

[HOSPITAL / HEALTH AUTHORITY NAME]

OBSTETRIC AND POSTPARTUM EMERGENCIES PATHWAY**Protocol 38: Rapid Maternal Stabilization, Fetal Assessment, Emergency Birth, Haemorrhage and Hypertension Control, Sepsis and Thromboembolism Treatment, Transfer, and Safe Disposition**

DRAFT FOR EMERGENCY MEDICINE, OBSTETRICS AND GYNAECOLOGY, MIDWIFERY, ANAESTHESIA / CRITICAL CARE, NEONATOLOGY / PAEDIATRICS, RADIOLOGY, HAEMATOLOGY / TRANSFUSION, RADIOLOGY, LABORATORY, PHARMACY, MENTAL HEALTH, NURSING, AND TRANSFER SERVICES

STATUS: This is a draft clinical-governance document. It must be adapted to local obstetric, midwifery, anaesthesia, neonatal, critical-care, blood-bank, operating-theatre, imaging, laboratory, pharmacy, mental-health, safeguarding and inter-island / tertiary-transfer capability. Drug concentrations, maternal and fetal viability thresholds, emergency-delivery procedures, uterotonic and antihypertensive regimens, massive-haemorrhage ratios, neonatal resuscitation, RhD prophylaxis, transfer criteria and scope of practice require local approval before implementation.

MATERNAL-FIRST RULE: Pregnancy changes priorities but does not replace ABCDE. Stabilize the pregnant or postpartum patient first, call obstetric and anaesthetic help early, and assess the fetus in parallel once maternal resuscitation is underway. Do not delay haemorrhage control, magnesium sulfate, treatment of severe hypertension, antibiotics, imaging, blood products, operative source control or resuscitative delivery because of concern about fetal exposure. In maternal cardiac arrest with a uterus at or above the umbilicus, begin preparation for resuscitative delivery at arrest recognition and aim to complete delivery by 5 minutes if there is no return of spontaneous circulation.

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Nursing Services / Clinical Governance
Clinical leads	Emergency Medicine; Obstetrics and Gynaecology; Midwifery; Anaesthesia / Critical Care; Neonatology / Paediatrics; Haematology / Transfusion; Cardiology; Radiology; Pharmacy
Applies to	Pregnant patients at any gestation, patients in labour or immediately after birth, and postpartum patients with pregnancy-related emergencies, including those presenting to non-obstetric areas
Interfaces	Protocol 3 Sepsis / Shock; Protocol 13 Chest Pain; Protocol 15 Shortness of Breath; Protocol 17 Altered Mental Status; Protocol 19 Seizures; Protocol 20 Headache / Intracranial Emergency; Protocol 23 Severe Hypertension; Protocol 25 GI Bleeding; Protocol 29 Poisoning; Protocol 31 Major Trauma; Protocol 39 Acute Gynaecological Emergencies; Protocol 41 Neonatal Emergencies; Protocol 42 Mental-Health Crisis; Protocol 48 Airway; Protocol 49 Major Haemorrhage; local obstetric, neonatal, transfusion, safeguarding and transfer policies
Version / status	Draft 1.0 for local multidisciplinary validation
Review cycle	After any maternal or neonatal death, severe maternal morbidity, unplanned emergency birth, major haemorrhage, eclampsia, cardiac arrest, transfer failure, medication incident, guideline update, service change, or at least every 2 years
Required approval	Emergency Department; Obstetrics; Midwifery; Anaesthesia / ICU; Neonatology / Paediatrics; Blood Bank; Radiology; Laboratory; Pharmacy; Mental Health; Nursing; Clinical Governance

1. Purpose

To provide a standardized emergency-department pathway for rapid recognition, maternal stabilization, fetal assessment, emergency birth, control of obstetric haemorrhage and severe hypertension, treatment of eclampsia, sepsis, thromboembolism and cardiopulmonary emergencies, and safe transfer or disposition while protecting dignity, informed decision-making, newborn care and family support.

2. Scope

This protocol applies from pre-alert or first contact through discharge, observation, admission, emergency birth, operative care, critical care, specialist transfer, bereavement care or death. It covers later-pregnancy and intrapartum emergencies, maternal collapse, antepartum and postpartum haemorrhage, hypertensive disorders, emergency delivery, cord prolapse, shoulder dystocia, breech birth, uterine inversion, maternal sepsis, venous thromboembolism, peripartum cardiomyopathy and other postpartum

emergencies. Early-pregnancy bleeding, ectopic pregnancy, ovarian torsion and non-obstetric acute pelvic pain are addressed in Protocol 39 but require the same maternal-resuscitation principles. Major trauma, poisoning and general medical emergencies remain governed by their linked protocols with pregnancy-specific modifications in this document.

3. Core policy statements

- Maternal resuscitation is the best initial fetal resuscitation. Airway, oxygenation, ventilation, circulation, haemorrhage control and treatment of reversible causes take priority over fetal monitoring or diagnostic completion.
- Any pregnant or postpartum patient with haemodynamic instability, severe hypertension, seizure, major bleeding, severe abdominal pain, respiratory distress, chest pain, altered mental status, fever with organ dysfunction, or imminent birth requires immediate senior ED and obstetric activation.
- Do not use the absence of known risk factors to rule out postpartum haemorrhage, pre-eclampsia, venous thromboembolism, sepsis, cardiomyopathy or placental catastrophe. Pregnancy-related complications may first present in the emergency department and may occur after discharge.
- Objective blood-loss measurement is preferred. Treat postpartum haemorrhage when blood loss is at least 500 mL, or at least 300 mL with an abnormal vital sign or concerning bleeding feature, or whenever clinical judgement indicates dangerous bleeding.
- Sustained blood pressure of 160 systolic or 110 diastolic mmHg or higher in pregnancy or postpartum is a time-critical emergency. Confirm promptly, treat immediately using the approved obstetric regimen and assess for pre-eclampsia / eclampsia and end-organ injury.
- Magnesium sulfate is first-line treatment for eclampsia. Protect the airway, position safely, treat severe hypertension and monitor for magnesium toxicity. Do not substitute diazepam or phenytoin routinely for magnesium sulfate.
- Never perform a digital vaginal examination for later-pregnancy bleeding until placenta praevia / vasa praevia has been excluded or an obstetric clinician determines that imminent birth makes examination necessary.
- Necessary imaging, surgery, blood products, antibiotics, anticoagulation or critical-care treatment must not be withheld solely because of pregnancy. Use the safest effective test or treatment without harmful delay.
- Prepare a separate trained team and equipment for the newborn whenever birth is possible. Maternal and newborn records, medications, times and handovers must remain distinct.
- Every emergency birth, major haemorrhage, eclampsia, maternal collapse, severe sepsis or unexpected neonatal compromise requires structured team debriefing, incident review and follow-up support for the patient, family and staff.

