PROTOCOL
Childbirth

Overview: 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 a prehospital childbirth is imminent. If childbirth appears imminent, immediately prepare to assist with the delivery, using appropriate obstetrical equipment.

Emergency Medical Responder /BLS / ILS and ALS Care should be focused on assessing the situation and initiating Routine Patient Care and preparing or providing patient transportation. Special attention should be given to the privacy of the expected mother and concerns of immediate family members. Prepare for infant care.

1. Render initial care in accordance with the Routine Patient Care Protocol (ILS/ALS may initiate IV line).
2. OXYGEN: preferably 15 L/min by mask. If the patient does not tolerate a mask, then administer 4-6 L/min by nasal canal. Be prepared to coach the patient on proper respiration techniques. Coach mother to take slow deep breaths.
3. Obtain an obstetrical history on the patient, including:
    a. Number of pregnancies (Gravida).
    b. Live births (PARA).
    c. Expected delivery date.
    d. Length of previous labor(s).
    e. Narcotic use in last 4 hours.
4. Allow the patient to remain in a position that is most comfortable. If deliver is not imminent, allow mother to assume most comfortable position and transport (preferably on her left side).
5. Determine if there is adequate time to transport:
    a. Assess nature, extent and time of contractions.
    b. Assess the patient for high risk factors.
    c. Assess the status of the membranes and any discharges.
    d. Assess if patient is pushing with contractions.
    e. Consider length of previous labor(s).
6. If delivery is believed to be imminent, exam the patient for bloody show, bulging perineum, crowning Note nature and amount of discharge; assure body fluid precautions are followed.
7. If delivery is imminent, prepare for delivery.
    a. DO NOT ATTEMPT TO RESTRAIN OR DELAY DELIVERY.
8. Position mother supine on flat surface, if possible.
9. Put on FULL blood and body fluid barriers.

ILS/ALS Care

10. IV FLUID THERAPY: (If the patient has an altered level of consciousness or hypotension.)
    a. Administer a 200-300 ml fluid bolus
11. If delivery begins:

a. 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. Puncture (with gentle finger pressure) amniotic membrane if it is still intact and visible outside the vagina.

b. Check for cord around the neck. Gently remove cord from around neck if present.

c. With bulb syringe, suction Mouth, then nose of infant as soon as head is delivered.

d. As shoulders emerge - guide head and neck downward to deliver anterior shoulder. Support and lift head and neck slightly to deliver posterior shoulder.

e. The rest of the infant should deliver with passive participation - get a firm hold on baby.

f. Keep the newborn level with the mother's vagina until the cord stops pulsating and is double clamped.

g. Cut Cord

12. Post-Partum Care – Infant

a. Begin Emergency Childbirth Record.

b. Continue to suction mouth and nose; spontaneous respirations should begin within 15 seconds after stimulating reflexes. If not, begin artificial ventilations at 30-40 breaths/minute. If apneic, cyanotic, or HR less than 100 began neonatal resuscitation (see in Pediatric section) and CONTACT MEDICAL CONTROL.

c. Dry baby and wrap in warm blanket. Keep newborn level with mother's vagina.

d. 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, do not cut the cord and lay the infant (with the cord clamped) on the mother's abdomen.

e. Check the cord ends for bleeding. If there is any bleeding from the cord, reclamp in another place close to the original clamp.

f. Obtain 1 minute APGAR Score.

g. Place ID tags on the mother and infant: Name of mother, sex of infant, date and time of delivery. DO NOT separate the mother and infant unless both have ID tags.

13. Post-Partum Care – Mother

a. Placenta should 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.

b. If the perineum is torn and bleeding, apply direct pressure with sanitary pads, and have patient bring legs together.

c. Massage abdominal wall (fundus) until firm.

d. Initiate transport when delivery of the child is complete and mother can tolerate movement.

14. Documentation requirements

a. Complete the Emergency Childbirth Record.

b. Document the following on the prehospital care reports:

c. Date, time and place of delivery.

d. Whether or not cord was wrapped around the neck (nuchal cord). If so, how many times.

e. Appearances of amniotic fluid, if known, especially if it was green, brown or tinged with blood.

f. Time placenta was delivered and its condition (whether or not it appeared intact).

g. APGAR score at 1 minute & 5 minutes.

h. Any infant resuscitation initiated and response.

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.
- Contractions indicate the first stage of labor and may occur every 3 to 5 minutes.
- The desire to push during contractions indicated the beginning of the second stage of labor and that delivery is imminent.
- Be respectful of the expected mother's privacy, do not exam the pelvic region if delivery is obviously not imminent and the patient is not having complications or distress.
- 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.
- Indications for IV include; third trimester bleeding, high-risk delivery factors, signs of shock, obstetrical complications, medical Control orders. Do not delay transport of the patient with third trimester bleeding 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).

