BLS Standing Orders

- **Universal Patient Protocol**
- Monitor O2 saturation, ECG, capnography, 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)
  - 20 weeks gestation can be estimated if the patient's fundus is to the level of the umbilicus or higher
- 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)
  - During this period, keep the infant at the same level, or have the placenta slightly elevated relative to the infant to ensure blood is not preferentially being pulled by gravity to the placenta
- 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, aggressively massage the fundus until fundus is firm and there is no significant vaginal bleeding
- Save placenta and deliver with patient to the hospital

COMPLICATIONS

Bleeding During Pregnancy (Prior to Delivery)

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

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

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

Birth Complications

Umbilical Cord Wrapped Around Infant's 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 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

Postpartum 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

Neonatal Resuscitation

- 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, capnography and blood pressure continuously PRN
- Establish IV PRN (mother)

Postpartum Hemorrhage

- NS 500-1,000 mL IV MR x 1 to a max of 2,000 mL to maintain a SBP of ≥ 90 mmHg
- Refer to **Hemorrhage Control Protocol**
- Refer to **Shock Protocol**

ALS Standing Order Protocol

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

Postpartum Hemorrhage

- NS 500-1,000 mL IV MR x 1 to a max of 2,000 mL to maintain a SBP of ≥ 90 mmHg
- 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**

Notes

- Make every effort to transport pregnant patients to a hospital with obstetric physicians available. If hospital destination is unclear, early base hospital contact is recommended.

APGAR Scoring System

To be performed at 1 minute and 5 minutes post birth.
Can repeat at 10 minutes if exam warrants and time permits.

	0 Points	1 Point	2 Points	Points Totaled
Appearance	Blue, pale grey	Body pink, extremities blue	Completely pink	
Pulse	Absent	Below 100 bpm	Over 100 bpm	
Grimace	Flaccid	Some flexion of extremities	Active motion (sneeze, cough, pull away)	
Activity	Absent	Arms and legs flexed	Active movement	
Respiration	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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