4. Definitions and severity framework

Term	Operational definition / response
Maternal emergency	Any pregnancy or postpartum presentation with actual or threatened failure of airway, breathing, circulation, neurological function, haemostasis, organ function or safe birth. Activate senior multidisciplinary care.
Severe hypertension	Systolic BP at least 160 mmHg or diastolic BP at least 110 mmHg, persistent on repeat measurement. Treat urgently; do not wait for proteinuria or laboratory confirmation.
Eclampsia	New generalized seizure in pregnancy or postpartum that is not better explained by another cause. Treat as eclampsia while assessing for stroke, cerebral venous thrombosis, infection, hypoglycaemia and epilepsy.
Primary postpartum haemorrhage	Excessive bleeding within 24 hours of birth. Use the WHO diagnostic trigger of at least 500 mL, or at least 300 mL plus an abnormal vital sign / concerning bleeding feature, or clinical concern.
Secondary postpartum haemorrhage	Abnormal or heavy bleeding from 24 hours to 6 weeks after birth, often related to retained tissue, infection, placental-site subinvolution or coagulopathy.
Maternal collapse	Acute deterioration with reduced consciousness, severe hypotension, respiratory failure or cardiac arrest during pregnancy or the puerperium.
Imminent birth	Visible presenting part, involuntary pushing, crowning, rapid cervical / perineal change, or birth expected before safe transfer to an obstetric unit.
Postpartum risk window	The first 6 weeks carries high risk for haemorrhage, hypertension, sepsis and thrombosis; pregnancy-related cardiomyopathy, thromboembolism and mental-health emergencies may present later, including up to 1 year after pregnancy.

5. Roles and accountability

Role	Minimum responsibility
Triage / receiving nurse	Identify pregnancy or recent birth; measure complete vital signs and pain; ask about bleeding, headache, vision, epigastric pain, dyspnoea, chest pain, fever, fetal movement, contractions and rupture of membranes; trigger obstetric emergency response.
ED clinician	Lead maternal ABCDE, define the immediate syndrome, begin time-critical treatment, document gestation / postpartum timing, coordinate obstetric and anaesthetic escalation, and ensure safe handover.
Obstetric clinician / midwife	Assess labour, fetal status, placental and uterine causes, birth route, source control, uterotonics and operative requirements; support emergency delivery within scope.
Anaesthesia / critical care	Lead difficult airway, major haemorrhage resuscitation, invasive monitoring, vasopressors, analgesia / anaesthesia, cardiac arrest and critical-care transfer.
Neonatal / paediatric team	Prepare for birth, receive and resuscitate the newborn, provide thermoregulation, glucose and respiratory support, and arrange neonatal admission or transfer.
Blood bank / laboratory	Prioritize crossmatch, coagulation and fibrinogen testing; activate major-haemorrhage support; communicate delays, incompatibility and product availability.
Radiology / cardiology / other specialists	Provide urgent imaging and disease-specific consultation without delaying maternal stabilization or source control.
Transfer coordinator	Confirm accepting obstetric / ICU / neonatal service, transport level, blood and medication continuity, weather / island logistics, documentation and family communication.
Team leader / scribe	Assign roles, use closed-loop communication, record times, blood loss, medicines, manoeuvres, responses, decisions and debrief actions.

6. Pre-alert, preparation, and triage

Pre-alert / triage question	Operational significance
How many weeks pregnant, or how many days / weeks since birth?	Defines fetal viability, aortocaval-compression risk, labour likelihood and postpartum differential; do not deny emergency care when dates are uncertain.
Is there heavy bleeding, clots, collapse, severe abdominal pain or shoulder-tip pain?	Activates haemorrhage / rupture pathway, blood bank, obstetrics and theatre; consider concealed bleeding.
Is BP at least 160/110, or is there severe headache, visual disturbance, epigastric / right-upper-quadrant pain, dyspnoea or seizure?	Triggers severe pre-eclampsia / eclampsia pathway and immediate antihypertensive / magnesium readiness.
Are there contractions, pressure, urge to push, visible presenting part, ruptured membranes or a cord / limb at the introitus?	Determines whether birth is imminent and whether transfer is unsafe; prepares obstetric and neonatal teams.
Is there chest pain, breathlessness, orthopnoea, haemoptysis, syncope or unilateral leg swelling?	Raises pulmonary embolism, cardiomyopathy, pulmonary oedema, ACS or aortic pathology.
Is there fever, rigors, foul discharge, uterine / wound pain, dysuria, mastitis or confusion?	Activates maternal sepsis assessment, cultures, antibiotics and source control.
Prior caesarean, placenta praevia / accreta, multiple pregnancy, prior PPH, anticoagulation or bleeding disorder?	Predicts haemorrhage / rupture / operative risk and informs blood-product and transfer preparation.
Fetal movement normal?	Reduced or absent movement requires urgent fetal assessment after maternal stabilization; maternal compromise remains the first priority.

TRIAGE OVERRIDE: A pregnant or postpartum patient with collapse, seizure, severe hypertension, respiratory distress, major bleeding, shock, severe abdominal pain, cord prolapse or imminent birth bypasses routine waiting and moves directly to resuscitation / delivery care.

7. The first 10 minutes

1. Activate the maternal emergency response: senior ED clinician, obstetrician / midwife, anaesthesia / critical care, neonatal / paediatric team when birth is possible, blood bank and theatre / transfer services as indicated.
2. Perform maternal ABCDE. Use continuous left lateral uterine displacement when the uterine fundus is at or above the umbilicus and the patient is supine; do not compromise effective chest compressions.
3. Attach ECG, pulse oximetry and non-invasive BP cycling; obtain temperature, glucose and mental status. Give oxygen for hypoxaemia or critical illness, not routinely when saturation is normal.
4. Insert two large-bore IV lines when major haemorrhage or shock is possible. Send full blood count, group and crossmatch, coagulation including fibrinogen, renal / liver profile, lactate and syndrome-directed tests. Activate the major-haemorrhage protocol early when indicated.
5. Quantify external blood loss, examine uterine tone after birth, check for ongoing flow and calculate shock index. Warm the patient, fluids and blood products; use balanced haemostatic resuscitation for major bleeding.
6. For seizure or severe pre-eclampsia, protect the airway, place in the left lateral position when feasible, give magnesium sulfate, treat severe hypertension and monitor urine output, reflexes, respiratory rate and consciousness.
7. Assess fetal heart rate and labour status in parallel once maternal resuscitation is established. Do not allow fetal monitoring or ultrasound to delay maternal treatment or transfer to theatre.
8. When birth is imminent, move to the safest prepared area, open the emergency birth and neonatal equipment, assign separate maternal and newborn leads, and prevent unattended delivery.
9. In cardiac arrest, start high-quality CPR and standard defibrillation immediately, use continuous left uterine displacement, obtain IV / IO access preferably above the diaphragm, stop magnesium if infusing and give calcium for suspected toxicity, and prepare resuscitative delivery at once.
10. Explain what is happening, preserve privacy, invite a support person when safe, use an interpreter, and document exact times and responses.

