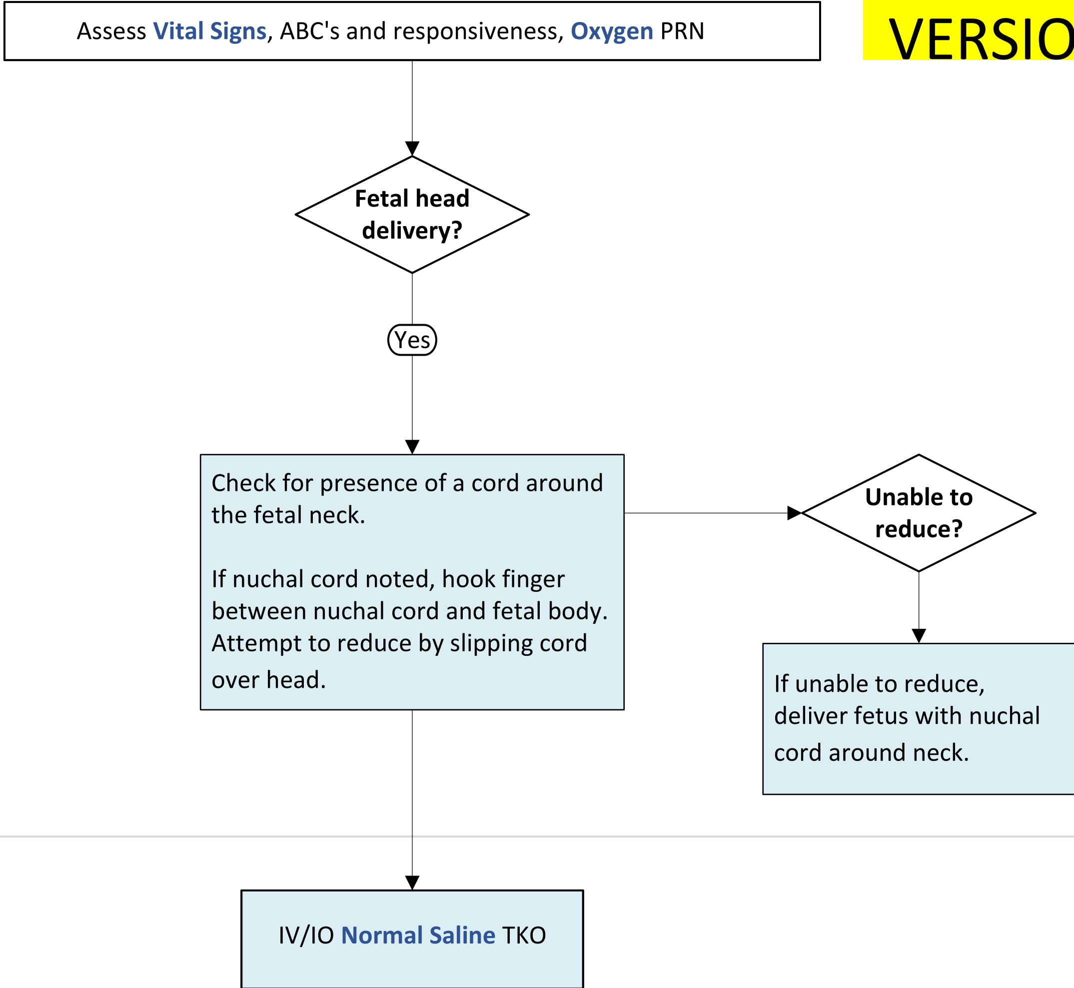
5.04 CHILDBIRTH: COMPLICATIONS: NUCHAL CORD – PUBLIC COMMENT APRIL 2024

BLS – FAQ Link

DRAFT VERSION



ALS

IV/IO Normal Saline TKO

Comments
If multiple nuchal cord loops are noted, reduce one at a time.

