MERCED COUNTY EMS AGENCY

POLICY ADULT M17 OB-GYN EMERGENCIES

Effective Date : November 18, 2018
Last Review: October 3, 2011
Next Review: November 2020

Authority: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

DEFINITION:

Birth may be imminent if the woman is having regular contractions/low back pain, bloody show, rupture of membranes or feels like bearing down/pushing/or having a bowel movement. Attempt to provide privacy and psychosocial support. Allow position of comfort and encourage controlled breathing. Obtain pertinent history: last menstrual period (LMP) and how many weeks the pregnancy is. **Gravida (G)** = how many pregnancies; **Para (P)** = how many live births; determine the length of contractions and how far apart they are occurring. Assess for mental changes or change in vision (signs of Eclampsia). Attempt to provide privacy and psychosocial support. Allow position of comfort and encourage controlled breathing. Ask for permission and visualize vaginal opening for signs of crowning or abnormal presentations.

BLS TREATMENT: MOTHER

OXYGEN: as appropriate, goal to maintain SPO2 at least 94%; assist ventilations as necessary.
POSITION & VITALS: if in distress position mother in left lateral condition; assess vitals; monitor for pregnancy-induced hypertension (systolic blood pressure of greater than 140 mmHg, diastolic blood pressure greater than 90 mmHg) after 20th week

ALS TREATMENT: MOTHER

OXYGEN: as appropriate, goal to maintain SPO2 at least 94%; secure airway and assist ventilations as necessary.
POSITION & VITALS: if in distress position mother in left lateral condition; assess vitals; monitor for pregnancy-induced hypertension (systolic blood pressure of greater than 140 mmHg, diastolic blood pressure greater than 90 mmHg) after 20th week
MONITOR: treat rhythm as appropriate
IV ACCESS: if time permits establish large bore IV; rate as appropriate. If patient is hypotensive see **Adult M12 Non-Traumatic Shock Protocol.**

ROUTINE DELIVERY:

- If no time for transport, proceed with delivery.
- Using sterile gloves drape the patient and encourage her to take slow, deep breaths. Allow delivery to continue normally and when the baby's head emerges, support gently**. Do NOT pull the infant at any time.** If the amniotic sac is still intact, rupture the membrane.
- Check to see that the cord is not around baby's neck; if it is, slip it over the baby's head. Clamp and cut the cord if it is wrapped too tightly.
- Suction infant's airway if meconium is present at perineum.
- Gently deliver the anterior shoulder, then the posterior shoulder. Be sure the infant is breathing.

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- Dry infant and assess infant for APGAR scoring at one (1) and five (5) minutes; continually reassess ABC's. See **Pediatric M17 Newborn Resuscitation** protocol as indicated.
- Place baby on mother's stomach; may delay clamping cord. Double clamping the cord at approximately 7" and 10" from baby's navel and cut between clamps.
- Wrap infant in a blanket and put the baby to the mother's breast to nurse and keep warm.

DELIVERY OF THE PLACENTA:

- Should occur within twenty (20) minutes after the delivery of the infant.
- Don't delay transport for extended period of time to deliver the placenta.
- When the placenta presents in the birth canal, encourage the mother to push the placenta out.
- NEVER pull on the umbilical cord to deliver the placenta.
- When the placenta is delivered, place it in a bag and transport it to the hospital for inspection.
- Massage fundus of the uterus to help stop bleeding

DOCUMENTATION:

If field delivery note time infant was born and complete APGAR scores at 1 & 5 minute intervals

APGAR SCORING

SIGN	0	1	2
Appearance	**Body blue, pale**	**Body pink, extremities blue**	**Completely pink**
Pulse	**Absent**	**Less than 100 bpm**	**Greater than 100 bpm**
Grimace	**No response to stimulus**	**Some motion, weak cry**	**Vigorous motion, strong cry**
Activity	**Limp**	**Some flexion of extremities**	**Active motion**
Respiratory rate & effort	**Absent**	**Slow, Irregular or labored**	**Normal**

ABNORMAL DELIVERIES:

PREMATURE LABOR

- Infant may be delivered in the standard method.
- Premature infant often times present with immature respiratory. Be prepared to resuscitate infant, see neonatal resuscitation protocol.
- If non-viable, save and transport any tissue or fetal remains.

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PROLAPSED CORD:

- Position mother in knee chest position or elevate pelvis with pillows or wedge device. Head should be lower than the pelvis.
- Insert sterile gloved hand into vagina & gently push presenting part (head or shoulder) off the cord.
- **Do not** tug on the cord
- **Do not** attempt to push the cord back into the birth canal; Cover exposed portion of cord with saline soaked gauze.
- **Do not** remove hand until hospital personnel assume care.
- **Do not** attempt to reposition cord

BREECH DELIVERY: BUTTOCKS PRESENTATION

- Allow the infant to deliver buttocks and trunk (waist appears) spontaneously
- Once the legs are delivered, support the infants body and allow the head to deliver
- Gently rotate the baby to a face down position and continue with the delivery
- If the head does not deliver, insert sterile gloved hand into the vagina and make a "V" around the baby's nose to push the birth canal away from the face to allow for ventilation. This also takes some pressure off the cord.

BREECH DELIVERY: LIMB PRESENTATION

- If foot (leg) or hand (arm) presentation place mother in knee chest position or elevate pelvis with pillows or wedge device. Head should be lower than the pelvis.
- It is unlikely that the baby will deliver and immediate transport should be initiated.

SEIZURES: ECLAMPSIA

MIDAZOLAM: 2 mg IV/IO push. Titrate in 1 mg increments for seizure control; max dose 5 mg IV/IO. 5 mg IN or IM if no immediate IV/IO access available; may repeat once after 10 minutes if seizures continue.
MAGNESIUM SULFATE: 24 weeks pregnant or more, 2 gms in 10 ml saline slow IV push over 2 minutes.