



Portage County EMS Patient Care Guidelines



Childbirth

Note:

- This Guideline pertains to care of the mother. Refer to *Care of a Newborn Guidelines*
- If maternal seizures occur, refer to *Obstetrical Emergencies Guideline*

Priorities	Assessment Findings
Chief Complaint	"Abdominal pain", "Delivering a baby", "Urge to push", "Gush of fluid from the vagina"
LOPQRST	Due date, time contractions started & how often, location of their OB/GYN physician
AS/PN	Rupture of membranes (bag of water); vaginal bleeding; sensation of fetal activity;
AMPL	Number of prior pregnancies including this one (gravida) & number of deliveries (para); past delivery history (duration of labor, complications); pre-natal care; history of diabetes, heart disease or hypertension
Initial Exam	Check ABC's and correct any immediate life threats
Detailed Focused Exam	Vitals: BP, HR, RR, Temp, SpO ₂ General Appearance: Distress? Lungs: Wheezes, rales or rhonchi? Signs of respiratory distress? Heart: Rate and rhythm? Signs of hypoperfusion? Neuro: Seizures? Vaginal Exam: Crowning, leaking fluids, bleeding, limb or cord presentation?
Data	Blood glucose, SpO ₂ , ETCO ₂
Goals of Therapy	Determine immediate transport or assist with delivery on scene; prepare for abnormal delivery
Monitoring	Repeat vitals, cardiac monitoring, capnometry

EMERGENCY MEDICAL RESPONDER/ EMERGENCY MEDICAL TECHNICIAN

- Routine Medical Care
- Administer oxygen 2 – 4 LPM per nasal cannula if SpO₂ < 94%. Increase flow and consider non-rebreather mask to keep SpO₂ > 94%
- Determine if the birth is imminent:
 - Has delivered previously
 - History of short labors
 - Feels urge to push
 - Child's head is crowning
 - Head or scalp visible at perineum during contractions
- See Footnotes for additional considerations in abnormal deliveries[1]
- Delivery should be controlled so as to allow a slow controlled delivery of the infant. This will prevent injury to the mother and infant
 - Place a hand with firm, gentle pressure on the top of the head.
- Support the infant's head as needed
 - Be prepared for the infant to be slippery
- Check for the umbilical cord surrounding the neck[1]
- Suction the mouth and nose with a bulb syringe

- Aggressive suctioning of the infant's airway is not required unless there are signs of obstruction
- Grasping the head with hands over the ears, gently pull down to allow delivery of the anterior (upper) shoulder
- Gently pull up on the head to allow delivery of the posterior (lower) shoulder
- Slowly deliver the remainder of the infant
- Clamp the cord with 2 clamps and cut the cord between the clamps
 - Keep the infant at the level of the vaginal opening until the cord is clamped
- Record APGAR[2] scores at 1 and 5 minutes
- Follow the *Care of the Newborn Guidelines* for further treatment of the infant
- The placenta will deliver spontaneously, usually within 10 – 15 minutes of the infant
 - Do not force the placenta to deliver
 - Do not delay transport to wait for the placenta to deliver
- Massaging the uterus may facilitate delivery of the placenta and decrease bleeding by facilitating uterine contractions

Give a status report to the ambulance crew by radio ASAP.

**ADVANCED EMERGENCY MEDICAL TECHNICIAN/
INTERMEDIATE/
PARAMEDIC**

- Notify the receiving hospital as soon as possible of a potential delivery
- IV normal saline @ KVO
- If SBP < 100 mmHg, initiate a fluid bolus of 500 ml normal saline
- Transport the infant in a car seat secured to the ambulance
 - Car seat must be rear-facing on either the cot or the captain's chair
 - Do not allow the mother to hold the infant during transport
 - Consider a second ambulance if either patient is unstable

Contact Medical Control for the following:

- Additional fluid orders

FOOTNOTES:

[1] Abnormal birth emergencies:

GENERAL CONSIDERATIONS	<ul style="list-style-type: none"> • Notify Medical Control as soon as possible • Do not pull on any presenting body parts • Prepare for immediate transport • Monitor the condition of the mother closely
Cord around neck	<ul style="list-style-type: none"> • Loosen cord and slip it over the head • If unable to free the cord from the neck, double clamp the cord and cut between the clamps
Prolapsed cord	<ul style="list-style-type: none"> • Do not encourage the mother to push • Transport mother with hips elevated and knees to chest

	<ul style="list-style-type: none"> • Insert fingers into vagina to relieve pressure on cord • Cover cord with sterile saline dressing • Do not attempt to push cord back in
Breech birth	<ul style="list-style-type: none"> • Transport unless delivery is imminent • Do not encourage the mother to push • Support but do not pull presenting parts <ul style="list-style-type: none"> ◦ Wrap in a towel • If delivery is in progress and the head is clamped inside the vaginal, create an air passage by supporting the body of the infant and displacing the vaginal walls away from the nose with two fingers <ul style="list-style-type: none"> ◦ Gently elevate trunk and legs to aid in delivery of head (if face down) • If unable to deliver, transport the mother with hips elevated and knees to chest
Limb presentation	<ul style="list-style-type: none"> • Transport emergently • Normal delivery is not possible
Shoulder dystocia	<ul style="list-style-type: none"> • Transport the mother with hips elevated and knees to chest • Insert fingers into the vagina to relieve pressure on the cord • Support the baby's head • Place pressure above symphysis pubis in an attempt to widen the pelvic opening

[2] APGAR Scores are performed at 1 minute and 5 minutes after birth according to the following table:

SCORE	0	1	2
APPEARANCE	Blue/pale	Pink Body/Blue Extremities	Pink
PULSE	Absent	Slow (< 100/minute)	> 100/minute
GRIMACE	No response to suction	Grimace to suction	Cough or Sneeze to suction
ACTIVITY	Limp	Some Flexion	Active Motion
RESPIRATIONS	Absent	Slow/Irregular	Good/Crying

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