

PRIMARY POSTPARTUM HAEMORRHAGE GUIDE

This guide is to be used in conjunction with the Standard Maternal Observation Chart (SMOC)



RECOGNISE

Is the woman at risk of Primary PPH?

Severe **Primary PPH** with symptoms of **shock** is a **life-threatening maternal emergency**

Does the woman have:

- any risk factors for PPH?
- a relevant Advance Care Directive or specific care plan?
- signs or symptoms of PPH



Recognise the impact of Human Factors on you and the team

Perform an A-G assessment and document a full set of vital sign observations

Does the woman have any signs of organ dysfunction?

*The most important single warning sign of diminishing blood volume and mild shock is tachycardia
This often precedes a fall in blood pressure*

Does the woman have any Red Zone observations or cumulative blood loss > 1000 mL

Does the woman have continued bleeding with any Yellow Zone observations and/or cumulative blood loss $\geq 500 - 1000$ mL

Does the woman have continued bleeding with cumulative blood loss ≥ 300 mL

RESPOND

- **Call a Rapid Response (as per local CERS)**
- Inform senior obstetrician and request urgent assistance
- Activate Massive Haemorrhage Protocol (MHP) if blood loss ≥ 1500 mL
- Commence resuscitation treatment (over page)
- Discuss the management plan with the woman and her partner and or/family
- Consider early consultation and escalation via the Tiered Perinatal Network (TPN) to support clinical management

- Continue cumulative measurement of blood loss
- Consider medication management of PPH
- Monitor for signs of deterioration
- Remain with the woman
- Consider whether additional assistance is required

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 RESUSCITATE	1. Stabilise and continue monitoring • Lie the woman flat • Commence oxygen (10-15 L/min) to maintain SpO₂ > 95% • Seek urgent anaesthetic assistance if breathing is compromised • Monitor vital signs: • BP, HR, RR and SpO₂ every 5 minutes • Temperature every 15 minutes (initiate strategies to prevent hypothermia)			
	2. Obtain access and collect Pathology • Gain IV access: 2 large bore cannulas (14 or 16g) <i>Do not delay - Call for expert assistance after two failed attempts at cannulation</i> • Collect pathology (FBC, coagulation screen, fibrinogen, group and hold, LFT, EUC, Ca2+, blood gas and lactate)			
	3. Commence fluid resuscitation • Commence rapid infusion: 1000 mL of warmed crystalloid fluid (e.g. Hartmann's) • Aim to maintain Systolic Blood Pressure (SBP) ≥ 90 mmHg • If SBP < 90 mmHg after initial bolus call a Rapid Response • Consider early blood transfusion of O negative blood (or group specific where available) <i>Crystalloid fluid more than 2L is only recommended where blood is unavailable</i> • Activation of Massive Haemorrhage Protocol (MHP) if blood loss ≥ 1500 mL • Insert IDC: measure hourly urine output (aim for > 30 mL/hr) • Monitor and document fluid input/output			
IDENTIFY & TREAT THE CAUSE	TISSUE Placenta out and complete? 	TONE Fundus firm? 	TRAUMA Perineum, vagina, cervix, uterus intact? 	THROMBIN Blood clotting? 
	• Do not massage the fundus • Consider medication management of PPH • Apply controlled cord traction and attempt to birth the placenta • Transfer to theatre if placenta retained or incomplete	• Massage the fundus and expel clots • Consider medication management of PPH • Consider bimanual compression • Transfer to theatre for further care	• Identify and repair any trauma (if appropriate in birth room) • Consider and correct uterine inversion • Consider medication management of PPH • Transfer to theatre for repair of any significant trauma	• Consider medication management of PPH • Review blood test results • Consult with Haematologist • Observe for Disseminated Intravascular Coagulation (DIC)
RESASSESS & REFER	4. Reassess (Once bleeding is controlled and the woman is stable) • Ensure maintenance medications have been commenced: syntocinon infusion • or misoprostol • Monitor ongoing blood loss, uterine tone, fluid balance and urine output • Re-test coagulation screen, Ca2+ and blood gas every 30-60 minutes • Record vital sign observations and uterine tone every 30 minutes (at a minimum) • Document and discuss an ongoing care plan with the woman including her partner/family (when appropriate)			
	5. Refer • Consider higher level care as required (i.e. Intensive care or a close observation unit) • Escalate via the Tiered Perinatal Network in line with service capability levels			