Obstetrical/Childbirth

Signs and Symptoms

- Abdominal pain
- Seizures
- Hypertension
- Severe headache
- Visual changes
- Edema of hands and feet
- Contractions
- Vaginal discharge or bleeding
- Crowning or urge to push
- Presence of meconium

History

- Pre-existing Hypertension
- Prenatal care
- Gravida/Para
- High risk pregnancy
- Gestational age/ Due date
- Time contractions started and how often
- Rupture of membranes
- Time and amount of any vaginal bleeding
- Sensation of fetal activity
- Drug use

Differential

- Pre-Eclampsia/Eclampsia
- Placenta previa
- Abruptio placenta
- Spontaneous abortion
- Prolapsed cord
- Abnormal presentations
  - Buttock/Breech
  - Foot
  - Hand

Care

B E I P

Follow General Directive #3, Orders for All Patients.

Determine if the patient has vaginal bleeding or abdominal pain, and/or crowning.

E I P

Establish IV **Normal Saline** run at KVO.

No crowning:

B E I P

Monitor and reassess

Document frequency and duration of contractions

E I P

Administer IV fluid wide open up to 1,000 ml NaCl in the presence of hemorrhage or premature contractions.

Crowning:

B E I P

If delivery is imminent, prepare the patient for delivery by placing the patient into Semi-Fowler's position, administering 15 liters of oxygen by nonrebreather mask, remove all clothing from the patient's lower extremities, preparing the OB Kit and prepping the patient by draping the lower extremities.

Pearls

- Document all times (delivery, contraction frequency and length)
- If maternal seizures occur, refer to Non Cardiac Protocol #11 Seizures.
- After delivery, massaging the uterus (lower abdomen) will promote uterine contractions and help to control post-partum bleeding.
- Some perineal bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal.
- Efforts to keep newborn warm are essential.
- Severe headache, vision changes and or RUQ pain may indicate preeclampsia.
- In the setting of pregnancy, hypertension is defined as BP greater than 140 systolic or greater than 90 diastolic, or a relative increase of 20 systolic and 20 diastolic from the patient's normal (pre-pregnancy) blood pressure.
- Maintain patient in a left lateral position to minimize risk of supine hypotensive syndrome.
- Pregnant patients with even minor blunt trauma (e.g. slow speed MVC) should be urgently evaluated by a physician especially after 20 weeks gestation.
- Do not insert fingers into the vagina to ascertain either cervical dilation or crowning.
- Lack of prenatal care should alert the provider to unknown complications such as multiple births or distressed newborns.
- If the patient states that the baby is coming now, prepare for imminent delivery.

Performance indicators

- Accurate determination and documentation of APGAR score at 1 and 5 min. intervals.

Normal delivery

B E I P

Upon initial presentation of the baby's head, suction the baby's mouth first and then the nose with the bulb syringe found in the OB Kit.

If the umbilical cord is wrapped around the baby's neck causing an obstruction to the airway and you are unable to loosen or unravel it to prevent choking; clamp the cord with two clamps and carefully cut the cord between the clamps with the sterile scalpel or scissors found in the OB Kit.

Upon delivery record the time.

Monitor mother for excessive vaginal hemorrhage. Gentle massage of the lower abdomen will assist in hemorrhage control.

Prepare for the delivery of the afterbirth (placenta) or in cases of multiple births, the next baby. When the afterbirth (placenta) is delivered, place it and the connected umbilical cord into a plastic sack. **Do not assist** the delivery of the afterbirth (placenta) by pulling on the umbilical cord. **Do not delay transport** waiting for the delivery of the afterbirth (placenta).

Abnormal delivery

B E I P

Prolapsed cord

Elevate Mother's hips.

In the case of prolapsed cord, place a gloved hand into the vagina to attempt to hold the baby's head from pressing against the cord and maintain this position throughout transport.

Transport immediately.

