Transcript

Normal Delivery

In the dynamic and challenging world of emergency medical services, paramedics are often the first and most critical point of contact for those in need. Among the myriad emergencies we navigate, obstetric cases hold a unique place, where the joy of bringing new life intersects with the complexities of medical care outside the hospital setting. Until now, a gap has existed in evidence-based clinical practice guidelines specifically tailored for obstetric issues encountered by EMS teams in the field. This gap challenges our adaptability and demands a high level of preparedness to manage childbirth emergencies effectively. Despite the absence of pre-hospital-specific obstetric guidelines, we are fortunate to draw upon a wealth of high-quality recommendations from hospital settings and midwife-run delivery units. These insights offer invaluable guidance for managing obstetric emergencies before reaching the hospital, ensuring that every practitioner is equipped to provide the best possible care during these critical moments. The reality is that while the delivery and birth process ideally takes place within the well-equipped walls of a hospital, emergencies wait for no one. As first responders, it is imperative that we are prepared to manage deliveries and provide immediate care, intervening within the limits of our scope of practice to safeguard the health and well-being of both mother and child. In the journey of childbirth, normal delivery encompasses a diverse array of experiences, each unique to the individuals involved. Defined by the World Health Organization, a normal birth is spontaneous in onset, and low risk at the start of labor, continuing so throughout the process.

It culminates in the joyful moment when a baby is born spontaneously in the vertex position, anywhere between 37 and 42 completed weeks of pregnancy. Your essence of care in these moments is profound. You are the bearer of comfort and the provider of support, not just for the mother but for the newborn as well. Your expertise guides you in closely monitoring the situation, ready to assist when necessary, and ensuring

a safe transfer to the appropriate health facility. Yet, the path of a normal delivery can take unexpected turns.

What appears to be low risk can escalate without warning, a stark reminder of the unpredictable nature of childbirth. This reality underscores the importance of your vigilance, preparedness, and the ability to adapt swiftly to the needs of mother and child. As paramedics, the heart of your approach lies in the ability to connect with and understand the women you are assisting through one of the most significant experiences of their lives. that there is a critical need for healthcare professionals, including EMS teams, to establish empathetic relationships with women in labor. Engaging with expectant mothers goes beyond medical procedures, it involves asking about their expectations, understanding their needs, and providing support that aligns with their wishes. Your attitude, the tone of your voice, and the words you choose play a pivotal role in creating a supportive environment that respects and honors the birthing process. Being aware of how you communicate is vital. It's about more than just the information you convey, it's how you make the mother feel supported, valued, and understood.

This empathetic approach not only enhances the care you provide, but also fosters a sense of safety and trust during a profoundly vulnerable time. In every interaction, remember that your support can significantly influence the birthing experience. Understanding the stages of labor is fundamental to your role as a paramedic in providing care to pregnant women. The journey of labor is divided into distinct stages, each with its specific challenges and needs. The first stage begins with the onset of regular labor pains and lasts until the cervix is fully dilated. This stage can vary greatly in duration but typically lasts between 5 to 8 hours. During this time, your support, reassurance and comfort are invaluable to the mother.

Ensuring hydration and providing appropriate pain relief are also key aspects of care. As we move to the second stage of labor, the pace often quickens. This stage starts

once the cervix is fully dilated and continues until the baby is born. The initial passive phase precedes the active phase, where there are expulsive contractions, maternal pushing, and the fetus becomes visible. During the active phase, mothers should be encouraged to push, and the fetus supported as it emerges. In the presence of fetal distress, it may be appropriate to expedite delivery by encouraging the mother to push earlier than the recommended active phase at the end of the second stage of labor.

Fetal distress during labor is suspected when the fetal heart rate is abnormally high or low. It should be managed as follows. Explain the problem to the woman.

Place the woman in the left lateral position. Stop oxytocin infusion if applicable. Give oxygen by face mask at 6 liters per minute for 20 to 30 minutes.

Start an intravenous IV infusion of Ringer's lactate to run at 240 mL per hour for 1-2 hours, unless the woman is hypertensive or has cardiac disease. Consider transferring the patient to a facility with the capability to perform a cesarean section. Following the birth, we enter the third stage, which involves the delivery of the placenta.

Normally, this occurs spontaneously within 30 minutes. The active method of managing the third stage is recommended to prevent excessive bleeding and includes the following. Immediately after delivery of the baby, ensure by abdominal palpation that there is no previously undiagnosed second twin, even if antenatal ultrasound found a singleton pregnancy. If there is no second twin, immediately give oxytocin 10 units intramuscularly. Await uterine contraction for 2-3 minutes then feel for uterine contraction every 30 seconds. Do not massage or squeeze the uterus with the placenta still inside.

When the uterus is felt to contract, put steady tension on the umbilical cord with the right hand, while pushing the uterus upwards with the left hand. Deliver the placenta by applying continuous gentle traction on the umbilical cord. The period immediately after the placenta's delivery is critical. Known as the fourth stage, this is when the mother is monitored for signs of postpartum hemorrhage.

Your vigilance during this hour ensures any signs of excessive bleeding are quickly addressed. Now let's look at some of the recommendations for newborn care. For a fetus in distress requiring resuscitation, there should be immediate cord clamping to facilitate optimal resuscitation. Otherwise, delayed cord clamping would usually be advocated. Clamp the umbilical cord after the second minute or after it stops pulsing. Assess the baby's opgar score at one minute. To keep the baby warm, he or she should be covered and dried with a blanket or towel that has previously been warmed, whilst maintaining skin-to-skin contact with the mother. The mother and baby should not be separated for the first hour or until the first feed has been given. During this period the paramedic should remain vigilant and periodically observe, interfering as little as possible in the relationship between the mother and neonate, checking the neonate's vital signs, color, respiratory movements, tone, and if necessary heart rate.