Evaluation of blood loss following Postpartum Haemorrhage

Adrienne Brady CMM3 LW, NICU, MLU OLOLH, AnnMarie Connor ADOM Maternity Practice Development Co-ordinator OLOLH, Laura Muckian, Maternity Clinical Audit Facilitator.

Aim

To determine if an increase in incidences of Postpartum Haemorrhage in September and October 2022 may have been associated with non compliance with any one of the following preventative measures;

- PROMPT training including quantification of blood loss and use of PPH Proforma
- OLOLH local clinical guideline on the Prevention and Management of Primary PPH (2022).

Context

Fortunately PPH results in very few cases of maternal deaths in Ireland today, however it continues to remain a leading cause of maternal morbidity (NPEC 2021). Conducting clinical audits on the incidence of PPH prevents us from focusing on just the so called " tip of the iceberg" but focuses attention on measuring the quality of care provided, the effectiveness and suitability of existing processes and identify and implement measures for improvement thus reducing preventable maternal deaths whilst improving both maternal fetal and neonatal outcomes

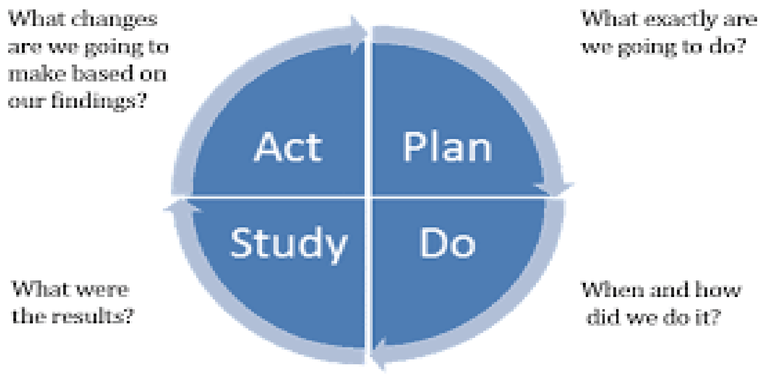
The key to the management of PPH is the early recognition of excessive blood loss and appropriate fluid replacement. Nationally three methods are used to evaluate maternal blood loss; full quantification, blood collection measures plus visual estimation and finally visual estimation only (NPEC & NWHIP 2021). In OLOLH the longstanding practice of evaluating maternal blood loss in theatre and delivery suite has been by full quantification. Currently OLOLH has one of the lowest PPH rates nationally at 4.3%, nationally the figure is 7.3%. On foot of an increase in our rate of PPHs during September and October an audit was carried out.

What are we trying to accomplish?

- To audit healthcare records against the standards as set out in OLOLH guideline Prevention and Management of Primary PPH.
- Determine if our local PPH Proforma as outlined in our local PROMPT training programme was utilised to document a PPH and that blood was evaluated by means of full quantification.
- Identify any deficits in training and education around PPH and implement an education programme to meet those needs.

What We Did

Plan Do Study Act Cycle (PDSA)



Plan

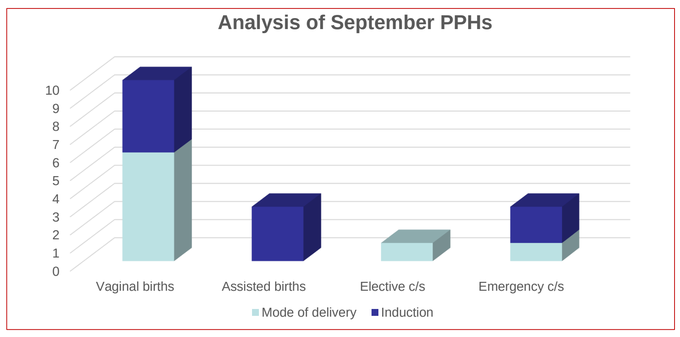
- Identified and obtained the Healthcare records of women who had PPHs during the months of September and October (2022).
- Developed an audit tool based on our local PPH guideline and our local PPH Proforma.

