STANDING MEDICAL ORDERS FOR
OBSTETRIC/GYNECOLOGIC PATIENTS
PRE-ECLAMPSIA, ECLAMPSIA, TOXEMIA

Signs/symptoms of Pre-eclampsia/Eclampsia/Toxemia: Elevated BP>30mmHg, edema hands/feet Marked hypertension (ex: 160/110), headache, blurred vision, pulmonary edema.
Coma and convulsive seizure or systolic BP > 140 or diastolic > 90, occurring between the 20th week of pregnancy and the end of the first week postpartum.

FR-AED

1. Routine Medical Care
2. Assure minimal stimulation (handle gently, **DO NOT** check pupils for reaction to light – this may precipitate seizure)
3. If patient is having seizure, follow seizure protocol
4. Place patient on left side

BLS

1. F.R. Care
2. Obtain 12 lead ECG if indicated by chief complaint or patient presentation and transmit to:
   OSF Saint Elizabeth Medical Center Emergency Department (It is beyond the scope of the EMT-Basic to interpret 12-leads and/or cardiac rhythms)

ILS/ALS

1. BLS Care
2. Initiate IV of Normal Saline @ KVO (20mL/hr)
3. **Valium 5 mgm IV** for seizure activity that is greater than 5 minutes and witnessed by EMS after **contact with Medical Control**

Transport agencies:

Rapid transport – avoid sirens if possible (may precipitate seizure)

COMPLICATIONS DURING PREGNANCY

Placentae Previa

Occurs as a result of abnormal implantation of the placenta on the lower half of the uterine wall. Bleeding occurs when the lower uterus begins to contract and dilate in preparation for labor and pulls the placenta away from the uterine wall. The hallmark of placenta previa is the onset of painless bright red vaginal bleeding, usually in the 3rd trimester of pregnancy.

Abruptio Placentae

The premature separation of a normally implanted placenta from the uterine wall. Signs and symptoms can vary depending on the extent and character of the abruption.

- sudden onset of sharp, tearing pain and the development of a stiff, board like abdomen but no vaginal bleeding (bleeding is trapped between the placenta and the uterine wall.
- f the abruption is complete (totally separated from the uterine wall) massive vaginal bleeding and profound maternal hypotension occur

FR-AED/BLS

1. Note the amount of bleeding
2. Place patient on her left side
3. Load and Go ASAP
4. Consider ILS/ALS intercept
5. **Contact Medical Control early**

ILS/ALS

1. Initiate IV of 500 mL Normal Saline give 200 cc bolus to maintain BP of > 90 mmHg
2. If able, start a second IV
3. May repeat IV bolus as needed to maintain BP at or > 90mmHg

Care of the Pregnant Patient

FR-AED

1. Routine Medical Care
2. Obtain a pregnancy history
   - length of gestation (# of months pregnant)
   - previous pregnancies (gravida)
   - # of children from previous pregnancies (para)
   - due date
   - history of complications of pregnancy
   - any current pain
   - contractions
   - frequency of contractions
   - membranes intact or ruptured
   - expecting multiple births
   - estimate amount of bleeding if any (# of pads saturated)
   - any risk factors (see note below)
3. Position patient on left side if in 2nd or 3rd trimester. Elevate feet 10-12 inches if hypotensive
4. Take and record vital signs every 5 minutes

BLS

1. FR-AED care
2. Obtain 12 lead ECG if indicated by chief complaint or patient presentation and transmit to:
   OSF Saint Elizabeth Medical Center Emergency Department
   (It is beyond the scope of the EMT-Basic to interpret 12-leads and/or cardiac rhythms)
3. Determine if there is time to transport based on the following:
   - assess nature, extent and time of contractions
   - assess patient for high-risk factors
   - assess the status of the membranes and any discharge
   - assess for pushing with contractions
   - consider length of previous labor

ILS/ALS

1. BLS Care
2. Initiate IV of Normal Saline @ KVO (20mL/hr)
3. If hypotensive, (B/P < 90 systolic) give 200mL IV bolus and reassess

****factors which may cause a high-risk of complications for the pregnant patient****

- lack of prenatal care
- drug abuse
- teenage pregnancy (mid-or-early teens)
- history of diabetes
- hypertension
- cardiac disease
- previous breech or c-section deliveries
- pre-eclampsia, eclampsia or toxemia
- twins or multiple births

