Information Needed:

1. History of pregnancy: due date, vaginal bleeding, broken water, meconium staining, previous pregnancies (gravida), complications of current and past pregnancies, prenatal care, number of abortions (spontaneous which is also called miscarriage and therapeutic), live births (para) and general health.
2. Pain: location, frequency, severity, duration, and urge to push.
3. Medical history: medications, past medical problems, and patient's age.
4. Physical findings: Swelling of face and extremities, duration and frequency of contractions, vaginal discharge, crowning, abnormal presentation.

Treatment:

1. Labor (delivery not imminent***)***
    a. Position left lateral recumbent.
    b. Administer O_2 moderate to high flow as needed.
    c. Determine vital signs (pulse, blood pressure, respirations, SPO2)
    d. Establish venous access and draw blood.
    e. If heavy bleeding prior to delivery give fluid boluses.
2. Imminent delivery. Follow the above and in addition prepare for delivery.
    a. Use sterile technique, drape patient.
    b. Guide and control infant. Do not pull.
    c. Suction neonate's mouth and nose with bulb syringe only if the infant has an obvious obstruction to spontaneous breathing. Deep tracheal suctioning is only done when meconium-stained amniotic fluid is seen or was reported in broken waters and the neonate is not vigorous. (See meconium). If there is or has been meconium staining but the neonate is vigorous, do not do tracheal suctioning.

d. Dry infant, wrap in clean dry blanket, keep warm.

e. Use tactile stimulation if needed to initiate respirations.

f. Observe neonate and determine APGAR score at 1 minutes and 5 minutes.

g. Clamp cord in two places 8-10 inches from infant. Cut cord between clamps.

h. Give infant to mother to nurse.If placenta delivers, place in bag and bring with patient. Do not attempt to deliver the placenta; however, if patient is having heavy vaginal bleeding, consult medical control for possible instructions on removing the placenta.

i. Massage uterus and encourage mother to attempt breast feeding her newborn to stimulate the uterus to contract and reduce post-partum bleeding.

j. Consult medical control for postpartum bleeding that is not controlled by the above techniques. You may be given instructions for placenta removal

3. Meconium

a. Attempts should be made to keep the neonate from aspirating meconium. Suction mouth repeatedly to remove. A vigorous neonate will not need deep suction and will assist in protecting his/her own airway.

b. A listless neonate with meconium staining needs to have airway visualize and deep suctioning done with a Delee. The neonate can also be orally intubated with an endotracheal tube and then that tube can be used as a suction catheter. You may need to intubate multiple times until airway is clear, using a clean tube each time. If you are to ventilate via the endotracheal tube is should be clear of meconium.

4. Infant Resusitation

a. If neonate does not breathe after stimulation or heart rate < 100, ventilate with BVM.

b. If no pulse or pulse < 80 despite assisting ventilations, do chest compressions. The best way is too grasp the neonate in both hands, fingers around back and thumbs on chest, and then compress chest with both thumbs.

c. If no response to treatment, intubate and establish venous access via the cut umbilical cord. Use either artery or vein, whichever is easier to cannulate. Cannulate using an angiocath without the needle. Do not insert the catherter any farther than the abdominal wall. Secure by wrapping umbilical tape around the outside of the cord, blocking off the vessels not being used. Treat any dysrhythmia.

5. Cord around neck

   a. Cord can usually be slipped over head as it presents. If wrapped too tightly, clamp, cut and unwrap.

6. Prolapsed Cord

   a. Dire emergency for the infant.

   b. Place mother in knee-chest position. If infant is crowning push head up and off of cord. Do not attempt to replace cord.

   c. Notify hospital early to prepare for “Code Red” c-section.

7. Abnormal Presentation

   a. Place mother in knee-chest position and transport.

   b. Breech (buttocks) presentation may deliver. If arms and legs follow, head may lodge in birth canal. If this occurs, may be able to ease head out gently or push vaginal wall away from face to create airway.

   c. Arm or single foot presentation will require a c-section.

Notes

1. Ask patient if she is delivering, most will know. Usually the more times a patient has delivered, the faster the delivery will progress. However, it is better to avoid delivery in the ambulance if mother can hold off pushing.

2. If no vaginal bleeding, you can check vagina for degree of dilation and presenting body part.

3. Infants have poor temperature regulation, dry them well, bundle and protect from heat loss.

4. Infants are slippery.

5. APGAR Scale:

a. * Infants with scores of 7-10 usually require supportive care only
** A score 4 – 6 indicates moderate depression
*** Infants with score of 3 or less require aggressive resuscitation.

	0 Points	**1 Point**	**2 Points**
Heart Rate	*Absent*	*<100*	*>100*
Respiratory Effort	*Absent*	*Slow, irregular*	*Strong cry*
Muscle Tone	*Flaccid*	*Some flexion*	*Active motion*
Irritability	*No response*	*Some*	*Vigorous*
Color	*Blue, pale*	*Body pink, Extremities blue*	*Fully Pink*