Frimley Health
NHS Foundation Trust

Retained Placenta

Key Points

- The placenta is considered to be retained if it is not delivered after 30 minutes following active management of 3rd stage or 60 minutes following physiological management
- If the placenta is retained, check and record heart rate, blood pressure, fundal height and blood loss every 15 minutes.
- This guideline has to be read in conjunction with the guidelines on the Care of Women in Labour and Post Partum Haemorrhage (PPH).

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Contents

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1. Introduction

The placenta is considered to be retained if it is not delivered after 30 minutes following active management of 3rd stage or 60 minutes following physiological management. The incidence of retained placenta is 0.5-3%.

- Active management of the third stage involves a package of care comprising the following components:
  - routine use of uterotonic drugs.
  - cord clamping and cutting of the cord (after a minimum of one minute unless there is concern about the integrity of the cord or the baby has a heart rate below 60 beats a minute that is not getting faster).
  - controlled cord traction after signs of separation of the placenta.

- Physiological management of the third stage involves a package of care that includes the following components:
  - no routine use of uterotonic drugs.
  - no clamping of the cord until pulsation has stopped, or after delivery of the placenta.
  - delivery of the placenta spontaneously or by maternal effort.

2. Management while waiting for the placenta to deliver

In the absence of bleeding, intervention may be delayed for up to 30 minutes for active management and 60 minutes for physiological 3rd stage of labour.

If the baby has not already been put to breast, encourage mothers to put the baby to breast to release endogenous oxytocin.

Ensure the urinary bladder is emptied.

Avoid cord traction when the uterus is not well contracted as excessive cord traction may cause the cord to tear or inversion of the uterus.

3. Management when the placenta is retained

- Inform labour ward co-ordinator and obstetric registrar.
- Transfer the woman to consultant led care and transfer her from the birth centre or from home to the labour ward
- Ensure bladder is empty, use a catheter if woman has not passed urine since delivery,
- Check pulse and blood pressure every 15 minutes.
- Record blood loss every 15 minutes.
- Check and record fundal height every 15 minutes.
- Site IV access (16G cannula),
- Take bloods for FBC, Group & Save.
- The obstetric registrar should assess the woman on labour ward prior to transfer to theatre as necessary. This assessment includes a vaginal examination; it should be with all due care using Entonox as analgesia if necessary and stopped if the woman reports pain.
- Inform the anaesthetist and book theatre.

- Patient should be transferred to theatre in a timely manner. If bleeding, immediate transfer should take place. If not bleeding, the patient should be transferred within 75 minutes of diagnosis of retained placenta. A second theatre may be used to facilitate this if necessary.
- Careful documentation of these events and observations must occur post delivery.

Do not do umbilical vein injections with oxytocin or saline as evidence shows this is not effective.

4. Following active management of the third stage

If the woman is not bleeding do not give additional syntometrine or oxytocin (including an infusion) because it may contract the cervix and make manual removal more difficult. Furthermore, once the diagnosis of retained placenta has been made, no pharmacologic treatment has been shown to be effective.

If the woman is bleeding and there is no obstetrician available immediately or if you are at a homebirth it is advisable **to administer ergometrine (and/or a oxytocin** infusion of 40 units of oxytocin in 500 mls of 0.9% sodium chloride at 125ml/hr).

Bimanual compression should also be considered where possible. These measures will not be harmful and should minimise the bleeding until reaching the hospital or theatre.

(The obstetrician can dilate the cervix if required at a later stage to deliver the placenta).

5. Following physiological management of the third stage

Advise a change to active management if the placenta has not delivered after 60 minutes, if the woman has bleeding or if she would like to shorten the third stage.

If the placenta is not delivered after the change to active management, then manage as a retained placenta. In the absence of bleeding, it is reasonable to allow 30 minutes following active management, i.e., a total of 90 minutes after birth; but intervention can be offered earlier, taking into account the woman's individual circumstances and her preferences.

6. In theatre

Perform manual removal of placenta under anaesthesia (in some cases general anaesthesia may be required at the discretion of the anaesthetist).

Give prophylactic single dose of IV antibiotics according to the microguide.

If the cervix is contracted or there is an isthmical contraction ring and manual removal is not possible, consider giving glyceryl trinitrate 100µg IV to relax the uterus and facilitate manual removal. Dilute if necessary to maximum 1mg/mL in sodium chloride 0.9% or glucose 5% and give using a polyethylene syringe as GTN is incompatible with PVC.

A retained placenta in a patient with a previous caesarean section must be treated with great care; the likelihood of a placenta accreta is increased. During manual

removal if there is any suggestion that the placenta is not separating call a consultant for further advice.

7. Post operative care

Post operative observations;
Pulse, BP, respiratory rate, oxygen saturations, lochia and palpation of the fundus every 30 minutes for 1 hour and every hour for a further 2 hours.

MEOWS every 4 hours for the next 24 hrs.

Maintain an indwelling urinary catheter until the woman is mobile and the effect of any regional anaesthesia on the bladder has worn off (usually a minimum of 12 hours).