8. Focused assessment and investigations

8.1 Maternal and obstetric assessment

Domain	Minimum assessment
History	Gestation / estimated due date, gravida / parity, antenatal complications, prior caesarean / uterine surgery, placenta location, multiple pregnancy, fetal movement, contractions, membrane rupture, bleeding, pain, delivery date / mode, retained placenta, postpartum course, medications / anticoagulants, allergies and blood group / RhD if known.
Airway / breathing	Voice, aspiration risk, oxygenation, work of breathing, crackles, wheeze, unilateral findings, pulmonary oedema, PE features and difficult-airway predictors.
Circulation	Pulse, BP in correct cuff, capillary refill, skin, shock index, external and concealed blood loss, uterine tone, perfusion, urine output and signs of cardiac failure.
Neurology	GCS / AVPU, severe headache, visual symptoms, seizure, focal deficit, clonus, reflexes, meningism and medication / magnesium exposure.
Abdomen / uterus	Fundal height, tenderness, rigidity, contractions, scar pain, fetal lie / presentation when trained, uterine tone postpartum, peritonism and flank / renal findings.
Vaginal / perineal	Bleeding amount and character, fluid, cord / presenting part, tissue, laceration, haematoma, wound and discharge. Avoid digital examination with later-pregnancy bleeding until placenta praevia / vasa praevia is excluded or birth is imminent.
Postpartum	Lochia, uterine involution, perineal / caesarean wound, breasts, calf swelling, bladder / bowel function, headache after neuraxial procedure, mood, sleep, psychosis, suicidality and infant safety.

Domain	Minimum assessment
Fetal / newborn	Fetal heart rate and movement once maternal care is underway; after birth assess breathing, tone, colour, temperature, cord, glucose risk and need for neonatal resuscitation.

8.2 Targeted investigations

- Use syndrome-directed testing; do not delay life-saving treatment. Core tests in major illness are full blood count, blood group / crossmatch, coagulation including fibrinogen, electrolytes, creatinine, liver enzymes, glucose and lactate. Add blood film, LDH and haptoglobin when HELLP / haemolysis is suspected.
- Obtain urine protein assessment in suspected pre-eclampsia, but do not require proteinuria to diagnose severe disease or to treat severe hypertension / eclampsia.
- Use ECG, troponin, BNP / NT-proBNP, chest radiography and urgent echocardiography for chest pain, dyspnoea, pulmonary oedema, shock or suspected cardiomyopathy. Pregnancy is not a reason to omit necessary chest imaging.
- Use compression ultrasound for suspected DVT and a validated pregnancy-adapted imaging pathway for suspected PE. Start anticoagulation while awaiting objective testing when clinical suspicion is significant and bleeding risk does not prohibit treatment.
- Use bedside obstetric ultrasound for fetal activity, presentation, free fluid and gross placental assessment when expertise is available. A normal ultrasound does not exclude placental abruption, uterine rupture or early haemorrhage.
- CT, CT angiography, MRI or nuclear imaging may be required for stroke, PE, aortic disease, trauma or sepsis. Choose the test most likely to answer the emergency question and minimize delay; discuss fetal exposure without allowing it to prevent indicated care.
- Obtain cultures before antibiotics when feasible, but never delay antimicrobial therapy in shock or high-likelihood maternal sepsis.

9. Maternal collapse and cardiac arrest

Action	Pregnancy-specific requirement
Call and position	Activate cardiac arrest, obstetric, anaesthetic, neonatal, theatre and major-haemorrhage teams. Place supine on a firm surface and perform continuous manual left uterine displacement when fundus is at or above the umbilicus.
CPR / defibrillation	Use standard high-quality CPR, pad placement, energy and medications. Do not delay defibrillation. Remove fetal monitors that obstruct care.
Airway / access	Prioritize early airway management by the most experienced available clinician because hypoxaemia and difficult intubation are more likely. Use IV / IO access preferably above the diaphragm.
Reversible causes	Search for anaesthetic complication, bleeding, cardiovascular disease, drugs / toxicity, embolism including PE or amniotic fluid embolism, fever / sepsis, standard Hs and Ts, and hypertension / eclampsia.
Magnesium exposure	If magnesium sulfate is infusing, stop it and give calcium for suspected magnesium toxicity while continuing resuscitation.
Resuscitative delivery	If the fundus is at or above the umbilicus and there is no ROSC, begin preparation at recognition of arrest and aim to complete resuscitative hysterotomy / delivery by 5 minutes. Perform at the arrest location rather than transferring for surgery.
After ROSC	Continue haemorrhage control, oxygenation / ventilation, temperature and organ support; assess the newborn separately; transfer to ICU and obstetric care; preserve a detailed timeline and debrief.

RESUSCITATIVE DELIVERY IS A MATERNAL RESUSCITATION PROCEDURE. Its purpose is to relieve aortocaval compression and improve venous return. Do not wait for fetal viability confirmation, fetal monitoring, ultrasound, consent from an unavailable surrogate, operating-theatre transfer or prolonged specialist travel when criteria are met and trained clinicians can act.

10. Severe hypertension, pre-eclampsia, eclampsia, and HELLP

Problem	Immediate management
Severe BP at least 160/110	Repeat promptly with correct cuff while preparing treatment. Give an approved first-line agent immediately: IV / oral labetalol, oral immediate-release nifedipine, or IV hydralazine. Recheck every 10 to 15 minutes during acute treatment and avoid precipitous hypotension.
Eclamptic seizure	Call for help; protect from injury; left lateral position when possible; airway suction / oxygen as needed; check glucose; give magnesium sulfate 4 g IV over 5 to 15 minutes then 1 g/hour. Give an additional 2 to 4 g IV over 5 to 15 minutes for recurrent seizure.
Magnesium monitoring	Record respiratory rate, oxygenation, consciousness, deep-tendon reflexes and urine output. Reduce / stop infusion with renal failure or toxicity. Keep calcium gluconate 1 g IV (10 mL of 10%) immediately available per local protocol.
Severe features	Persistent headache, visual scotomata, epigastric / RUQ pain, dyspnoea / pulmonary oedema, oliguria, rising creatinine or transaminases, haemolysis, falling platelets, fetal compromise or recurrent severe BP require critical-care and urgent birth planning.
HELLP syndrome	Obtain serial platelets, blood film / haemolysis markers, liver enzymes, creatinine and coagulation. Treat hypertension, give magnesium when indicated, avoid IM injections and neuraxial procedures when unsafe, and expedite specialist delivery / critical care.
Fluids	Avoid routine volume expansion. In severe pre-eclampsia use careful fluid balance and generally restrict maintenance fluid unless there are measured losses such as haemorrhage. Treat pulmonary oedema with oxygen / ventilatory support and specialist-directed diuresis / afterload management.
Definitive care	Delivery is the definitive treatment but only after immediate maternal stabilization. Mode and timing depend on maternal, fetal and obstetric circumstances; involve senior obstetric, anaesthetic and neonatal teams.

POSTPARTUM ECLAMPSIA WARNING: Pre-eclampsia and eclampsia can first present after birth, including after an apparently normal pregnancy. Severe headache, visual symptoms, epigastric pain, dyspnoea, confusion or seizure in the postpartum period requires immediate BP measurement and obstetric neurological assessment.

