Cephalic presentation

Breech presentation

Delivery presentation is the position of the presenting part of the fetus (head, feet, etc.) as it comes down the birth canal.
TAB 4 GUIDELINE 1
OB PATIENT TRANSPORT

1. Transport of an obstetrical patient by air or ground should be considered when:
   a. The resources immediately available to the patient are not sufficient to deal with the patient’s actual or predicted obstetrical, medical or surgical complications.
   b. There is the reasonable expectation of the birth of one or more infants who may require neonatal intensive care greater than that available at the referring hospital.
   c. The patient’s obstetrical, medical or surgical circumstances require continuous attendance by trained personnel not available at the referring hospital.

2. The following conditions usually require transport to a high-risk perinatal center:

<table>
<thead>
<tr>
<th>Obstetrical Complications</th>
<th>Medical Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Preterm labor causing delivery of an infant of &lt; 34 weeks gestation or less than 2000 grams</td>
<td>• Hepatitis</td>
</tr>
<tr>
<td>• Severe pre-eclampsia / eclampsia</td>
<td>• Pyelonephritis</td>
</tr>
<tr>
<td>• Multiple gestation</td>
<td>• Influenza / Pneumonia</td>
</tr>
<tr>
<td>• Poorly controlled maternal diabetes mellitus</td>
<td>• Severe organic heart disease</td>
</tr>
<tr>
<td>• Meconium stained amniotic fluid visualized</td>
<td>• Poorly controlled diabetes</td>
</tr>
<tr>
<td>• Third trimester bleeding</td>
<td>• Thyrotoxicosis</td>
</tr>
<tr>
<td>• RH iso-immunization</td>
<td>• Renal disease with deteriorating function or increased hypertension</td>
</tr>
<tr>
<td>• Premature dilation of cervix greater than 2-3 cm with uterine activity</td>
<td>• Drug overdose</td>
</tr>
<tr>
<td></td>
<td>• HELLP (Hemolytic anemia, Elevated Liver enzymes, Low Platelet count) Syndrome</td>
</tr>
</tbody>
</table>

3. Transport:
   a. **OB transfers will be considered “LOAD AND GO” situations unless the patient is crowning**
   b. Fetal heart tones should be obtained before and after the transport and during transport when necessary
   c. Imminent delivery is defined as being likely to occur prior to completion of the transport
   d. In the case of a potential en route delivery, all-appropriate equipment will be readied and at the patient’s side throughout the transport
   e. The patient should be transported lying on her left side in such a fashion as to prevent vena cava pressure from the gravid uterus
**VAGINAL BLEEDING | POST PARTUM HEMORRHAGE**

### HISTORY
- Blood loss – vaginal, ectopic pregnancy
- Fluid loss - vomiting, diarrhea, fever
- Infection
- Cardiac ischemia (MI, CHF)
- Medications
- Allergic reaction
- Pregnancy – Last menstrual cycle
- History of poor oral intake

### SIGNS / SYMPTOMS
- Cramping, passage of clots or tissue
- Evidence of blood loss, clots or tissue fragments (bring tissue to ED)
- Restlessness, confusion
- Lightheaded, weakness or thirst
- Weak, rapid pulse
- Pale, cool, clammy skin
- Delayed capillary refill
- Hypotension

### DIFFERENTIAL
- Shock
- Hypovolemia
- Cardiogenic
- Septic
- Neurogenic
- Anaphylactic
- Ectopic pregnancy
- Dysrhythmias
- Vasovagal
- Physiologic (pregnancy)

---

**Diagram:**
- Universal Patient Care
  - Observe and Reassess
    - NO
    - Symptomatic
      - YES
      - IV / IO Access
      - Cardiac Monitor / 12-Lead EKG
      - Assess Rhythm
      - Fluid Bolus
        - 250 – 1000 mL (repeat PRN)
      - Postpartum (within 24 hours)
        - massage uterus
      - Norepinephrine
        - 0.5 – 30 mcg / min IV / IO
        - or-
        - Dopamine
        - 5 – 20 mcg / Kg / min IV / IO
        - Titrate for SBP > 90 mmHg
      - Contact Medical Control
      - Transport to appropriate facility
  - Consider Oxytocin
    - 20 units in 1 L NS, 500 cc bolus over 12 – 20 minutes then infuse at 125 ml / hr
  - EMT-P
  - Nurse
  - MC Order
SPECIAL CONSIDERATIONS:

1. Always consider pregnancy (specifically ectopic) as a cause of vaginal bleeding

2. Try to get an estimate of number of saturated pads in previous 6 hours. Discreet inspect of the perineum may be useful to determine if clots or tissue are being passed.

