OBSTETRICAL EMERGENCIES

ALL PROVIDERS / EMT

- ❑ Focused history and physical exam
  - Do not perform pelvic exam
- ❑ Cardiac monitor, ETCO2, and pulse oximetry monitoring when available.
- ❑ Administer high flow oxygen to mother
- ❑ **Treatment Plan**
  - Imminent Deliveries: normal delivery procedures
    - o Attempt to prevent explosive delivery.
    - o As delivery occurs, do not suction nose and mouth. Wipe nose and mouth to clear excess secretions
    - o Instruct the mother to stop pushing.
    - o Keep newborn at level of vagina until cord is cut.
    - o Place one clamp 2 inches away from baby, place second clamp 2 inches farther, cut cord between the clamps.
    - o Keep newborn warm and dry with vigorous stimulation.
    - o Allow infant to nurse.
    - o In multiple births, do not allow babies to nurse until all have been delivered.
    - o APGAR score at 1 minute and again at 5 minutes
  - Special Situations – **TRANSPORT TO THE CLOSEST HOSPITAL**
    - o **Excessive hemorrhage** following delivery or delayed placenta delivery.
      - Unless multiple birth is anticipated, begin fundal massage.
    - o **Nuchal cord**: cord is wrapped around the infant's neck
      - Attempt to slip cord over the head.
      - If cord is too tight to remove, immediately clamp in two places and cut between clamps.
    - o **Prolapsed cord or limb presentation**: cord or limb out of the vagina before the baby – DO NOT ATTEMPT DELIVERY
      - Maintaining a pulsatile cord as the objective, insert two fingers of gloved hand into vagina to raise presenting portion of newborn off the cord.
      - If possible, place mother in Trendelenburg position. Otherwise, use knee-chest position.
      - Keep cord moistened with sterile saline.
      - Continue to keep pressure off cord throughout transport.
    - o **Breech presentation** (coming buttocks first)
      - Position mother with her buttocks at edge of bed, legs flexed.
      - Support baby's body as it delivers.
      - As the head passes the pubis, apply gentle upward pressure until the mouth appears over the perineum. Immediately suction mouth, then nose.
      - If head does not deliver, but newborn is attempting to breath, place gloved hand into the vagina, palm toward newborn's face, forming a "V" with the index and middle finger on either side of the nose. Push the vaginal wall from the face. Maintain position throughout transport.
    - o **Shoulder Dystocia**: head is out but shoulder will not pass
      - Position mother with buttocks off the edge of the bed and thighs flexed upward as much as possible.
      - Apply firm, open hand pressure above the symphysis pubis.
      - If delivery does not occur, maintain airway patency as best as possible, immediately transport.
    - o **Stillborn/Abortion**
      - All products of conception should be carefully collected and transported with the mother to the hospital. Anything other than transport should be coordinated with on-line medical consultation and/or law enforcement.

- ❑ **Key Considerations**
  - Attempt to attain a sanitary environment
  - Transport in left lateral decubitus position

ADULT

PEDIATRIC (<15 years of Age)
NOTE: Pediatric weight based dosing should not exceed Adult dosing.

ADULT AEMT

- ❑ Vascular access and fluid therapy per ***IV/IO Access and Fluid Therapy Guideline***
- ❑ Treat seizures as per ***Seizure Guideline***

PEDIATRIC AEMT

- ❑ Vascular access and fluid therapy per ***IV/IO Access and Fluid Therapy Guideline***
- ❑ Treat seizures as per ***Seizure Guideline***

ADULT PARAMEDIC

- ❑ **.**In the event of uterine inversion, make one attempt to put the uterus back into place. Using the palm of the hand, push the fundus of the inverted uterus toward the vagina. If unsuccessful, cover uterus with moistened sterile gauze.

PEDIATRIC PARAMEDIC

- ❑ Refer to the ***Newborn Resuscitation Guideline***

OPTIONAL ORDERS BY OLMC ONLY

- ❑ **High-risk preterm labor when delivery is imminent:** (1) Rapidly infuse 1 liter of NS, (2) Magnesium Sulfate 1gram IV and titrate per OLMC.