OLD DOMINION EMERGENCY MEDICAL SERVICES ALLIANCE

Obstetrical and Gynecological Emergencies – ALS

7818 E. Parham Road, Suite 911 • Richmond, VA 23294
PHONE: 804-560-3300 • FAX: 804-560-0909 • www.odemsa.vaems.org

OB/GYN – Childbirth/Labor/Delivery – ALS

OVERVIEW:

In women with regular menstrual cycles, a history of one or more missed cycles (periods) is suggestive of pregnancy.

Labor is defined as progressive dilation of the uterine cervix in association with repetitive uterine contractions resulting in complete dilation (10 cm) and effacement (thinning) of the cervical lining.

Vertex, or head-first presentation, is the ideal presentation for all deliveries. Crowning is observed as the second stage of labor begins.

Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes - ROM
        xv. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Fundal Harding noted
            4. Frequency of Pain – Need to time intervals.
            5. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST
    f. MOI – NOI
    g. Need for ALS.
    h. Pulse Ox

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- i. End Tidal CO_2
- j. Place on Cardiac Monitor/Obtain 12 lead EKG.
- k. IV Access
- l. Primary Assessment
    - i. XABCDE Format
- m. Life Threat Bleeding
    - i. Assessment
    - ii. Correction
- n. Airway
    - i. Assessment
    - ii. Correction
- o. Breathing
    - i. Assessment
    - ii. Correction
- p. Circulation
    - i. Assessment
    - ii. Correction
- q. Disability
    - i. Assessment
    - ii. Correction
- r. Exposure
    - i. Assessment
    - ii. Correction

2. Demonstrates the following skills.
    - a. Proper Physical Exam
        - i. Head to toe format
        - ii. All major body parts/systems
        - iii. Vital Signs / Documentation
    - b. Frequently assess for Crowning/Vaginal Bleeding/Shock
        - i. If shock develops follow the appropriate Shock Protocol
    - c. If Delivery is imminent
        - i. Stop Ambulance if Applicable.
        - ii. Call for manpower if Applicable.

- iii. PPE
- iv. OB Kit
  1. Layout contents in orderly fashion.
  2. ID all needed components.
- v. Position Mother
  1. Supine – Knees drawn up towards head as much as possible.
  2. Elevate Buttocks
  3. Create workspace – Sterile is Best Practice
  4. Child(ern) Delivery
     - a. IF the Amniotic Sac remains intact – break with blunt object.
     - b. Remove from Head/Nose/Mouth
     - c. Back Pressure on Skull – Gentle
     - d. Determine position of Umbilical Cord – Move if needed.
     - e. Support Head and Neck
     - f. As reminder of baby presents support the entire child with both hands/arms as needed
     - g. Wipe Fluids from mouth and nose – sterile gauze
       - i. Evaluate the need to suction Mouth then Nose.
     - h. Keep child level with the Vagina until Cord is cut
     - i. Note time.
     - j. If Newborn requires Immediate Resuscitation
       - i. Clamp and Cut cord
         1. Clamp approx. 4 inches from Newborn
         2. Clamp 2nd approx. 6 inches from Newborn
         3. Follow Current Resuscitation Guidelines
            - a. AHA BLS / PALS
         4. ALS
         5. Evaluate Mother
         6. APGAR Scores
            - a. 1 minute
            - b. 5 Minute

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7. Immediate Transport to the proper Facility as Soon as Possible

k. If Newborn does not require Immediate Resuscitation
   i. Clamp and Cut cord
      1. Clamp approx. 4 inches from Newborn
      2. Clamp 2nd approx. 6 inches from Newborn
      3. APGAR Scores
         a. 1 minute
         b. 5 Minute
      a. Evaluate Need for Resuscitation
         i. Follow Current Resuscitation Guidelines
         ii. AHA BLS / PALS
         iii. ALS
         iv. Evaluate Mother
   ii. Can Delay Clamping and Cutting cord if Newborn not Critical for approx. 1 minute.

