Childbirth

Protocol

Douglas County KS EMS System **November 2022**

Referenced Procedures: None

Goals for patient care:

1. Care of mom and baby
2. Expedite transport to closest capable facility

Medications:

ADULT Medication: • **Oxytocin:** 10 units IM • **TXA:** 2g IV slow or IO given as soon as possible after injury but not after 3 hours • **Normal Saline:** 500mL, IV/IO for dehydration, hemodynamic instability • **Fentanyl:** 25-100mcg IV/IO Slow Push, IM/IN (Titrate to effect, may repeat 5-10 min) (***Total Max. dose 200mcg***)	

Procedures/Interventions

- Obtain brief history:
  - Due date, history of multiple births, onset of labor, timing of contractions, history of ruptured membranes including color or history of previous prenatal complications
- Assess abdomen
- As appropriate assess for crowning, abnormal presentation, or significant vaginal bleeding
- Monitor contractions including strength and frequency

Delivery NOT Imminent

- Transport in position of comfort as soon as possible while monitoring vital signs
- If the patient is hypotensive, place in left lateral recumbent position
- Notify the receiving hospital of impending arrival
- Be prepared to stop transport and deliver infant if indicated

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Delivery Imminent

- Request a 2nd medic unit
- Establish IV access and consider fentanyl for severe pain
- If normal presentation and crowning, control the delivery of the head, but do not attempt to delay or restrain the delivery in any fashion
- Reduce nuchal cord as necessary. If unable to reduce, clamp the cord in two places and cut the cord between the two clamps
- Suction the mouth and then the nose with a bulb syringe after the head is delivered
- Deliver the anterior shoulder followed by the posterior shoulder
- Keep the infant level with the perineum; dry with towel; wrap in a blanket
- Clamp the cord in two places. Leave 8-10 inches between the abdominal wall and the first clamp. Cut the cord between the two clamps
- Prepare to deliver placenta
    - Maintain tension on the umbilical cord, but DO NOT PULL on the cord.
- Provider caring for infant should refer to Neonatal resuscitation protocol
- If the mother develops profuse hemorrhage or shock treat appropriately
- Transport while monitoring vital signs
- If not already notified, contact medical control and notify about impending arrival/delivery
- Evaluate APGAR at 1 and 5 minutes

Postpartum Hemorrhage

Acute Blood loss in immediate recovery period and up to 4 weeks post-partum. If evidence of postpartum hemorrhage:

- Massage uterus until firm
- Start large-bore IV
- Notify ED/LDR or patient condition and ETA
- Administer Oxytocin
- Consider TXA administration if post-partum hemorrhage (PPH) is < 3 HOURS after birth
    - Administration of TXA should be considered as part of the standard PPH treatment package and be administered as soon as possible after onset of bleeding and within 3 hours of birth.
    - TXA should be used in all cases of PPH, regardless of whether the bleeding is due to genital tract trauma or other causes.
- Transport while monitoring vital signs frequently
- Treat pain as needed
- Administer Oxygen

	0 (Points)	1	2
Appearance	Blue or pale all over	Blue extremities, but torso pink	Pink all over
Pulse	None	< 100	≥ 100
Grimace	No response	Weak grimace when stimulated	Cries or pulls away when stimulated
Activity	None	Some flexion of arms	Arms flexed, legs resist extension
Respirations	None	Weak, irregular or gasping	Strong cry

0-3 Critically Low, 4-6 Fairly Low, 7-10 Generally Normal

Most deliveries occur without complications but if complications of delivery occur, transport and contact medical control immediately to mobilize OB resources. Consider the following scenarios:

- PROBLEM: If abnormal part (arm or foot) presents, advise medical control immediately
- PROBLEM: If umbilical cord is prolapsed/protruding during transport, do the following:
  - Consider elevate mother's hips (prone in Knee/chest position)
  - With a sterile, gloved hand, gently lift the head/body off the cord
  - Assess for pulsation in cord
  - Maintain this position during transport until relieved by hospital staff
  - Apply high-flow oxygen to mother
- PROBLEM: If breach birth and the head has not delivered
  - Allow the legs, buttocks and trunk to deliver
  - Use two gloved fingers to create an air passage for the infant and maintain until arrival at receiving facility
  - Maintain this position until relieved by hospital staff or head delivers
  - Apply high-flow oxygen to mother
- PROBLEM: Pre-eclampsia/ Eclampsia
  - Refer to OBGYN protocol
- PROBLEM: Maternal cardiac arrest
  - Apply manual pressure to displace uterus from right to left
  - Treat cardiac arrest per protocol and expedite transport to closest facility
    - AutoPulse use is **NOT** contraindicated in pregnant patients
  - Transport as soon as possible if est. gestation is >20 week (uterus palpable at umbilicus or higher)

Notes:

Remember there are 2 patients – mother and baby (save mom, save baby)
- mother's well-being is necessary to baby's well-being

Ensure there is adequate personnel on scene if birth is eminent

All births shall have APGAR noted at 1 min and 5 min following delivery

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Considerations-

Considerations for first responding crew before ambulance arrival.

1. Determine scene safety if birth is imminent.
   a. If birth is imminent (strong, regular contractions 5 -10 minutes apart and lasting longer than 1 minute, mom feels like she has to have a bowl movement, visualization of baby's head) consider putting down sheets/blankets to keep area as clean as possible.
   b. Stress on mom is stress on the baby so it is important to keep pt as comfortable as possible. Keep both mom and baby warm and covered.

2. Get a detailed medical hx from pt including due date, number of previous births, and length of time between contractions, current medications, prior medical hx, and medication allergies. Ask about any abnormal discharge or changes in pregnancy.
   a. If crew has ems capabilities and resources available obtain a full set of vitals including BP, HR, SP02 and BG.