**childbirth**

**Clinical Indications**

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| * Imminent delivery with crowning |

**PROCEDURE GUIDELINES**

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| **R- EMR** | **E-EMT** | **A-AEMT** | **P-PARAMEDIC** | **\*\*M-Medical Control \*\*** |

**\*\*\*Higher level providers are responsible for lower level treatments\*\*\***

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| 1. Most babies deliver themselves with no assistance; however, controlling an abrupt delivery will help prevent injury to the mother and infant. Remember to don protective gloves, mask, eyewear and gown  2. Allow the mother to push the infant’s head out of the vaginal opening. Keep a gloved hand near the crowning head to keep a control on an abrupt delivery. Reminder: the baby is VERY SLIPPERY!  3. With one finger, gently feel the infant’s neck for the umbilical cord. If it is there, gently lift it over the baby’s head. Caution: Do not pull hard on the cord as it could avulse and cause a severe hemorrhage. If the cord is wrapped around the baby’s neck, gently slip it over the shoulder and head **(EMT or Paramedic level procedure)**. If this cannot be done because it is tightly wrapped, carefully place two umbilical cord clamps approximately 2 inches apart and cut the cord between the clamps **(EMT or Paramedic level procedure).**  4. As soon as the baby’s head clears the vagina, instruct the mother to stop pushing. While supporting the baby’s head, using a bulb syringe, suction the baby’s mouth, then nose. If meconium stained fluid is noted, suction the mouth, nares and pharynx. If thick “pea soup” meconium-staining is present and noted at the vocal cords, the meconium aspirator **(AEMT and Paramedic skill)** will be needed. See Airway; Suctioning-Advanced (9014).  5. Have the mother resume pushing as you support the baby’s head as it rotates. Gently guide the baby’s head downward to allow delivery of the upper shoulder. Gently guide the baby’s body upward to allow delivery of the lower shoulder. Once head and shoulders are delivered, the rest of the body will deliver rapidly. Be prepared to support the baby’s body as it emerges. Babies are **VERY SLIPPERY!!**  6. Do not hold the baby higher than the uterus or womb prior to clamping the cord because it may lead to a decrease in the infant’s blood volume (due to transfusion of blood from the baby to the placenta). Do not hold baby too low as excess blood may drain from the placenta and cause a fluid overload.  7. Supporting the baby, place the first clamp 8 inches from the baby. Place the second clamp approximately 2 inches above the first clamp. Carefully cut the cord between the two clamps. Be sure to assess the cord (portion attached to the infant) for any active bleeding. If active bleeding is noted, another clamp will need to be placed beside the first clamp.  8. Wipe the baby’s face clean of blood and mucus; repeat suctioning the mouth and nose with the bulb syringe. Dry the infant thoroughly and then cover with warm, dry blankets/towels and position the baby on its side with its head and upper body lower than its lower body (helps facilitate fluid drainage).  9. The placenta should delivery naturally within 20 minutes of the infant’s birth. DO NOT pull on the umbilical cord to hurry the placenta delivery.  10. An APGAR (A1) score must be completed on the infant at 1 minute and 5 minutes after delivery. Document the time of birth and procedure on the patient record. **Abnormal, multiple deliveries, and pre-term deliveries, require rapid transport and contact with Medical Control.**  11. Follow Newly Born Guidelines (7083). | **R** |
| * Assist with advanced suctioning of newborn for thick meconium staining. | **A** |

**If sores or lesions are noted on the genital area when birth is imminent, with your gloved hands, try to keep the newborn from contacting the sores/lesions during delivery. Be sure to ask the patient if she is being treated for the sores.**