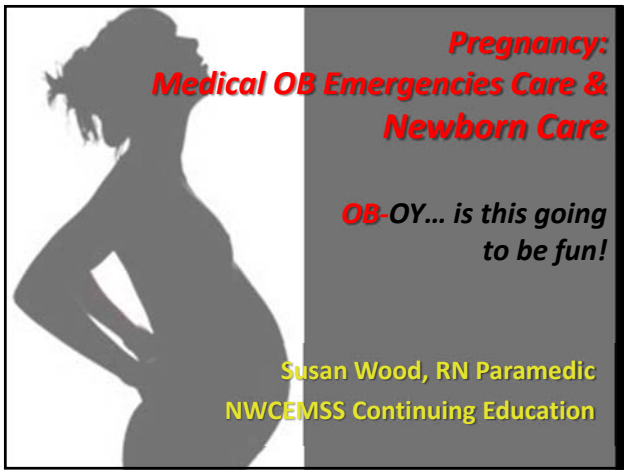


Uh oh….famous last words of an EMS Provider!

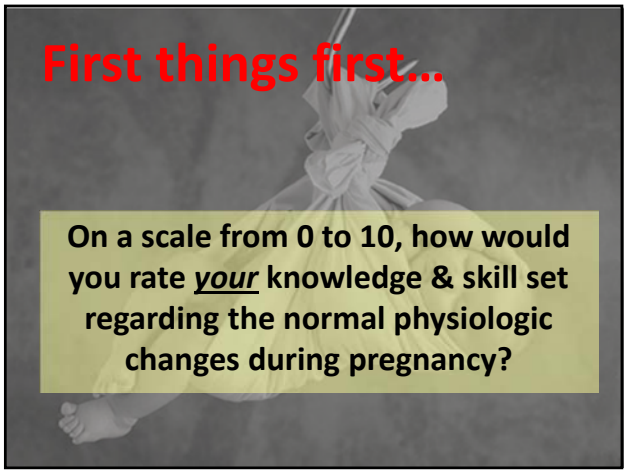
Anyone feel inadequately prepared, tremendously anxious and downright uncomfortable at the thought of delivering a baby prehospital?

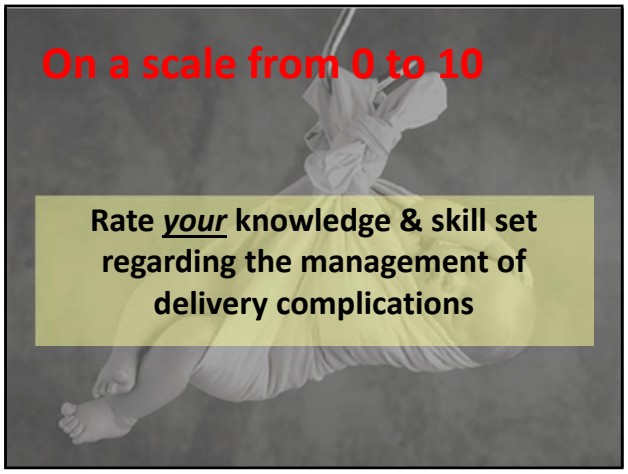
3 key things to relieve stress in these situations:

1. Available equipment
2. Train for the situation
3. Know how to document correctly

Documentation Pearls

On slides when you see this scroll, it will offer a tip for documentation in the EMS pt care report.





On a scale from 0 to 10

Rate ***your*** knowledge
& skill set regarding the initial resuscitation of a newly born infant in distress.

Great, then let's prove it!

The Pregnancy Challenge

1. Why are females said to be "glowing" when pregnant?
2. Why do they often complain of ↑ SOB?
3. Why do they "appear "to be waddling when ambulatory?
4. Why is heartburn a common complaint especially in later pregnancy?
5. Identify three different positions in which a baby can present during birth

The Pregnancy Challenge

6. Identify 3 imminent signs of delivery.
7. In which stage of labor is the baby delivered?
8. What 5 areas are evaluated in an APGAR score?
9. Identify two things found in an OB kit.
10. Identify 3 complications of pregnancy.

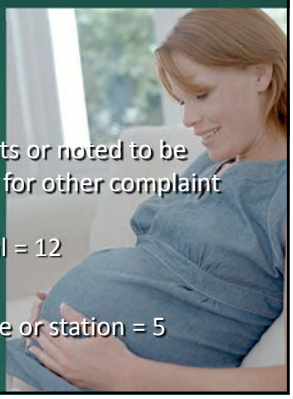
We will check answers at the end

Why are we talking about this?

System Stats: 2014

Total: 600
Pts w/ either OB complaints or noted to be pregnant upon evaluation for other complaint

Total deliveries prehospital = 12
Prior to EMS arrival = 7
Either in ambulance, house or station = 5



Prehospital Impression

1. OB/pregnancy complications	89
2. OB / Childbirth	67
3. Other OB/Gyne	67
4. Traumatic Injury	64
5. Vaginal Hemorrhage	50
6. Abdominal Pain / Problems	48

Prehospital Impression

Pain	41
No apparent illness / injury	41
Behavior / Psychiatric Disorder	22
Syncope / Fainting	15
Dizziness / Vertigo	14
Other Illness / injury	12
All other complaints	single stats

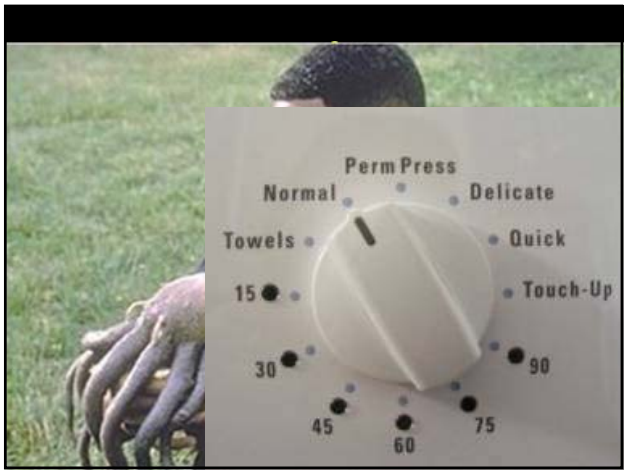
Pregnancy Documented

Yes	473
No	43
Not documented	78
Not applicable	3
Not known	3

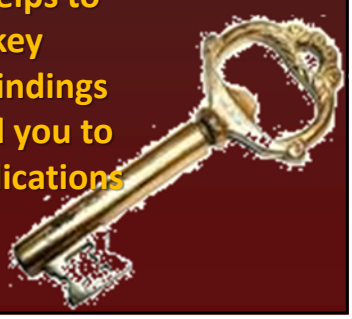
Of the 12 deliveries we had in 2014

- 9/12 had reports on both mother & newborn (1 mutual-aid to non-system EMS, 1 delivered on ED ramp w/NICU waiting, 1 NO excuse!)
- (2/2) When the SBP was either ≤ 90, an IV was established & a fluid bolus was appropriately given
- 4 documented the use of a car seat
- 7 females and 5 males!

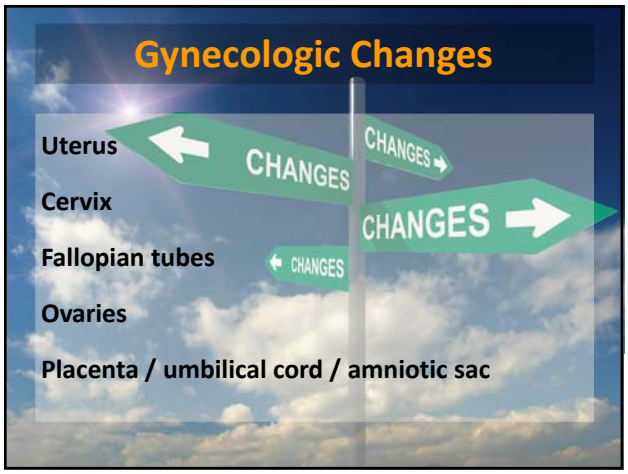
NO multiples, what else would you like to know?