Breech , caudel (buttocks) presentation

Proceed with delivery as indicated with normal delivery.

Once the chest has delivered, place two gloved fingers of your hand into the patient's vagina to effect an open airway for the baby. Maintain the infant's airway in this fashion until the head delivers.

If the head does not deliver within 3 min., a true emergency exists.

Elevate Mother's hips.

Transport immediately with gloved fingers continually maintaining the baby's airway. Notify the hospital of your impending arrival and be prepared to provide the patient's name and the patient's obstetrician's name.

Management of birth complicated with meconium

Do not stimulate before suctioning the oropharynx.

Suction.

Maintain airway.

I P

If newborn delivers through thick meconium and is unresponsive (or not "vigorous") at birth, the orophayrnx should be inspected and cleared of meconium followed by intubation and suctioning of the trachea using a meconium aspirator.

Management of the newborn

B E I P

Be careful to support the baby after delivery.

Suction the baby's mouth and nose again immediately after delivery. Dry the baby quickly.

Confirm that the baby is still breathing; if breathing is not present begin artificial ventilation with oxygen. If a pulse is not present or the pulse is less than 60 beats per minute, begin CPR.

Obtain APGAR scores at one and five minutes.

The second APGAR score is less than 7 or central cyanosis is present, blow-by oxygen should be administered to the baby.

While keeping the baby at or below the level of the mother and after determining that the umbilical cord is no longer pulsating, apply a clamp about 2 to 4 inches from the baby's navel and another clamp at least two inches distal to the first clamp.

Only if a sterile cutting device (scalpel, scissors) is available, cut the umbilical cord between the two clamps with the sterile cutting device. If a sterile cutting device is not available, carefully transport the baby with the cord attached and insure at all times that the cord is not pulled tight.

Cover the baby to maintain body temperature. Pay special attention to insure that the baby's head is covered.

If not previously in contact with Medical Control Physician, do so to relay findings and obtain further orders.

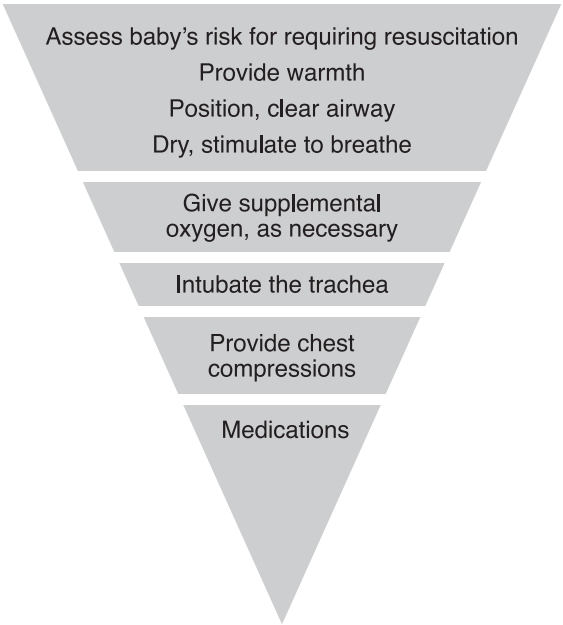
Transport the patient(s) to the hospital or as directed by the Medical Control Physician.

References for Obstetrical/Childbirth

The APGAR Score

	0
Appearance (skin color)	Body and extremities blue, pale
Pulse rate	Absent
Grimace (irritability)	No response
Activity (muscle tone)	Limp
Respiratory effort	Absent

	1
Appearance (skin color)	Body pink, extremities blue
Pulse rate	Below 100/min.
Grimace (irritability)	Grimace
Activity (muscle tone)	Some flection of extremities
Respiratory effort	Slow and regular

	2
Appearance (skin color)	Completely pink
Pulse rate	100/min. or above
Grimace (irritability)	Cough, sneeze, cry
Activity (muscle tone)	Active motion
Respiratory effort	Strong cry

Inverted triangle of newborn management