11. Antepartum and intrapartum haemorrhage

Likely cause / presentation	Priority response
Placenta praevia / accreta spectrum	Usually painless bleeding; risk increased with prior caesarean and known low placenta. Resuscitate, call obstetrics / anaesthesia / blood bank, avoid digital vaginal examination and avoid disturbing the placenta. Prepare for major haemorrhage and specialist surgery / transfer.
Placental abruption	Painful bleeding, uterine tenderness / rigidity, contractions, fetal compromise or shock; bleeding may be concealed. Resuscitate, correct coagulopathy, monitor fetus after maternal stabilization and expedite birth / operative care. A normal ultrasound does not exclude abruption.
Vasa praevia	Bleeding after membrane rupture with sudden fetal bradycardia and relatively stable maternal observations. Activate immediate obstetric / neonatal delivery response.
Uterine rupture	Sudden severe pain, shock, fetal bradycardia, cessation of contractions, loss of station or abnormal abdominal contour, especially with uterine scar. Activate major haemorrhage and immediate laparotomy / delivery; do not delay for imaging.
Genital trauma / cervical lesion	Control visible bleeding, avoid blind clamping, resuscitate and obtain urgent obstetric examination / repair. Consider sexual assault or non-obstetric injury when relevant.

Likely cause / presentation	Priority response
RhD-negative unsensitized patient	Arrange anti-D immunoglobulin after sensitizing bleeding, trauma or procedures according to gestation, fetomaternal-haemorrhage testing and local transfusion policy; never delay maternal treatment.

12. Postpartum haemorrhage

12.1 Recognition and first-response bundle

MOTIVE element	Required action
M - Massage	Massage a boggy uterus immediately and expel clots when appropriate. Empty the bladder. Continue repeated tone and blood-flow assessment.
O - Oxytocic	Give oxytocin promptly using the locally approved IV / IM regimen. Add another uterotonic according to response and contraindications.
T - Tranexamic acid	Give TXA 1 g IV over about 10 minutes as early as possible and within 3 hours of birth. Repeat 1 g after 30 minutes if bleeding continues or restarts within 24 hours, according to local policy.
I - Intravenous fluids / blood	Establish large-bore access, use warmed isotonic crystalloid while blood is prepared, activate major-haemorrhage support early, and prioritize balanced blood-component therapy in ongoing major bleeding.
V - Vaginal / genital examination	Examine for cervical, vaginal and perineal trauma, uterine inversion, retained placenta / tissue and concealed haematoma. Repair or escalate for source control.
E - Escalation	Call senior obstetrics, anaesthesia, theatre, blood bank and transfer / interventional radiology early. Escalate to balloon tamponade, surgery, embolization or hysterectomy before physiological collapse.

12.2 Cause-directed control: the 4 Ts

Cause	Assessment and treatment
Tone - uterine atony	Boggy enlarged uterus. Bimanual uterine massage / compression, empty bladder, oxytocin and additional uterotonics; assess retained tissue; move early to balloon tamponade or operative control if persistent.
Trauma	Firm uterus with ongoing bleeding suggests laceration; inspect cervix, vagina and perineum. Consider uterine rupture, inversion, broad-ligament / retroperitoneal haematoma and surgical bleeding. Repair or operate urgently.
Tissue	Inspect placenta and membranes for completeness. Retained placenta or products require obstetric manual / operative removal with analgesia / anaesthesia and antibiotic policy; do not use forceful cord traction.
Thrombin	Check coagulation, fibrinogen, platelets and clinical oozing. Activate major-haemorrhage protocol; replace fibrinogen and platelets according to local thresholds / viscoelastic testing; treat the underlying abruption, sepsis, AFE or massive bleeding.

12.3 Uterotonic safety and escalation

Agent / intervention	Operational safeguards
Oxytocin	First-line. Use the locally approved diluted IV infusion or IM regimen; avoid an unmonitored rapid undiluted IV bolus because hypotension and tachycardia may occur.
Ergometrine / methylergometrine	Avoid in hypertension, pre-eclampsia, significant cardiac disease or peripheral vascular disease. Follow local dose and route policy.

Agent / intervention	Operational safeguards
Carboprost	Avoid or use extreme caution in asthma; monitor for bronchospasm, diarrhoea, vomiting and cardiovascular effects. Follow local maximum-dose policy.
Misoprostol	Useful when injectable uterotonics are unavailable or as an approved adjunct; fever, shivering and gastrointestinal effects are common. Use the local route / dose.
Balloon tamponade	Use after first-line bundle when atony persists and when blood products, monitoring and surgical rescue are available. Continue resuscitation and prepare definitive control; do not allow tamponade to delay surgery in ongoing shock.
Surgery / embolization	Compression sutures, uterine / internal iliac artery procedures, embolization and hysterectomy depend on cause and resources. The threshold for definitive control falls as bleeding, shock, coagulopathy or transfer time increases.

PPH ESCALATION RULE: Do not wait for an arbitrary blood-loss number when the rate of bleeding, shock index, anaemia, poor response or limited blood / theatre access indicates danger. Call early, transfuse early when clinically required and move to definitive source control before coagulopathy and hypothermia become established.

13. Emergency birth in the emergency department

13.1 Preparation and uncomplicated cephalic birth

Step	Required action
Prepare	Call obstetric / midwifery and neonatal teams; warm the room; open delivery, PPH and newborn-resuscitation equipment; position safely; ensure lighting, suction, oxygen, clamps, uterotonic, towels, blood access and a documented timekeeper.
Assess imminence	Observe contractions, perineum, presenting part and urge to push. If birth is not imminent and the patient is stable, transfer to maternity with continuous support. Never leave a patient with imminent birth unattended.
Support birth	Use clean technique, support controlled delivery of the head without fundal pressure, check for a tight nuchal cord, and allow restitution and spontaneous delivery of shoulders with gentle axial support only.
After birth	Place a vigorous newborn skin-to-skin, dry and keep warm. Delay cord clamping for about 30 to 60 seconds when the newborn is vigorous and there is no maternal or neonatal reason for immediate clamping. Move a non-vigorous newborn to the prepared resuscitation area.
Third stage	Give the approved prophylactic uterotonic, observe for placental separation and use controlled cord traction only by trained staff. Do not pull on an unseparated placenta. Inspect placenta / membranes and quantify blood loss.
Maternal reassessment	Check uterine tone, bleeding, BP, pulse, pain, perineum, bladder and temperature at frequent intervals. Begin the PPH bundle immediately if criteria or concern arise.
Newborn reassessment	Assess breathing, heart rate, tone, colour, temperature, glucose risk, cord and congenital / birth trauma; follow Protocol 41 and the neonatal resuscitation algorithm.

13.2 Shoulder dystocia

- Announce shoulder dystocia, call obstetric / anaesthetic / neonatal help, note the time of head delivery, stop routine traction and instruct the patient not to push while the team repositions.
- Perform McRoberts positioning and suprapubic pressure. Do not use fundal pressure. Use gentle axial traction only.
- If unresolved, a trained clinician proceeds through approved internal rotational manoeuvres, delivery of the posterior arm and all-fours position. Last-resort procedures require senior obstetric expertise.

- After birth, assess the newborn for brachial plexus injury, fracture and hypoxic injury; assess the mother for PPH and genital trauma; document every manoeuvre and time.

13.3 Breech birth and trapped head

- Call obstetric, anaesthetic and neonatal teams immediately. Avoid pulling on the fetus or attempting to reverse a birth that is already advanced.
- Use a hands-off approach while the breech descends spontaneously to the umbilicus / scapulae when feasible. A trained clinician may use approved manoeuvres to release extended arms and flex / deliver the after-coming head.
- Keep the fetal body supported and avoid hyperextension, twisting or traction. If the cervix traps the head, obtain immediate senior obstetric / anaesthetic assistance for uterine / cervical relaxation and definitive manoeuvres.
- Prepare for neonatal resuscitation and maternal PPH. Document presentation, times, manoeuvres and personnel.