8. Auditable Standards

Time to transfer to theatre.

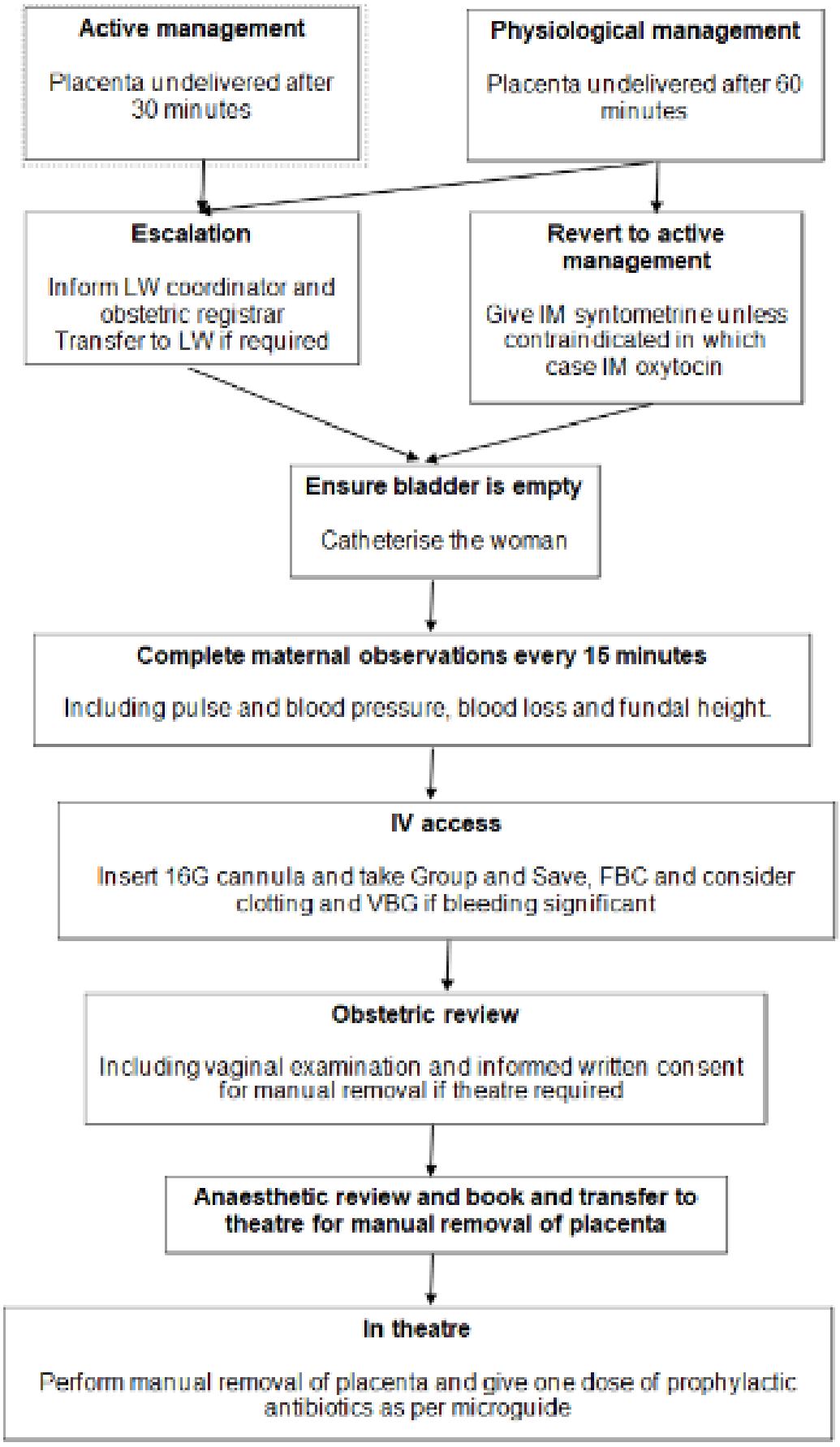
The use of antibiotic prophylaxis.

The post operative monitoring.

9. Monitoring compliance

This guideline will be subject to three yearly audit and results presented to the department clinical audit meeting. Action plans will be monitored at the quarterly department clinical governance meeting. The audit midwife takes responsibility for initiating and reporting the audit.

10. Flowchart



11. References

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Full version control record

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Sept 2015	V Novis, S Coxon, A Kirkpatrick, A Sierra	Final	First trust-wide guideline
2.0	Jan 2019	A Tillett	Final	Review and update.
2.1	Feb 2022	A Kirkpatrick	Draft	Scheduled review.
3.0	May 2022	A Kirkpatrick	Final	Approved at OCG.
4.0	June 2025	A Kermack	Final	Scheduled review. Approved at cross site OCG, 19 June 2025

Related Documents

Document Type	Document Name
Guideline	Care of Women in Labour
Guideline	Post Partum Haemorrhage (PPH)