Knowing the physiologic changes of pregnancy helps to identify key assessment findings that may lead you to suspect complications

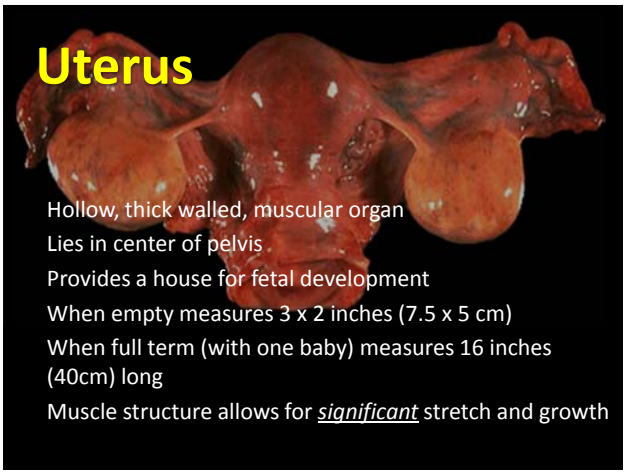


Gynecologic Changes



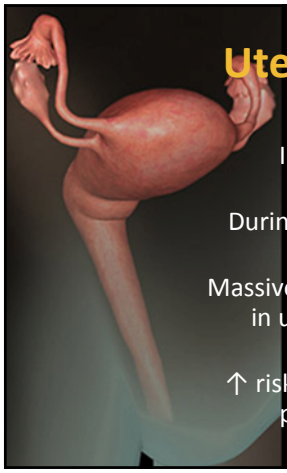
- Uterus
- Cervix
- Fallopian tubes
- Ovaries
- Placenta / umbilical cord / amniotic sac

Uterus



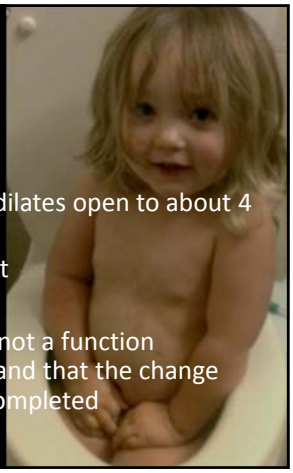
- Hollow, thick walled, muscular organ
- Lies in center of pelvis
- Provides a house for fetal development
- When empty measures 3 x 2 inches (7.5 x 5 cm)
- When full term (with one baby) measures 16 inches (40cm) long
- Muscle structure allows for *significant* stretch and growth

Uterine blood flow



- In non-pregnant state, uterus receives ~ 2% of blood flow
- During pregnancy, uterus receives ~ 20% of blood flow
- Massive ↑ in blood & blood vessels in uterus & related structures in pregnancy
- ↑ risk to miss blood loss potential prior to development of s & s

Cervix

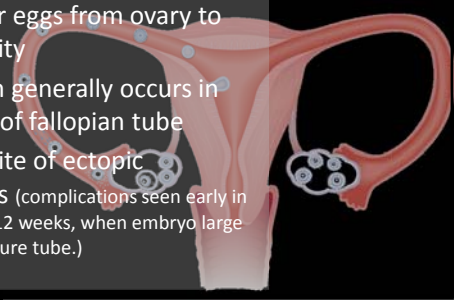


- Lower portion of the uterus
- Canal ~ 1 inch long (2.5 cm)
- During labor, thins down & dilates open to about 4 inches (10 cm)
- Muscle elasticity allows for it

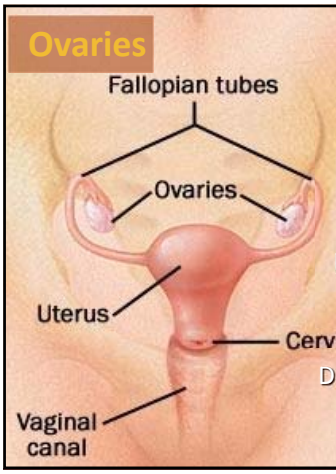
While internal inspection is not a function performed by EMS, understand that the change must occur for birth to be completed

Fallopian tubes

- Thin flexible pair of tubes ~ 4 inches (10 cm) x <1/2 inch (1 cm)
- Pathway for eggs from ovary to uterine cavity
- Fertilization generally occurs in distal third of fallopian tube
- Often the site of ectopic pregnancies (complications seen early in pregnancy ~8-12 weeks, when embryo large enough to rupture tube.)

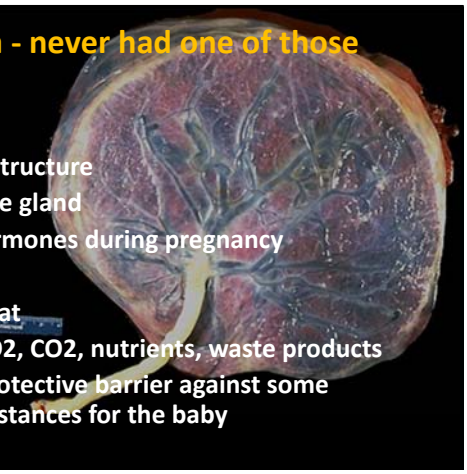


Ovaries



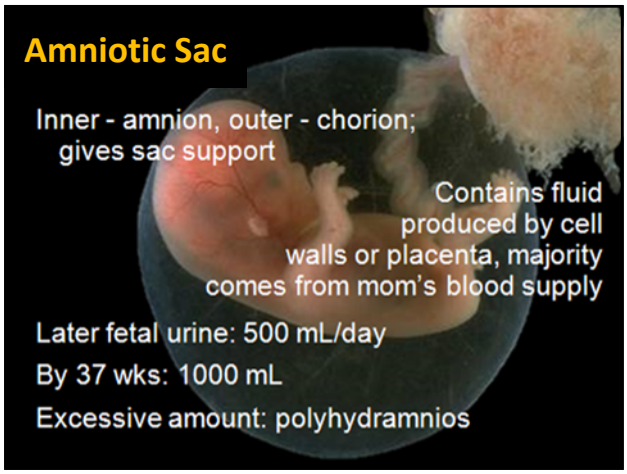
- Female sex organs
- Lies on either side of uterus in upper portion of pelvic cavity
- 2 functions:
- Secrete hormones
- Estrogen, progesterone, luteinizing hormone
- Develops & secretes eggs for reproduction

Placenta - never had one of those before!