14. Other time-critical intrapartum emergencies

Emergency	Immediate actions
Umbilical cord prolapse	Call for immediate delivery. Elevate the presenting part manually without compressing the cord; place the patient knee-chest or steep left lateral head-down; minimize cord handling and keep an exposed cord warm / moist. Consider bladder filling during transfer. Continue until operative or immediate vaginal birth.
Uterine inversion	Recognize a mass at / beyond the introitus with haemorrhage, shock and absent fundus. Call for help, resuscitate and attempt immediate manual replacement by a trained clinician before oedema / constriction worsens. Stop uterotonics until replacement; after replacement give uterotonic, antibiotics and PPH care.
Retained placenta	If bleeding or shock is present, activate PPH care and urgent manual / operative removal with anaesthesia. Do not use forceful traction. Consider placenta accreta when separation is difficult, particularly with previa / prior caesarean.
Prolapsed limb / transverse lie	Do not pull or attempt repeated reduction. Protect exposed tissue, assess cord / fetal status and arrange immediate obstetric operative delivery / transfer.
Preterm labour / PPRM	Confirm gestation and membrane status, assess infection / bleeding / fetal status, avoid unnecessary digital examinations, and obtain urgent obstetric / neonatal guidance on corticosteroids, magnesium for fetal neuroprotection, antibiotics and in-utero transfer.
Fetal compromise	Correct maternal hypoxia, hypotension, fever and uterine hyperstimulation; position laterally, stop oxytocin if running and call obstetrics for expedited birth. Do not give routine maternal oxygen when saturation is normal.

15. Maternal sepsis

Step	Required action
Recognize	Suspect with fever or hypothermia, tachycardia, tachypnoea, hypotension, altered mental status, oliguria, hypoxaemia, elevated lactate or rapidly progressive pain / swelling. Pregnancy may mask early shock.
Sources	Consider chorioamnionitis, endometritis, retained products, post-abortion infection, caesarean / perineal wound, urinary infection / pyelonephritis, mastitis / abscess, pneumonia / influenza, appendicitis, biliary disease, skin / soft tissue and invasive group A streptococcal infection.
First hour	Obtain cultures and lactate without delaying therapy; give broad-spectrum IV antibiotics promptly for septic shock or high-likelihood sepsis; provide oxygen / ventilation, cautious isotonic fluid boluses with frequent reassessment, and vasopressors when hypotension persists.
Source control	Urgent obstetric / surgical assessment for retained products, uterine / pelvic infection, abscess, necrotizing infection, infected obstruction or device. Delivery is not automatically required but may be necessary for maternal or fetal indications.

Step	Required action
Fetal / newborn	Assess fetus after maternal resuscitation. Alert neonatal team to maternal infection and antimicrobial exposure; obtain newborn sepsis assessment after birth.
Escalation	Early ICU, infectious-disease / microbiology and transfer input for shock, organ dysfunction, rapidly progressive pain, rash, coagulopathy, respiratory failure or concern for toxin-mediated infection.

16. Thromboembolic and cardiopulmonary emergencies

Condition	Emergency-department approach
Suspected DVT / PE	Use objective testing expeditiously. Begin therapeutic LMWH while awaiting testing when suspicion is significant and there is no major bleeding, imminent neuraxial / operative procedure or other contraindication. Coordinate dosing and delivery timing with obstetrics / haematology.
Massive PE	For shock or cardiac arrest, activate critical care, cardiology / PE response and obstetrics; consider systemic thrombolysis, catheter therapy, surgical embolectomy or ECMO according to resources. Pregnancy is not an absolute contraindication to life-saving reperfusion.
Peripartum cardiomyopathy	Suspect with new orthopnoea, pulmonary oedema, persistent tachycardia, raised JVP, chest discomfort or shock in late pregnancy or months postpartum. Obtain ECG, CXR, biomarkers and urgent echocardiography; involve cardiology / ICU / obstetrics and use pregnancy / lactation-compatible heart-failure therapy.
Pulmonary oedema in pre-eclampsia	Support oxygenation / ventilation, restrict unnecessary fluids, treat severe hypertension, consider diuresis and urgent critical care / delivery planning. Evaluate cardiomyopathy, renal failure and iatrogenic fluid overload.
Acute coronary syndrome / aortic syndrome	Use standard time-critical ECG, troponin, imaging and reperfusion / surgical pathways with pregnancy-informed medication choices. Do not dismiss chest pain as normal pregnancy.
Amniotic fluid embolism	Sudden hypoxaemia, hypotension / arrest and DIC during labour or soon after birth. Provide high-quality resuscitation, airway / ventilation, vasopressors, immediate delivery when indicated, balanced major-haemorrhage support and aggressive correction of coagulopathy. Diagnosis is clinical and by exclusion.

17. Other postpartum emergencies

Presentation	Priority differential and response
Heavy / recurrent bleeding	Secondary PPH: retained products, endometritis, placental-site subinvolution, vascular lesion or coagulopathy. Resuscitate, quantify loss, obtain bloods / cultures / ultrasound, give antibiotics when infection is suspected and arrange urgent uterine / vascular source control.
Severe headache / visual symptoms	Postpartum pre-eclampsia / eclampsia, PRES, cerebral venous thrombosis, subarachnoid haemorrhage, meningitis, migraine or post-dural-puncture headache. Measure BP immediately; perform neurological assessment and urgent imaging / anaesthetic review as indicated.
Dyspnoea / chest pain / syncope	PE, cardiomyopathy, pulmonary oedema, ACS, aortic dissection, anaemia, pneumonia or sepsis. Use full emergency cardiopulmonary evaluation.
Fever / pelvic or wound pain	Endometritis, retained products, wound infection, urinary infection, mastitis / abscess, septic pelvic thrombophlebitis or invasive streptococcal disease. Give antibiotics and obtain source control.

Presentation	Priority differential and response
Severe perineal / abdominal pain	Concealed haematoma, wound dehiscence, urinary retention, bowel / bladder injury, necrotizing infection, thrombosis or uterine pathology. Examine sensitively and image / operate urgently when indicated.
Agitation, insomnia, delusions or suicidality	Postpartum psychosis and severe mood disorder are emergencies. Do not leave the patient alone with the infant; assess medical causes, suicide / infanticide risk, safeguarding and capacity; involve mental health and obstetrics urgently.
Breast pain / redness	Assess mastitis, abscess and sepsis; support feeding / milk expression when appropriate, give analgesia and indicated antibiotics, and arrange drainage for abscess.

