Population:
- Newly delivered mom & baby arriving via EMS will be sent to the PED with the baby

History:
- Determine parity of mother – GxPx
- Determine gestation of baby (ie, 38wks by LNMP, EDC, U/S)
- Were Apgars done on the baby?
- Determine whether there was Prenatal Care and where
- Determine if mother had any problems or infections during pregnancy, including GBS status
- Determine approximate timing of Rupture of Membranes
- AMPLE Hx of mother
  - Allergies
  - Medications
  - PMHx – previous obstetric complications
  - Last meal
  - Events – time/place delivery, bleeding, fever, drug use

Physical Exam:

**MOM**
- General appearance (including vital signs)
- Rapid cardiopulmonary assessment
- Status and timing of placenta
- Evidence of lacerations
- Amount of bleeding

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<th>NEWBORN/DELIVERY CONTACT INFO</th>
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<td><strong>Dr. STORK Response</strong></td>
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<td><strong>Labor &amp; Delivery</strong></td>
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Evaluation & Management:
MOM
- IV, monitor
- Check bedside Hemoglobin (HemoCue®)
- Draw labs (can send T&S and hold others)

BABY
- Dry, warm, stimulate
- Check bedside blood glucose (Accuchek)
- Oxygen
- NRP guidelines
- NICU/Nursery evaluation

Paperwork & Disposition
- See UCMC Policy N 1406A “Initial Care of the Infant Born Outside of Women’s Center”
- Mom and Baby once stabilized go to Labor & Delivery for recovery.
- Sick babies go to the NICU as determined by the Sr. Pediatric Resident and/or NICU Fellow.

COMPLICATIONS & EMERGENCY DRUGS

DELIVERY OF THE PLACENTA
- Most placentas will spontaneously deliver within 10 minutes
- Signs of spontaneous placental separation:
  - Gush of blood at vagina
  - Lengthening of umbilical cord
  - Uterus becomes firm and fundus rises in abdomen
- Do Not pull or place traction on umbilical cord may result in uterine inversion, cord avulsion
- If placenta delivers in the ED, label it and send it with the mother

oxyTOCIN
Indications
- Routinely given after delivery of placenta or infant (no difference in outcomes)
Dosing
- 30 units in D5W 500 mL IV
- Run at 300 mL for first hour followed by 60 ml/hr for 1-2 hours
- Infuse via Hospira Pump (“PedsED” Library)
- If no IV access then administer 10 units IM establish IV access and initiate at 60 ml/hr until fundus is firm or patient is transferred to Postpartum Unit

**Hydralazine**
Indications
- Hypertensive crisis Dosing
- 5-10 mg IV every 15-20 minutes until desired response

**Magnesium Sulfate**
Indications
- Seizure prophylaxis/treatment Dosing
- 4 gram load over 30 minutes followed by 2 grams/hour

**Disclaimer:**
This clinical guideline has been developed for the purpose of unifying the general emergency care of the mother and baby when the baby is born outside of the hospital. It is intended to aid, rather than substitute for, professional judgment. It is not intended to serve as a rigid protocol or a written proxy for the standard of care. Failure to comply with this guideline does not represent a breach of the standard of care.

**References:**