Manitowoc County Emergency Childbirth Record

(Complete and attach to infant's run sheet)

1. Presentation (head or feet): _____
2. Time of Birth: _____

3. Date of Birth: _____

4. Nuchal (neck) Cord: _____ Yes _____ No

   Number of Times:_____

5. Membranes Ruptured at: _____ A.M. _____ P.M.
   Appearance of Fluid: _____ Clear (cloudy) _____ Meconium stained
   _____ Blood stained

6. Apgar Scoring:

	- 0 -	- 1 -	- 2 -	
A = Appearance (color)	Blue, pale	Body pink, blue hands and feet	Entirely pink	_____
P = Pulse (heart rate)	Absent	Less than 100	100+	_____
G = Grimace (reflex irritability)	No response	Grimace	Cough or sneeze	_____
A = Activity (muscle tone)	Limp	Some flexion of extremities	Active motion	_____
R = Respirations	Absent	Slow, irregular	Good crying	_____

TOTAL SCORE _____

7. Time Placenta Delivered: _____

   Appearance: _____ Intact _____ Not Intact

8. Number of Vessels in Cord: (if cut) _____

9. Infant Resuscitation: (if necessary) _____ Stimulation _____ Oxygen
   _____ CPR _____ Time Begun
   _____ Time Terminated

10. Remarks:_____

    _____

    _____

11. Signature of EMT/Delivery Personnel and ID Numbers:_____

PROTOCOL
Obstetrical Complications

Overview: Obstetrical complications can threat the health of the mother and child. Obstetrical complications may cause airway obstructions or hypovolemia shock of the mother or child and should be treated as life-threatening emergencies.

Emergency Medical Responder /BLS / ILS and ALS Care should be focused on assessing the situation and initiating Routine should be focused on assessing the situation and initiating Routine Patient Care to treat for shock. Special attention should be given to the privacy of the expected mother and concerns of immediate family members. Prepare for infant care.

1. Render initial care in accordance with the Routine Patient Care Protocol (ILS/ALS may initiate IV line).
2. ***OXYGEN:*** preferably 15 L/min by mask. If the patient does not tolerate a mask, then administer 6 L/min by nasal canal. Be prepared to support the patient's respirations with ventilation via bag-valve-mask.
3. Third Trimester Bleeding (6 - 8 months)
    a. suspect Placenta Previa, Abruptio Placenta
    b. Load and transport as soon as possible.
    c. Place the patient on her left side.
    d. Note type and amount of bleeding and/or discharge.
    e. ILS/ALS: IV FLUID THERAPY: (If the patient has an altered level of consciousness or hypotension.) Administer a ***200-300 ml NORMAL SALINE fluid bolus***
4. Pre-Eclampsia or Toxemia
    a. Systolic BP > 140, Diastolic BP > 90, hands or face edema, recent weight gain, seizures, headache
    b. Load and transport as soon as possible.
    c. Assure minimal CNS stimulation to prevent seizures - do not check pupillary light reflex.
    d. Place mother on her left side.
    e. BLS and ILS initiate ALS Intercept
    f. ALS: If patient seizes administer ***ATIVAN*** as outlined in Seizure Protocol.
5. Prolapsed Cord
    a. Load and transport as soon as possible.
    b. Elevate mother's hips.
    c. Initiate ALS Intercept.
    d. Place gloved hand in vagina between pubic bone and presenting part with cord between fingers and exert counter pressure against presenting part.
    e. Palpate cord for pulsations.
    f. Keep exposed cord moist and warm.
    g. Keep hand in position and transport immediately.
6. Breech Birth
    a. Load and transport as soon as possible.

b. Initiate ALS Intercept.

c. Never attempt to pull the baby from the vagina by the legs or trunk.

d. As soon as legs are delivered, support baby's body, wrapped in towel.

e. After shoulders are delivered, gently elevate trunk and legs to aid in delivery of head (if face down).

f. 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.

PROTOCOL
Rape/Sexual Assault

Overview: Rape and sexual assault are acts of violence and may be associated with traumatic injuries. All assault patients should be assessed according to patient assessment guidelines with special attention given to airway, breathing and circulation. The rape and sexual assault patient may also have mental health needs.

Emergency Medical Responder, BLS, ILS and ALS Care: should be focused on assessing the situation and initiating care to assure the patient is maintaining an airway, is breathing, has a perfusing pulse and begin treating for shock. Consider possible scene safety issues (notify police, if not on scene). See Crime Scene Preservation Protocol.

1. See Crime Scene Preservation protocol
2. Render initial care in accordance with the Routine Patient Care Protocol and Routine Trauma Care Protocol.
3. OXYGEN: preferably 15 L/min by mask. If the patient does not tolerate a mask, then administer 6 L/min by nasal canal. Be prepared to support the patient's respirations with ventilation via bag-valve-mask.
4. Treat obvious injuries or illnesses.
5. Survey the scene and give special consideration to preserving any articles of evidence on or around the patient.
6. Discourage patients from changing clothes, urinating, or washing/showering.
7. Collaborate with police to determine what articles (i.e., clothing) will be transported with the patient.
8. Do not physically examine genital area unless there are apparent injuries that need treatment.
9. All linen used by the patient should be left with the patient at the Emergency Department.
10. Transport the patient and inform police of destination.

Critical Thinking Elements:
- If patient refuses treatment, refer to Patient Right of Refusal Policy.
- Thoroughly document the patient's history and physical exam findings on the Prehospital Report.
- Description of where the patient was found and the surroundings should be documented on the prehospital care report.