SOP
On Manual Removal of Placenta

Department of Obstetrics & Gynaecology
Faculty of Medicine
UWUSL

Standard Operating Procedure (SOP)
On Manual Removal of Placenta

Title
SOP for Manual Removal of Placenta

Issued By
Faculty of Medicine, Uva Wellassa University of Sri Lanka

(1) Purpose
(1.1) To provide a standardized procedure for the safe and effective manual removal of a retained placenta to prevent postpartum haemorrhage and associated maternal complications.
(1.2) To systematically prevent postpartum haemorrhage (PPH) and associated maternal morbidity and mortality complications.

(2) Scope
This SOP applies to all qualified obstetricians, medical officers, clinical trainees, registered midwives, and nursing staff involved in intrapartum care and the management of the third stage of labour after a vaginal delivery.

(3) Responsibilities
(3.1) Clinician / Healthcare Provider
(3.1.1) Assess and confirm the clinical indication for the manual removal of the placenta.
(3.1.2) Explain the procedure, risks, and benefits clearly to the patient and obtain informed consent.
(3.1.3) Perform the operative procedure strictly adhering to surgical aseptic techniques.
(3.1.4) Monitor maternal haemodynamic stability and aggressively manage any acute complications.

(3.2) Assistant / Nursing Staff
(3.2.1) Rapidly prepare all necessary sterile equipment, uterotonic medications, and IV fluids.
(3.2.2) Assist patient positioning and monitoring.
(3.2.3) Maintain strict infection prevention and control practices throughout the environment.
(3.2.4) Ensure meticulous documentation of clinical observations, fluids, and post-procedure monitoring.

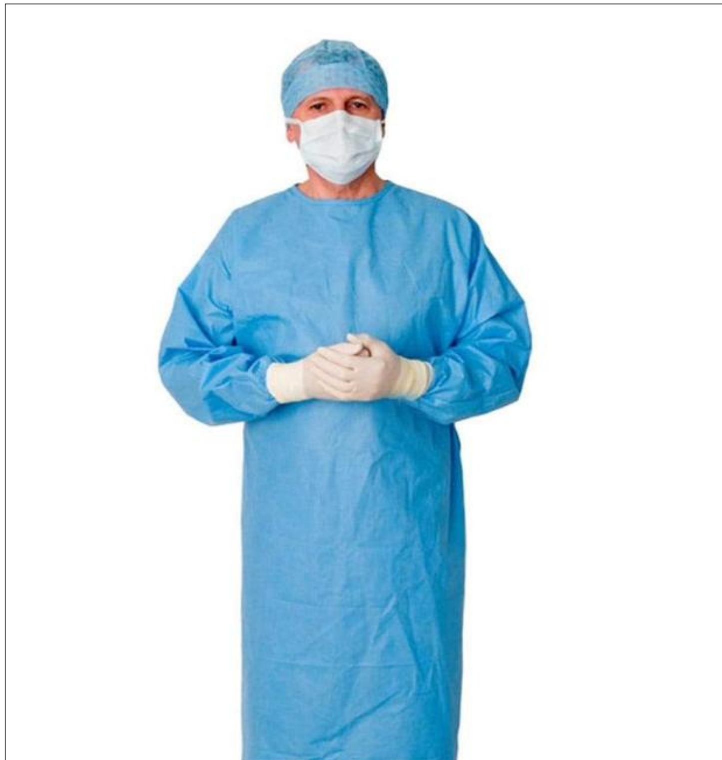
(4) Ethical and Clinical Considerations
(4.1) Maintain patient confidentiality at all stages of care
(4.2). Request and secure formal informed consent whenever clinical timeframes feasibly permit.
(4.3) Ensure the patient's visual and physical privacy and personal dignity are preserved at all times.
(4.4) Follow rigid infection prevention and control measures to eliminate healthcare-associated transmission.
(4.5) Ensure the immediate availability of maternal resuscitation facilities, an operating theatre slot, and cross-matched blood products before commencing.