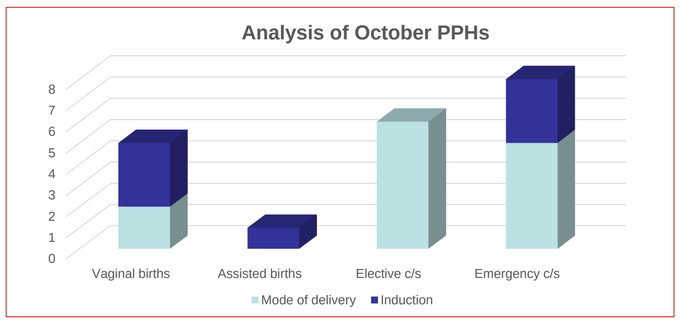
Do

- 37 healthcare records of women who had PPHs during the months of September and October were identified for the purposes of this audit.

Study

- Collaboratively collated and analysed the data.





Act

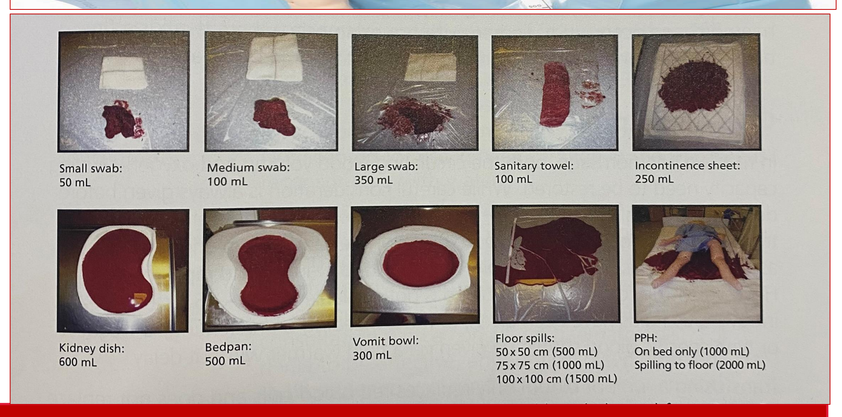
- Plan to introduce the PPH Proforma into theatre to aid clarity in the documentation of medications administered during PPHs.
- To continue monitoring PPH rates.

Key Learning

- Contribution that clinical audit makes towards improving and maintaining practice standards.
- Value of quality improvement initiatives derived from clinical audit

What We Achieved

- As a result of the audit findings we know that PPHs in the unit are managed in accordance with our local guideline and PROMPT training.
- We identified that in all cases blood loss were evaluated by full quantification which is one of the key components of successful management of PPH. As a safety measure it triggers early recognition of the problem and earlier fluid resuscitation ultimately affecting neonatal outcomes
- We identified that our local PPH Proforma was utilised in all instances of PPH on labour ward.
- The introduction of the PPH Proforma into theatre as part of a quality initiative, with the aim of standardising documentation of PPHs in the unit.



References

1. Leitao S., Manning E., Corcoran P.et al (2021) On behalf of the Severe Maternal Morbidity Group. National Perinatal Epidemiology Centre, Cork. Maternal morbidity and mortality: an iceberg phenomenon. *BJOG*, vol 129, issue 3, pg 402- 411. available at www.bjog.org .
2. National Perinatal Epidemiology Centre (NPEC) and the National Women and Children's Programme (NWHIP) (2021). *Postpartum Haemorrhage Quality Improvement Initiative*. National Perinatal Epidemiology Centre, Cork.
3. OLOLH (2022) *Prevention and Management of Primary Postpartum Haemorrhage Guideline*. V2 OLOLH-DEP-OBS-154.
4. Prompt (2020). *Practical Obstetric Multi-professional training*. The PROMPT Maternity Foundation. 3rd edn. Cambridge Press.
5. Leitao S., Manning E., Corcoran P.et al (2022) On behalf of the Severe Maternal Morbidity Group. *Severe Maternal Morbidity in Ireland, Annual report 2020*. National Perinatal Epidemiology Centre, Cork.