

OBSTETRICAL DELIVERY

SIGNS & SYMPTOMS:

1. Regular abdominal pain, cramping, or contractions
2. Bloody show, passage of clots or tissue
3. Perineal bulging, crowning
4. Amniotic sac rupture
5. ↑ contraction intensity and length
6. Urge to push or have bowel movement
7. Involuntary screaming

OBTAIN HISTORY OF:

1. Last menstrual period & expected due date
2. # of previous pregnancies
3. Prenatal care, known complications
4. Symptom onset & time between contractions
5. Presence of meconium when “water broke”
6. PMH/Meds/Allergies
7. Amount of bleeding

PRECAUTIONS:

1. Take appropriate infection control precautions.
2. Early notification of medical control is essential for known or suspected complications so that receiving facility can be appropriately selected and notified.

FIRST RESPONDER / BASIC LIFE SUPPORT:

1. Assess and support ABCs.
2. Begin high flow supplemental oxygen via mask if any complications are known or suspected.
3. Assess vital signs (BP, pulse, respirations, O₂ sats) minimally every 10 minutes; more often if unstable.
4. Assess length & time between contractions, measuring from beginning of one to beginning of the next.
5. Place patient in position of comfort and reassure.
6. During a contraction, assess for crowning, and prolapsed cord.
7. If delivery is imminent, open OB kit and prepare to deliver.
8. Suction infant’s mouth and nose as soon as head appears. Resuction immediately upon delivery. If amniotic fluid contained meconium, aggressive suctioning should be done prior to stimulating respirations.
9. Note delivery time. Keep infant at placental level until cord is cut.
10. Immediately stimulate respirations while drying and wrapping infant. Cover infant’s head ASAP.
11. Assess and record one minute APGAR.
12. Apply cord clamps once cord stops pulsating. Double clamp cord at 6” and 8” from infant and cut cord between the clamps.
13. Episiotomy is contraindicated in field. Control bleeding from perineal tears with direct pressure.
14. Assess and record five minute APGAR.
15. Assist in the delivery of placenta and retain in plastic bag.
16. Massage uterus to stimulate contractions and control postpartum bleeding. Allow nursing if desired.

BASIC LIFE SUPPORT:

1. Consider PASG for mother if systolic BP < 50. Consult medical control prior to inflation.
2. During a contraction, assess for perineal bulging.

BASIC-IV LIFE SUPPORT:

1. Establish IV of NS TKO in any woman with excessive prenatal or postpartum bleeding. Administer fluid bolus of 250 cc NS if systolic BP falls below 90.
2. Begin transport to medical facility.

INTERMEDIATE & PARAMEDIC/RN:

1. Monitor mother's ECG for abnormalities.
2. Consider IO access in the newborn as needed.
3. Consider ET intubation as needed in the newborn.
4. Paramedic/RN consider Terbutaline for patients with pre-term labor or limb presentation. Consult with medical control prior to administration.

NEONATAL RESUSCITATION:

1. Evaluate respirations
 - A. Spontaneous: Evaluate heart rate
 - B. None or gasping: Bag valve ventilation (BVV) with 100% supplemental oxygen
2. Evaluate heart rate (HR)
 - A. Above 100: Evaluate color
 - B. 80 - 100/min: Continue with BVV and 100% oxygen
 - C. < 80/min: CPR w/ 100% oxygen
3. Evaluate color
 - A. If blue: Administer oxygen
 - B. If pink or peripheral cyanosis: Observe & monitor

COMPLICATIONS:

1. *Limb Presentation:* Cover limb with towel; transport immediately. Do not attempt prehospital delivery.
PARAMEDIC/RN: Give Terbutaline 0.25 mg SQ. Contact medical control prior to administration.
2. *Breech Presentation:* Allow to deliver if in progress. If head doesn't deliver after 3 minutes, make a V with gloved fingers and insert into vagina on both sides of the infant's nose. Push the wall of the vagina away from infant's face, creating an air space if infant wants to breathe. Maintain this position as long as head remains undelivered. Transport rapidly to closest appropriate medical facility. Keep infant warm.
3. *Prolapsed Cord:* Immediately insert gloved fingers into vagina and attempt to push infant's head back up into pelvis and off the cord. Discourage mother from pushing by asking her to pant. Place on longboard in Trendelenburg, or in knee-chest position. Maintain this positioning during rapid transport to closest appropriate medical facility. Cover cord with moist dressing and keep warm; do not allow to dry out.
4. *Cord wrapped around the neck:* Attempt to loosen enough to slide over head. If unsuccessful, or wrapped more than once, encourage mother to stop pushing. Clamp cord in two places and cut. Infant should deliver. Apply second set of clamps once delivery is complete. Never cut cord without clamping it first.

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