- Temporary structure
- An endocrine gland
- Secretes hormones during pregnancy
- Blood-rich
- Transfers heat
- Exchanges O2, CO2, nutrients, waste products
- Serves as protective barrier against some harmful substances for the baby

Amniotic Sac



Inner - amnion, outer - chorion; gives sac support

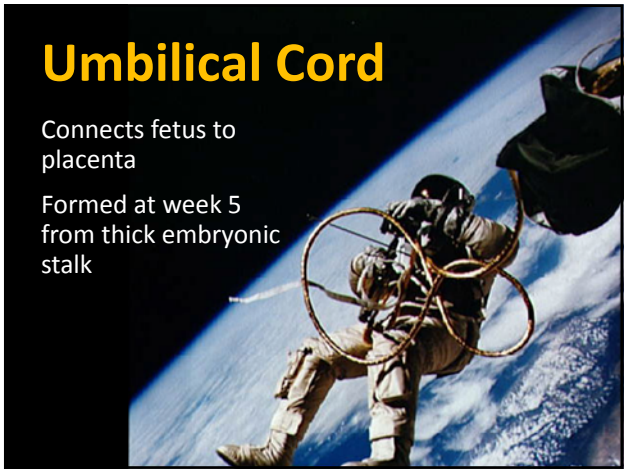
Contains fluid produced by cell walls or placenta, majority comes from mom's blood supply

Later fetal urine: 500 mL/day

By 37 wks: 1000 mL

Excessive amount: polyhydramnios

Umbilical Cord



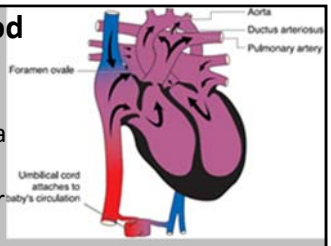
Connects fetus to placenta

Formed at week 5 from thick embryonic stalk

Umbilical Cord

- 2 arteries (unoxygenated blood)
- 1 vein (oxygenated blood)
- Connective tissue providing substance & protection: Wharton's jelly

Maternal-Fetal Blood Flow

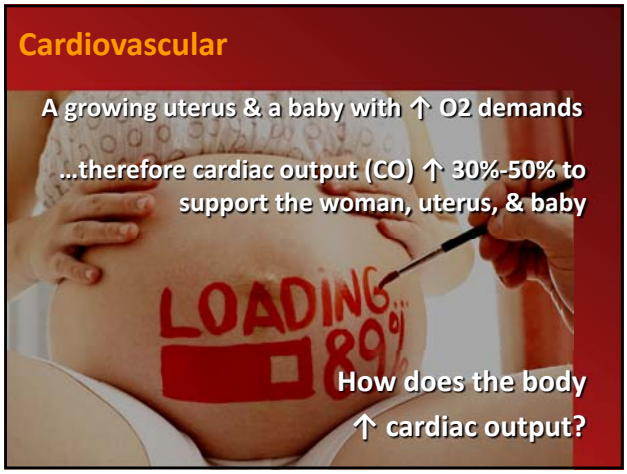


Blood flows from placenta in through umbilical vein which connects to inferior vena cava then to heart

Routed around the lungs through the ductus arteriosus, into aorta & then throughout baby.

Deoxygenated blood is filtered by the liver and then transported to the mother

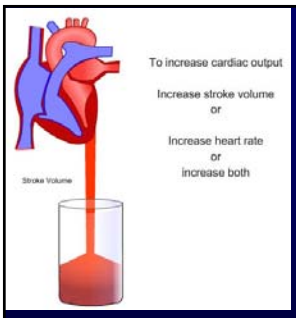
Cardiovascular



A growing uterus & a baby with ↑ O2 demands

…therefore cardiac output (CO) ↑ 30%-50% to support the woman, uterus, & baby

How does the body ↑ cardiac output?



CO = HR x SV

During Pregnancy:

HR increases ~20 bpm over baseline

Plasma volume increases

Dilutional anemia

Decreased O2 carrying capacity

BP fluctuates throughout trimesters

Cardiovascular changes

SV ↑ 30%

HR ↑15-20 bpm

CO ↑ 30-40%

SVR ↓ 5 to 15% (peripheral vasodilation d/t progesterone)

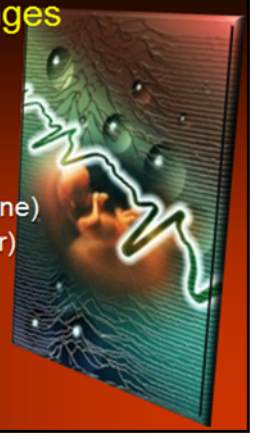
SBP ↓ 10 mmHg (2nd trimester)

DBP ↓ 15 mmHg

MAP ↓ 15 mmHg

(Return to normal wk 36)

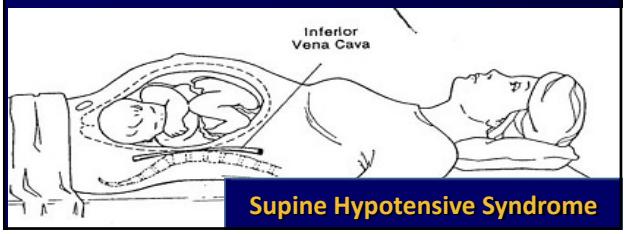
Implications?



By the third trimester…

The weight of uterus, infant, placenta & amniotic fluid totals ~ 24 lbs.

Laying flat on back is ***NOT*** a good idea!



Supine Hypotensive Syndrome

Remember those hormones?

Progesterone

Hormone: smooth muscle relaxant

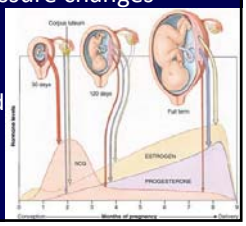
Prevents premature uterine contractions

Vasodilation: Causing blood pressure changes throughout trimesters

1st trimester - BP slightly lowered

2nd trimester - BP much lower

3rd trimester - BP normalizes



Neurological changes

Most experience headaches - migraine, stress, d/t hormonal changes

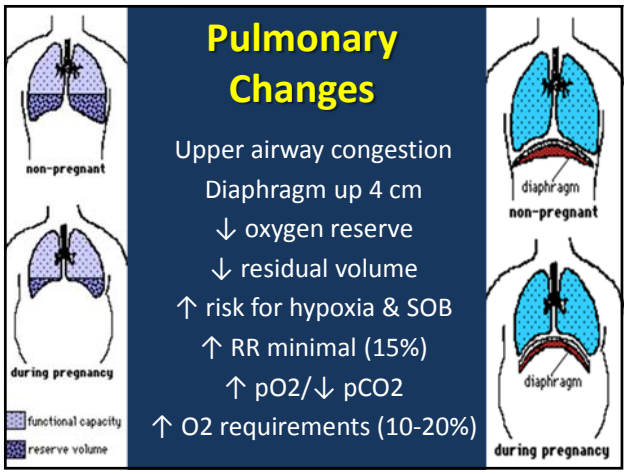
For change in LOC, personality, cognition

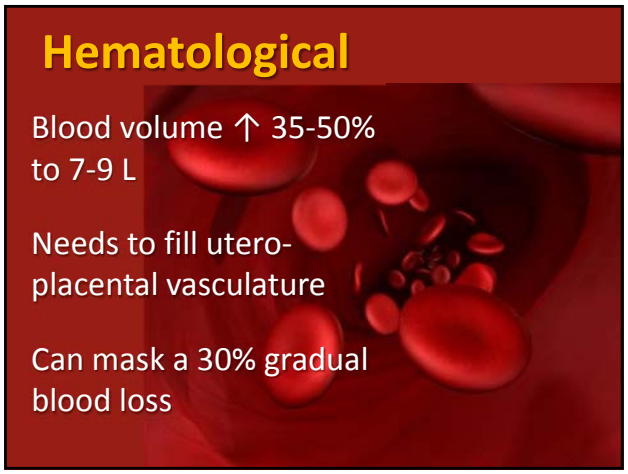
VS – HTN?

