MANAGEMENT OF MASSIVE OBSTETRIC HAEMORRHAGE AUDIT
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Background:
Post-partum haemorrhage (PPH) is the third most common cause of maternal death in the UK. Reducing the rate of massive PPH is a major challenge in obstetrics today. RCOG determines that all maternity centres should have protocols in place and training to promote a rapid response and to reduce mortality. One potentially effective tool for improving the quality of care is the clinical audit.
At South Tyneside District Hospital we audited the most recent twenty consecutive cases of massive PPH in November 2012 aiming to monitor departmental compliance with the ‘Massive Obstetric Haemorrhage’ protocol.

Standards:
100 % compliance in all criteria including Prophylactic syntocinon , immediate action, further management, staff involve, events recording and follow Up:

Data Collection:
Proforma developed using local protocol as a template
Retrospective case note review
Most recent 20 cases of PPH >1500 ml between 30/04/12-22/10/12

Results:
Documentation was not up to standards. PPH performa was used in most cases. Outcome was good; only one patient needed ITU admission. No permanent morbidity or mortality. All patients were debriefed and followed up at 6 weeks post natally.

Conclusions and Recommendations:
Risk factors are not a good prediction for massive PPH. Every effort should be exercised to prevent PPH specially if a risk factor is identified while being aware that some women without any risk may still develop massive PPH requiring multiple interventions (medical, mechanical, invasive non-surgical and surgical procedures) and different levels of skill and technical expertise.