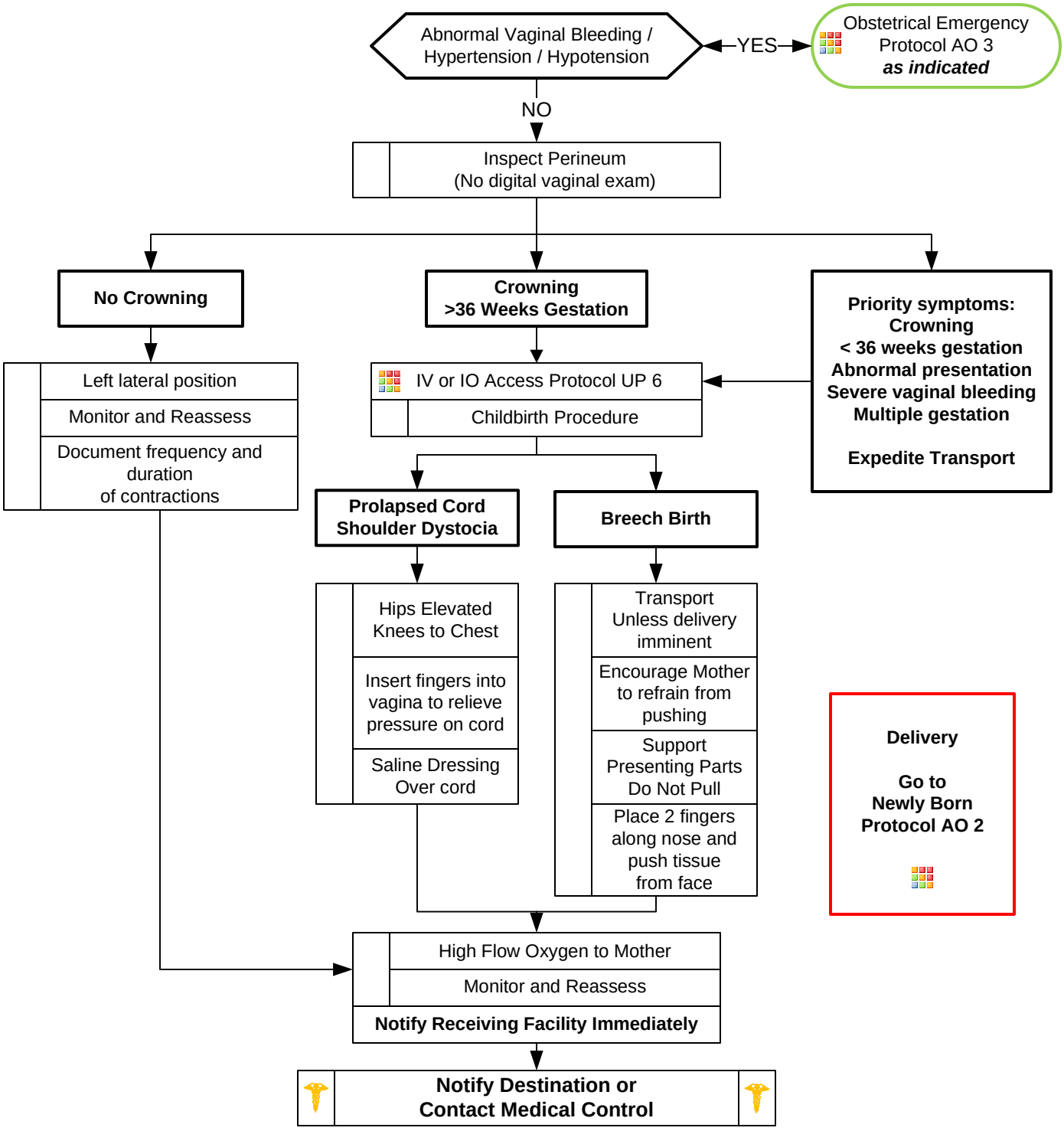
Childbirth/ Labor

History
- Due date
- Time contractions started / how often
- Rupture of membranes
- Time / amount of any vaginal bleeding
- Sensation of fetal activity
- Past medical and delivery history
- Medications
- Gravida / Para Status
- High Risk pregnancy