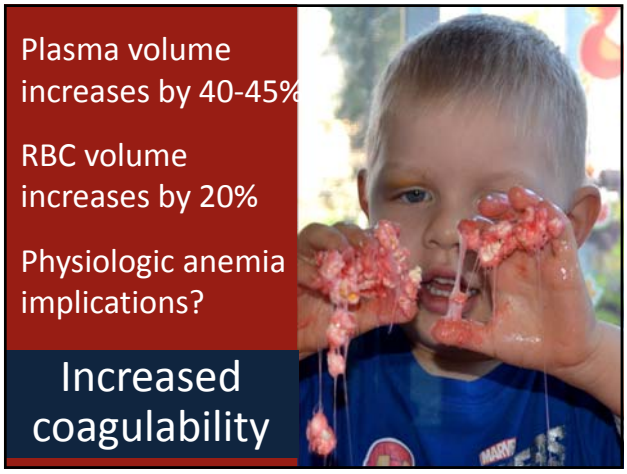
PMH (change in pattern of chronic HA) metabolic disorders; recent trauma (head/neck)

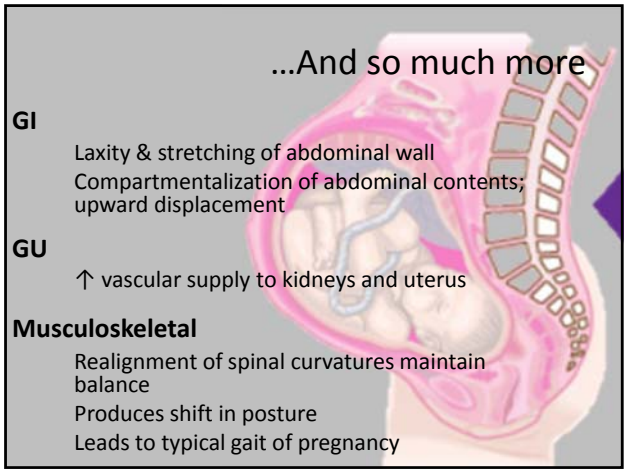
Meds (withdrawal)

Change in vision, photophobia, sound sensitivity, seizures

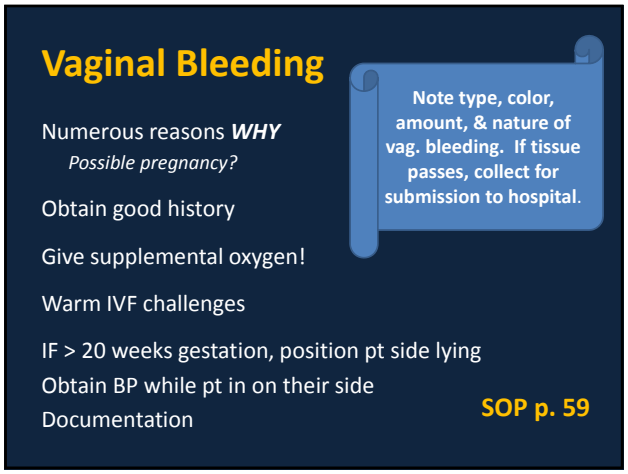

non-pregnant
during pregnancy
functional capacity
reserve volume
Pulmonary Changes
Upper airway congestion
Diaphragm up 4 cm
↓ oxygen reserve
↓ residual volume
↑ risk for hypoxia & SOB
↑ RR minimal (15%)
↑ pO2/↓ pCO2
↑ O2 requirements (10-20%)
diaphragm
non-pregnant
diaphragm
during pregnancy


Hematological
Blood volume ↑ 35-50% to 7-9 L
Needs to fill utero-placental vasculature
Can mask a 30% gradual blood loss


Plasma volume increases by 40-45%
RBC volume increases by 20%
Physiologic anemia implications?
Increased coagulability


…And so much more
GI
Laxity & stretching of abdominal wall
Compartmentalization of abdominal contents; upward displacement
GU
↑ vascular supply to kidneys and uterus
Musculoskeletal
Realignment of spinal curvatures maintain balance
Produces shift in posture
Leads to typical gait of pregnancy


It's complicated…
When things go wrong
Vaginal bleeding
Miscarriage ~ abortion
Ectopic pregnancy
Pre-eclampsia
Eclampsia
Vaginal infection
STD
Ruptured uterus
Abruptio placenta
Placenta previa


Vaginal Bleeding
Numerous reasons WHY
Possible pregnancy?
Obtain good history
Give supplemental oxygen!
Warm IVF challenges
IF > 20 weeks gestation, position pt side lying
Obtain BP while pt in on their side
Documentation
Note type, color, amount, & nature of vag. bleeding. If tissue passes, collect for submission to hospital.
SOP p. 59

A pregnant female is c/o midline lower abdominal cramping. LMP: 12 wks ago. She is experiencing moderate vaginal bleeding but has not passed any tissue. The abdomen is soft. VS are WNL. Which of these is likely?

A. Placenta previa
B. Abruptio placenta
C. Ectopic pregnancy
D. Spontaneous miscarriage

History

- Gravidity—number of pregnancies
- Para—number of viable fetus delivered
- Length of gestation
- Estimated date of confinement
- Previous complications with pregnancies

When did pain start?

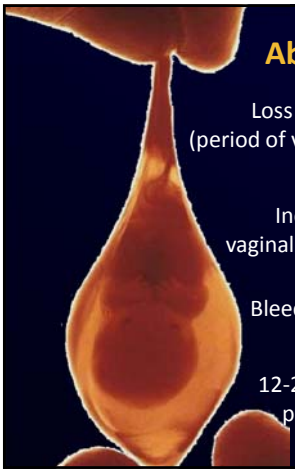
Onset, strength, duration, location, frequency

Regularity

Time: beginning of one to beginning of next

Proper prenatal care?

(assess for high risk)



Abortion - Miscarriage

Loss of a pregnancy before 20 wks (period of viability); most often between 12-14th wks

Incidence: ~21-27% experience vaginal bleeding in their 1st trimester
(Hasan et al, 2010)

Bleeding or pain may be 1st sign of miscarriage or ectopic preg.

12-25% of all clinically recognized pregnancies end in miscarriage
(Blohm et al, 2008)

Management

Assess / manage ABCs

Position supine if impending shock

Careful monitoring:
VS; SpO2, & rhythm

IV NS in 200 mL increments if hypoperfusing – (hypovolemic shock SOP)

Save all vaginal discharge containing passed tissue or clots & bring to hospital

Provide psychological support & reassurance

A 19y/o F is c/o sharp LLQ pain that began abruptly 2 hrs ago. LMP: 9 wks ago. She noticed increasing pressure in the LLQ for past week. Pt is anxious, pale, cool & moist w/ point tenderness & guarding to LLQ. No vag bleeding. VS: 98/66, P 110, R 24. Which of these is likely?

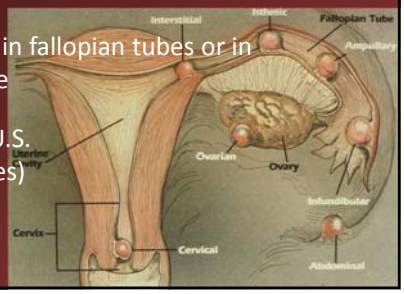
A. Placenta previa
B. Ectopic pregnancy
C. Ruptured ovarian cyst
D. Spontaneous miscarriage

Ectopic Pregnancy

Implantation of fertilized egg in any location other than uterine endometrium

Egg can implant in fallopian tubes or in abdominal tissue

Occurs ~ 2% in U.S. (1:50 pregnancies)
(Shima, 2002)



Ectopic Assessment

At risk for rapid development of shock

Take VS frequently

Abdominal—significant lower quadrant tenderness

Bleeding can range from spotting - profuse

Which of these is indicated to treat a pt w/ suspected ruptured ectopic pregnancy?

