Southern Illinois Regional EMS System

FF-1 EMERGENCY CHILDBIRTH

1. Phase 1 Labor:
    - 1.1. Obtain history and determine if there is adequate time to transport:
        - 1.1.1. Gravida (#of pregnancies) Para (# of live births).
        - 1.1.2. Number of
            - 1.1.2.1. Miscarriages.
            - 1.1.2.2. Stillbirths.
            - 1.1.2.3. Abortions.
            - 1.1.2.4. Multiple births.
        - 1.1.3. Due date (EDC) or LMP.
        - 1.1.4. Onset and current duration of contractions:
            - 1.1.4.1. Frequency of contractions:
                - 1.1.4.1.1. Time from beginning of one to the beginning of the next.
        - 1.1.5. Length of previous labors in hours.
        - 1.1.6. Status of membranes:
            - 1.1.6.1. Intact or ruptured.
            - 1.1.6.2. If ruptured:
                - 1.1.6.2.1. Inspect for prolapsed cord or evidence of meconium.
                - 1.1.6.2.2. Note time since rupture.
        - 1.1.7. High-risk concerns:
            - 1.1.7.1. Lack of prenatal care.
            - 1.1.7.2. Drug abuse.
            - 1.1.7.3. Teenage pregnancy.
            - 1.1.7.4. History of:
                - 1.1.7.4.1. Diabetes.
                - 1.1.7.4.2. Hypertension.
                - 1.1.7.4.3. Cardiovascular disease.
                - 1.1.7.4.4. Other pre-existing diseases that may compromise mother and/or fetus.
                - 1.1.7.4.5. Preterm labor (less than 37 weeks).
                - 1.1.7.4.6. Previous breech birth.
                - 1.1.7.4.7. Previous C-section.
                - 1.1.7.4.8. Multiple fetuses.
    - 1.2. Inspect for:
        - 1.2.1. Bulging perineum.
        - 1.2.2. Crowning.
        - 1.2.3. Whether patient is involuntarily pushing.
        - 1.2.4. Feel like she has to move her bowels with contraction.
        - 1.2.5. I contractions are 2 minutes apart or less, or any of the above are present, prepare for delivery.
    - 1.3. Initial Medical Care Special Considerations:
        - 1.3.1. IV with regular drip tubing.
        - 1.3.2. If mother is hyperventilating:
            - 1.3.2.1. Encourage eye contact.
            - 1.3.2.2. Coach to take slow, deep breaths.

1.3.3. If mother becomes hypotensive or lightheaded at any time:
1.3.3.1. Turn to left side.
1.3.3.2. 100% oxygen/NRM.
1.3.3.3. IV fluid challenge in 200ml increments if indicated.
1.4. If delivery is not imminent:
1.4.1. Allow mother to assume most comfortable position and transport.

2. Phase 2 Delivery:
2.1. Allow head to deliver passively.
2.2. Control rate of delivery by placing palm of one hand gently over occiput.
2.3. Protect perineum with pressure from other hand.
2.4. If amniotic sac still intact:
2.4.1. Gently twist or tear the membrane.
2.5. If meconium presenting in the fluid:
2.5.1. Gently suction the infant's nose and mouth as soon as the head delivers.
2.6. Once the head is delivered:
2.6.1. Allow it to passively turn to one side.
2.6.1.1. This is necessary for the shoulders to deliver.
2.7. Feel around the infant's neck for the umbilical cord (nuchal cord):
2.7.1. If present, attempt to gently lift it over the baby's head.
2.7.2. If unsuccessful, double clamp and cut the cord between the clamps.
2.8. To facilitate delivery of the upper shoulder:
2.8.1. Gently guide the head downward.
2.8.2. Support and lift the head and neck slightly to deliver the lower shoulder.
2.9. The rest of the infant should deliver quickly with the next contraction:
2.9.1. Firmly grasp the infant as it emerges.
2.9.2. Baby will be wet and slippery.
2.10 Keep newborn level with mom's vagina until the cord stops pulsating and is double clamped.
2.11 Proceed to Post-Partum Care (FF-4) SOP.