7000 CHILDBIRTH

EMR | EMT | EMT-IV | AEMT | INTERMEDIATE | PARAMEDIC

Overview:

- EMS providers called to a possible prehospital childbirth should determine if there is enough time to transport expectant mother to hospital or if delivery is imminent
- If imminent, **stay on scene** and immediately prepare to assist with the delivery

ABCs
O_2 15 lpm
IV access

Obtain obstetrical history

Specific Information Needed:

- Obstetrical history:
  - Number of pregnancies (gravida)
  - Live births (PARA)
  - Expected delivery date
  - Length of previous labors
  - Narcotic use in past 4 hours
  - Ruptured membranes?
  - Contraction pattern/frequency

If suspected imminent childbirth:

- Allow patient to remain in position of comfort
- Visualize perineum
- Determine if there is time to transport

Imminent Delivery

Delivery is imminent if there is crowning or bulging of perineum, or if mother feel urgent need to push.

Delivery not imminent

- Transport in position of comfort, preferably on left side to patient's requested hospital if time and conditions allow
- Monitor for progression to imminent delivery

Emergency Childbirth Procedure

If there is a prolapsed umbilical cord or apparent breech presentation, go to Obstetrical Complications and initiate immediate transport

For otherwise uncomplicated delivery:

- Position mother supine on flat surface, if possible
- Do not attempt to impair or delay delivery
- Support and control delivery of head as it emerges
- Protect perineum with gentle hand pressure
- Check for cord around neck, gently remove from around neck, if present
- If meconium present, suction mouth, then nose of infant as soon as head is delivered
- If delivery not progressing, baby is "stuck", see Obstetrical Complications and begin immediate transport
- As shoulders emerge, gently guide head and neck downward to deliver anterior shoulder. Support and gently lift head and neck to deliver posterior shoulder
- Rest of infant should deliver with passive participation – get a firm hold on baby
- Keep newborn at level of mother's vagina until cord stops pulsating and is double clamped. Cut before or at 60 seconds after delivery. Scissors adequate, no need for sterile scalpel.

Critical Thinking:

- Normal pregnancy is accompanied by higher heart rates and lower blood pressures
- Shock will be manifested by signs of poor perfusion
- Labor can take 8-12 hours, but as little as 5 minutes if high PARA
- The higher the PARA, the shorter the labor is likely to be
- High risk factors include: no prenatal care, drug use, teenage pregnancy, DM, htn, cardiac disease, prior breech or C section, preeclampsia, twins
- Note color of amniotic fluid for meconium staining
- During delivery, fetal head typically facing mother's rectum

Postpartum Care Infant

- Suction mouth and nose only if signs of obstruction by secretions
- Respirations should begin within 15 seconds after stimulating reflexes. If not, begin artificial ventilations at 30-40 breaths/min

If apneic, cyanotic or HR < 100, begin Neonatal Resuscitation

- Dry baby and wrap in warm blanket
- After umbilical cord stops pulsating, double clamp 6" from infant abdominal wall and cut between clamps. with sterile scalpel. If no sterile cutting instrument available, lay infant on mother's abdomen and do not cut clamped cord
- Document 1 and 5 minute APGAR scores

Postpartum Care Mother

- Placenta should deliver in 20-30 minutes. If delivered, collect in plastic bag and bring to hospital. Do not pull cord to facilitate placenta delivery and do not delay transport awaiting placenta delivery
- If the perineum is torn and bleeding, apply direct pressure with sanitary pads
- Postpartum hemorrhage – see Obstetrical Complications
- Initiate transport once delivery of child is complete and mother can tolerate movement