A. Dopamine drip for SBP < 90
B. NS IVF challenges in 200 mL increments
C. Position on side & manually displace uterus
D. Vasopressin 40 u IVP to tamponade bleeding

Emergency Management

Position supine

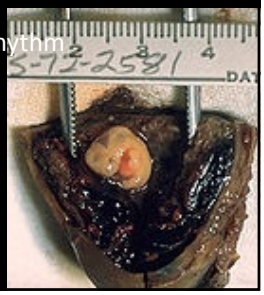
O2 per mask as indicated (SpO2 must be >94% for adequate fetal oxygenation)

Careful monitoring of VS & rhythm

IV NS titrated to pt response (hypovolemic shock SOP)

Psychological support

Reassure pt



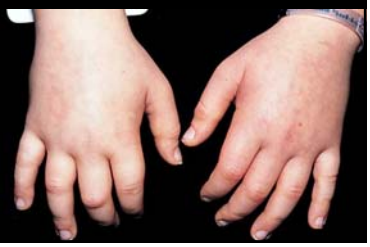
Pre-Eclampsia

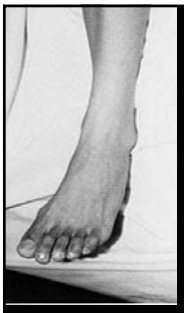
Multi-system disorder, neither primarily a seizure disorder nor a HTN condition

Disease of healthy young women and those w/ existing underlying dx

Challenges

- No definitive diagnostic test
- Onset and course unpredictable



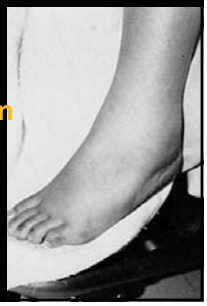


Associated w/ 5-10% of pregnancies

Responsible for 15% of all maternal deaths

Cause of fetal growth retardation & morbidity

Many theories regarding cause



What prehospital care is indicated for a pt with pre-eclampsia?

SOP p. 59

Management

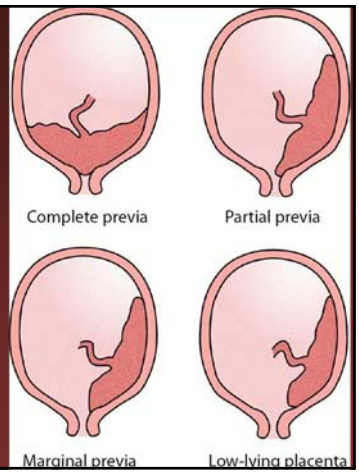
Time sensitive patient
Gentle handling; quiet environment
Minimize CNS stimulation
(No lights & sirens)
Position on side
Monitor FHTs if able
Monitor ECG, maternal VS
O_2, IV NS TKO
$MgSO_4$ 2 Gm in 16 mL NS, slow IVP over 5 min

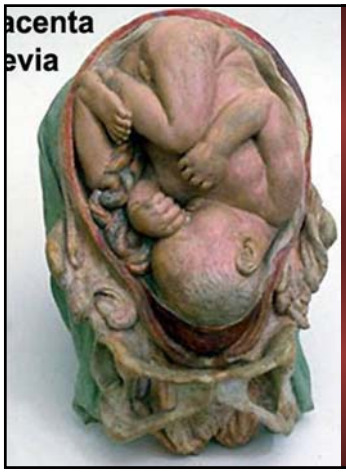
Placenta Previa

Implantation of embryo low in the uterus near or over the cervix

Placenta usually migrates up and away from cervix in late pregnancy

In small percentage, migration does not occur





Placenta Previa

- **Bright red vaginal spotting or bleeding**
- **Starts suddenly; described as painless**
- **With greater separation, often profuse**

Uterine tone generally soft & non-tender or pt may experience preterm labor

Compare uterine to abdominal wall tone

May present in shock

Pre-term Labor Assessment

Document:
Pregnancy history
Membrane status
Contractions?
Duration, interval

- **Status of membranes**
- **If ruptured BOW, assess for prolapsed cord**
- **Presence/ absence of fetal movements**
- **Inspect for bulging or crowning**

Which of these is indicated for the prehospital management of a prolapsed cord per SOP?

(More than one choice may be present)

A. Clamp & cut the cord immediately
B. Instruct mom to pant during contractions
C. Continuously palpate the cord for fetal HR
D. Insert gloved fingers b/t pubic bone & presenting part

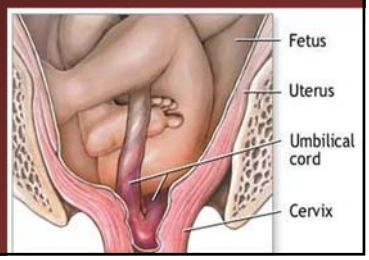
Prolapsed Cord

Incidence: 1:200-500 all births

Predisposing factors: preterm labor, abnormal fetal positions (7.5% of breech), multiple births

Danger to fetus: cord compression

Time to dead baby: 4-6 min if all blood has been cut off



Management

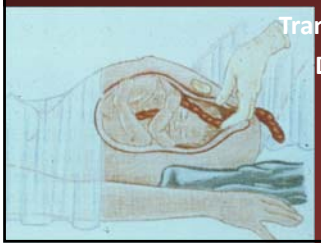
Do not push cord back into vagina

Keep exposed cord warm and moist

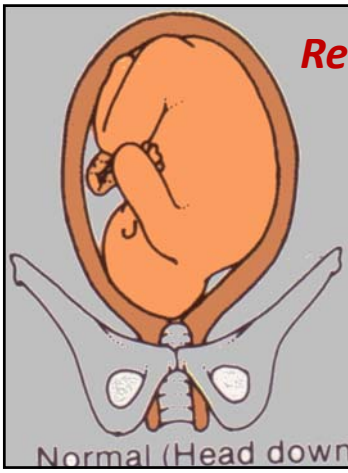
Time sensitive patient

Transport w/ hand in place

Do not manipulate cord



Ready or Not…



Between 30-36 weeks the baby moves into the cephalic position or head down position.

Braxton-Hicks Contractions

Irregular

Not sustained

Body's preparation

Not an indication of impending labor

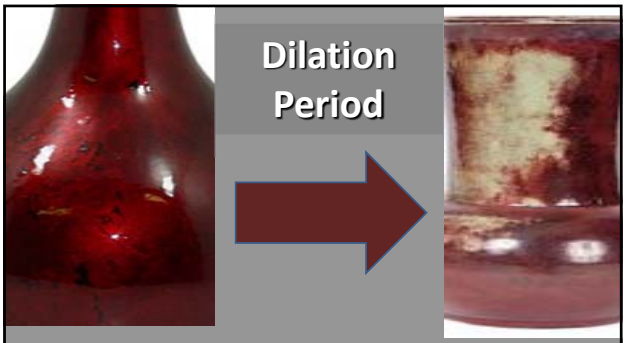
LABOR

3 Phases

First phase

Regular contractions, thinning & gradual dilation of cervix; ends when cervix is fully dilated

Dilation Period



Something's got to give!

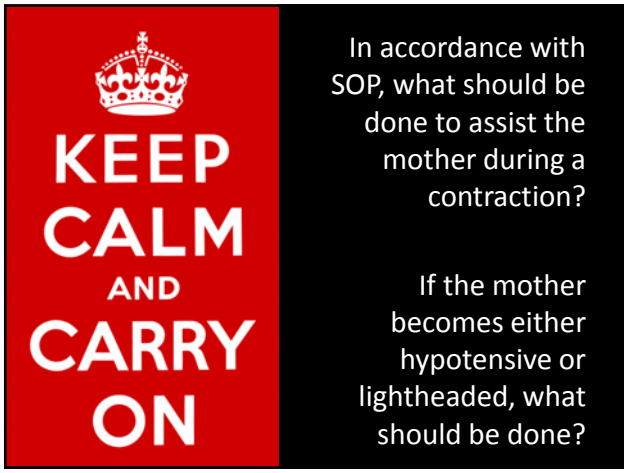
Which of these should be done by a paramedic to determine if delivery is imminent?

A. A vaginal exam to check cervical dilation (cm)
B. Quantify the severity of labor pains (0-10)
C. Determine the amount of bloody show
D. Check for crowning with contractions

Get Ready…GO!