Effective: xxxxxx
Supersedes: NEW

BLS – FAQ Link

DRAFT VERSION

Assess **Vital Signs**, ABC's and responsiveness, **Oxygen** PRN

- Hyperflex mother's hips (knees pressed firmly to patient's chest) by first provider.
- Second provider apply suprapubic (not fundal) pressure with fist directed downwards.
- Third provider provide gentle downward traction on fetal head.

(McRobert's Maneuver)

Transport immediately.
Communicate concern for "shoulder dystocia" in ring down.

ALS

IV/IO **Normal Saline** TKO

Report any incident of suspected domestic violence to emergency department staff

Comments

- Shoulder dystocia is when the fetal shoulder becomes wedged behind the pubic bone.
- Clinically, fetal head noted to retract back after progressing forward known as the "turtle sign."

DRAFT VERSION

BLS – FAQ Link

Assess **Vital Signs**, ABC's and responsiveness, **Oxygen** PRN

If presenting fetal part is anything other than the head:

Allow newborn to deliver unassisted. When the legs are delivered, support newborn body and wrap in towel, but do not provide any traction.

After shoulders spontaneously deliver, gently elevate trunk and legs to aid in delivery of head (infant face down).

Head delivery?

No

Place gloved hand in vagina, and position fingers on either side of neonate's nose and mouth to make a "V" to allow airflow to fetal mouth until the head delivers. Keep the fetal neck flexed.

Unable to deliver?

ALS

IV/IO **Normal Saline** TKO

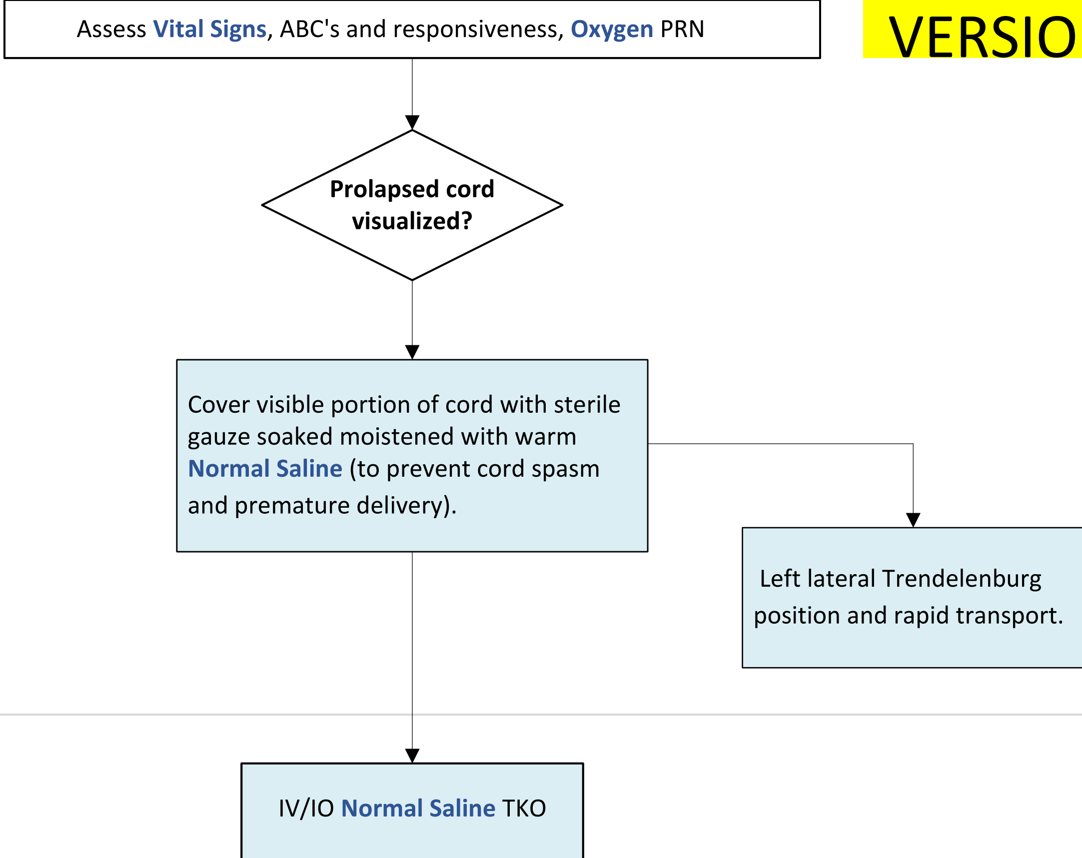
Left lateral Trendelenburg position and rapid transport.

Report any incident of suspected domestic violence to emergency department staff

Comments

- Not all breech presentations can be delivered vaginally, quick transport for potential surgical intervention is critical.
- Allowing spontaneous delivery of fetus up to level of umbilicus increases cervical dilation, decreasing risk of fetal head entrapment.

BLS – FAQ Link



ALS

IV/IO **Normal Saline** TKO

Report any incident of suspected domestic violence to emergency department staff

Comments

- Gently displace presenting part of fetus off cord and maintain displacement to achieve pulsatile cord blood flow.
- DO NOT pull or over-handle cord in order to prevent cord compression and spasm.
- Do NOT reposition or switch providers maintaining displacement. If provider, such as midwife, has already displaced fetus off cord they should maintain position and transport with patient.

5.04 Childbirth: Complications – Public Comment April 2024

Nuchal Cord

BLS Treatment

- Once fetal head is delivered, check for the presence of a cord around fetal neck.
- If nuchal cord noted, hook finger between nuchal cord and fetal body and attempt to reduce by slipping cord over head.
- If multiple nuchal cord loops are noted, reduce one at a time.
- If unable to reduce, deliver fetus with nuchal cord around neck.

Shoulder Dystocia

BLS Treatment

- Instruct mother to stop pushing immediately.
- Perform McRobert's Maneuver: Hyperflex mother's hips (knees pressed firmly to patient's chest) by first provider with second provider applying suprapubic (not fundal) pressure with fist directed downwards with third provider providing gentle downward traction on fetal head.
- Transport should be initiated immediately with communication of concern for "shoulder dystocia" in ring down report.

Comments

- Shoulder dystocia is when the fetal shoulder becomes wedged behind the pubic bone
- Clinically, fetal head noted to retract back after progressing forward known as the "turtle sign".

DRAFT

Breech Delivery

BLS Treatment

If presenting fetal part is anything other than head:

~~If baby is delivering (not head):~~

- Allow newborn to deliver unassisted. When the legs are delivered, support newborn body and wrap in towel, but do not provide any traction. After shoulders spontaneously deliver, gently elevate trunk and legs to aid in delivery of head (infant face down).
- ~~If unable to deliver, left lateral Trendelenburg position and rapid transport.~~
- If head does not deliver with next contraction, place gloved hand in vagina, and position fingers on either side of the neonate's nose and mouth to make a "V" to allow airflow to

fetal mouth until the head delivers. Keep the fetal neck **flexed**. • If unable to deliver, left lateral Trendelenburg position and rapid transport.
ALS Treatment
• IV / IO with **Normal Saline** at TKO.
Comments
• Not all breech presentations can be delivered vaginally, quick transport for potential surgical intervention is critical. • Allowing spontaneous delivery of fetus up to level of umbilicus increases cervical dilation, decreasing risk of fetal head entrapment.

Prolapsed Cord

BLS Treatment
• ~~Left lateral Trendelenburg position.~~ If prolapsed cord visualized: • ~~If the cord is visible,~~ Gently displace presenting part of fetus off cord and maintain displacement to achieve pulsatile cord blood flow. DO NOT pull or over-handle cord in order to prevent cord compression and spasm. • Cover visible portion of cord with sterile gauze moistened with warm **Normal Saline** (to prevent cord spasm and premature delivery). • Rapid transport in Left lateral Trendelenburg position. • Do NOT reposition or switch providers maintaining displacement. If provider, such as midwife, has already displaced fetus off cord they should maintain position and transport with patient.
ALS Treatment
• IV/IO with **Normal Saline** TKO.

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