3. **Internal or Bimanual VAGINAL EXAM IN THE FIELD IS NOT INDICATED**

4. If patient is pregnant, bring in any tissue that was passed. Laboratory analysis may be important in determining status of the pregnancy
TAB 4 GUIDELINE 3
OBSTETRICAL EMERGENCY

HISTORY
- Past medical history
- Hypertension medications
- Prenatal care
- Prior pregnancies / births
- Gravida / Para

SIGNS / SYMPTOMS
- Vaginal bleeding
- Abdominal pain
- Seizures
- Hypertension
- Severe headache
- Visual changes
- Edema of hands and face

DIFFERENTIAL
- Pregnancy Induced Hypertension
- Pre-eclampsia / Eclampsia
- Placenta previa
- Placenta abruptio
- Premature rupture of membrane
- Spontaneous abortion

LEGEND
- Nurse
- MC Order
- EMT-P

Universal Patient Care
- Maintain SpO₂ > 95%
- IV / IO Access

Vaginal bleeding / Abdominal pain

Known pregnancy / Missed period
- NO
- YES
  - Place in Left lateral position
  - Hypertension
    - NO
    - YES
      - Labetolol 10 mg IV q 10 min (max 300 mg)
      - Metoprolol 5 mg IV q 5 min (may repeat x 2)
  - NO
  - Seizure or seizure-like activity
    - Check Blood Glucose
      - YES
      - Magnesium Sulfate 4 grams IV / IO drip (over 15 – 30 min) then infuse 1 – 2 Grams / hour
      - Midazolam 2 – 5 mg IV / IO / IN / IM
    - NO
    - Glucose ≤ 60
      - 10% Dextrose 100 ml (10 gms) IV / IO q 3 – 5 minutes
        (D10 not available then)
      - 50% Dextrose 25 – 50 grams IV / IO
      - Glucagon 1 mg IN / IM (If no IV access)
      - Contact Medical Control
      - Transport to appropriate facility

Known pregnancy / Missed period
- NO
- YES
  - Abdominal Pain Guideline
    - Place in Left lateral position
    - Hypotension
      - NO
      - Fluid Bolus 250 – 1000 mL (repeat PRN)
    - NO
    - Complaint of labor
      - NO
      - YES
        - Fentanyl 25 – 50 mcg IV / IM / IN q 15 min prn Pain
        (Maximum 300 mcg)
      - YES
        - Preterm Labor
          - NO
          - YES
            - Fetal Delivery Guideline
              - Consider Obstetrical Complications
                - Magnesium Sulfate 4 Grams IV / IO over 30 min then infuse 1 – 2 Grams / hour – or –
                  Terbutaline 0.25 IM, q 15 minutes x 3 (PRN)
SPECIAL CONSIDERATIONS:

1. Tocolytics are generally contraindicated in uteroplacental hemorrhage because of the possibility of aggravating hypotension and increasing uteroplacental insufficiency

2. Placental Abruption
   a. The major risks to mother and fetus during transport are hypotension and shock due to blood loss, coagulation defects, premature labor and delivery, and fetal asphyxia secondary to placental separation. The risk to mother and fetus is relatively low if there has been minimal blood loss (less than 100 ml), vital signs are stable, there are no uterine contractions, the uterus is non-tender and there are normal fetal heart tones.
   b. Conversely, there is substantial risk to both mother and infant if there is active bleeding, contractions are occurring, there is maternal tachycardia, hypotension or hypertension, the uterus is tender or there are signs of fetal distress
   c. Assessment
      i. Associated with continuous painful contractions of the uterus with little or no vaginal bleeding

3. Pre-term labor
   a. Pre-term labor is defined as labor between 24 – 34 weeks of pregnancy and there is a risk of preterm birth within 7 days. These babies have less of a chance for survival and a greater incidence of birth defects. Treatment is to prevent labor from progressing and rapid transport to an appropriate facility
   b. Give Magnesium sulfate to stop pre-term labor
      i. Mix 10 grams of Magnesium sulfate in 250 ml normal saline of D5W. Give 100 ml over 30 minutes (4 grams), followed by an infusion of 25 – 50 ml / hr (1 – 2 grams / hr).
      ii. Check reflexes every 60 minutes, in the event of hypermagnesium (respiratory depression, depressed reflexes, hypotension) administer Calcium gluconate 1 gram IVP over 3 minutes

4. Premature rupture of membranes
   a. Check for cord prolapse and if present, position patient (knee-chest or Trendelenburg) to prevent compression

5. Pregnancy induced hypertension
a. The major risks to the mother and fetus being transported because of severe pre-eclampsia are development of seizures, CNS hemorrhage, premature labor and delivery, and fetal distress due to uteroplacental insufficiency

b. The patient is at significant risk of seizures or other serious complications if the blood pressure exceeds 150 / 110, there is significant proteinuria, and/or the patient manifests hyperreflexia, headaches, or epigastric pain

6. Seizures related to pregnancy (eclampsia)
   a. Give Magnesium sulfate to stop seizure activity
      i. Mix 10 grams of Magnesium sulfate in 250 ml normal saline of D5W. Give 100 ml over 15 – 30 minutes (4 grams), followed by an infusion of 25 – 50 ml / hr (1 – 2 grams / hr).
      ii. Check reflexes every 60 minutes, in the event of hypermagnesium (respiratory depression, depressed reflexes, hypotension) administer Calcium gluconate 1 gram IVP over 3 minutes
**TAB 4 GUIDELINE 4**

**OBSTETRICAL – NAUSEA | VOMITING**

### HISTORY
- Age
- Time of last meal
- Last bowel movement/emesis
- Improvement or worsening with food or activity
- Duration of problem
- Other sick contacts
- Past medical history
- Medications
- Menstrual history (pregnancy)
- Travel history

### SIGNS / SYMPTOMS
- Pain
- Character of pain
- Distention
- Diarrhea / Constipation
- Anorexia
- Radiation
- Fever, headache, blurred vision, weakness, malaise, cough, headache, dysuria, mental status changes, rash

### DIFFERENTIAL
- GI or renal disorders
- Diabetic ketoacidosis
- Gynecologic disease
- Infections (pneumonia, influenza)
- Electrolyte abnormalities
- Food or toxin induced
- Medication or substance abuse
- Pregnancy

---

**Universal Patient Care**
- Make NPO

**IV / IO Access**
- Fluid Bolus 250 – 1000 mL

**Check Blood Glucose**
- Glucose ≤ 60
- Glucose > 250

**Glucose ≤ 60**
- IV / IO Access
- Fluid Bolus 250 – 1000 mL

**Glucose > 250**
- Fluid Bolus 250 – 1000 mL

**Vomiting / Severe Nausea**

**YES**
- **Isopropyl Alcohol**
  - 1 packet inhaled q 10 minutes
- **Diphenhydramine**
  - 25 – 50 mg
  - IV / IO / IM / IN
- **Zofran**
  - 4 – 8 mg SL / IV / IO / IN / IM
  - (Avoid in 1st trimester)
- **Phenergan**
  - 12.5 – 25 mg IM

**NO**
- Monitor and Reassess throughout transport

**Contact Medical Control**
- Transport to appropriate facility

---

**LEGEND**
- EMT
- EMT-P
- A-EMT
- EMR
- EMT-SE
- MC Order

---

**10% Dextrose**
- 100 ml (10 grams) IV / IO
- q 3 – 5 minutes
- D10 not available then
- 50% Dextrose
- 25 – 50 grams IV / IO

