities of performance and decision making. Please contribute, we will all learn from each other's experiences.
- Like most things in life, the more that you put in the more you will take away with you.
- It is an open forum where everyone's ideas and thoughts are to be valued.
- If you could please switch your phones off or to silent or vibrate for the duration of the course.

Session Objectives

- Assessment of a patient after delivery
- Normal management of third stage of labour including delivery of placenta
- Assessment and management of obstetric hemorrhage



ASSESSMENT

Assessment of the woman in the post partum period is important. It is essential that the uterus be assessed to ensure that it is firmly contracted, that the placenta is complete, and that the genital tract is not bleeding excessively. Careful monitoring for blood loss, uterine tone, blood pressure and heart rate should occur every 5-10 minutes in the first 30 minutes, the 15-30 minutely over the first 4 hours post delivery. The principles of assessment for deterioration as outlined in the DETECT course in NSW, including activation of medical assessment should be adhered to.

PPH RISK FACTORS

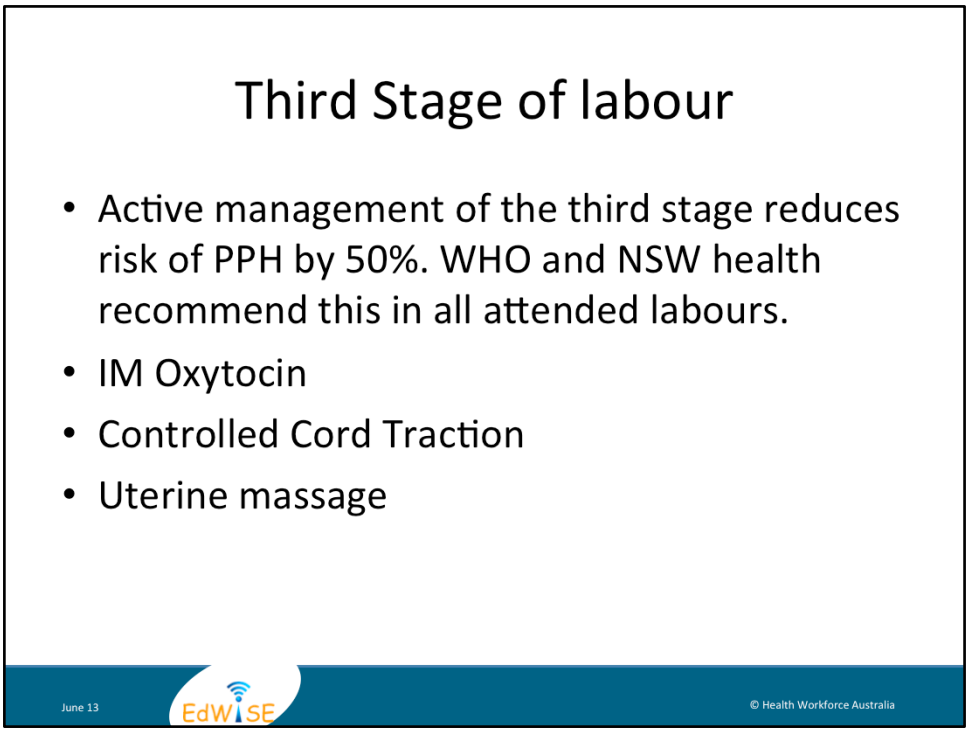
An assessment of maternal and delivery risk factors for PPH is important with close surveillance of every woman for PPH postbirth. However, PPH may occur in the absence of any of these risk factors.

Antenatal Risks:

- Coagulation disorders, especially those associated with hypertensive diseases of pregnancy.
- Previous PPH
- Multiple gestation / grand-multiparity
- Previous caesarian sections

Intrapartum Risks:

- Prolonged third stage
- Congenital uterine abnormalities (i.e; fibroids)



ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

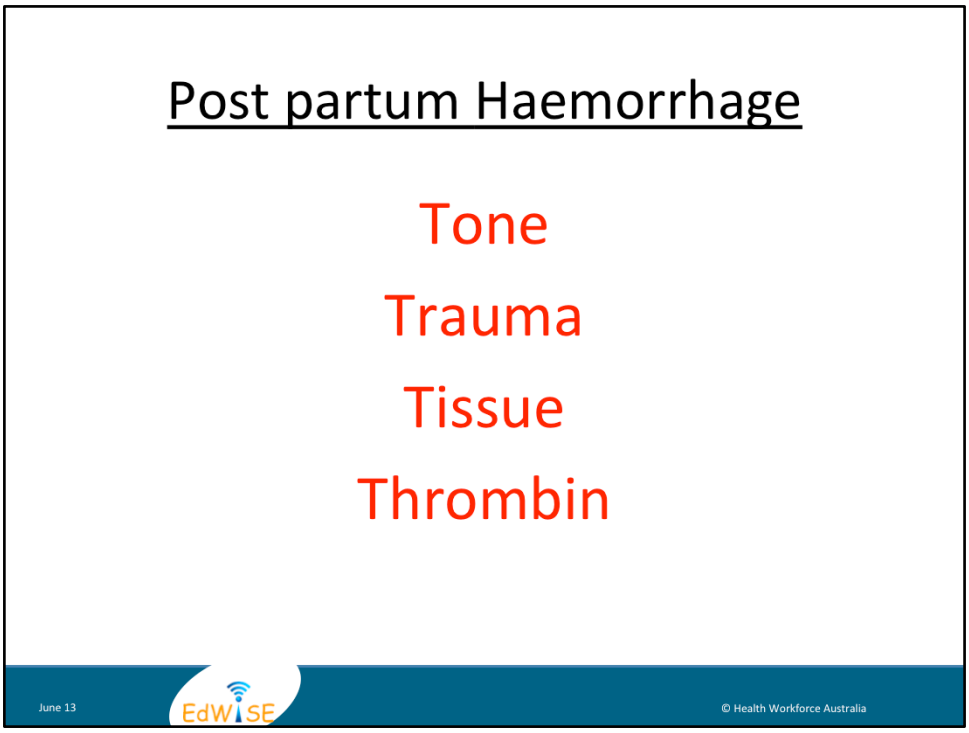
Compared to expectant (physiological) management, active management of the third stage of labour can reduce the incidence of PPH by 50%. This is done by giving intramuscular oxytocin (10units) within 1 minute of childbirth, controlled cord traction, and uterine massage after delivery of the placenta.

Active management of should be performed in all births, as recommended by WHO and FIGO. It is essential to first palpate the abdomen for additional babies. The oxyctocin should then be given into the lateral thigh.

Controlled cord traction is then performed after clamping the cord close to the perineum 2 minutes after delivery, the uterus must be stabilised with counter-traction, then apply slight tension to the cord until a uterine contraction, at which point have the mother deliver the placenta with pushing.

Following delivery of the placenta the uterus should be massaged every fifteen minutes for 2 hours. This is ongoing assessment for the tone of the uterus in the post partum period.

These interventions reduce the length of the third stage and reduce the incidence of PPH and the interventions associated with increased bleeding.



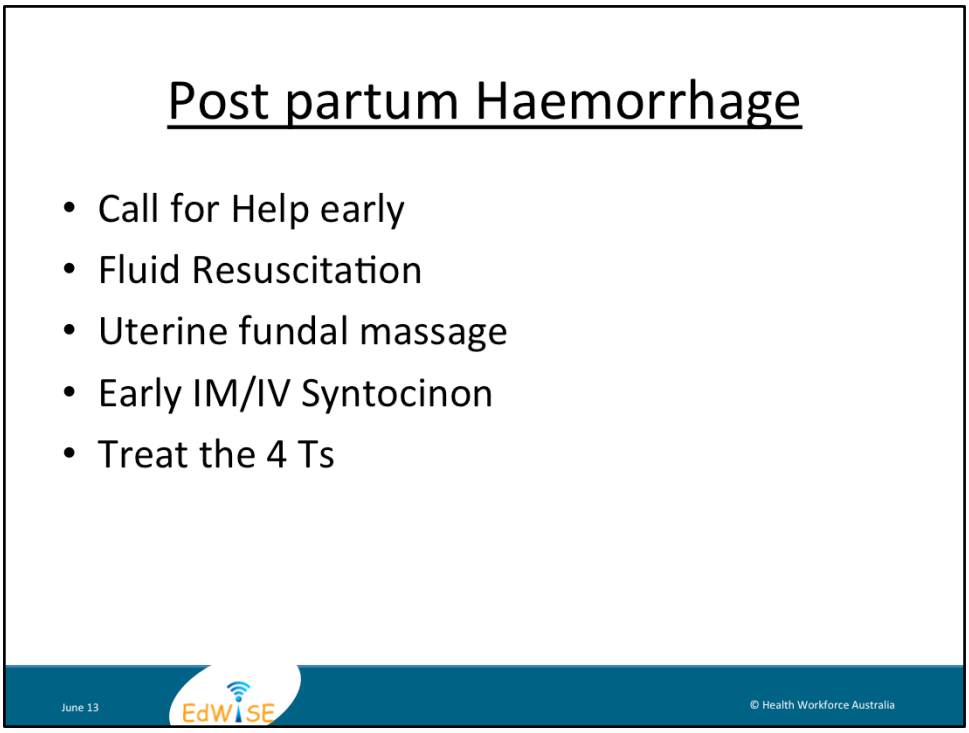
POST PARTUM HAEMORRHAGE

Postpartum haemorrhage (PPH) is commonly defined as blood loss of 500 ml or more during and after childbirth. PPH is a leading cause of maternal mortality in Australia and approximately one quarter of maternal deaths worldwide are due to PPH.

PPH can be either primary or secondary. Primary PPH occurs within 24 hours of the birth of a baby. Secondary PPH occurs between 24 hours and 6 weeks postpartum.