Childbirth: Field Delivery

FR/AED/BLS

If remaining on scene due to imminent delivery:

a. Contact Medical Control with decision to remain on scene
b. Place patient in position of comfort
c. Place patient on a firm surface
d. Prepare OB kit
e. Allow delivery to progress spontaneously
f. Support baby's head so that it does not emerge too quickly
g. Tear amniotic membrane, if it is still intact and visible outside the vagina
h. Check for cord around neck (if cord is around neck, try to slip it over the shoulder and head)
i. If unable to remove the cord from around the neck, place umbilical clamps 2 inches apart and cut cord between clamps
j. Carefully support head throughout delivery.
k. Suction baby's mouth and nose with bulb syringe as soon as head emerges
l. Tell mother to resume pushing. Support the head as it rotates. A slight lowering of the baby to allow delivery of the anterior (top) shoulder, and then gentle lifting to allow delivery of the posterior (bottom) shoulder may be helpful. DO NOT PULL on infant. The baby should delivery completely.
m. Baby will be wet and slippery. Be prepared to support baby during birth process with towel or blanket.

ILS/ALS

1. **FR/AED/BLS care**
2. IV of 500 mL Normal Saline give one bolus of 200 cc then TKA (20 mL/hr)

Care of the Newborn

FR-AED/BLS/ILS/ALS

1. Hold infant at level of mother
2. Suction mouth then nose with bulb syringe
3. Determine APGAR score at 1 minute and record - If less than 8 refer to Newborn Resuscitation Guideline and APGAR scoring sheet (pgs 57, 58, 59).
4. After the umbilical cord stops pulsating, clamp it 6 and 8 inches from the newborn's abdominal wall and cut the cord between the clamps with a sterile scalpel or scissors. (If no sterile cutting instrument is available, do not cut the cord. Lie the infant, with cord clamped, on the mother's abdomen)
5. Check the cord ends for bleeding. If there is any bleeding from the cord, re-clamp in another place close to the original clamp.
6. Place infant on a flat surface in sniffing, Trendelenberg position – use jaw thrust maneuver to open airway. If no respiration in 15 seconds, use BVM with 100% oxygen to ventilate
7. If no brachial pulse or pulse is <100 BPM begin CPR
8. Dry, warm, and vigorously stimulate infant for several minutes if necessary
9. Determine APGAR score at 5 minutes.
10. Do not separate mother and baby until both have ID bands on with date, name of mother, sex of child.

Post Delivery

Care of the Mother

FR-AED

1. Routine Medical Care
2. Placenta should deliver in 5-30 minutes.
3. Place sanitary pad over vaginal opening
4. Massage fundus
5. Observe for excessive bleeding. Refer to Vaginal Hemorrhage Protocol

BLS

1. FR-AED Care
2. Do not delay transport while waiting for placenta to deliver

ILS/ALS

1. BLS care
2. Initiate IV of Normal Saline @ KVO if systolic BP is above 100. If systolic BP is below 100 run IV @ rate to maintain systolic B/P at 90 – 100.

To massage the uterus post delivery, place one hand with fingers fully extended just above the mother's pubic bone and use the other hand to press down into the abdomen and gently massage the uterus approximately 3 – 5 minutes until it becomes firm. This procedure will help to stop any vaginal bleeding.

Severe Vaginal Hemorrhage

Postpartum or Miscarriage

FR-AED/BLS

1. Routine Medical Care
2. Place a sanitary napkin (use large bandage if needed) over the vaginal opening. Make note of time placed. Remove any pads as they become soaked, but save all pads to use in evaluating blood loss.
3. Save all tissue that is passed.
4. Massage fundus of uterus to keep firm and contracted.
5. If patient becomes hypotensive, position patient on left side with legs elevated.
6. Promptly transport patient.
7. Consider ILS intercept.
8. Apply pulse oximeter and record value

ILS/ALS

1. BLS Care
2. Initiate IV of Normal Saline @ KVO if systolic BP > 90 mmHg
3. Run IV @ rate to maintain B/P @ 90 if systolic BP < 90 mmHg.

