

CENTRAL CALIFORNIA EMERGENCY MEDICAL SERVICES

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| Manual: | Emergency Medical Services Administrative Policies and Procedures | Policy Number: 510.33 Page: 1 of 3 |
| Subject: | Basic Life Support (BLS) Protocols CHILDBIRTH | |
| References: | California Administrative Code, Title 22, Division 9, Chapter 2 | Effective: 11/15/83 |

I. TREATMENT

- A. Delivery in progress upon BLS arrival (establish contact with base hospital physician as soon as possible).
1. Oxygen – Low flow 6 liters if no complications or prolonged labor. High flow 15 liters for abnormal or difficult deliveries.
 2. Control the descent of the fully crowned head with your hand cupped over the cranium.
 3. As the head delivers, suction mouth and nose with bulb syringe before the first breath is taken. Check for the cord looped around the neck.
 4. If the cord is around the neck, gently slip it over the head or across the shoulder, if possible. Clamp and cut between the clamps only as a last resort if the cord is tight and obstructing the descent of the baby. (Once the cord is clamped, baby is without oxygen supply until it breathes on its own).
 5. When the head is delivered, it will rotate naturally to face laterally. Gently lower the head to deliver the anterior (upper) shoulder.
 6. When upper shoulder is delivered, gently raise the head to deliver the posterior (lower) shoulder. The body should then deliver smoothly.
 7. Immediately suction the mouth and nose with a bulb syringe. Hold the baby in a slightly head down position.
 8. Dry and wrap warmly.
 9. Clamp and cut the cord with sterile scissors or scalpel. Leave a minimum of 6 inches of cord from the umbilicus. There is no hurry to clamp the cord, but do not delay drying and wrapping baby. Document if the cord is cut by sterile or non-sterile equipment.

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| Approved By: EMS Division Manager | Signatures on File at EMS Agency | Revision: 04/19/2005 |
| EMS Medical Director | Signatures on File at EMS Agency | |

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10. Assess the baby (APGAR) at 1 and 5 minutes. See chart in Section II.D.
 11. Assess the infant's heart rate.
 - a. Heart rate greater than 100 beats per minute, assess, reassess and begin transport.
 - b. Heart rate less than 100 beats per minute, provide ventilation's at a rate of 40-60 per minute.
 - c. Heart rate between 60 and 80 beats per minute and rising, continue assisted ventilation, but chest compressions are not necessary.
 - d. Heart rate less than 60 beats per minute, or between 60 and 80 beats per minute and not rising, continue assisted ventilation's and begin chest compressions.

Reassess heart rate after 30 seconds.
 12. Always consider the possibility of twins.
- B. Delivery prior to arrival or performed by BLS
1. If resuscitation not necessary:
 - a. Suction mouth and nose.
 - b. Clamp and cut the cord with sterile scissors or scalpel. Leave a minimum of 6 inches of cord from the umbilicus. There is no hurry to clamp the cord, but do not delay drying and wrapping the baby. Document if the cord is cut by sterile or non-sterile equipment.
 - c. Dry and wrap warmly.
 2. Mother
 - a. Oxygen – Low flow 6 liters if no complications or prolonged labor. High flow 15 liters for abnormal or difficult deliveries.
 - b. If BP less than 100, heavy bleeding or signs of shock, refer to Shock Protocols. Massage abdomen over the uterus to aid in contraction. Putting the infant to the mother's breast (if infant's condition allows) will also stimulate contraction.
 - c. If placenta has delivered, place in plastic bag and transport with mother and newborn. If placenta has not delivered, do not apply traction to cord in attempts to deliver it.
 - d. Monitor blood pressure and pulse enroute to hospital.
- C. If a prolapsed cord is visible at perineum, immediately place mother in Trendelenberg position, place on high flow oxygen, and proceed Code 3 to the hospital. Exception: When head is crowning with prolapsed cord, immediate delivery is the most rapid means of restoring oxygen to infant.
- D. If an abnormal presentation is noted (i.e. other than head), the patient should be transported Code 3 to the hospital. Exceptions: Very long transport time and frank breech or double footling presentation, the base hospital physician may elect a directed delivery at scene if all other options have been considered. Any hand or shoulder presentation is criteria for immediate Code 3 transport regardless of distance from hospital.

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II. SPECIAL CONSIDERATIONS

- A. Assessment – Examine infant first (vital signs, lung sounds, color, muscle tone, response to suctioning or flicking foot).

Assess APGAR on all newborns (refer to APGAR Chart in Section II.D. Evaluate at 1 minute and 5 minutes. If signs of obvious distress, begin resuscitation immediately.

Maternal vital signs. Estimate blood loss. Placenta delivered?

- B. Delivery in the hospital environment where adequate facilities and personnel are available for neonatal resuscitation is always preferable to field delivery. However, if labor is far advanced and it is obvious that delivery will occur prior to arrival at the hospital, the more prudent course may be to assist delivery at the scene. Variables to be considered are: distance to hospital, road conditions, stage of labor, parity of mother, experience of prehospital personnel, and quantity and skill of available assisting personnel. BLS personnel are encouraged to start transport unless delivery is imminent.
- C. If inspection of perineum reveals abnormal presentation (i.e. foetus, buttocks, hand or face) STAT transport is indicated. The rare exception may be when transport time is long and delivery is far advanced (i.e. body delivered to beyond umbilicus). In this situation, the only hope for infant survival may be a directed delivery at the scene. Contact base hospital physician immediately.
- D. APGAR Chart – Perform APGAR score 1 and 5 minutes after delivery.

| <u>APGAR SCORE</u> | | | |
|--------------------|--------------|---------------------------|--------------------|
| | 0 | 1 | 2 |
| Appearance | Blue or Pale | Body Pink, Limbs Blue | Complete Pink |
| Pulse | 0 | Less than 100 | 100 or greater |
| Grimace | No Response | Grimace | Cough, Sneeze, Cry |
| Activity | Flaccid | Some Flexion | Active Movement |
| Respiratory Effort | Absent | Slow, Irregular, Weak Cry | Strong Cry |

- E. The vast majority of deliveries are completely uncomplicated and require minimal, if any, assistance. The major life threats are perinatal or neonatal asphyxia and maternal hemorrhage. Neonatal hypothermia is a real, but easily preventable, threat. Dry and wrap infant as soon as possible.
- F. The outline listed under treatment is not a substitute for direct physician contact by radio or phone. Adequate communications shall be maintained.