**Glucagon**
- 1 mg IN / IM
- (If no IV access)
**TAB 4 GUIDELINE 5**

**FETAL DELIVERY**

<table>
<thead>
<tr>
<th>HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Due date</td>
</tr>
<tr>
<td>• Time contractions started / how often</td>
</tr>
<tr>
<td>• Rupture of membranes</td>
</tr>
<tr>
<td>• Time / amount of any vaginal bleeding</td>
</tr>
<tr>
<td>• Sensation of fetal activity</td>
</tr>
<tr>
<td>• Past medical and delivery history</td>
</tr>
<tr>
<td>• Medications / Drug use</td>
</tr>
<tr>
<td>• Gravida / Para status</td>
</tr>
<tr>
<td>• High risk pregnancy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNS / SYMPTOMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Spasmodic pain</td>
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<tr>
<td>• Vaginal discharge or bleeding</td>
</tr>
<tr>
<td>• Crowning or urge to push</td>
</tr>
<tr>
<td>• Meconium</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIFFERENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abnormal presentation</td>
</tr>
<tr>
<td>• Buttock</td>
</tr>
<tr>
<td>• Foot</td>
</tr>
<tr>
<td>• Hand</td>
</tr>
<tr>
<td>• Prolapsed cord</td>
</tr>
<tr>
<td>• Placenta Previa</td>
</tr>
<tr>
<td>• Abruptio Placenta</td>
</tr>
</tbody>
</table>

**Universal Patient Care**

**IV / IO Access**

**Left lateral position**

**Hypertension or Abnormal vaginal bleeding**

**Hypotension**

**Inspect perineum for crowning**

(NO digital vaginal exam)

**No crowning**

**Monitor and reassess**

Document frequency and duration of contractions

**Crowning**

> 36 weeks gestation

**Fetal Delivery Procedures**

**Fetus Delivered**

**YES**

**NO**

**Neonatal Resuscitation Guideline**

**Prolapsed cord -or- Shoulder Dystocia**

**Fetal Delivery Complications Guideline**

**Contact Medical Control**

**Transport to appropriate facility**

**Legend**

- EMT-P
- Nurse
- MC Order

**Fluid Bolus**

250 – 1000 mL (repeat PRN)

**Priority Symptoms:**

- Crowning
- < 36 weeks gestation
- Abnormal presentation
- Severe vaginal bleeding
- Multiple gestation

**Unable to Deliver**

Create air passage by supporting presenting part of infant

Place 2 fingers along side of nose and push away from face

Transport in Knee to Chest Position or Left Lateral Position
TAB 4 GUIDELINE 6
FETAL DELIVERY PROCEDURES

• As the head appears support it with gentle pressure.
• Support the head during the delivery and examine for the presence of a nuchal cord. If the cord is wrapped around the neck slip over the infant’s head. If the cord will not go over the head, clamp the cord in two (2) placed and cut the cord between the clamps.
• Suction the mouth and then the nose as soon as possible.
• Support the head as it delivers for a shoulder presentation.
• Guide the infant’s head downward to deliver the anterior shoulder and then upward to deliver the posterior shoulder.

NORMAL VAGINAL DELIVERY

• Keep newborn at level of mother’s vagina until cord stops pulsating and is double clamped
• Clamp the cord approximately ten (10) inches from the baby and again seven (7) inches from the baby and then cut between the cut clamps. Examine the cord for bleeding, if present apply another clamp.

BREECH PRESENTATION DELIVERY

• If delivery is imminent, allow the buttocks and trunk of the baby to deliver spontaneously. Do not allow the infant’s body to rotate with the abdomen upwards. Always look at the back of the baby.
• Once the legs are delivered, support the body on the palm of your hand and surface of your arm.
• Allow the head to be delivered. If the head is not delivered spontaneously without delay, place your gloved hand in the vagina with your palm toward the baby’s face.
• Form a ‘V’ with fingers on either side of the infant’s nose and push the vaginal wall away from the face until delivery of the head.
• If the delivery is not completed without delay:
  • Rotate the infant’s body 45 degrees clockwise and attempt to deliver the infant’s shoulder.
  • If unable to do so, rotate the infant’s body counter clockwise 90 degrees and attempt to deliver one of the shoulders.
  • As soon as one of the shoulders is delivered, rotate again in the opposite direction of the last rotation and deliver the second shoulder.
  • Gently restore the original position of the infant with the back up again and lift the infant’s body upward toward the maternal abdomen, while depressing the perineum.
  • Allow the head to be delivered.