d. Keep Newborn Warm
e. Place Newborn on Chest/Breast
f. Prepare for Delivery of Placental Tissue
   i. Collect in Supplied Bag from OB Kit
g. Place Sterile Pad over the Vaginal Opening of Mother
   i. Lower mothers Legs
   ii. Ask Mother to hold legs together (reduce bleeding)
h. **Do Not Separate Mother and Child(ern) unless Life Threat Present**
i. Pulse Ox Measurement
j. Oxygen/Ventilation based on Assessment.
k. Demonstrates the appropriate transport mode and destination.
l. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – Childbirth/Labor/Delivery – ALS**

Student's Name and Signature – date below:

_____________________________ ____________________________ Date_________

Printed Name Signature

FTO's Name and Signature – date below:

_____________________________ ____________________________ Date_________

Printed Name Signature

Medical - Newborn/Neonatal Resuscitation - ALS

OVERVIEW:

Most newborns will require only warmth, stimulation, and occasionally some oxygen after birth. The above treatment is recommended before attempting the more aggressive interventions of Positive-Pressure Ventilation (PPV) and chest compressions.

Remember that a newborn's cardiac output is rate-dependent.
Bradycardia usually is the result of hypoxia.
Once the hypoxia is corrected, the heart rate may spontaneously correct itself.

A **"newborn"** is defined as within one month of age post-delivery.

Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST
    f. MOI – NOI
    g. Pulse Ox
    h. Need for ALS.
    i. End Tidal CO_2
    j. Place on Cardiac Monitor/Obtain 12 lead EKG.
    k. IV Access
    l. Primary Assessment
        i. XABCDE Format
    m. Airway
        i. Assessment
        ii. Correction
    n. Breathing
        i. Assessment
        ii. Correction
    o. Circulation
        i. Assessment
        ii. Correction
    p. Exposure
        i. Assessment
        ii. Correction
2. Demonstrates the following skills.
    a. Proper Physical Exam
        i. Head to toe format

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- ii. All major body parts/systems
- iii. Vital Signs / Documentation
- iv. PPE
- v. Create workspace – Sterile is Best Practice
    1. IF the Amniotic Sac remains intact – break with blunt object.
    2. Remove from Head/Nose/Mouth
    3. Support Head and Neck s well as the entire body with both hands and arms as needed.
    4. Wipe Fluids from mouth and nose – sterile gauze
        - a. Evaluate the need to suction Mouth then Nose.
    5. Keep child level with the Vagina until Cord is cut
    6. Note time.
    7. If Newborn requires Immediate Resuscitation
        - a. Clamp and Cut cord
            - i. Clamp approx. 4 inches from Newborn
            - ii. Clamp 2nd approx. 6 inches from Newborn
            - iii. Follow Current Resuscitation Guidelines
                1. AHA BLS / PALS
                2. Airway
                    - a. Suction Mouth then Nose.
                    - b. Evaluate Respiratory Rate Rate
                        - i. Respirations Inadequate
                        - **ii.** BVM – **Room Air**
                        - iii. Rate 40-60 BPM
            - iv. ALS
            - v. Evaluate Mother
            - vi. APGAR Scores
                1. 1 minute
                2. 5 Minute
            - vii. Immediate Transport to the proper Facility as Soon as Possible

3. Keep Newborn Warm
4. **Do Not Separate Mother and Child(ern) unless Life Threat Present if possible.**

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5. Pulse Ox Measurement
6. Oxygen/Ventilation based on Assessment.
7. Demonstrates the appropriate transport mode and destination.
8. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **Medical - Newborn/Neonatal Resuscitation - ALS**

Student's Name and Signature – date below:

______________________________ ____________________________ Date________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ____________________________ Date________

Printed Name Signature

OB/GYN – Childbirth/Labor/Delivery – ALS

Shoulder Dystocia

OVERVIEW:

Shoulder dystocia is a labor complication caused by difficulty delivering the fetal shoulders.

After delivery of the head, the fetus seems to try to withdraw back into the birth canal (**Turtle Sign**).

Further birth of the infant is prevented by the impaction of the fetal shoulders within the maternal pelvis.

Digital exam reveals that the anterior shoulder is stuck behind the pubic symphysis. In more severe cases, the posterior shoulder may be stuck at the level of the sacral promontory.

Although this is more common among women with gestational diabetes and those with very large fetuses, it can occur with babies of any size.