(5) Indications

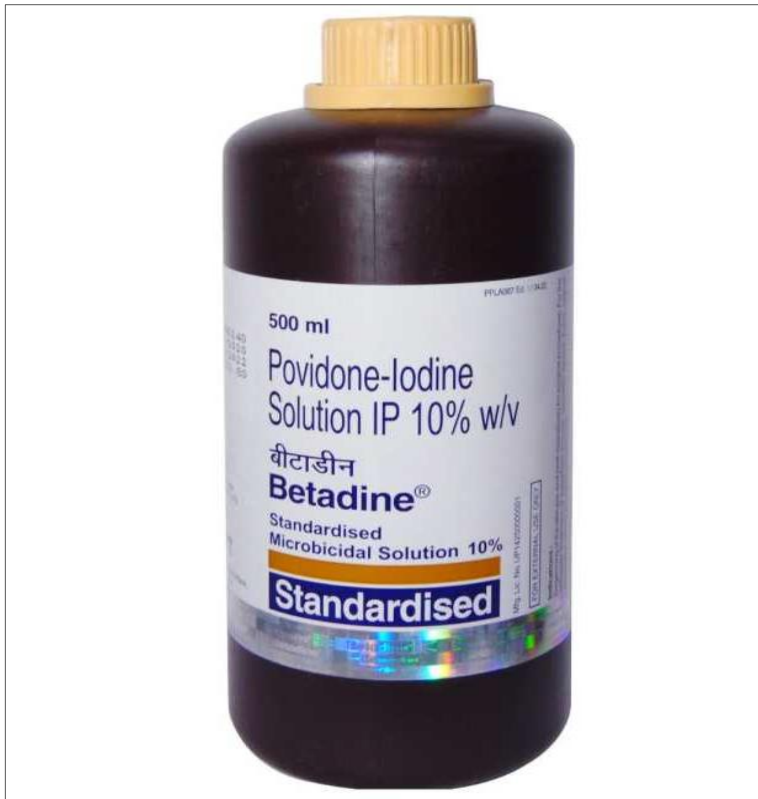
(5.1) Placenta not spontaneously expelled within 30 minutes after delivery of the neonate despite active management of the third stage of labour.
(5.2) Significant, life-threatening postpartum haemorrhage occurring prior to spontaneous placental expulsion.
(5.3) Retained placenta causing acute maternal haemodynamic instability.

(6) Equipment Required

(6.1) Sterile gloves, gown & face mask



(6.2) Antiseptic solution (e.g., Povidone-Iodine solution 10% w/v).



(6.3) Sterile drapes

(6.4) Intravenous access

(6.5) Oxytocin

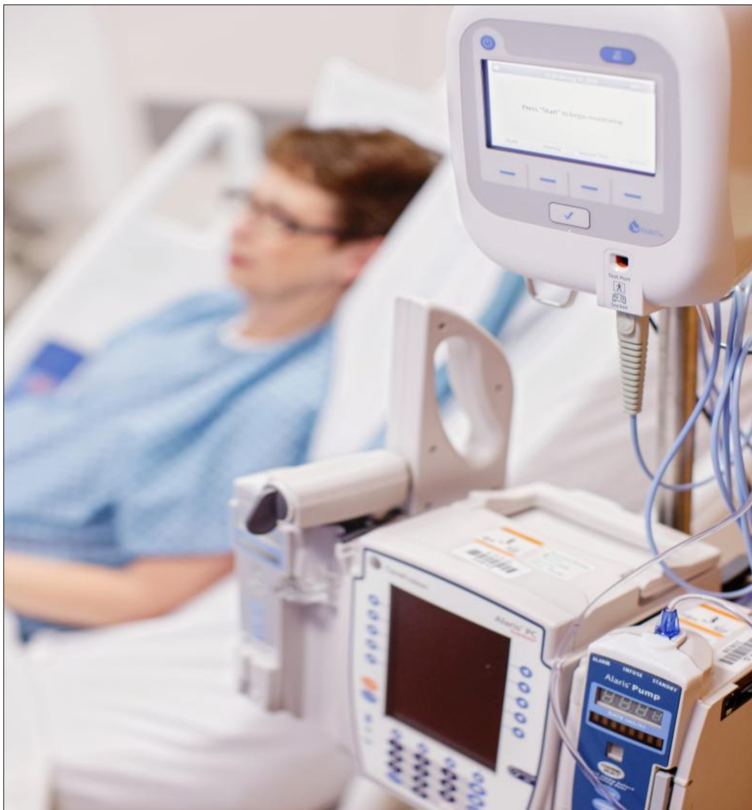
(6.6) Monitoring equipment (BP, pulse, oxygen saturation)

(7) Procedure

(7.1) Patient Preparation

(7.1.1) Confirm the medical indication and review the patient's overall haemodynamic status.
(7.1.2) Explain procedure and request informed consent.

(7.1.3) Ensure IV access and commence monitoring.

