

5.01 CHILDBIRTH: NORMAL DELIVERY AND COMPLICATIONS EMSAC JUNE 2026



BLS
ALS

- Assess ABC's, vital signs, **Oxygen** PRN (goal >94%)
- Obtain history including: gestational age, # of prior pregnancies, prenatal care and pregnancy complications
- Plan for resources based on number of anticipated patients (e.g. multiple births)
- **Assess for signs of imminent delivery:** crowning, urge to push, presentation of fetal part, contractions < 2 minutes apart

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For childbirth complications → Initiate transport immediately and see below

Crowning?

YES

NO

Prepare obstetric kit and facilitate delivery

- Support infant head as needed
- Grasping the head with hand over the ears, gently guide down to allow delivery of the anterior shoulder
- Gently guide head up to allow delivery of posterior shoulder
- Delay cord clamping for *at least* 1 minute.
- Massage uterus (at the umbilicus) and deliver placenta (do **NOT** pull). Contain all tissue in plastic bag and transport

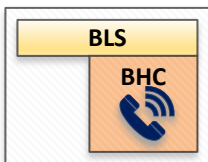
Infant management

- Dry, stimulate and warm baby.
- If unresponsive, see **Neonatal Resuscitation**
- If stable, place skin to skin and wrap mother and baby together.
- Do **NOT** routinely suction infant airway unless concern for obstruction.
- Assess APGAR at 1 and 5 minutes (Appendix A)

Start IV with **Normal Saline**
For maternal pain consider **Fentanyl**

Transport to OB center (5000.1)

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Childbirth Complications

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Nuchal Cord

- After head is delivered, palpate neck for a nuchal cord and if present slip over the head.
- If the loop is too tight to slip over the head, attempt to slip the cord over the shoulders and deliver body through the loop.
- If unsuccessful, cord can be doubly clamped and cut between the clamps; deliver newborn immediately.

Post-Partum Hemorrhage

- Deliver placenta. Assist with very gentle downward pulling of the umbilical cord. Once delivered, assess if placenta is intact
- Perform uterine fundal massage: rub abdomen below naval with flat hand X 15 seconds.

Prolapsed Cord

- If possible, transport with mother supine position head lower than hips
- Insert a gloved hand to gently push the presenting neonate part off the cord (do **NOT** tug)
- Avoid repositioning the cord. Cover the exposed cord with saline soaked gauze.

Shoulder Dystocia

- Hyperflex mother's hips to supine knee-chest position/ McRobert's Maneuver (**Appendix B**)
- Apply firm suprapubic pressure to attempt to dislodge shoulder
- Angle baby's head posteriorly but never pull.
- Continue with delivery as normal once anterior shoulder delivered

Breech

- Allow delivery to proceed passively until the baby's waist appears. Gently rotate the baby to a face down position and continue with the delivery.
- If head does not deliver, place hand gloved in vagina, and position fingers on either side of neonate nose and mouth to make a "V"

Hemorrhage before delivery

- There are many possible causes (e.g. abruptio placenta, placenta previa etc.) all of which require transport and specialty care.
- For hypotensive patients, see **shock** protocol

If there are concerns about need for resuscitation based on fetus' gestational age and viability



Comments

- Most deliveries proceed without complications – if complications of delivery occur, apply high flow oxygen to mother and expedite transport. Maternal resuscitation is critical for best fetal outcome.
- Physician on-scene (including Nurse Practitioner or Certified Professional Midwife) may provide additional medications and management (**Policy 4041**)
- If mother has hypotensive before delivery, place patient in lateral recumbent position or manually displace gravid uterus to the left in supine position.
- The obstetric age of viability is generally considered to be 20 to 25 weeks of gestation. Miscarriages are spontaneous abortions <20 weeks gestational age and may be associated with intermittent pelvic pain and vaginal bleeding. If heavy vaginal bleeding is reported see hemorrhagic **shock** protocol.