Unfortunately, it cannot be predicted or prevented.

Improperly relieving the dystocia can result in unilateral or bilateral clavicular fractures.

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1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes - ROM
        xv. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Fundal Harding noted
            4. Frequency of Pain – Need to time intervals.
            5. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST
    f. MOI – NOI
    g. Need for ALS.
    h. Pulse Ox

i. End Tidal CO_2
j. Place on Cardiac Monitor/Obtain 12 lead EKG.
k. IV Access
l. Primary Assessment
    i. XABCDE Format
m. Life Threat Bleeding
    i. Assessment
    ii. Correction
n. Airway
    i. Assessment
    ii. Correction
o. Breathing
    i. Assessment
    ii. Correction
p. Circulation
    i. Assessment
    ii. Correction
q. Disability
    i. Assessment
    ii. Correction
r. Exposure
    i. Assessment
    ii. Correction

2. Demonstrates the following skills.
    a. Proper Physical Exam
        i. Head to toe format
        ii. All major body parts/systems
        iii. Vital Signs / Documentation
    b. Frequently assess for Crowning/Vaginal Bleeding/Shock
        i. If shock develops follow the appropriate Shock Protocol
    c. If Delivery is imminent
        i. Stop Ambulance if Applicable.
        ii. Call for manpower if Applicable.

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iii. PPE
iv. OB Kit
    1. Layout contents in orderly fashion.
    2. ID all needed components.
v. Position Mother
    1. Supine – Knees drawn up towards head as much as possible.
    2. Elevate Buttocks
    3. Create workspace – Sterile is Best Practice
    4. Evaluate for Presence of "Turtle Sign".
    5. ALS
    6. Child(ern) Delivery
        a. Determine position of Umbilical Cord – Move if needed.
        b. IF the Amniotic Sac remains intact – break with blunt object.
        c. Remove from Head/Nose/Mouth
        d. Gentle downward traction on the Chest and Back to **Try and Free Shoulder**
        e. Place Mother in the MacRobert's position
            i. Gentle downward traction on the Chest and Back to **Try and Free Shoulder**
            ii. Have an assistant downward suprapubic pressure to drive shoulder downward to clear the suprapubic bone and apply coordinated downward traction on the baby.
            iii. If unsuccessful
                1. Repeat but have the suprapubic pressure applied in a more lateral direction.
                2. Immediate Transport
        f. Support Head and Neck
        g. Wipe Fluids from mouth and nose – sterile gauze
            i. Evaluate need to suction Mouth then Nose.
        h. Note time.

d. Frequent Reassessment of Mother

e. Pulse Ox Measurement
f. Oxygen/Ventilation based on Assessment.
g. Demonstrates the appropriate transport mode and destination.
h. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – Childbirth/Labor/Delivery – ALS - Shoulder Dystocia**

Student's Name and Signature – date below:

______________________________ ____________________________ Date________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ____________________________ Date________

Printed Name Signature

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OB/GYN – Pregnancy-Related Emergencies – ALS

(Delivery – Breech/ Extremity Presentation)

OVERVIEW:

Although most babies are born without difficulty, complications may occur.
Breech presentation is an abnormality in which the buttocks or legs of the fetus, rather than the head, appear first in the birth canal.

This is the most common atypical birth presentation, occurring in approximately 4% of all full-term deliveries, and up to 25% of all premature births.

In any breech birth, there are increased risks of umbilical cord prolapse or compression and delivery of the feet through an incompletely dilated cervix, leading to arm or head entrapment.

These risks are greatest when a foot is presenting ("footling breech"). Delivery may be prolonged for these newborns, which are at great risk of delivery trauma.

Birth trauma can occur from forceful delivery management, such as cervical spine trauma, injury to the brachial plexus, and fractures to the humerus, clavicle, skull, and neck.

The cause of breech presentation is only known in approximately half of the cases. Predisposing factors can include fetal and uterine anomalies, abnormal placental implantation, uterine over-distention, previous breech, multiple gestation, high parity, and pelvic obstruction (from

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placenta previa or tumors).