18. Trauma, poisoning, and special contexts

Population / context	Additional safeguards
Major trauma	Follow trauma protocols with maternal-first resuscitation, left uterine displacement when appropriate, early obstetric / neonatal involvement, RhD prophylaxis assessment, fetal monitoring after stabilization and low threshold for placental / uterine injury. Do not withhold CT.
Poisoning / overdose	Treat toxidromes and maternal physiology promptly; consult toxicology and obstetrics; consider altered pharmacokinetics, fetal monitoring and safeguarding. Maternal stabilization remains the best fetal treatment.
No antenatal care / concealed pregnancy	Assume gestational dates and blood group may be unknown; assess anaemia, hypertension, infection, fetal presentation and social risk; use non-judgmental communication and urgent obstetric support.
Adolescents / vulnerable adults	Use safeguarding, consent and confidentiality law; assess coercion, trafficking, abuse, sexual assault and safe discharge arrangements.
Domestic violence	Ask privately when safe, document objectively, treat injuries, assess homicide / strangulation / child risk, and activate safeguarding and advocacy resources.
Female genital mutilation	Anticipate difficult examination, scarring, obstructed birth, laceration and haemorrhage; use trauma-informed care and specialist obstetric support.
Pregnancy loss / stillbirth	Provide the same physiological emergency care, sensitive confirmation, privacy, cultural / faith support, memory-making options, lactation advice, bereavement follow-up and investigation according to gestation and local law.
Obesity / multiple gestation / mobility limits	Anticipate difficult airway, IV access, imaging, transfer, positioning, uterotonic dosing and thromboembolism risk; mobilize equipment and additional staff early.
Language / disability / migration	Use qualified interpretation and accessible communication; do not rely on children as interpreters; preserve autonomy and explain procedures during rapid care.

19. Medication, blood-product, and procedural safety

- Use weight, renal function, gestation, breastfeeding status and local formulary to verify every medication. In emergencies, do not delay proven maternal treatment while seeking perfect fetal-risk information.
- Keep separate, clearly labelled maternal and newborn medication areas. Use independent double-checks for magnesium sulfate, oxytocin infusions, concentrated electrolytes, insulin, anticoagulants, vasopressors and neonatal drugs.
- In major obstetric haemorrhage, use the local balanced massive-transfusion protocol, active warming, ionized-calcium monitoring / replacement, serial fibrinogen and coagulation assessment, and early haemostatic source control. Avoid large volumes of cold crystalloid.
- Confirm compatibility, RhD and emergency-release blood processes. When crossmatched blood is unavailable and delay is life threatening, use approved emergency blood and document the decision.
- Procedural sedation, anaesthesia, manual placental removal, balloon tamponade and emergency operative procedures require airway-capable monitoring, informed consent when feasible, analgesia, antibiotics when indicated and clear post-procedure observation.

- Radiation and contrast counselling should be factual and proportionate. Document why the test is needed and how delay could harm the patient; use shielding only when it does not interfere with imaging.

20. Monitoring and reassessment

Situation	Minimum monitoring
Unstable / active resuscitation	Continuous ECG and oxygen saturation, BP every 3 to 5 minutes or arterial line, respiratory rate, mental status, temperature, blood loss, uterine tone, urine output, shock index, point-of-care tests and repeated response after every intervention.
Severe hypertension / eclampsia	BP every 10 to 15 minutes during acute treatment, continuous oxygenation, neurological status, reflexes, respiratory rate, urine output, fluid balance, serial platelets / renal / liver tests and fetal status after maternal stabilization.
PPH	Continuous haemodynamic monitoring; objective cumulative blood loss; uterine tone and flow; serial haemoglobin, coagulation, fibrinogen, calcium, temperature, lactate and urine output; reassess after each uterotonic, TXA, transfusion, tamponade or operation.
Sepsis / cardiopulmonary emergency	Continuous monitoring, lactate / perfusion trend, respiratory support, fluid responsiveness / congestion, urine output and organ function; repeat fetal assessment when it will change management.
After emergency birth	Maternal vitals, tone and blood loss at least every 15 minutes initially, then according to stability and local obstetric standard; continuous newborn warmth / breathing observation and scheduled glucose monitoring when indicated.
Transfer	A clinician capable of managing maternal airway, haemorrhage, seizure and birth accompanies high-risk transfer; continue monitors, oxygen, infusions, blood and manual cord / presenting-part elevation as required.

21. Disposition, admission, and transfer

Disposition	Minimum criteria / triggers
Immediate theatre / delivery pathway	Uncontrolled haemorrhage, uterine rupture, placenta accreta catastrophe, cord prolapse, persistent fetal compromise, failed shoulder dystocia manoeuvres, retained placenta with bleeding, uterine inversion not corrected, or another condition requiring operative birth / source control.
ICU / high-dependency admission	Cardiac arrest / ROSC, major transfusion, vasopressors, respiratory failure, severe sepsis, eclampsia, HELLP with organ dysfunction, pulmonary oedema, cardiomyopathy, massive PE, DIC, severe neurological event or unstable postpartum haemorrhage.
Urgent specialist transfer	Required obstetric, anaesthetic, neonatal, blood-bank, interventional-radiology, cardiac or ICU capability is unavailable locally. Stabilize only to the extent that does not create harmful delay and obtain accepting consultant-to-consultant handover.
Obstetric admission / observation	Any significant later-pregnancy bleeding, severe hypertension, pre-eclampsia symptoms, reduced fetal movement with concern, preterm labour / PPROM, infection, unresolved pain, post-procedure monitoring, emergency birth or postpartum complication not meeting safe discharge criteria.
Possible discharge	Only after obstetric / relevant specialist agreement when maternal observations are normal and stable, bleeding and pain are controlled, no severe hypertension / sepsis / VTE / cardiopulmonary concern exists, fetal or newborn assessment is reassuring, mobility / feeding / voiding are safe, and reliable follow-up and transport exist.
Discharge information	Give written red flags for heavy bleeding, severe headache / vision change, chest pain / dyspnoea, seizure, fever, worsening pain, foul discharge, calf swelling, wound problems, reduced fetal movement, labour signs, depression / psychosis or concerns about infant safety; provide named contacts and review time.

22. Communication, dignity, bereavement, and safeguarding

- Address the patient directly, explain rapidly evolving priorities, obtain consent whenever feasible and document emergency best-interest decisions when capacity is impaired.
- Provide privacy, respectful exposure, pain relief, an interpreter and a support person when safe. Avoid stigmatizing language related to pregnancy intention, age, parity, substance use, mental health, migration or prior care.
- Keep the patient and family informed during haemorrhage, seizure, transfer, emergency birth and neonatal resuscitation. Assign a team member to communication when possible.
- After severe morbidity or loss, offer bereavement, spiritual / cultural and mental-health support; explain what is known, what remains uncertain and how follow-up / investigation will occur.
- Activate safeguarding for domestic violence, coercion, trafficking, sexual assault, concealed pregnancy, child protection concerns, impaired parenting capacity or risk to the newborn. Do not allow safeguarding processes to delay emergency care.

23. Documentation and handover

Required element	Document explicitly
Pregnancy context	Gestation / due date, parity, antenatal / delivery history, placenta, prior caesarean, blood group / RhD, medications, anticoagulation, allergies and postpartum day / week.
Timeline	Arrival, recognition, calls, first senior review, severe BP confirmation and treatment, seizure / magnesium times, haemorrhage diagnosis, uterotonics, TXA, blood products, procedures, birth, cord clamping, placenta, ROSC and transfer.
Physiology	Serial vital signs, shock index, GCS, oxygenation, urine output, temperature, blood loss, uterine tone, fetal heart rate and newborn status.
Examination / cause	Abdominal, vaginal / perineal and wound findings; placenta completeness; lacerations; 4-T cause; neurological, sepsis, VTE or cardiac findings; contraindications to medicines.
Interventions and response	Drug name, concentration, dose, route, time, response and adverse effect; fluids / blood / calcium; manoeuvres; tamponade / surgery; fetal / newborn interventions.
Decision-making	Consultants contacted, recommendations, consent / capacity, imaging rationale, treatment not given and why, transfer acceptance, ceiling of care, family communication and safeguarding.
Handover	Maternal and newborn handovers separately using SBAR; include ongoing infusions, blood availability, airway risks, last observations, pending results and next critical action.