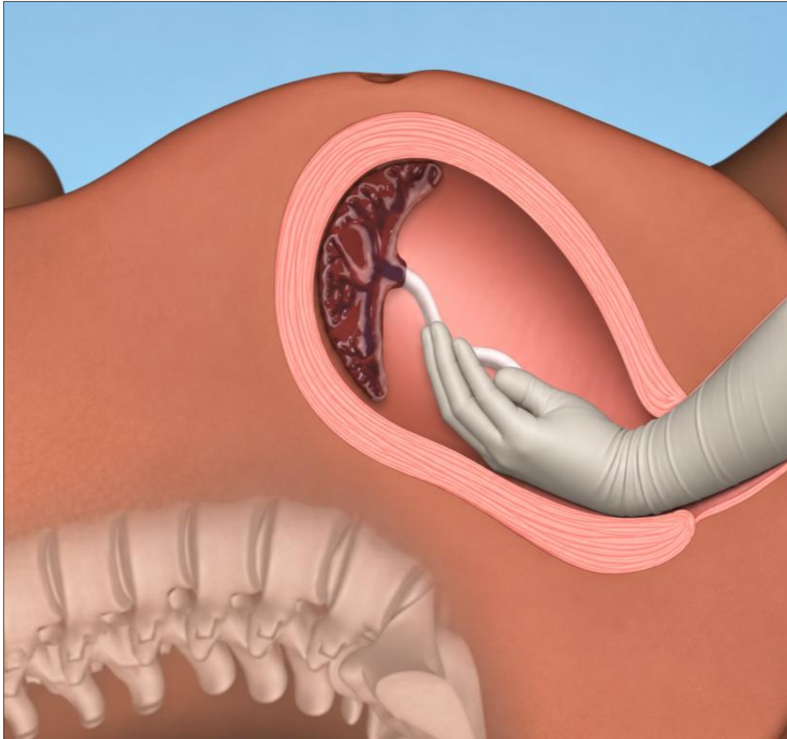


(7.1.4) Provide adequate analgesia or anaesthesia.

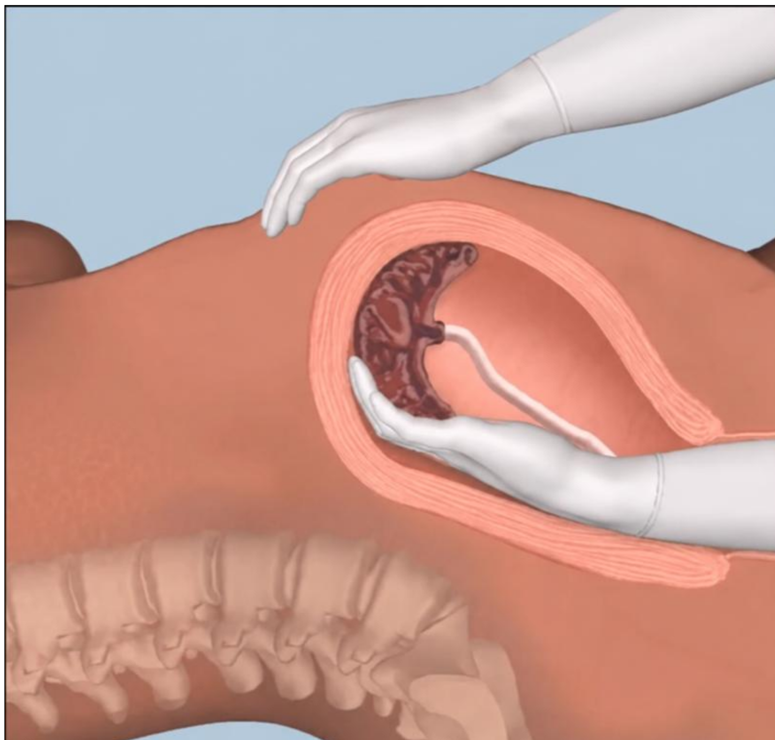
(7.1.5) Position patient in lithotomy position and prepare the perineum with antiseptic solution maintaining strict asepsis.