The first phase of labor is completed when the contractions last between 30 seconds and 1 minute and are 2-3 minutes apart

This is an indication that delivery of the baby is imminent



In accordance with SOP, what should be done to assist the mother during a contraction?

If the mother becomes either hypotensive or lightheaded, what should be done?

Dear God, What's going on in there?

What's in all this stuff I carry anyway?

2nd Phase ~ Delivery

The time from when baby enters birth canal until one is born

Delivering the head

While the head is to deliver passively, remember that controlling the rate of descent is needed, but how?

After the head is delivered

As soon as head delivers…
Have mother stop pushing
If no meconium: *Do **NOT** suction yet as bulb syringe may trigger a vagal reflex*

Thick meconium *ONLY*

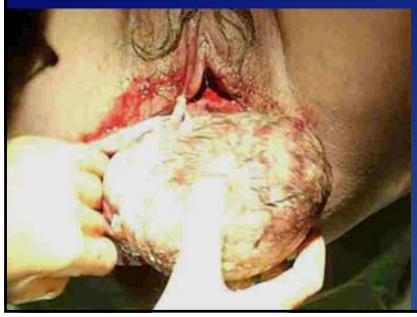
Gently suction mouth then nose w/ bulb syringe
Anticipate need for newborn resuscitation of a *nonvigorous* infant using tracheal suction after delivery

If no meconium, just wait until baby delivers to bulb syringe suction

Which is indicated *first* after head delivery if there is no evidence of meconium in the amniotic fluid?

A. Suction nose & mouth with an 8 Fr catheter.
B. Guide head upwards to deliver posterior shoulder.
C. Rotate infant's head so it faces downward.
D. Feel around the neck for nuchal cord.

Nuchal Cord



Feel deep in neck folds for cord

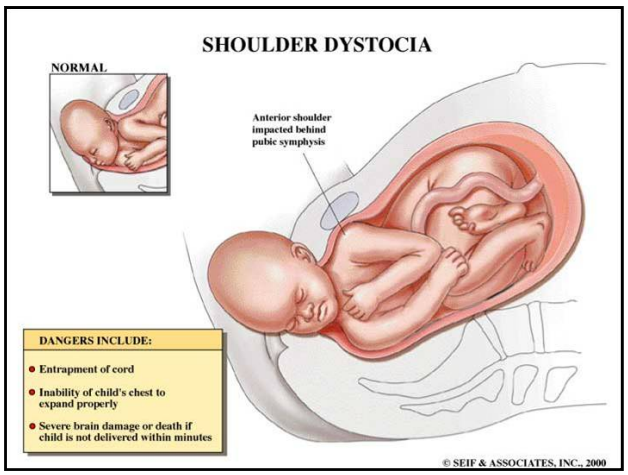
Gently slip cord over infant's head

Gestational Diabetes

While we do not have time to discuss in class, it is discussed in the handout

The mention here is to remind EMS that if a mother should mention that she has gestational diabetes, the baby is prone to be larger than normal and that creates the potential for other complications

…such as?

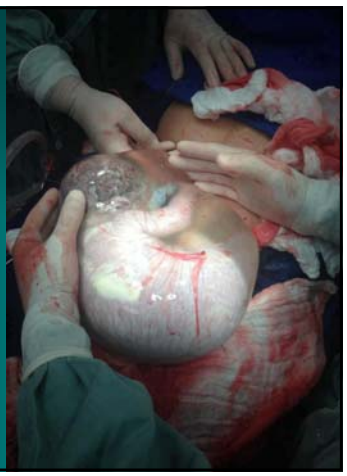


En Caul

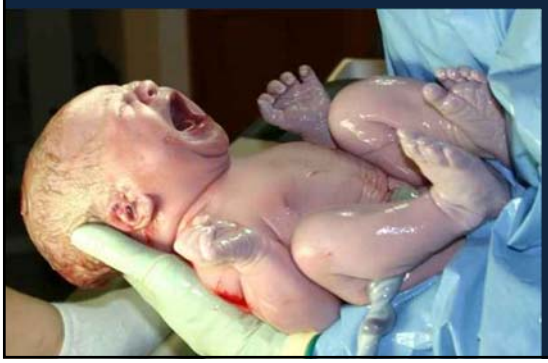
"With a veil"

Rare events

No risk to baby as they are still receiving nutrients through placenta



Remember, they are slippery!



Delivery

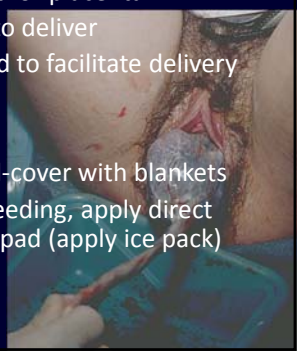
There's more?

Placental delivery

- Do NOT delay transport for placenta
- Can take up to 30 min to deliver
- Do NOT pull on the cord to facilitate delivery

Post-Partum Care

- Mother may be cold-cover with blankets
- If perineum torn/bleeding, apply direct pressure w sanitary pad (apply ice pack)
- Fundal massage



Newborn Care

APGAR

The APGAR score is a widely used, standard method to assess a newborn infant

Easy, quick, & is consistent between health care providers to trend newborn's condition at critical times of 1 & 5 min after delivery

After delivery, umbilical cord is clamped & cut, the infant is dried…

A bulb syringe works well if suctioning is needed

Compress the bulb prior to suctioning secretions.

Suctioning: 1 mouth/2 nares

First mouth, then nose: this prevents aspirating secretions.

Dry & suction: effective at stimulating respirations.

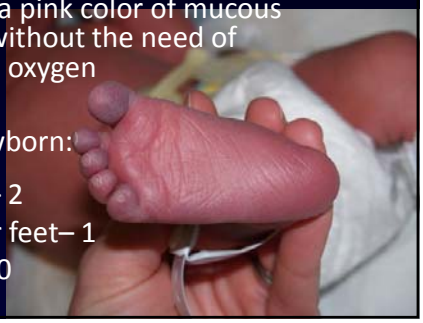
APGAR

Appearance & Color

Newborn infants who are uncompromised will maintain a pink color of mucous membranes without the need of supplemental oxygen

A normal newborn:

Entirely pink– 2
Blue hands or feet– 1
Blue or pale- 0



Breathing with good effort, but hands & feet a little blue yet?

Acrocyanosis

Blow by oxygen can help

With a newborn, pulse may best be determined by palpation at base of umbilical cord

The rate should be:
> 100 bpm – 2
< 100 bpm - 1
(providers should be initiating oxygenation)
An absent pulse rate - 0

(providers should be initiating chest compressions)

Pulse

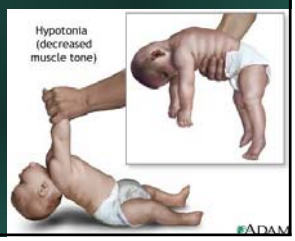
Grimace or reflex irritability

Normal newborns will cry, especially when stimulated by drying

Vigorous cry:	**2**
Faces/grimacing:	**1**
No response:	**0**

Most newborns are active and have good muscle tone.

Active moving of all extremities	2
Limited movement / some flexion	1
Newborn is flaccid or limp	0



Activity

Respiratory effort

Most newborns normally breathe & begin to cry almost immediately after birth
(& never stop!)

Crying 2
A slow or irregular rate of breathing 1
(Would necessitate need for assisted ventilation)

If breathing is slow or irregular, stimulation may be attempted with 100% O_2
An absent respiratory effort is a zero & requires provider to initiate ventilations

A newborn makes a face but no sounds when mouth & nose are suctioned w/bulb syringe. What APGAR rating for reflex irritability should be given?