Signs and Symptoms
- Spasmodic pain
- Vaginal discharge or bleeding
- Crowning or urge to push
- Meconium

Differential
- Abnormal presentation
  - Buttock
  - Foot
  - Hand
- Prolapsed cord
- Placenta previa
- Abruptio placenta



Adult Obstetrical Protocol Section

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Stages of Labor:

Stage 1 (Dilatation stage):

First stage of labor begins with onset of true labor contractions and ends with the complete dilatation of the cervix. Complete dilatation is 10 cm. The first stage typically lasts for 8 to 10 hours for women experiencing their first pregnancy and 5 to 7 hours for multiparous females. Typically the contractions are mild and last for 15 to 20 seconds and recur about every 10 to 20 minutes. As labor progresses the contractions become intense, lasting about 60 seconds and are every 2 to 3 minutes.

Stage 2 (Expulsive stage):

Second stage begins when the cervix is dilated to 10 cm. This typically lasts 60 minutes for those experiencing their first pregnancy. In the multiparous this this may last only 30 minutes. Contractions in this stage last for 60 to 80 seconds and recur about every 2 minutes. The membranes usually rupture in this stage, back pain and the urge to push are prominent. Crowning occurs when the head or presenting part is visible in the vaginal opening.

Stage 3 (Placental stage):

Third stage of labor begins when the infant is delivered and ends when the placenta delivers. The placenta generally delivers within 5 to 30 minutes. Often a rush of blood may be seen, lower abdominal shape change due to uterine contractions may occur and the umbilical cord may lengthen all of which signal the placenta delivery is imminent.

Hypothermia:

Immediately following delivery place infant onto mother's abdomen skin-to-skin and wrap to maintain warmth.

General approach:

- Place IV access anticipating need for fluid replacement. Average blood loss during delivery is 500 mL.
- Following birth treat pain per pain control protocol.
- Do not carry infant. Infant should be with mother, skin-to-skin. Carrying the infant is a fall / drop risk.
- If you must carry infant, sit in a wheelchair and have someone push you and infant to Labor and Delivery.

Pearls

- **Recommended Exam (of Mother): Mental Status, Heart, Lungs, Abdomen, Neuro**
- **Record APGAR at 1 minute and 5 minutes after birth. Do not delay resuscitation to obtain APGAR.**
- **If neonate requiring resusciation, move quickly to AO 2 Newly Born Protocol**
- **After delivery, massaging the uterus (lower abdomen) will promote uterine contraction and help to control post-partum bleeding.**
- **Tranexamic Acid (TXA):**
  Postpartum hemorrhage: NOT indicated and should NOT be administered where birth occurred > 3 hours prior to EMS arrival.
- **Transport or Delivery?**
  Decision to transport versus remain and deliver is multifactorial and difficult. Generally it is preferable to transport. Factors that will impact decision include: number of previous deliveries; length of previous labors; frequency of contractions; urge to push; and presence of crowning.

Apgar score

	Score 2	Score 1	Score 0
Appearance	Pink	Extremities blue	Pale or blue
Pulse	> 100 bpm	< 100 bpm	No pulse
Grimace	Cries and pulls away	Grimaces or weak cry	No response to stimulation
Activity	Active movement	Arms, legs flexed	No movement
Respiration	Strong cry	Slow, irregular	No breathing

- **Maternal positioning for labor:**
  Supine with head flat or elevated per mother's choice. Maintain flexion of both knees and hips. Elevated buttocks slightly with towel. If delivery not imminent, place mother in the left, lateral recumbent position with right side up about 10 – 20°.
- **Umbilical cord clamping and cutting:**
  Place first clamp about 10 cm from infant's abdomen and second clamp about 5 cm away from first clamp.
- **Multiple Births:**
  Twins occur about 1/90 births. Typically manage the same as single gestation. If imminent delivery call for additional resources, if needed. Most twins deliver at about 34 weeks so lower birth weight and hypothermia are common. Twins may share a placenta so clamp and cut umbilical cord after first delivery. Notify receiving facility immediately.
- Document all times (Contraction onset, contraction duration and frequency, delivery, APGAR 1 and 2, and placenta delivery).
- If maternal seizures occur, refer to the Obstetrical Emergencies Protocol.
- Some perineal bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal.