BLS Standing Orders

- **Universal Patient Protocol**
- Monitor O2 saturation, ECG, capnography (if ALS present), and blood pressure continuously PRN
- Give oxygen and/or ventilate PRN per **Airway Policy**
- If delivery not imminent, transport immediately on left lateral recumbent (if > 20 weeks gestation)
- If birth is imminent, request another unit, for potential second patient
- Assess APGAR at 1 min, and at 5 min if neonate delivered
- Document name of person cutting cord, time cut, and location/address of delivery

STABLE

Routine Delivery

- If no time for transport (patient is crowning or pushing), proceed with delivery

Following delivery:

- Suction baby's mouth then nose
- Stimulate baby by tapping soles of feet and/or rubbing back
- Clamp and cut cord once it stops pulsating (minimum one minute post delivery)
- Dry baby, wrap warmly and place to mother's breast
- Positive pressure ventilation, PRN if HR <100 BPM
- Do not wait on scene to deliver placenta
- Once placenta is delivered, massage the fundus
- Save placenta and deliver with patient to the hospital
- Place identification bands on mother and infant.

COMPLICATIONS

Bleeding During Pregnancy (Prior to Delivery)

- Immediate transport
- Refer to **Hemorrhage Control Protocol**
- Refer to **Shock Protocol**
- Bring tissue/fetus to hospital

Pre-Eclampsia/Eclampsia (BP > 140/90 +/- Seizures)

- Immediate transport
- Avoid sirens/excessive stimulation
- Treat seizures per **Seizure Protocol**

Birth Complications

Umbilical Cord Wrapped Around Neck

- If unable to deliver infant with cord in place, attempt to slip over head
- If unsuccessful, insert a gloved hand into the vagina and gently push the presenting part of the baby (head or shoulder) off of the umbilical cord. Do not tug on the umbilical cord
- Place fingers on each side of the baby's nose and mouth, split fingers into a "V" to create an opening
- Transport immediately while retaining this position until relieved by hospital
- Cover the exposed umbilical cord with saline soaked gauze

- Place mother on high flow oxygen

Prolapsed Cord

- Place mother in head down position with hips elevated on pillows
- Insert gloved hand into the vagina and gently push presenting part off the cord. Do not handle or push cord back into vagina
- Transport immediately while retaining this position until relieved by hospital
- Place mother on high flow oxygen

Breach Birth

- Immediate transport with mother in head down, hips elevate position
- Allow infant to deliver to waist
- Once legs and buttocks are delivered, the head can be assisted out
- If head does not deliver within 3 minutes, insert gloved hand and create an airway for the infant.
- Do not try to pull infant's head out
- Place mother on high flow oxygen

Hand/Arm Presentation

- Delivery should not be attempted in the field
- Immediate transport with mother in head down, hips elevated position
- Place mother on high flow oxygen

Post Partum Hemorrhage

- Massage fundus
- Refer to **Hemorrhage Control Protocol**
- Refer to **Shock Protocol**
- Place pad to vagina if external source of bleeding (do not pack vagina)
- Immediate transport

Premature and/or Low Birth Weight Infants

- Resuscitate as needed
- Wrap baby in blanket and place on mother's abdomen
- Suction infant's mouth and nose PRN
- Monitor infant's O2 saturation
- Immediate transport

<u>Neonatal Resuscitation</u>

- After initial care of newborn, to include tactile stimulation, if newborn has:
  - Apnea or gasping respirations OR
  - Heart rate < 100 bpm
    1. Begin BVM ventilation with room air 40-60 breaths/min
    2. Reassess breathing effort after 90 seconds
- If despite adequate ventilation
    1. Heart rate < 60 bpm after 90 seconds
    2. Ventilate via BVM @ 100% O2
    3. Begin chest compressions at a rate of 100 per min with interposed ventilations at 30/min (3:1 ratio) until spontaneous HR 60/min or greater
        - If HR > 60, resume BVM ventilation with room air 40-60 breaths/min

- If HR persists < 60, continue chest compressions with interposed ventilations as above.
- Assess APGAR score
- Immediate transport

LALS Standing Order Protocol

- Monitor O2 saturation, ECG, capnography (if ALS present), and blood pressure continuously PRN
- Establish IV PRN (mother)

Post Partum Hemorrhage

- IV Fluid bolus, 500-1,000 mL NS x one (1) to SBP > 90
- Refer to **Hemorrhage Control Protocol**
- Refer to **Shock Protocol**

ALS Standing Order Protocol

- Monitor O2 saturation, ECG, capnography, and blood pressure continuously PRN
- Establish IO PRN (mother)

Post Partum Hemorrhage

- IV/IO fluid bolus, 500-1,000 mL NS x one (1) to SBP > 90
- Refer to **Hemorrhage Control Protocol and consider TXA administration**
- Refer to **Shock Protocol**

Eclampsia (seizures)

- Per **Seizure Protocol**

Adult Base Hospital Orders

Eclampsia (seizures)

- **BH –** Repeat midazolam dosing per **Seizure Protocol**

APGAR Scoring System

	0 Points	1 Point	2 Points	Points Totaled
***A**ppearance*	Blue, pale grey	Body pink, extremities blue	Completely pink	
***P**ulse*	Absent	Below 100/min	Over 100/min	
***G**rimace*	Flaccid	Some flexion of extremities	Active motion (sneeze, cough, pull away)	
***A**ctivity*	Absent	Arms and legs flexed	Active movement	
***R**espiration*	Absent	Slow, irregular	Vigorous cry	

Severely Depressed	**0-3**
Moderately Depressed	**4-6**
Excellent Condition	**7-10**

APPROVED:

Signature on File
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