A. Absent
B. Grimace
C. Cough or sneeze
D. Active motion

Newborn's legs are pulled up to the body & baby mildly resists efforts to extend them w/weak muscle tone. What APGAR rating for activity should be given?

A. Limp
B. Some extremity flexion
C. Active motion
D. Absent

What are the implications if a crying newborn w/ a RR of 40 has dusky toes & fingers but a pink torso at the 1 min APGAR score?

A. Acrocyanosis is normal & the newborn may need blow-by O2.
B. The infant likely has a congenital heart defect & needs full resuscitation.
C. The infant needs immediate intubation & ventilation w/ a neonatal BVM.
D. The infant likely has meconium aspiration & needs deep tracheal suctioning.

Transport Considerations

How secure is that baby in mother's arms?

Now that we successfully delivered a bouncing baby and mom got through that we are golden, right?

Not so quick…

How would you rate your knowledge and skill regarding management of delivery complications???

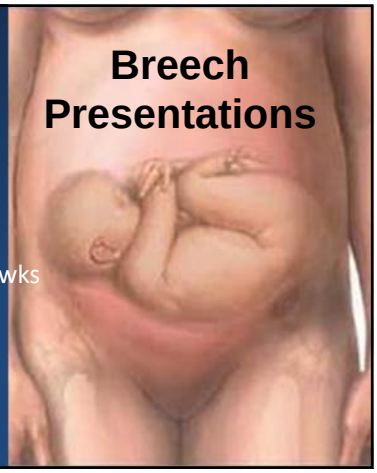
Yep…that's a foot!

Could it get any worse? Remember, that's what mom is saying.

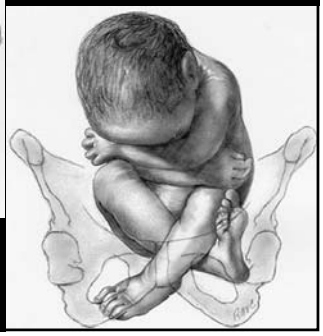
Nope, I'm not coming out!

Incidence of births:
25% occur before 28 wks
7% occur at 32 wks
1-3% occur at term

Breech Presentations



Frank breech (top)
50-70%



Footling breech (right)
5-10%

Communication with the hospital

This information is helpful…

Patient's age
Previous pregnancy history (gravida/para)
Due date (gestational age)
Onset of labor
Status of membranes
Presence or absence of abnormal bleeding
Risk factors for complicated delivery: pre-eclampsia, breech, twins, etc.
Vital signs; physical exam findings
Treatment administered and ETA

Breech deliveries are usually slow, so you will often have time to transport to the hospital…but if the delivery is in progress you need to know what to do!

Leave fetal membranes intact as long as possible

they act as a dilating wedge; prevent cord pressure

Thick meconium passage is common as baby is squeezed through the birth canal

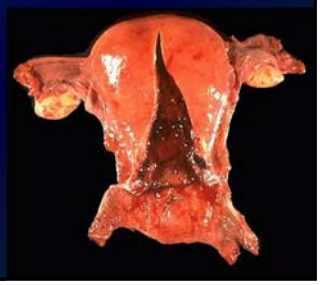
This is not usually associated with meconium aspiration because the meconium passes out of the vagina and does not mix with amniotic fluid

O2 NRM
IV (anticipate hemorrhage)
Do not tear membranes
Allow legs/buttocks to deliver passively
Support body wrapped in towel
Loosen cord if possible

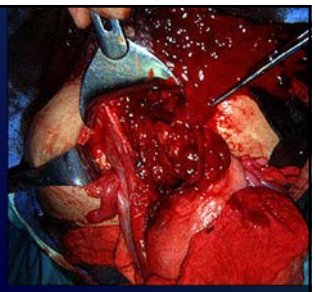
Trauma

Uterine rupture

Severe pain
Increased uterine irritability
Hypotension, shock
Abnormal uterine contour
May feel fetal parts directly under skin
Contractions cease
Fetal death



Management



Time sensitive patient
O2 12-15 L/NRM
IVF to patient response
Monitor ECG
Monitor fetal movements as able
Transport on side or tilted
Requires surgical intervention

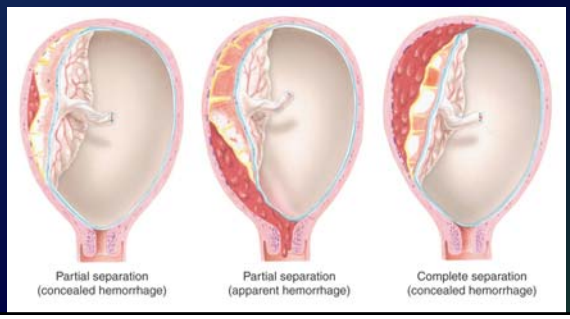
Abruptio Placenta (Pain)

Premature separation of placenta from uterine wall
Occurs in 1:50-100 deliveries; up to 50% in severe blunt abdominal trauma
Causes hemorrhage in mom; hypoxia in fetus
Maternal mortality < 1%; fetal mortality up to 100%
Leading cause of fetal trauma
Increased risk up to 5 days post-trauma

Predisposing Factors

Multiparity
Diabetes
Hypertension
Blunt uterine trauma
Short umbilical cord

Sudden onset sharp uterine pain that is unrelenting, constant & severe
Hx of precipitating event/disease or previous abruption



TIME SENSITIVE PATIENT
Position on side or tilt backboard
O_2 12-15 L/NRM
IVF challenges titrated to pt & fetal response
Psychological support

Abruptio Placenta Management

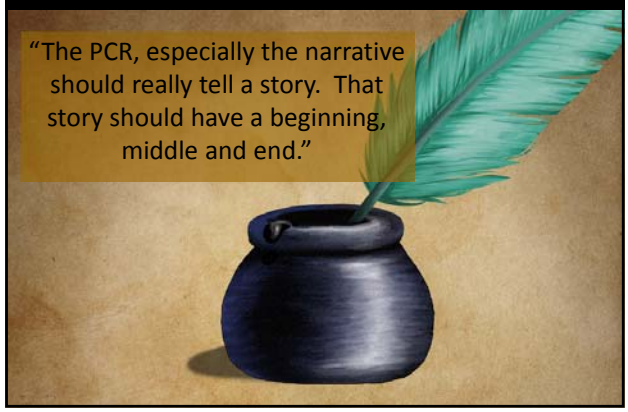
Alright, so now how do we document this little miracle?

EACH PATIENT NEEDS THEIR OWN PATIENT CARE REPORT

With their own specific information documented

Documentation according to Dr. O

"The PCR, especially the narrative should really tell a story. That story should have a beginning, middle and end."



Mother's PCR

Absolutely everything that you saw, were told, performed and witnessed should be completed on the run report

Care given to mother is specified on this report

This document is no different than any other pts report with detailed medical history

Infant's PCR

1. Date and time of delivery
2. Presence/absence of nuchal cord (how many times)
3. Appearance of amniotic fluid, if known; esp if brown, green or blood tinged
4. APGAR scores at 1 min & 5 min post delivery
5. Time of placenta delivery & if it was intact
6. Any infant resuscitation initiated & response

