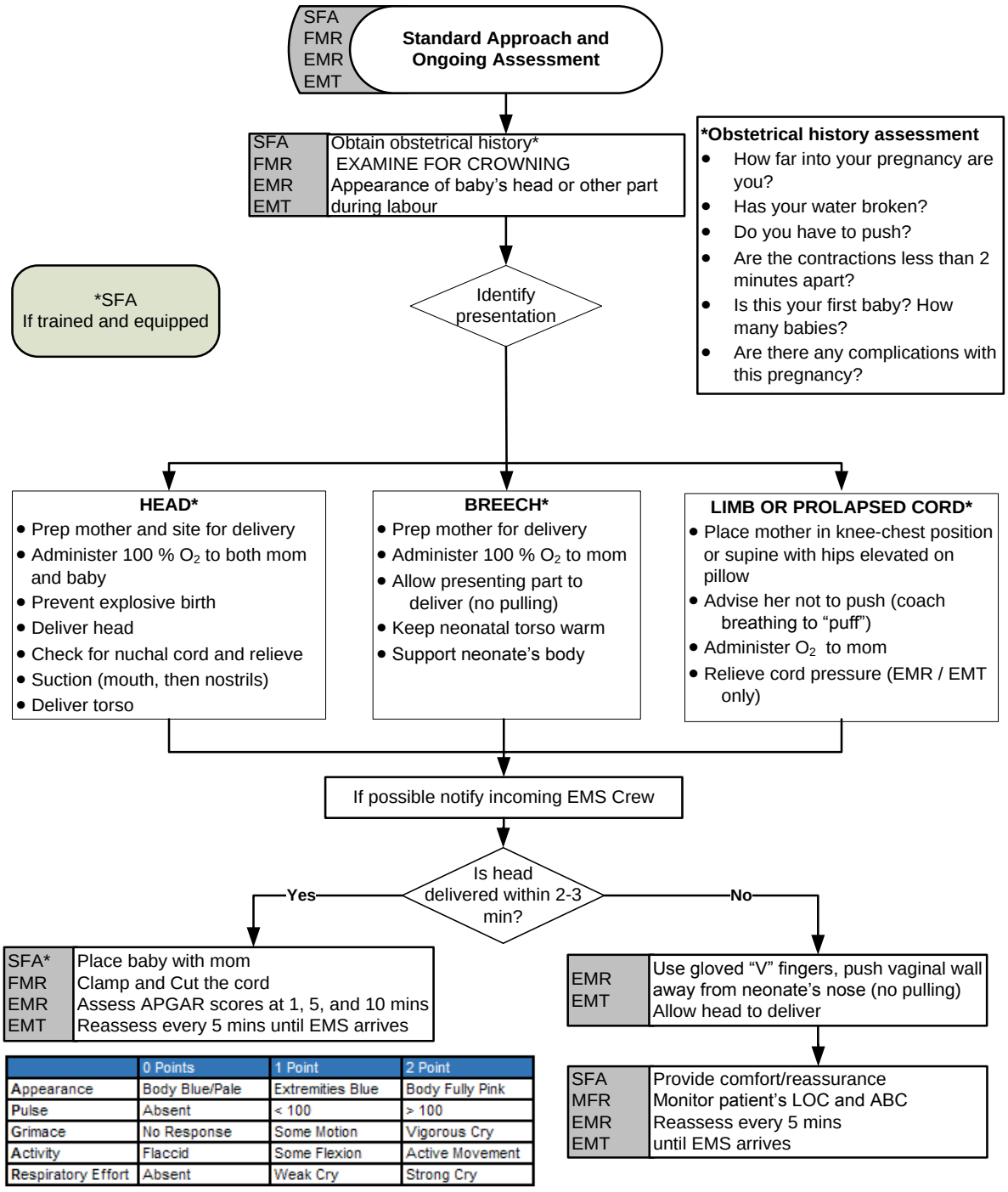
Algorithm 19 Obstetrics and Gynecology – Childbirth



	0 Points	1 Point	2 Point
Appearance	Body Blue/Pale	Extremities Blue	Body Fully Pink
Pulse	Absent	< 100	> 100
Grimace	No Response	Some Motion	Vigorous Cry
Activity	Flaccid	Some Flexion	Active Movement
Respiratory Effort	Absent	Weak Cry	Strong Cry

Obstetrics and Gynecological

Vaginal bleeding or pelvic pain is found and managed by performing a primary survey, assessing and initiating early oxygen (if trained and equipped), and treating for shock, even in the absence of obvious signs and symptoms.

