Kittitas County Prehospital EMS Protocols

SUBJECT: OBSTETRICAL EMERGENCIES

A. Obtain history and perform physical assessment.

B. If stable, administer O_2 @ 4-6 lpm per nasal cannula.

C. If unstable, administer O_2 @ 12-15 lpm per non-rebreather mask.

D. If multiparous patient, and contractions < 2 minutes apart, and transport time > 15 minutes, prepare to deliver.

1. When infant's head begins to emerge, support gently to prevent explosive delivery.

2. Clear infant's airway as soon as face delivers.

3. Determine APGAR score and record time of delivery.

4. Clamp cord approximately 8 inches from infant in two places (approximately 2 inches apart) and cut.

E. Consider delivering placenta while en route to hospital. Once placenta has been delivered, control bleeding by massaging the fundus. Save the placenta.

F. Keep infant warm and provide supportive measures as necessary.

G. Establish large-bore peripheral IV with 1,000 mL bag of **Isotonic Crystalloid** @ TKO.

H. After delivery, administer **Oxytocin**, 40 units in 1,000 mL **Isotonic Crystalloid**, and titrate to control post-partum bleeding as needed. 10 units IM if no IV access.

I. If post-partum bleeding is severe, increase **Oxytocin** rate. Expedite transport.

J. If post-partum hemorrhage profuse and patient exhibiting signs of shock massage uterus firmly, treat hypovolemia with positioning, oxygen and IV Fluids. **Contact Medical Control if considering TXA administration.**

J. For mothers who suffer cardiopulmonary arrest, for whatever reason, and who are in their third trimester of pregnancy, full resuscitative measures should be continued, even if it is obvious that the mother will not survive. An emergency C-section at the hospital may potentially save the infant.

K. In the presence of eclamptic seizures, administer **Magnesium Sulfate** 2-4g IV, IO, or IM and repeat to max dose of 10 g total (optional to carry).