Documentation

Narrative Summary of Events

responded for a woman in labor. UOA we found a 25 y/o female pt conscious a/ox4 laying on her fold out bed in the living room. Pt is in active labor and states her contractions began last evening around 2130 last evening. Pt states she was seen at the and she was sent home because she was not dilated and her contractions were 14 minutes apart at that time. Pt states her contractions are near constant at this time. Pt states she has been pregnant once prior and delivered one vaginal birth prior. Pt states her expected due date is March 25th. Pt states her pregnancy thus far has been normal without any complications. EMS gathered vitals and attempted to place pt on stair chair. Pt instructed EMS she was ready to deliver after she was sat up; pt was then assisted back into the fold out bed. Pt was placed in a position of comfort with family member assisting her breathing. Pt delivered baby head first. Once head and top shoulder were delivered, pt was instructed to stop pushing. Baby was suctioned immediately and began to cry. Mom then was instructed to push once more and the rest of the baby was delivered and wrapped in a warm, clean blanket. Baby was suctioned further. Umbilical cord was clamped at 4" and 10". Baby was placed on mothers chest and umbilical cord was cut once it stopped pulsing. Mother was carried down the stairs in a blanket. IV established in MICU with warm fluids. Hospital was contacted and no further orders were given. Pt transported in position of comfort; baby was resting on mothers chest. Two paramedics were assisting to hold the baby as well while en route. Pt and baby were transported without incident and pt care transferred to OB Rn/Dr. at

Documentation

Infant Report

Narrative Summary of Events

Crew called to scene for emergency of childbirth. U/A crew found mother AOX4 sitting on the floor of the bathroom with newborn baby pt. in her arms. Crew noted APGAR of 10 on arrival and 10 five minutes after arrival. Female baby was entirely pink, pulse greater then 100, actively crying and moving all extremities and moved when foot was gently pinched. Crew took vitals as stated, clamped and cut cord. Baby cleaned, mouth and nose suctioned with no meconium present. Baby wrapped in blanket and cap applied to head. Mother was only Spanish speaking but crew gathered that baby was born approximately 10 minutes prior to EMS arrival. Crew moved pt. to ambulance w/o problem. Baby transported in child seat with mother. Crew applied child/mother ID tags. No change in pt. condition en route to hospital. NWCH contacted for report with no orders given. Pt. care transferred and report given to RN in OB department.

Documentation

Narrative Summary of Events

Crew called to scene for emergency of childbirth. U/A crew found pt. AOX4 sitting on the floor of the bathroom with newborn baby in her arms. Crew noted APGAR of 10 on arrival and mother stating mild pain in abdomen, placenta not passed yet. Crew took vitals as stated, clamped and cut cord. Hx obtained from pt. who was primarily Spanish speaking along with family member on scene who spoke English. Crew moved pt. to ambulance w/o problem. Baby transported in child seat with mother. Crew started IV in left AC as noted and fluid bolus given. No change in pt condition en route to hospital. Pt. did not pass placenta prior to delivery to contacted for report with no orders given. Pt. care transferred and report given to RN in OB department.

Same call, mom's report

Documentation

Infant's report

Narrative Summary of Events

received a walk in patient in labor with crowning. Baby delivered at Time / date No presence of nuchal cord. Bag of waters is partially intact around babies head. As soon as the head delivers, bag is moved from the babies head. Shoulders deliver immediately after the head. Suctioning done at this time. Patient has an APGAR of 9 at 1 minute. APGAR is 10 after 5 minutes. Cord clamped after pulsation stopped. Cord cut. Baby cleaned and dried and wrapped in blankets. Patient placed in child seat and secured in the ambulance next to mom. contacted with no orders given. Patient brought to OB room. Patient transferred to table in delivery room. Verbal report given to staff RN at bedside. RN assumes care of patient. All times and weight are approximate. EOR.

Documentation

Narrative Summary of Events

Station crew accepted a walk in patient in labor. Patient is in passenger seat of a minivan on the front apron. Patient assessed in the front seat of the van, crowning noted. Patient assisted to bay floor and propped up with blankets and towels. Delivery is imminent at this time. Babies head is protruding from vagina. Delivery facilitated. Baby delivered at time listed above. Patient transferred to cot without incident. Patient does not deliver placenta on scene. Patient continues to have contractions en route. contacted with no orders given. Patient transported without incident en route. At destination, patient transferred to OB bed without incident. Verbal report given to staff RN at bedside. RN assumes care of patient. All times and weight are approximate. EOR.

Same call, mom PCR

Narrative Summary of Events

Upon arrival PT was sitting on toilet A/O 3/3 after just delivering a child. E/A were on scene with newborn. PT had given birth shortly prior to crews arrival. PT stated her placenta had not delivered yet and was having abdominal pain. Para: 2 Gravida: 3. PT stated she was not sure how far into her pregnancy she was and her LMP was around . PT had no pre-natal care. PT denied chest pain, trouble breathing, headache, N/V, blurred vision, or numbness/tingling in extremities. PT was given IV NS TKO. PT was placed on the cardiac monitor to find NSR. A transported newborn. Placenta did not deliver while in transport. contacted with no orders given. PT was transported to and met by nursing staff who took crew and PT to OB room. Crew transferred care to RN.

Called for child being born. Second MICU called to scene while en route. arrived on scene @ same time as arrived in house to find baby in wet towel, on mother's lap w/cord already cut w/unknown object. Estimated T.O.D. . No appearance of amniotic fluid. No resuscitation needed besides suctioning/stimulation. Mother sitting on toilet in bathroom and states cord was around baby's neck. Mother states no pre-natal care, Gravida=3 Para=2 w/no other medical history or allergies. Crew suctioned, stimulated, dried and warmed child. APGAR = 5 @ 1min and 8 @ 5min. Child carried to MICU and wrapped more for warmth. ontacted w/abbreviated report. Pt. transported w/out incident.

Narrative Summary of Events

A dispatched to the scene for the pregnant lady. Upon arrival pt was laying on living room floor and the roommate was there helping her. Baby was crowning upon arrival. Baby was delivered at 0321. Pt pushed four times and baby was delivered. No trauma or tears noted during delivery. Pt stated that she did not know that she was pregnant. She had what she thought to be normal menstrual periods throughout all of her pregnancies. She states that she thought she had her period five weeks ago. She also states that she had bleeding throughout all 3 of her pregnancies. Gravida 7 para 3. Appropriate care of newborn per SOP, care transferred to Pt packaged and transported prior to delivery of placenta. Placenta delivered en-route at 0336. Placenta was intact with minor bleeding. Fundal massage en-route. Pt was very alert and oriented throughout pt contact, no change in status. ontacted and pt brought directly to OB unit. Report and pt care transferred to RN.

Dispatched for the woman giving birth. was second due on this call and arrived minutes after A delivered the neonate. Upon our arrival EMS crew found a newborn baby with an initial APGAR of 8 exactly 1 minute after birth. Per crew there was no meconium noted, no nuchal cord and was delivered head first, face down. Per mom she did not know she was pregnant however there were no complications throughout her term and during the actual childbirth. Baby presented as warm, pink and dry once care was transferred to us from Engine crew. Vitals were assessed and noted to be within normal limits. Lung sounds noted to be clear, absent any adventitious sounds. Second APGAR of 10 noted 5 minutes after initial APGAR. Baby was born at 03:21an contacted with report/findings with no orders given to EMS crew. Patient transported to nd transferred up to Labor and Delivery with RN at bedside.

The Pregnancy Challenge

Why are females said to be "glowing" when pregnant?

- ↑ blood volume

Why do they often complain of ↑ SOB?

- ↑ O_2 demand with ↓ lung capacity
- ↑ pulse rate

Why do they "appear" to be waddling when ambulatory?

- Extra weight carried; ligaments stretched
- Sway back posture; more off balance

Why is heartburn a common complaint especially in later pregnancy?

- Enlarging fetus; displacement GI tract
- Enlarging belly, nausea, heartburn

Identify three different positions in which a baby can present?

- Vertex, frank breach, footling breach

Identify 3 Imminent Signs of Delivery

- Contractions 2 minutes or less apart, crowning / presenting parts, bulging perineum, involuntary pushing w/ contractions

In which stage of labor is the baby delivered?

- Stage two

What 5 areas are evaluated in an APGAR score?

- Heart beat, breathing, muscle tone, reflexes and skin color

Questions?

We would never leave you hanging…