All women of child-bearing age who are presenting with abnormal vaginal bleeding and/or abdominal pain should be considered to have an ectopic pregnancy until proven otherwise. Prompt on-scene assessment and treatment for shock are essential. The preferred positioning for a pregnant patient is left lateral recumbent. Spontaneous abortion (miscarriage) is the loss of pregnancy before 20 weeks gestation. A potential abortion is indicated by vaginal bleeding and cramping. The products of conception should always be saved and transported to hospital with the patient. (Gestational age and fetal viability are difficult to estimate in the field. When in doubt, assume the fetus is potentially viable.)

Vaginal bleeding in the third trimester should always be regarded as a critical emergency. Bleeding may abruptly become very massive. In order to determine external blood loss, the patient should be asked how many pads she has soaked over the last 30 - 60 min. More than three pads in 30 min or more than five pads in 60 min are indicative of a serious hemorrhage. The total number should be recorded on the PCR and the EMS crew should be informed upon their arrival.

In any type of vaginal bleeding do not under any circumstances place dressings inside the vagina. Instead, apply bulky dressing externally.

To avoid embarrassment to the patient, it is important to make every attempt to preserve the patient's privacy and dignity. The number of personnel in immediate attendance should be limited to only those needed for the patient's care. It is extremely important to maintain a professional demeanour, and to be empathetic and discreet. Provide emotional support for the patient.

Obstetrics and Gynecology – Childbirth (Algorithm 26)

The MFR will provide assistance where delivery is imminent but must use caution not to over extend their scope of practice. If you haven't been trained and licensed to perform the following then avoid these skills:

Identify Imminent Birth

- Ask target questions:
- Is this your first baby?
- How far along in your pregnancy are you?
- Are you having twins?
- How many minutes apart are your contractions?

- Do you have an urge to push or to move your bowels?
- Has your water broken?
- Are there any complications with this pregnancy?

Perform a Visual Examination (with discretion and permission)

1. Vulvar bulging, or the appearance of the top of the neonate's head during or between contractions indicates that birth is near (crowning). If any body part besides the head is visible, do not handle it. Prevent heat loss and notify incoming EMS crew.

2. Head Presentation (Cephalic)
    a) Prepare the Mother and the Site for Delivery
    b) Provide privacy and prepare all equipment including the obstetric kit and a pediatric BVM.
    c) Remove the patient's clothing from the waist down and place her in the delivery position on her back with her knees flexed.
    d) Place a disposable yellow blanket underneath her buttocks and another blanket over her abdomen and legs.
    e) Encourage the partner to remain with you and the mother during the delivery.

3. Deliver the Head
    a) Encourage her to push with her contractions.
    b) Maintain gentle pressure on the fetal head with your palm to prevent explosive birth.
    c) Once the head is delivered, instruct the patient to stop pushing (puff, puff), check for and relieve nuchal cord (cord wrapped around neck), and suction the neonate (mouth first then nostrils – "M before N").

4. Nuchal Cord (umbilical cord around the baby's neck)
    a) Attempt to slip the cord over the head.
    b) If the cord is too tight to remove, clamp the cord in two places as far apart as possible and immediately cut the cord between the clamps. Use caution!
5. Encourage the mother to push to expel the torso.
    a) Deliver the Torso
    b) After checking the neck, instruct the patient to resume pushing with her contractions.
    c) Guide the neonate's anterior shoulder and then its posterior shoulder. The body will quickly follow.

6. Suction and Dry
    a) Suction the mouth and then the nostrils ('M' before 'N').
    b) Briskly dry and cover the neonate.

c) Maintenance of body warmth is a priority (silver swaddler).
d) Place the baby on the mother's bare chest. Keep the baby level with the mom.

7. Cut the Cord

The cord is made of tough fibrous material. To cut it:

a) Ensure that the cord has stopped pulsing.
b) Place a clamp on the cord 6 inches from the baby.
c) Place a second clamp 9 inches from the baby.
d) With the scalpel, cut the cord in-between the clamps.
e) Use extreme caution and be prepared for blood.

Caution: If the stump is actively bleeding, hold direct pressure on it. Without appropriate action, the baby could quickly bleed to death.

Placenta

The placenta will naturally deliver shortly after the baby. When it does, place it in the plastic bag provided in the OB kit, and give it to EMS. The placenta must be evaluated in the hospital.

APGAR Score

Assess the APGAR score at 1, 5, and 10 minutes; and record the scores on a Patient Care Report.			
	0 Points	1 Point	2 Point
Appearance	Body Blue/Pale	Extremities Blue	Body Fully Pink
Pulse	Absent	< 100	> 100
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