An understanding of the potential causes of PPH allows for simultaneous assessment and management of the woman with PPH, especially in those who are haemodynamically unstable. These are often described as the 4 Ts of PPH.

- Tone (70%) – Abnormalities of uterine contraction
- Trauma (20%) – Episiotomy or laceration of perineum, vagina, cervix/ genital tract trauma
- Tissue (10%) – Retained placental tissue
- Thrombin (1%) – Abnormalities of coagulation



A STEP WISE APPROACH TO MANAGEMENT of PPH

- Call for help - obstetrics and anaesthetics back up
- Insert 2 large bore IVC (16G)
- FBC, Blood Group & Hold, Cross match, Venous blood gas including Hb.
- Personal protective equipment on staff, gloves and masks advised.
- Apply monitoring - BP, ECG, Pulse Oximetry
- Treat hypovolaemia with crystalloids and blood product replacement.
- Perform uterine fundal massage
- Oxygen - high flow initially
- Consider IDC insertion to improve massage ability
- Administer oxytocins as soon as possible - IM syntocinon10units
- Consider the 4 Ts further for tone, trauma, tissue, thrombins.
- Obstetric advice may include further drug therapy or physical

techniques which are outlined below.
The NSW policy on management of PPH is a useful and widely available resource which should be referred to.

DRUG THERAPY for PPH
All drug therapy for PPH should only be given after excluding a twin pregnancy.
Oxytocins (Syntocinon) - stimulates the smooth muscle of the uterus, producing rhythmic contractions, particularly towards the end of pregnancy, during labour, after

BAT CALL

- I – 32 year old woman with post partum haemorrhage after delivering the baby and placenta en route.
- M – Delivery of healthy baby girl in the ambulance, ongoing maternal bleeding. The placenta has been delivered.
- I – Approximately 1 litre of blood loss with patient feeling lightheaded.
- S – RR 25/min, Sats 99% on oxygen, HR 115 regular, BP 100/65, GCS 15 and a BSL of 6.4.
- T – High flow oxygen, 2 IVC and 500ml normal saline. The baby is healthy and with dad at the moment.

Summary

- Prevent PPH by actively managing the third stage of labour.
- If PPH occurs call for help early and begin resuscitation.
- Treat the 4 Ts early, 70% are tone related and syntoconin must be given immediately.

References

- NSW Health Policy, Prevention, early recognition and management of post partum haemorrhage. 2010
- Advanced Life Support in Obstetrics Manual, 4th
- FIGO Safe Motherhood and Newborn Health Committee Prevention and treatment of post partum haemorrhage in low-resource settings International Journal of Gynecology and Obstetrics 117 (2012)

Acknowledgments

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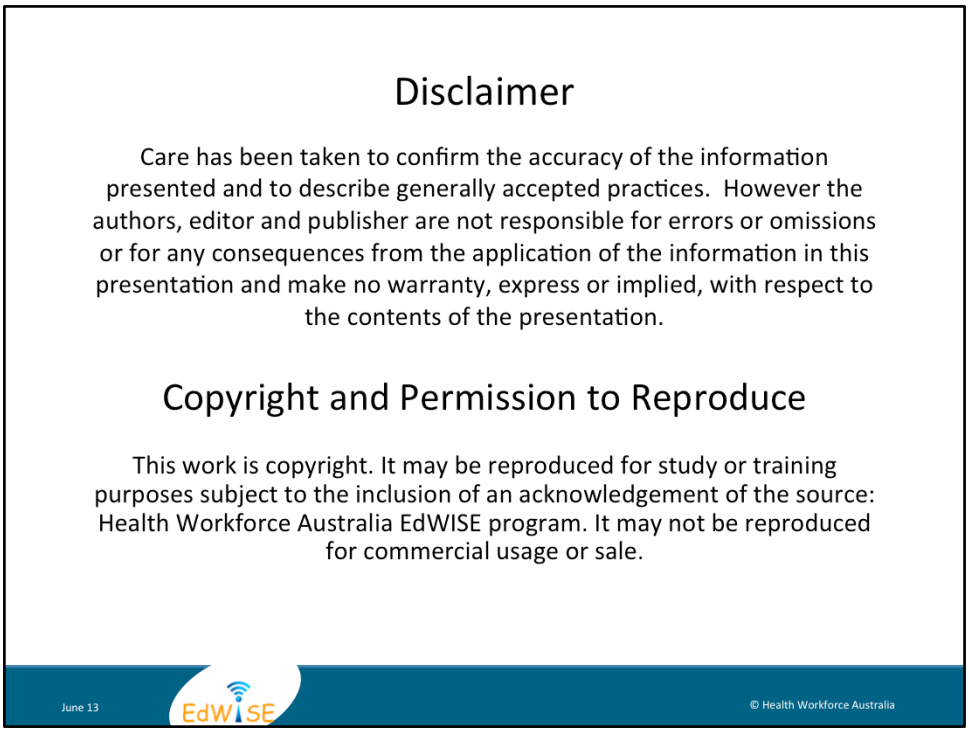

Same for all presentations