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Risk management and medicolegal issues related to postpartum haemorrhage

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Postpartum haemorrhage (PPH) is a major cause of maternal mortality and morbidity. Despite several local and national guidelines and recommendations, the incidence of major obstetric haemorrhage has not declined significantly over the years. A high proportion of these cases involve patient safety incidents. The major themes in such incidents are: delay in diagnosis, failure to adhere to protocols, lack of consultant supervision, communication and documentation problems, inefficient teamwork and organizational failure. This chapter deals with ways of identifying the major contributory factors for adverse events associated with PPH and suggests solutions to minimize errors.

Key words: postpartum haemorrhage; maternal morbidity; hysterectomy; risk management; safety; adverse events; medicolegal.

INTRODUCTION

Reducing maternal mortality and morbidity is an essential component of safer childbirth in the twenty-first century. Although maternal mortality in developed countries is low (13.9/100,000 maternities in UK), postpartum haemorrhage (PPH) is one of the commonest causes of mortality and morbidity.[1] Despite several audits, guidelines and recommendations for its management the incidence of PPH has not reduced

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significantly over the years. A culture of safety in maternity units, with risk management central to this, is extremely important in dealing with this problem, which accounts for thousands of maternal deaths worldwide. Safety should be everybody's business and the responsibility of each and every member of the maternity team.[2]

According to the latest Confidential Enquiries into Maternal and Child Health (CEMACH) report, 17 women died in the UK as a result of haemorrhage between 2003 and 2005, giving an incidence of 0.66 per 100,000 maternities.[1] Of these maternal deaths, 59% of the women were found to have received major substandard care during the management of obstetric haemorrhage. A British study by Vincent, in 2001, highlighted that 10.8% of hospital patients in the UK suffer an adverse event.[3] Half of these are preventable and a third lead to moderate or greater disability or death. The adverse event rate in obstetrics was 4.0%, with 71% of events being preventable.

Massive PPH and peripartum hysterectomy are 'near-miss' events for maternal mortality. Study of such events greatly improves our knowledge of the risk factors and management associated with massive obstetric haemorrhage and also identifies the means of prevention. A recently published Scottish Confidential Audit of Severe Maternal Morbidity had a incidence of major obstetric haemorrhage of 3.7 per 1000 births.[4] Since the commencement of annual maternal morbidity audits by Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH) in 2003, major obstetric haemorrhage has remained the most common cause of severe maternal morbidity.[5–8] The quality of care these women received was noted to be suboptimal in 31–40% of cases. However, the majority of cases received incidental or minor substandard care (different care might have made a difference) and only 3% of women received major substandard care (i.e. management that contributed significantly to the morbidity; different management might have been expected to result in a more favourable outcome). This could reflect the impact that regular audits and learning from adverse events have on the quality of care. Data from the UK Obstetric Surveillance System (UKOSS) describe the reported causes, management and outcome of peripartum hysterectomy and associated haemorrhage in the UK.[9] For each woman who dies in the UK following peripartum hysterectomy, more than 150 survive. However, obstetric haemorrhage is managed in a variety of ways, which might not be according to the existing guidelines.

Postpartum haemorrhage can be avoided by prophylaxis and responds to simple measures in the majority of cases. The recurring theme of substandard care in most studies highlights the need to identify the reasons, contributory factors and learning points in cases of massive obstetric haemorrhage and develop an action plan locally and nationally. The following paragraphs focus on these points and deal with risk management in PPH.

MAJOR THEMES IN RISK MANAGEMENT OF ADVERSE CLINICAL EVENTS

Several authors, including Brace et al[4], and Neale et al[10], have identified certain recurring themes in the risk assessment of adverse events. These include: misdiagnosis or delay in diagnosis, failure to adhere to protocols, lack of communication, inadequate senior input, underestimating the speed and extent of haemorrhage, poor documentation and systems failure.

Adverse events usually occur as a result of a combination of factors occurring at the same time. In the Scottish audit, the most common contributing factor was 'patient