Jackson Hole Fire/EMS Operations Manual

Approved by: _____
Will Smith, MD, Medical Director

Approved by: _____
Willy Watsabaugh, Chief

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OBSTETRICAL EMERGENCIES
(Treatment Protocol)

ALL PROVIDERS

- Childbirth is a natural process. EMS providers called to a possible prehospital childbirth should determine whether there is enough time to transport the expected mother to the hospital or prepare for an imminent prehospital childbirth.
- Check ABC's
  - Administer high flow oxygen
- Obtain vitals and pregnancy history
  - Due date?
  - Pre-natal care? Ultrasounds? Known complications?
  - Para and Gravida?
  - Length of previous labors?
- Obtain history of current event
  - Is the patient in active labor?
  - How far apart are the contractions
  - Have the membranes ruptured? Color of fluid?
  - Is there crowning?
- Determine transport priority
  - Prepare for delivery if birth is imminent
  - Rapid transport if possibility of placenta abruption or placenta previa
- Contact medical control ASAP

Imminent delivery

- Prepare for neonatal resuscitation (if needed) and supportive infant care.
- Control delivery of head so it does not emerge too quickly. Support infant's head as it emerges and protect perineum with gentle hand pressure (do not pull on head).
- Puncture (with gentle finger pressure) amniotic membrane if it is still intact and visible outside the vagina.
- Check for cord around the neck. Gently reduce cord from around neck if present.
- Use bulb syringe to suction mouth first, then nose of infant if there is not vigorous respiratory effort. **Routine suctioning is not needed in the vigorous infant.**
- As shoulders emerge - guide head and neck downward to deliver anterior shoulder. Support and lift head and neck slightly to deliver posterior shoulder.
- The rest of the infant should deliver with passive participation - get a firm hold on baby.

Post-Partum Care – Infant

- Continue to suction mouth and nose; spontaneous respirations should begin within 15 seconds after stimulating (drying, rubbing feet, etc.). If not, begin artificial ventilations at 30-40

breaths/minute. If apneic, cyanotic, or HR less than 100 began neonatal resuscitation and NOTIFY MEDICAL CONTROL.

- Dry baby and wrap in warm blanket. Keep newborn level with mother's vagina.
- After the umbilical cord stops pulsating, clamp the umbilical cord 6"- 8" from newborn abdominal wall and cut the cord between the 2 clamps, with the sterile scalpel found in the OB kit. If no sterile cutting instrument is available, leave clamped cord intact and lay the infant on the mother's abdomen (if possible).
- Check the cord ends for bleeding. If there is any bleeding from the cord, reclamp in another place close to the original clamp.
- Obtain 1 minute APGAR Score.
- Obtain 5 minute APGAR Score.

Post-Partum Care – Mother

- Placenta should spontaneously deliver in 20-30 minutes. If delivered, collect placenta in plastic bag and bring to hospital. DO NOT pull on cord to facilitate placental delivery. DO NOT delay transport while waiting for placenta to deliver.
- If the perineum is torn and bleeding, apply direct pressure with sanitary pads, and have patient bring legs together.
- Massage abdominal wall (fundus) until firm.
- Initiate transport when delivery of the child is complete and mother can tolerate movement.

Critical Thinking Elements

- Usual vital sign changes during pregnancy include lower than usual blood pressure and higher than usual pulse rate. Do not confuse these normal physiological changes with shock.
- Signs and symptoms of shock in the pregnant patient include a systolic blood pressure less than 90mmHg, lightheadedness and altered level of consciousness.
- Average labor last 8 to 12 hours, but could be as short as 5 minutes if high PARA.
- The desire to push during contractions or sensation of the need to have a bowel movement indicates the beginning of the second stage of labor and that delivery may be imminent.
- High-risk factors include; lack of prenatal care, drug abuse, teenage pregnancy (mid to early teens), history of diabetes, hypertension, cardiac diseases, previous breech of C-Section deliveries, pre-eclampsia, eclampsia, toxemia, twins or multiple births.
- Assess the patient for peripheral edema. This may indicate toxemia and the threat of seizures from eclampsia.
- Do not delay transport to establish an IV.
- Tag the mother and baby with same information by wrapping tape around their wrists. Write the mother's name, sex of infant and date and time of delivery on each tape. (Example: Jane Doe; Female; 6/28/98, 5:10pm).

Obstetrical Complications

Third Trimester Bleeding (6 - 8 months):

- Suspect Placenta Previa, Abruptio Placenta
- Load and transport as soon as possible.
- Place the patient on her left side.
- Note type and amount of bleeding and/or discharge.
- ALS: IV FLUID THERAPY: (If the patient has an altered level of consciousness or hypotension.) Administer a **1000 ml NORMAL SALINE fluid bolus**

Pre-Eclampsia or Toxemia

- Systolic BP > 140, Diastolic BP > 90, hands or face edema, recent weight gain, seizures, headache
- Load and transport as soon as possible.
- Assure minimal CNS stimulation to prevent seizures - do not check pupillary light reflex.
- Place mother on her left side.
- BLS and ILS initiate ALS Intercept
- ALS: If patient seizes administer **Valium or Versed** as outlined in Seizure Protocol.

Prolapsed Cord

- Load and transport as soon as possible.
- Elevate mother's hips.
- Initiate ALS Intercept.
- Place gloved hand in vagina between pubic bone and presenting part with cord between fingers and exert counter pressure against presenting part to maintain cord blood flow.
- Palpate cord for pulsations.
- Keep exposed cord moist and warm.
- Keep hand in position and transport immediately.

Breech Birth

- Load and transport as soon as possible.
- Initiate ALS Intercept.
- Never attempt to pull the baby from the vagina by the legs or trunk.
- As soon as legs are delivered, support baby's body, wrapped in towel.
- After shoulders are delivered, gently elevate trunk and legs to aid in delivery of head (if face down).
- Head should deliver in 30 seconds. If not - reach 2 fingers into the vagina to locate infant's mouth.
- Press vaginal wall away from baby's mouth to access an airway. Apply gentle pressure to mother's fundus.

Trauma and pregnancy

- Rapid trauma assessment and transport – notify medical control and trauma team activation
- Place patient in left lateral recumbent position (tilt backboard if needed).

ADULT	PEDIATRIC
EMT-BASIC PROVIDER	**EMT-BASIC PROVIDER**
▪ Follow as above	▪ N/A
EMT-INTERMEDIATE PROVIDER	**EMT-INTERMEDIATE PROVIDER**
▪ Establish IV NS TKO ▪ If post-partum hemorrhage/hypotension, external uterine massage to encourage contraction of uterus. Administer 1000 ml NS bolus	▪ N/A
EMT-PARAMEDIC PROVIDER	**EMT-PARAMEDIC PROVIDER**
▪ Follow as above	▪ N/A