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A. General Care

BLS

1. Initial Assessment/Care [Protocol 1](#).
2. Obtain and document the following history;
 - a) Number of previous pregnancies, including abortions and miscarriages (termed Gravida).
 - b) Number of previous live births > 20 weeks gestation (termed **Para**).
 - c) Expected date of delivery (termed **EDC** “estimated date of confinement”).
 - d) When did contractions begin?
 - e) What is the frequency of contractions?
 - f) Evidence of bloody show, spotting, etc.
 - g) Did the water break? If so, what was the nature of the discharge (color, unusual odor)?
 - h) Any history of premature or multiple births?

B. Ante-Partum Hemorrhage

Three major causes of massive vaginal bleeding in the third trimester are abruptio placenta, placenta previa and uterine rupture.

BLS

1. Place the patient lying on her left side.

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ALS

2. Establish IV access.
3. Treat hypovolemic shock [Protocol 35](#).

C. Pregnancy Induced Hypertension (PIH)

Pregnancy induced hypertension (PIH) should be suspected in any female in her second half of pregnancy presenting with a blood pressure **equal to or greater than 140/90 mmHg** and who otherwise has a normal blood pressure.

Additionally, any pregnant female whose blood pressure exceeds **30 mmHg systolic and/or 15 mmHg diastolic** above her normal B/P should also be treated for PIH and transported ALS via Fire-Rescue to the closest appropriate facility.

BLS

1. Place the patient on her left side.

ALS

2. Establish IV access.

D. Pre-Eclampsia

Generalized edema is the usual presenting sign and can be often noted in the patients face, hands, sacral area, lower extremities, and the abdominal wall. In addition to the edema, the patient may complain of associated frontal headaches, blurred vision or any visual disturbances, nausea, vomiting, irritability, difficulty breathing, and hypertension.

BLS

1. Place the patient on her left side.
2. Deliver oxygen.

ALS

3. Establish IV access (KVO). Monitor the infusion closely, as these patients are already in a state of fluid overload.
4. If **BP $\geq$ 200 Systolic OR $\geq$ 110 Diastolic** is present, administer **Magnesium Sulfate 2 grams** IV Infusion over 8-9 minutes [Appendix 9-4](#).
5. During transport, lights should be dim and discretion should be used as to the operation of audible devices (sirens, air horns). Bright lights and loud noises have been known to cause seizures in the pre-eclamptic patient.

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E. Eclampsia

ALS

When a patient presents with active seizure:

1. Administer **Midazolam (Versed) 5 mg** IV/IM [Medication 24](#).
 - a) If no IV available, Intranasal via MAD 5 mg (max 1 mL per nostril).
2. Administer **Magnesium Sulfate 4 grams** IV infusion over 8-9 minutes [Appendix 9-4](#). May be repeated if BP remains above 160 systolic, 5 minutes after complete administration of first dose.

F. Normal Childbirth

BLS

1. Start a new ePCR report for the newborn. It will be patient # 2 on the same alarm number. Additionally, if there are multiple births continue with distinct numbers for each patient.
2. Place the mother in a comfortable, supine position.
3. Prepare to receive the newborn.
4. Gently and carefully assist expulsion of the newborn from the birth canal in its natural descent. Do not pull or push newborn.
5. Upon complete presentation of the newborn's head:
 - a) Inspect and palpate the newborn's neck for the umbilical cord. If present, carefully unwrap the cord from the neck. If unable to remove the cord, apply the umbilical clamps and cut the cord.
 1. If the cord cannot be easily unwrapped, place two clamps and cut in between to release the cord.
 - b) Clear the airway by gentle suction of mouth, then nose with bulb syringe.
6. Upon complete delivery of the newborn:
 - a) Apply two umbilical cord clamps (two inches apart and at least 8 inches from the navel) then cut the cord between the clamps.
 - b) Dry and wrap the newborn in a blanket to preserve body heat. Be sure to cover the head of the infant as this is a major area of heat loss
 - c) Evaluate and manage as outlined in [Section J](#).

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6. If active hemorrhage is noted from the vagina, apply firm, continuous massage manually to the uterine fundus. DO NOT pull on the umbilical cord.
7. If the placenta delivers, preserve it in a plastic bag and transport it with the mother.

ALS

8. Establish IV access in all cases of imminent delivery or as soon as practical during emergency childbirth.

G. Breech Delivery

BLS

1. Allow the delivery to proceed normally, supporting the newborn with the palm of your hand and arm.
2. If the head is not delivered within three minutes, you must take action to prevent suffocation of the newborn. Place a gloved hand in the vagina, with your palm toward the newborn's face, and create air-space for the newborn until delivery of the head.

H. Umbilical Cord Prolapse

BLS

1. Place the mother in a knee-chest position.
2. Do not attempt to push the cord back. Wrap cord in warm saline dressing and transfer patient over to the stretcher limiting movement or having mother stand up.
3. Palpate the cord for a pulse. If no pulse is felt, push the newborn's head or presenting part back only far enough to regain a pulse in the umbilical cord.
4. Continuously monitor the pulses in the cord.

ALS

5. Establish IV access.
6. Transport immediately while maintaining pressure.

I. Limb Presentation

BLS

1. The presentation of an arm or leg through the vagina is an indication for immediate transport to the hospital. **Delivery should not be attempted.**

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J. Uterine Inversion

A condition when the uterus protrudes through the vagina with the placenta still attached and is associated with severe vaginal bleeding and shock.

BLS

1. Keep patient flat.
2. If the placenta is still attached, do not attempt to remove it.
3. Cover all protruding tissues lightly with moist, sterile towels.

ALS

4. Establish IV access.
5. Treat hypovolemic shock [Protocol 35](#).

K. Newborn Examination

BLS

1. The newborn is a separate patient, will be patient # 2 on the same alarm.
2. Ensure a clear airway by gentle suctioning of the mouth, then nose using a bulb syringe.
3. Determine an APGAR Score [Appendix 8](#) at one and five minute intervals. DO NOT delay resuscitation to obtain an APGAR Score.
4. If the APGAR is < 7 refer to the Newborn Resuscitation [Protocol 20P](#).

L. Suspected Meconium Aspiration

Characterized by a green or green/black watery particulate discharge upon rupture of the bag of waters. The newborn may also be covered with a thick, dark substance.

BLS

1. When the newborn's head has delivered, instruct the patient to stop pushing until aggressive upper airway suctioning of the mouth and then nose with a bulb syringe can be accomplished.

Do not stimulate breathing prior to suctioning

ALS

2. If meconium is thick or if the patient is apneic, intubate the trachea and suction the lower airways with either a Meconium aspirator device or through the endotracheal tube.

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