Treatment Protocol: CHILDBIRTH (MOTHER) **Ref. No. 1215**

Base Hospital Contact Required. ❶

1. Assess the mother's airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

2. Administer **Oxygen** prn *(MCG 1302)*

3. Establish vascular access prn *(MCG 1375)*
   Vascular access should not take precedence over controlled delivery or emergency transport

4. Place mother in Semi-Fowler's or Lateral Sims position

5. If mother has the urge to push or crowning is evident, prepare for delivery
   Prepare OB kit

6. If crown is showing with amniotic sac intact, pinch sac and twist the membrane to rupture

7. If maternal hypertension, breech presentation, shoulder dystocia, or prolapsed or nuchal cord treat in conjunction with *TP 1217, Pregnancy Complication*

8. Once delivered, dry newborn with a towel, clamp and cut the cord ❷
   Treat newborn per *TP 1216-P, Newborn/Neonate Resuscitation*

9. For management of the placenta:
   The placenta may deliver spontaneously; do not pull on cord but allow placenta to separate naturally
   Place placenta in plastic bag from the OB kit and bring to the hospital with the mother

10. Massage the mother's lower abdomen (fundus) after the placenta delivers
    For post-partum hemorrhage, treat in conjunction with *TP 1217, Pregnancy Complication* ❸

11. For signs of poor perfusion in mother:
    Normal Saline 1L IV rapid infusion
    Reassess after each 250 mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops
    CONTACT BASE for persistent poor perfusion to obtain order for additional **Normal Saline 1L IV**

12. If delivery occurs in the field, determine destination based on stated or estimated gestational age and **CONTACT BASE**: ❶
    Transport both patients to a Perinatal Center with an EDAP if newborn > 34 weeks gestation
    Transport both patients to a Perinatal Center with an EDAP and a NICU if ≤34 weeks gestation

SPECIAL CONSIDERATIONS

❶ Any delivery after the first trimester (12 weeks) should be considered childbirth for the purposes of this treatment protocol and paramedics should contact Base to discuss the management and transport. In general, delivery prior to 20 weeks gestation is nonviable and does not require resuscitation. However, dates can be incorrectly estimated, therefore, Base Contact is strongly encouraged. Any *potentially viable birth* should be resuscitated in the field and transported to a perinatal center that is also an EDAP (with a NICU if ≤34 weeks gestation). Births prior to 20 weeks do not necessarily require specialty center care and can be transported to the MAR.

❷ Delay in clamping and cutting the cord for up 30 to 60 seconds is recommended unless newborn needs immediate resuscitation

❸ Some bleeding is normal during delivery, typically up to 500mL. Bleeding is reduced with fundal massage after placental delivery, which promotes contraction of the uterus. Post-partum hemorrhage is defined as blood loss with signs of poor perfusion and/or cumulative blood loss ≥1000mL.