

Obstetrical Emergencies

Purpose: To provide the process for the assessment and management of the patient with an obstetrical related emergency.

1. Follow **General Pre-hospital Care Protocol**
2. Assessment Information
 - A. History:
 - a. Past Medical History: previous births, previous complications
 - b. Current History: duration of gestation (weeks), whether single or multiple births are expected.
 - B. Specific Objective Findings: vital signs, assess contractions
 - C. Determine whether to transport or remain at scene due to imminent delivery. Indications of impending imminent delivery may include:
 - a. Multiple pregnancy, strong regular contractions, every 2 minutes or less; ruptured membrane, bloody show, need to push or bear down, crowning
 - Ⓢ D. Obtain vascular access, if time permits.
3. Management of Normal Delivery
 - A. Have oxygen and suction readily available for care of the newborn.
 - B. **If signs of newborn delivery are imminent, and there is no time to transport, prepare for delivery.**
 - a. Try to find a place for maximum privacy and cleanliness.
 - b. Position patient on back, on stretcher if time permits or on bed.
 - i. Monitor patient for signs of hypotension. If signs develop, position patient so weight of uterus is to patient's left side.
 - c. Drape if possible, using clean sheets.
 - d. Encourage mother to relax and take slow deep breaths through her mouth.
 - e. Reassure her throughout procedure.
 - f. As baby's head begins to emerge from vagina, support it gently with hand and towel to provide a controlled delivery.
 - g. After head is delivered look and feel to see if cord is wrapped around baby's neck.
 - i. **If the cord is around neck and loose**, slide gently – over the head **DO NOT TUG**.
 - ii. **If the cord is around neck and snug**, clamp the cord with 2 clamps and cut between the clamps.
 - h. As the shoulders deliver, carefully hold and support the head and shoulders as the body delivers, usually very suddenly – and the baby is very slippery! **Note the time of delivery.**
 - i. Place the baby on its side with head lower than the body. (Suction with a bulb syringe should be reserved for infants with obvious obstruction)
 - j. Prevent heat loss.

- i. Place baby in warm environment
- ii. Dry baby off and remove all wet linen.
- k. Evaluate respirations
 - i. **If the baby does not breathe spontaneously**, stimulate by gently rubbing its back or slapping the soles of its feet. If still no response, initiate ventilation with 100% high flow oxygen per **Pediatric Newborn Assessment, Treatment and Resuscitation Protocol**.
 - ii. If spontaneous breathing begins, administer oxygen for a few minutes until baby's color is pink.
- l. When infant is delivered and breathing normally, cord should be tied or clamped 8 inches from the infant with 2 clamps (ties) placed 2 inches apart. Cut the cord between the clamps, and assure that no bleeding occurs.
 - i. If child is being resuscitated or is in distress, the cord may be cut and clamped and kept moist with a small dressing. (In case Umbilical Vein IV is needed.)
- m. Score **APGAR** at **one minute** and **five minutes** after delivery.
 - i. A – appearance (color)
 - ii. P – pulse (heart rate)
 - iii. G – grimace (reflex irritability to slap on sole of foot)
 - iv. A – activity (muscle tone)
 - v. R – respiration (respiratory effort)
 - vi. Each parameter gets a score of 0 to 2.

APGAR SCORING

Sign	0	1	2
Appearance – skin color	Bluish or paleness	Pink or ruddy; hands or feet are blue	Pink or ruddy; entire body
Pulse – heart rate	Absent	Below 100	Over 100
Grimace – reflex irritability to foot slap	No response	Crying; some motion	Crying; vigorous
Activity – muscle tone	Limp	Some flexion of extremities	Active; good motion in extremities
Respiratory effort	Absent	Slow and Irregular	Normal; crying

- n. If **APGAR** is less than 6, refer to **Pediatric Newborn Assessment, Treatment and Resuscitation Protocol**.
- o. When delivery of baby is complete, prepare for immediate transport. Placenta can be delivered in route or at the hospital
- p. Delivery of placenta generally takes place within 20 minutes.
- q. Following placental delivery, massage the uterus to aid in contraction of the uterus.
- r. Place placenta in basin or plastic bag and transport with mother.



- s. Contact medical control.

4. If there are signs of airway obstruction or respiratory distress, suction and refer to **Pediatric Newborn Assessment, Treatment and Resuscitation Protocol**.

5. Abnormal Deliveries


A. Contact Medical Control as soon as appropriate.

B. Breech position

- a. Allow buttocks and trunk to deliver spontaneously.
- b. Once legs are clear, support body on the palm of your hand and surface of your arm, allowing head to deliver.
- c. If the head doesn't deliver immediately, transport rapidly to the hospital with mother's buttocks elevated on pillows with baby's airway maintained throughout transfer.
 - i. Place **gloved** hand in the vagina with your palm towards the baby's face. Form a "V" with your fingers on either side of the baby's nose and push the vaginal wall away from baby's face until the head is delivered.

C. Prolapsed Cord – Life Threatening Condition

- a. Place mother in a supine position with hips supported on a pillow.
- b. Evaluate and maintain airway, provide oxygen.
- c. **With sterile gloved hand, gently push** the baby up the vagina several inches to release pressure on the cord.

- d. **DO NOT ATTEMPT TO PUSH CORD BACK!**
- e. Transport maintaining pressure on baby's head.
- D. **Arm or limb presentation – Life threatening condition.**
 - a. Immediate transportation
 - b. Delivery should not be attempted outside the hospital.
 - c. Place mother in position of comfort or with hips elevated on pillow.
 - d. Evaluate and maintain airway, provide oxygen.
- E. **Multiple births**
 - a. Immediate transportation
 - b. Multiple birth infants are typically small birth weight and will need careful management to maintain body heat.
 - c. After first infant is delivered, clamp cord and proceed through airway, drying and warming procedures while awaiting delivery of other births, (See step 3a.)
 - d. Prepare additional supplies for subsequent births.
 - e. There may be time to transport between births.
- 6. **Pre-eclampsia/Eclampsia**
 - A. Signs of preeclampsia
 - a. BP 160/110 or higher
 - b. Marked peripheral edema
 - c. Diminished level of consciousness
 - d. Seizure (eclampsia)
 - B. Immediate transport
 -  C. If seizure occurs
 - a. Administer Magnesium Sulfate 2 gm over 10 minutes IV/IO until seizure stops. Administration of Magnesium Sulfate is best accomplished by adding Magnesium Sulfate 2gm to 100 or 250 ml of NS and infusing over approximately 10 minutes.
 - b. If eclamptic seizure does not stop after magnesium, then refer to **Seizure Protocol**