(7.2) Manual Removal Technique

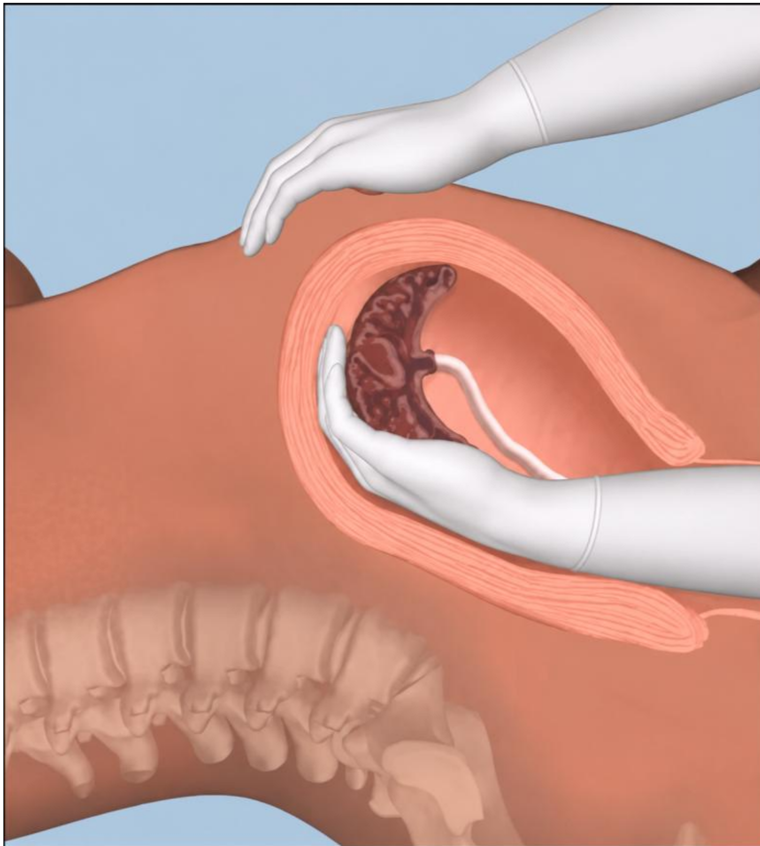
(7.2.1) Introduce one hand gently into the vagina and advance it into the uterine cavity, following the path of the umbilical cord to locate the placenta.



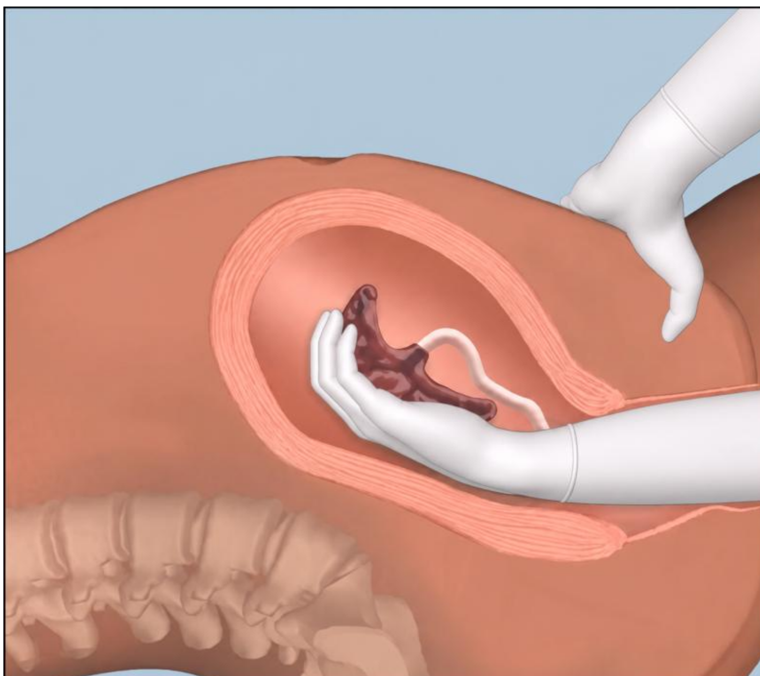
(7.2.2) Cup the uterine fundus externally with other hand and support it.