24. Quality standards and audit indicators

Suggested indicator	Target / review question
Pregnancy / postpartum status recorded at triage	100% of patients of reproductive potential when clinically relevant and all known pregnant / postpartum patients.
Time to obstetric emergency activation	Immediate for red-flag presentations; every avoidable delay reviewed.
Severe hypertension treated promptly	First approved antihypertensive administered within the locally agreed emergency target, ideally within 30 to 60 minutes of confirmed persistent severe BP.
Eclampsia magnesium treatment	Loading dose started without avoidable delay; toxicity monitoring complete.
PPH objective blood-loss measurement	Used for every emergency birth and suspected PPH when equipment is available.
PPH MOTIVE bundle completion	All indicated elements initiated promptly, with contraindications / omissions documented.
TXA timing	Given as early as possible and within 3 hours of birth for diagnosed PPH unless contraindicated.

Suggested indicator	Target / review question
Major-haemorrhage activation and blood availability	Activation, first product and fibrinogen / calcium monitoring times reviewed.
Maternal arrest resuscitative delivery	Preparation begins at arrest recognition and delivery completed by 5 minutes when criteria are met and no ROSC.
Maternal sepsis antibiotic timing	Prompt administration for septic shock / high-likelihood sepsis; delays and source-control barriers reviewed.
Emergency birth documentation	Head / body / cord / placenta times, manoeuvres, maternal blood loss and newborn condition complete.
Debrief and follow-up	100% after maternal death, severe morbidity, emergency birth with complication, major haemorrhage, eclampsia or arrest.

25. Minimum equipment, medication, and training readiness

Capability	Minimum readiness requirement
Maternal resuscitation	Adult resuscitation equipment, difficult-airway cart, suction, capnography, IV / IO access, warming, ultrasound, vasopressors and transport ventilator.
Obstetric emergency cart	Delivery set, sterile gloves / drapes, cord clamps, scissors, specula, bladder catheter, fetal Doppler, calibrated blood-loss drape, uterine massage / compression aids and examination lighting.
PPH response	Oxytocin and approved alternative uterotonics, TXA, emergency fluids, pressure infuser, blood warmer, rapid infuser where available, uterine balloon tamponade, major-haemorrhage pack and bedside coagulation / fibrinogen pathway.
Hypertension / eclampsia	Magnesium sulfate, infusion pump, calcium gluconate, approved labetalol / hydralazine / nifedipine regimens, BP cuffs including large sizes, reflex hammer and toxicity chart.
Newborn care	Radiant warmer or equivalent, warm towels / hat, neonatal bag-mask devices, suction, oxygen / air blender where available, pulse oximeter, laryngoscopy / airway kit, cord equipment, glucose testing and neonatal medication chart.
Emergency procedures	Resuscitative hysterotomy set immediately accessible; shoulder dystocia / breech / cord prolapse cognitive aids; balloon tamponade and operative transfer pathway.
Blood / laboratory	24-hour emergency-release blood, crossmatch, platelets, plasma, cryoprecipitate / fibrinogen replacement, calcium, point-of-care blood gas and rapid communication with laboratory.
Training	At least annual multidisciplinary simulation for PPH, eclampsia, maternal arrest / resuscitative delivery, shoulder dystocia, cord prolapse, emergency birth, neonatal resuscitation and inter-facility transfer; more frequent low-dose drills encouraged.

26. Selected evidence and guidance base

Source	Use in this protocol
World Health Organization. Consolidated guidelines for the prevention, diagnosis and treatment of postpartum haemorrhage. 2025; implementation guide 2026.	Objective blood-loss assessment, early PPH diagnosis, MOTIVE first-response bundle, uterotonics, TXA, escalation and implementation readiness.
American Heart Association. 2025 Guidelines for CPR and ECC: Cardiac Arrest in Pregnancy Algorithm and Special Circumstances.	High-quality CPR, left uterine displacement, airway / access modifications, causes, major transfusion for AFE and resuscitative delivery by 5 minutes.
NICE NG133. Hypertension in pregnancy: diagnosis and management. Current online version reviewed 2023 / accessed 2026.	Severe hypertension, magnesium regimen, antihypertensive options, fluid restriction, critical-care and postpartum monitoring.
NICE NG235. Intrapartum care. 2023, updated online 2026.	Emergency intrapartum assessment, third-stage care, postpartum observation and person-centred communication.

Source	Use in this protocol
RCOG Green-top Guideline No. 64. Identification and management of maternal sepsis during and following pregnancy. 2024.	Recognition, antimicrobial treatment, source control and antenatal / postpartum sepsis pathways.
RCOG Green-top Guideline No. 56. Maternal Collapse in Pregnancy and the Puerperium.	Differential diagnosis, team planning, resuscitation and post-collapse care.
RCOG Green-top Guidelines No. 37a / 37b. Thrombosis and Embolism during Pregnancy and the Puerperium.	VTE risk, urgent objective diagnosis and anticoagulation.
RCOG Green-top Guidelines No. 42 and No. 50. Shoulder Dystocia; Umbilical Cord Prolapse.	Emergency manoeuvres, prohibited actions, expedited delivery and documentation.
RCOG Green-top Guidelines No. 27a / 27b. Placenta Praevia, Accreta Spectrum and Vasa Praevia.	Bleeding precautions, avoidance of placental disruption, major-haemorrhage planning and specialist delivery.
European Society of Cardiology. 2025 Guidelines for cardiovascular disease and pregnancy.	Peripartum cardiomyopathy, PE, aortic disease, ACS and pregnancy heart-team principles.
ACOG. Obstetric Emergencies in Nonobstetric Settings; Practice Bulletins on Postpartum Haemorrhage and Gestational Hypertension / Pre-eclampsia.	Recognition of pregnancy-related complications in EDs, haemorrhage bundles and severe-hypertension / postpartum risk.
American Heart Association / American Academy of Pediatrics. 2025 Neonatal Resuscitation Guidelines.	Preparation, initial newborn care and neonatal resuscitation interface.

Annex A. One-page maternal emergency workflow

Step	Action
1. Recognize	Pregnant or postpartum? Red flags: collapse, seizure, BP at least 160/110, major bleeding, severe pain, dyspnoea / chest pain, fever / organ dysfunction, cord / presenting part, imminent birth.
2. Activate	Senior ED + obstetrics / midwifery + anaesthesia / ICU; neonatal team if birth possible; blood bank / theatre / transfer as indicated.
3. Stabilize mother	ABCDE; left uterine displacement if fundus at / above umbilicus; monitors; glucose; oxygen for hypoxaemia; two IVs; bloods; warm; treat shock / cause.
4. Treat syndrome now	PPH MOTIVE + TXA; magnesium + severe-BP treatment; antibiotics + source control; anticoagulation / reperfusion for VTE; CPR + resuscitative delivery; prepare emergency birth.
5. Assess fetus / labour	Fetal heart and movement, contractions, membranes, presentation and imminence once maternal care is underway. No digital vaginal exam in later-pregnancy bleeding until previa excluded.
6. Reassess	Vitals, shock index, bleeding, tone, neurological status, urine, labs, fetal / newborn condition and response after every intervention.
7. Definitive care	Theatre, birth, tamponade / surgery / embolization, ICU, antibiotics / source control, cardiopulmonary treatment or urgent specialist transfer.
8. Close safely	Separate maternal / newborn handovers, written red flags, safeguarding / bereavement support, debrief, incident review and follow-up.