Abnormal Deliveries

Prolapsed Cord

FR-AED

1. Routine Medical Care
2. Oxygen at 15 L per NRB
3. Place mother in knee-chest position with hips elevated on pillows
4. Protect cord from being compressed by placing a sterile gloved hand in vagina between pubic bone and presenting part with cord between fingers. Exert counter pressure against presenting part. Keep hand in position until relieved by hospital personnel.
5. Palpate cord for pulsations.
6. **DO NOT ATTEMPT TO PUSH CORD BACK**. **OR PULL ON THE CORD**
7. Keep exposed cord moist and warm.
8. Apply pulse oximeter and record value

BLS/ILS/ALS

1. FR-AED care
2. Initiate transport immediately.

Abnormal Presentation (breech or limb)

FR-AED

1. Routine Medical Care
2. Oxygen at 15 L per NRB
3. Notify Medical Control asap of situation
4. **DO NO ATTEMPT TO PULL BABY FROM VAGINA BY LEGS OR TRUNK or EXTREMITIES**
5. Elevate mothers hips
6. If breech presentation : As soon as legs are delivered, support baby's body
7. After shoulders are delivered, gently elevate trunk and legs to aid in delivery of head (if face down)
8. Head should deliver in 30 seconds. IF NOT – place 2 fingers into vagina to locate the infant's mouth. Press vaginal wall away from baby's mouth to force an airway. Apply gentle pressure to the mother's fundus.
9. If limbs are presenting part Patient needs rapid transport by transport agency
10. Avoid touching the presenting limb as that stimulation may cause baby to take a breath.

BLS/ILS/ALS

1. FR-AED care
2. Initiate transport immediately

NEWBORN ASSESSMENT

FR-AED/BLS/ILS/ALS

Evaluate APGAR score at 1 minute and 5 minutes

APGAR SCORING

SIGN	0	1	3
Heart Rate	Absent	< 100	> 100
Respirations	Absent	Slow	>40
Muscle Tone	Limp	Some flexion	Vigorous
Reflex irritability	None	Grimace	Grimace
Color	Diffusely pale/blue	Centrally pink	Completely pink

Neonatal Resuscitation

FR/BLS

- Deliver head
- Suction mouth and nose and posterior pharynx with #10 Fr catheter or bulb syringe
- Deliver body
- Clamp/cut cord

If meconium absent:

- Dry/stimulate/cover head
- Keep warm
- Evaluate respiratory rate
- Evaluate heart rate

If meconium present (thick/particulate)

- Visualize and suction back of oral cavity as deep as possible without trauma
- Ventilate between suctioning attempts with BVM
- Dry/stimulate/cover head after thorough suctioning complete
- Evaluate respiratory rate
- Evaluate heart rate

Respiratory rate slow/gasping, absent:

- Position airway
- Support ventilation with BVM @ 100% oxygen
- Ventilate at 12-20 per minute (every 3-5 seconds)
- Re-evaluate frequently

Respiratory rate spontaneous with good effort:

- Evaluate heart rate
- Keep warm

Heart Rate < 60:

- Continue ventilations @ 12-20/min
- Begin chest compressions @ 30-2 if single EMT, 15-2 if two EMT
- Compression: ventilation ratio @ 3:1
- Evaluate APGAR at 1 min and repeat at 5 minutes

Heart Rate 80 – 100:

- Support ventilations with BVM
- Re-evaluate frequently

Heart Rate > 100:

- Continue to warm and re-evaluate frequently
- Evaluate color
- APGAR at 1 min and repeat at 5 minutes
- PINK:
  Contact Medical Control
  Transport ASAP
  Keep warm
  Re-evaluate frequently
- BLUE:
  Administer 100% oxygen by mask or BVM
  Contact Medical Control
  Keep warm, re-evaluate frequently

Neonatal Resuscitation Continued

ILS/ALS

1. BLS/FR care
2. IF heart rate < 80/min:
   - Secure advanced airway – intubate as indicated
   - **Epinephrine 0.01-0.03mg/kg ET (0.1-0.3mL/kg) of 1:10,000** May **repeat every 3-5 minutes** as indicated
   - Initiate IV of Normal Saline @ KVO
   - Cardiac monitor
   - Pulse oximeter
   - Re-evaluate frequently
   - Contact Medical Control
3. If heart rate 80 – 100/min:
   - Support ventilations with BVM and 100% oxygen
   - Advanced airway as indicated – intubate orally
   - Evaluate color:
   - PINK:
     Transport ASAP
     Observe
     Keep warm
   - BLUE:
     Contact medical control
     Consider**: NARCAN 0.1mg/kg ET/IV**
     Dextrose 12.5% 1-2 mL/kg IV
     Fluid bolus 10 mL/kg

Special Considerations

Small amounts of meconium may merely discolor the amniotic fluid with no particles of meconium visible. Special management of these infants is not necessary. Meconium management is indicated for amniotic fluid that is "pea soup" in appearance, or contains particles of meconium.