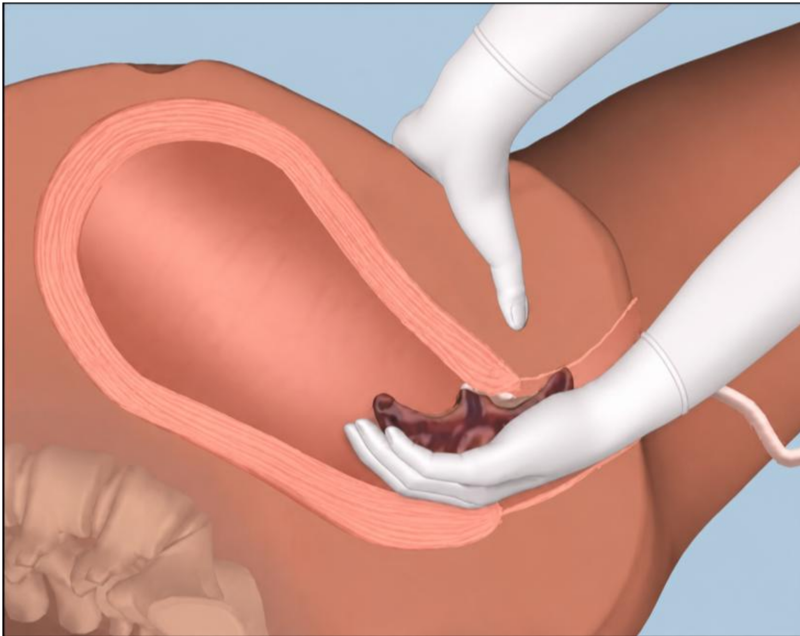
(7.2.3) Advance the intrauterine hand to the edge of the placenta and carefully identify the cleavage plane between the placenta and the decidual uterine wall.



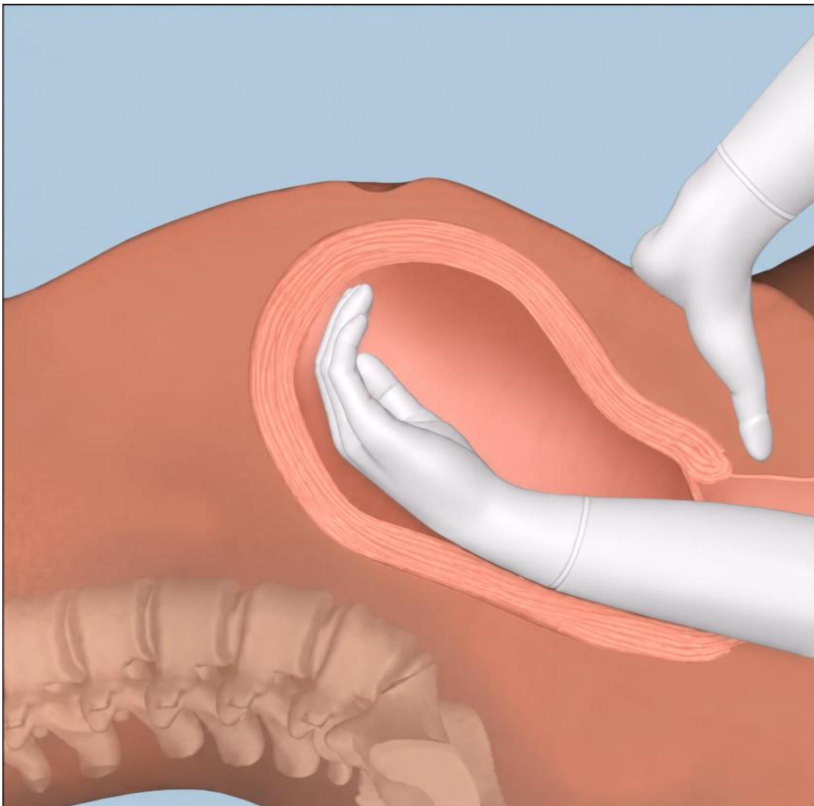
(7.2.3) Using the side of the hand in a sweeping motion, gently separate the placenta from the uterine wall.



(7.2.4) Remove the placenta completely while maintaining uterine support.