Annex B. Maternal emergency initial assessment record

Required field	Entry
Gestation / EDD or postpartum day / week	_____
Gravida / parity / prior caesarean / uterine surgery	_____
Presenting emergency / onset / trigger	_____
Placenta / multiple pregnancy / fetal movement	_____

Required field	Entry
Delivery date / mode / retained placenta / blood loss	_____
Medications / anticoagulants / allergies	_____
Blood group / RhD / antibodies if known	_____
Initial ABCDE / GCS / glucose / temperature	_____
BP / pulse / RR / SpO2 / shock index	_____
Bleeding / uterine tone / contractions / membranes	_____
Fetal heart / presentation / imminence of birth	_____
Teams activated / times	_____
Immediate treatments / response	_____
Working diagnosis / definitive plan	_____

Annex C. Postpartum haemorrhage checklist

Check	Complete / finding
PPH recognized: at least 500 mL; or at least 300 mL + warning sign; or clinical concern	_____
Senior obstetric / anaesthetic / blood-bank / theatre call time	_____
Objective cumulative blood loss / shock index	_____
Uterine massage / bimanual compression / bladder emptied	_____
Oxytocin time / route / dose	_____
Additional uterotonic and contraindication check	_____
TXA 1 g IV time; repeat dose if indicated	_____
Two IVs / bloods / crossmatch / major-haemorrhage activation	_____
Blood / plasma / platelets / fibrinogen / calcium / warming	_____
4 Ts assessed: tone / trauma / tissue / thrombin	_____
Balloon / manual removal / repair / surgery / embolization	_____
Urine output / serial labs / response / transfer	_____

Annex D. Severe hypertension and eclampsia checklist

Check	Complete / finding
Severe BP confirmed promptly with correct cuff	_____
Symptoms: headache / vision / RUQ pain / dyspnoea / nausea / oliguria	_____
Airway / lateral position / glucose / oxygenation / seizure time	_____
Magnesium loading dose / infusion / recurrent-dose time	_____
First antihypertensive / repeat BP / target response	_____
Reflexes / RR / SpO2 / urine / renal function / calcium available	_____
Platelets / creatinine / AST-ALT / haemolysis / coagulation	_____
Pulmonary oedema / fluid balance assessed	_____

Check	Complete / finding
Fetal assessment after maternal stabilization	_____
Senior obstetric / anaesthetic / neonatal / ICU plan	_____
Birth timing / mode / transfer decision	_____

Annex E. Emergency birth and newborn readiness checklist

Check	Complete / finding
Obstetric / midwifery and neonatal teams called	_____
Maternal resuscitation / IV / blood / uterotonic / PPH cart ready	_____
Warm room / towels / hat / newborn warmer	_____
Neonatal bag-mask / suction / oxygen-air / pulse oximeter ready	_____
Presentation / fetal heart / membranes / cord / imminence	_____
Head delivery time / shoulder dystocia manoeuvres if used	_____
Body delivery / newborn condition / cord-clamp time	_____
Placenta time / completeness / laceration / blood loss	_____
Maternal tone / vitals / analgesia / bladder / ongoing bleeding	_____
Newborn breathing / HR / temperature / glucose risk / disposition	_____
Separate records / labels / handovers completed	_____

Annex F. Maternal cardiac arrest / resuscitative delivery checklist

Action	Time / complete
High-quality CPR / defibrillation / arrest team activated	_____
Continuous manual left uterine displacement	_____
Airway by most experienced clinician / capnography	_____
IV / IO above diaphragm / standard ACLS medications	_____
Obstetric / neonatal / anaesthetic / theatre / blood bank called	_____
Reversible causes reviewed: anaesthetic, bleeding, cardiac, drugs, embolic, fever, Hs/Ts, hypertension	_____
Magnesium stopped / calcium given if toxicity suspected	_____
Fundus at / above umbilicus; resuscitative delivery preparation start	_____
Delivery completed by 5 minutes if no ROSC	_____
Newborn resuscitation separate / maternal ALS continues	_____
ROSC / haemorrhage control / ICU / debrief / documentation	_____

Annex G. Postpartum emergency return precautions

Return immediately / call emergency services for	Examples
Heavy bleeding	Soaking pads rapidly, large clots, persistent trickle, dizziness, fainting, racing heart or bleeding that is increasing rather than settling.

Return immediately / call emergency services for	Examples
Hypertension / neurological danger	Severe or persistent headache, blurred vision / flashing lights, epigastric or RUQ pain, confusion, weakness, seizure or BP at / above the locally stated emergency threshold.
Breathing / circulation danger	Chest pain, shortness of breath, orthopnoea, haemoptysis, fainting, unilateral leg swelling or sudden palpitations.
Infection	Fever, rigors, foul discharge, worsening pelvic / abdominal / breast / wound pain, spreading redness, pus, severe weakness or reduced urine.
Wound / pelvic complication	Wound opening, severe perineal pressure, rapidly increasing swelling, inability to pass urine, severe abdominal pain or vomiting.
Mental-health danger	No sleep with agitation or unusual energy, confusion, hallucinations, delusions, thoughts of self-harm / harming the baby, or feeling unable to keep self or infant safe.
Pregnancy before birth	Reduced / absent fetal movement, vaginal bleeding, fluid loss, regular painful contractions, severe abdominal pain or cord / body part visible.

Annex H. Local configuration checklist

Local element	Complete before approval
24-hour obstetric / midwifery emergency contact and response time	Name / number: _____
Anaesthesia / ICU / theatre activation pathway	Name / number: _____
Neonatal / paediatric response and transfer destination	Name / number: _____
Major obstetric haemorrhage pack / blood-product ratios / emergency blood	Approved pathway: _____
Approved PPH uterotonics / concentrations / doses / contraindications	Policy reference: _____
Approved TXA, magnesium and severe-hypertension regimens	Policy reference: _____
Uterine balloon tamponade device and trained operators	Location / names: _____
Resuscitative hysterotomy kit and competent clinicians	Location / names: _____
Emergency birth and neonatal resuscitation equipment checks	Owner / frequency: _____
RhD prophylaxis and fetomaternal-haemorrhage testing	Policy reference: _____
Maternal sepsis antimicrobial regimens / microbiology contact	Policy reference: _____
VTE imaging / anticoagulation / thrombolysis pathway	Policy reference: _____
Referral hospitals / air-sea transfer / weather contingency	Contacts: _____
Safeguarding, domestic violence, bereavement and mental-health contacts	Contacts: _____
Simulation programme / audit owner / review date	Lead / date: _____