Neonatal Resuscitation Protocol

• If neonatal resuscitation is not necessary:
  • Record the APGAR score at one (1) and five (5) minutes.
  • Deliver the placenta. Never pull on the umbilical cord to aid in the placental delivery. Place the placenta in a suitable container for transport.
  • Apply dressings to control bleeding from tears in the perineum.

Document all times (delivery, contraction frequency, and length).
### TAB 4 GUIDELINE 7

#### FETAL DELIVERY COMPLICATIONS

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS / SYMPTOMS</th>
<th>DIFFERENTIAL</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>- Meconium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hypotension</td>
<td></td>
<td></td>
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<tr>
<td>- Uterine contraction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Abnormal presentation</td>
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<tr>
<td>- Buttock</td>
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</tr>
<tr>
<td>- Abruptio Placenta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shoulder dystocia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Post-partum hemorrhage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Universal Patient Care**
- Left lateral position
- IV / IO Access
  - Fluid Bolus 250 – 1000 mL
- Contact Medical Control
- Transport to appropriate facility

**Breech Presentation**
- Discourage pushing by mother
- Position mother in Trendelenberg or supine with hips elevated
- Place gloved hand in mother’s vagina and elevate the presenting fetal part off of cord until relieved by physician
- Feel for cord pulsations
- Keep exposed cord moist and warm

**Prolapsed Cord**
- Support baby’s head
- Suction oral and nasal passages
- DO NOT pull on head
- May facilitate delivery by placing mother with buttocks just off the end of bed, flex her thighs upward and gentle open hand pressure above the pubic bone

**Shoulder Dystocia**

**Complication Post Delivery**
- Post-Partum Hemorrhage
  - Massage abdomen (uterine fundus) until firm
  - Note type and amount of bleeding
  - Treat for hypotension

**LEGEND**
- EMT-P
- Nurse
- MC Order

**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 / Drug use
- Gravida / Para status
- High risk pregnancy

**SIGNS / SYMPTOMS**
- Spasmodic pain
- Vaginal discharge or bleeding
- Crowning or urge to push
- Meconium
- Hypotension
- Uterine contraction

**DIFFERENTIAL**
- Abnormal presentation
- Buttock
- Foot
- Hand
- Prolapsed cord
- Placenta Previa
- Abruptio Placenta
- Shoulder dystocia
- Post-partum hemorrhage
SPECIAL CONSIDERATIONS:

1. Prolapsed umbilical cord.
   a. Clinical presentation includes:
      i. Spontaneous Rupture of Membranes.
      ii. Cord visible at vaginal opening.
      iii. Fetal Heart Rate variable with rapid decline in heart rate.
   b. Position the mother in Trendelenburg or knee chest position to relieve pressure on the umbilical cord.
   c. Have the mother pant with each contraction to prevent her from bearing down.
   d. Insert two gloved fingers into the vagina and gently elevate the presenting part to relieve pressure on the cord and to restore and umbilical pulse. DO NOT attempt to reposition the cord.
   e. If possible place a moist dressing over the exposed cord.

2. Shoulder dystocia
   a. McRoberts Maneuver
      i. Involves hyperflexing the mother's legs tightly to her abdomen. It is effective due to the increased mobility at the sacroiliac joint during pregnancy, allowing rotation of the pelvis and facilitating the release of the fetal shoulder.
      ii. If this maneuver does not succeed, an assistant applies pressure on the lower abdomen (suprapubic pressure), and the delivered head is also gently pulled.
   b. Woods’ Screw technique
      i. In this maneuver, the anterior shoulder is pushed towards the baby's chest, and the posterior shoulder is pushed towards the baby's back, making the baby's head somewhat face the mother's rectum.
      ii. This maneuver is tried only after the McRoberts maneuver
   c. Gaskin maneuver
      i. Involves rolling the patient to the “all fours” position
TAB 4 GUIDELINE 8
NEONATAL RESUSCITATION

**HISTORY**
- Due date and gestational age
- Multiple gestation
- Meconium
- Delivery difficulties
- Congenital disease
- Medications (maternal)
- Maternal risk factors
  - Substance Abuse
  - Smoking

**SIGNS / SYMPTOMS**
- Respiratory distress
- Peripheral cyanosis or mottling (normal)
- Central cyanosis (abnormal)
- Altered level of response
- Bradycardia