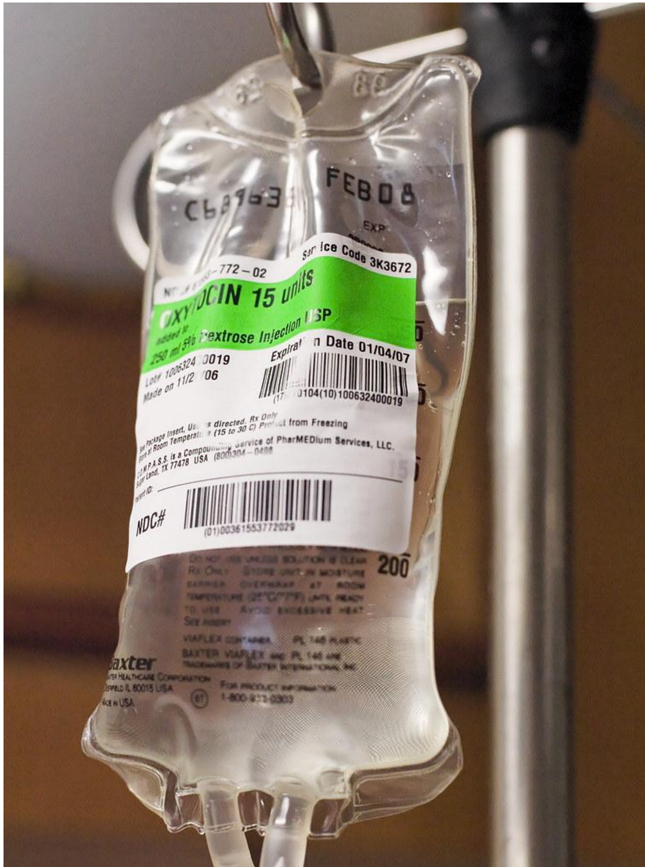


(7.2.5) Re-explore the uterine cavity to ensure no retained placental tissue remains.



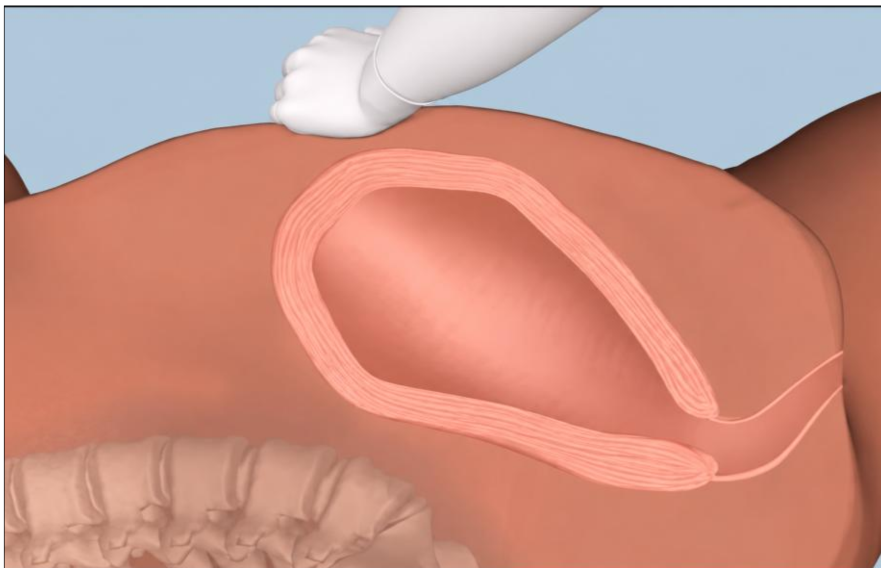
(7.3) Post Removal Management

(7.3.1) Administer prophylactic or therapeutic uterotonic agents (e.g., an Oxytocin infusion) to promote sustained myometrial contraction.as indicated.



(7.3.2) Administer IV antibiotics after the procedure.

(7.3.3) Assess uterine tone and vaginal bleeding.



(7.3.4) Examine the placenta for completeness.

(7.3.5) Continue maternal monitoring.

(8) Complications

(8.1) Postpartum haemorrhage
(8.2) Acute Uterine inversion
(8.3) Uterine perforation (rare)
(8.4) Retained placental fragments
(8.5) Puerperal infection, endometritis, or pelvic sepsis.
(8.6) Anaesthetic complications
(8.7) Escalation Protocol: Escalate immediately to a senior obstetrician and anaesthetist if excessive bleeding, suspected perforation, or maternal instability occurs.

(9) Infection Prevention and Control

(9.1) Infection Prevention and Control
(9.2) Perform surgical hand hygiene before and after the procedure.
(9.3) Use sterile single-use equipment and aseptic technique.
(9.4) Dispose of placenta and clinical waste appropriately.
(9.5) Clean and sterilize reusable instruments.

(10) Documentation

(10.1) Date and time of procedure.
(10.2) Indication for manual removal.
(10.3) Informed consent obtained.
(10.4) Analgesia / anaesthesia used.
(10.5) Findings and completeness of placenta.
(10.6) Estimated blood loss.
(10.7) Maternal condition after procedure.
(10.8) Name, signature, and designation of healthcare provider.

(11) Post-Procedure Monitoring

(11.1) Monitor pulse, blood pressure, and bleeding.
(11.2) Assess uterine tone regularly.
(11.3) Observe for signs of infection.
(11.4) Continue appropriate postpartum care.

(12) References

(12.1) NICE Intrapartum Care (2023)
(12.2) Royal Berkshire NHS Foundation Trust (2023).

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