Normal Delivery

**Basic Treatment Guidelines:**

1. Follow initial protocol for all patients
2. If delivery is imminent with crowing, prepare for onsite delivery; if delivery does not occur within 10 minutes, contact medical direction to initiate transport.
3. Have mother lie with knees drawn up and spread apart.
4. Elevate buttocks with blankets or pillow.
5. If time allows, create sterile field around vaginal opening with sterile towels or paper barriers.
6. When the infant’s head appears during crowning, place fingers on bony parts of skull and exert very gentle pressure to prevent explosive delivery. Use caution to avoid fontanelles and the newborns face.
7. If the amniotic sac does not break, or has not broken, use a clamp to puncture the sac and push it away from the infant’s head and mouth as they appear.
8. As the infant’s head is being born, determine if the umbilical cord is around the infant’s neck; slip over the shoulder or clamp, cut and unwrap.
9. After the infant’s head is born, support the head; suction the mouth two or three times and the nostrils. Use caution to avoid contact with back of the mouth.
10. As the torso and full body are born, support the infant with both hands. As the feet are born, grasp the feet.
11. Wipe blood and mucus from the mouth and nose with sterile gauze, suction mouth and nose again.
12. Vigorously rub the infant with dry towel to stimulate and dry.
13. Note and Record the time of birth.
14. Wrap infant in a warm blanket and place on its side, head slightly lower than trunk.
15. Keep infant level with the vagina until the cord is cut.
16. Assign partner to monitor infant and complete initial care of the newborn.
17. Clamp or tie, and cut umbilical cord (between clamps) as pulsations cease approximately 4 finger’s width from infant.
18. Observe for delivery of placenta while preparing mother and infant for transport.
19. When delivered, wrap placenta in towel and put in plastic bag; transport placenta to hospital with mother.
20. Perform APGAR score at one and five minutes.
21. If mother and infant’s conditions permit, place infant on mother’s chest.
22. Continuously warm infant and place hat on infant’s head.

**Abnormal Delivery**

**Frank Breech Delivery (Buttocks presentation):**
1. Allow spontaneous delivery.
2. As delivered, support the infant’s body. If the head delivers spontaneously, proceed with normal delivery guidelines.
3. If head DOES NOT deliver within 3 minutes, insert gloved hand into the vagina, keeping your palm TOWARD baby’s face; form a V with your fingers and push wall of vagina away from baby’s face, thereby creating an airway for baby.
4. TRANSPORT IMMEDIATELY AND DO NOT REMOVE YOUR HAND UNTIL RELIEVED BY HOSPITAL STAFF.

**Limb Presentation:**
1. Place mother in Trendelenburg position.
2. Cover any exposed limbs to maintain warmth.

**Prolapsed Cord:**
1. Place mother in Trendelenburg position
2. Insert gloved hand into the vagina and gently push up on the baby’s head to take pressure off the cord. DO NOT REMOVE YOUR HAND UNTIL RELIEVED BY HOSPITAL STAFF.

**Multiple Births:**
1. This is usually not a surprise to mother, as she has probably been told to expect the same by her doctor, but BE ALERT for the multiple birth possibility. Monitor your patient closely.
2. Deliver as you would for normal delivery of one infant.

**Heavy Vaginal Bleeding Following Delivery:**
1. Control bleeding - massage lower abdomen firmly.
2. Consider putting baby to breast.

**Miscarriage:**
1. May result in profuse vaginal bleeding
2. Save all expelled tissues, (to include fetus), and transport with patient

**Eclampsia:**
1. Seizures >20 weeks gravida, administer **MAGNESIUM SULFATE** 4 grams IV infusion over 20 minutes.
Mix 4 grams of **MAGNESIUM SULFATE** in 50 milliliters of **NORMAL SALINE**. Using the infusion pump, administer medication over 20 minutes.

**Special Considerations:**
Consider the possibility of pregnancy in any female of child bearing age with complaints of vaginal bleeding, menstrual cycle irregularity, abdominal cramping and / or pain, low back pain (not associated with trauma), or shoulder pain (not associated with trauma).

The greatest risk to the mother is postpartum hemorrhage so watch closely for signs of hypovolemic shock and excess vaginal bleeding.

In instances where delivery is not proceeding normally and the mother exhibits sudden onset of severe abdominal pain and the clinical signs of shock, treat for shock.