**DIFFERENTIAL**
- Airway failure
- Secretions
- Respiratory drive
- Infection
- Maternal medication effect
- Hypovolemia
- Hypoglycemia
- Congenital heart disease
- Hypothermia

---

**LEGEND**
- EMT-P
- Nurse
- MC Order

**SPO2 Level After Birth**
- 1 Min: 60 – 65%
- 2 Min: 65 – 70%
- 3 Min: 70 – 75%
- 4 Min: 75 – 80%
- 5 Min: 80 – 85%
- 10 Min: 85 – 95%

---

**Term gestation**
- Amniotic fluid clear
- Breathing or crying
- Good muscle tone

**Contact Medical Control**
- Transport to appropriate facility

---

**Provide Warmth**
- Bulb syringe suction mouth / nose
- Dry, stimulate, reposition

**Consider**
- 10% Dextrose
  - mL / Kg IV / IO
- Narcan
  - 0.1 mg / Kg IV / IO
- Normal Saline Bolus
  - 10 mL / Kg IV / IO

---

**Nasopharyngeal suctioning**
- Visualize hypopharynx
- and perform deep suction, repeat until free of meconium

**Approach**
- Breathing > 30 / min
- HR > 100 / min
- Pink

---

**Effective Ventilation**
- HR > 100 & Pink

**Monitor and Reassess**
- 5 Minute APGAR

---

**Positive-pressure ventilation**
- Airway Management

---

**Apnea or Gasping**
- for breaths
- HR < 100
- Cyanotic

---

**Evaluate respirations, heart rate and color**
- Breathing > 30, HR > 100
- but Cyanotic

---

**Reassess heart rate**
- HR < 60

---

**Chest Compressions**
- IV / IO / Umbilical Vein Cannulation Access

---

**Epinephrine (1:10,000)**
- 0.01 mg / Kg IV / IO

---

**Consider**
- 10% Dextrose
  - 5 – 10 mL / Kg IV / IO
- Narcan
  - 0.1 mg / Kg IV / IO
- Normal Saline Bolus
  - 10 mL / Kg IV / IO

---

**Contact Medical Control**
- Transport to appropriate facility

---
SPECIAL CONSIDERATIONS:

1. **Neonatal resuscitation priorities:**
   a. Airway
   b. Breathing
   c. Circulation
   d. Temperature

2. Avoid stimulation of the back of the pharynx during suctioning. This may cause bradycardia in the newborn. Suction the neonate’s airway with a bulb syringe starting with the mouth and then the nares.

3. Light meconium staining, if present, may only need standard oral/nasal suctioning maneuvers with a neonate that presents vigorous (strong respiratory efforts, good muscle tone, heart rate > 100) upon assessment. If thick meconium is present, or an open adequate airway cannot be obtained, use laryngoscope and suction to clear the airway under direct visualization to avoid contamination of the lungs with meconium. Hypoxia and vagal stimulation can result if prolonged suctioning occurs. Do not stimulate the neonate to cry until the airway is cleared.

4. Supplementary oxygen is recommended whenever positive-pressure ventilation is indicated for resuscitation; free-flow oxygen should be administered to neonates who are breathing but have central cyanosis.

5. Endotracheal intubation may be indicated if bag-mask ventilation is ineffective. The timing of endotracheal intubation (field vs. ED) may also depend on the skill and experience of the available providers.

6. Establish intravascular access as necessary for volume and/or medication administration. In a severely depressed neonate consider IO first for vascular access.

<table>
<thead>
<tr>
<th>Score</th>
<th>Appearance</th>
<th>Pulse</th>
<th>Grimace</th>
<th>Activity</th>
<th>Respi rations</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Blue centrally</td>
<td>0</td>
<td>None</td>
<td>Absent</td>
<td>Absent</td>
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<tr>
<td>1</td>
<td>Blue extremities</td>
<td>&lt; 100</td>
<td>Grimace</td>
<td>Arm / Leg Flexed</td>
<td>Slow</td>
</tr>
<tr>
<td>2</td>
<td>Pink</td>
<td>&gt; 100</td>
<td>Pulls Away</td>
<td>Active Movement</td>
<td>Crying, Good</td>
</tr>
</tbody>
</table>