Goal: Recognition – Immediate Transport – Contact Medical Control

Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes - ROM
        xv. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Fundal Harding noted
            4. Frequency of Pain – Need to time intervals.
            5. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST

f. MOI – NOI
g. Need for ALS.
h. Pulse Ox
i. End Tidal CO_2
j. Place on Cardiac Monitor/Obtain 12 lead EKG.
k. IV Access
l. Primary Assessment
    i. XABCDE Format
m. Life Threat Bleeding
    i. Assessment
    ii. Correction
n. Airway
    i. Assessment
    ii. Correction
o. Breathing
    i. Assessment
    ii. Correction
p. Circulation
    i. Assessment
    ii. Correction
q. Disability
    i. Assessment
    ii. Correction
r. Exposure
    i. Assessment
    ii. Correction

2. Demonstrates the following skills.
    a. Proper Physical Exam
        i. Head to toe format
        ii. All major body parts/systems
        iii. Vital Signs / Documentation
    b. Frequently assess for Crowning/Vaginal Bleeding/Shock
        i. Breech/Extremity Presentation Noted upon Exam

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ii. ALS

c. Position Mother
   i. Supine – Knees drawn up towards head as much as possible.
   ii. Elevate Buttocks
   iii. Create workspace – Sterile is Best Practice

d. Immediate Transport

e. Contact Medical Control as soon as Possible
   i. OB Kit
      1. Layout contents in orderly fashion.
      2. ID all needed components.

f. Note time.

g. Frequent Reassessment of Mother

h. Pulse Ox Measurement

i. Oxygen/Ventilation based on Assessment.

j. Demonstrates the appropriate transport mode and destination.

k. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – Childbirth/Labor/Delivery – ALS - (Delivery – Breech/ Extremity Presentation)**

Student's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

OB/GYN – Pregnancy-Related Emergencies – ALS
(Ectopic Pregnancy/Rupture)

OVERVIEW:

An ectopic pregnancy is one in which the fetus implants anywhere outside of the uterus. This can occur in the fallopian tubes, interstitial portion of the tube, horn of the uterus, cervix, abdomen, or the ovary.

Generally, the patient will begin complaining of cramping, dull abdominal pain within 3 - 5 weeks of the first missed menstrual period.

However, if the ectopic pregnancy ruptures the fallopian tube, the patient may complain of sudden, sharp abdominal pain. The pain may be concentrated on one side of the abdomen or may be generalized.

There may or may not be vaginal bleeding, as blood loss may be concealed in the pelvic cavity causing referred shoulder pain.

Blood in the peritoneal cavity may cause a blue tinge around the umbilicus, known as **Cullen's sign**.

Depending on the amount of blood loss, the patient may also exhibit signs of shock.

Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Frequency of Pain – Need to time intervals.
            4. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST
    f. MOI – NOI
    g. Need for ALS.
    h. Pulse Ox
    i. End Tidal CO_2
    j. Place on Cardiac Monitor/Obtain 12 lead EKG.

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   k. IV Access
   l. Primary Assessment
      i. XABCDE Format
   m. Life Threat Bleeding
      i. Assessment
      ii. Correction
   n. Airway
      i. Assessment
      ii. Correction
   o. Breathing
      i. Assessment
      ii. Correction
   p. Circulation
      i. Assessment
      ii. Correction
   q. Disability
      i. Assessment
      ii. Correction
   r. Exposure
      i. Assessment
      ii. Correction
2. Demonstrates the following skills.
   a. Proper Physical Exam
      i. Head to toe format
      ii. All major body parts/systems
      iii. Vital Signs / Documentation
   b. Frequently assess for Vaginal Bleeding/Shock
      i. If Shock Symptoms Present
      ii. Refer to Shock Medical Hypotension Protocol
      iii. ALS
   c. Position Mother in position of comfort
   d. Immediate Transport
   e. Note time.

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f. Frequent Reassessment
g. Pulse Ox Measurement
h. Oxygen/Ventilation based on Assessment.
i. Demonstrates the appropriate transport mode and destination.
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Competency – ODEMSA – Regional Protocols – **OB/GYN – OB/GYN – Pregnancy-Related Emergencies – ALS - (Ectopic Pregnancy/Rupture)**

Student's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

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OB/GYN – Pregnancy-Related Emergencies – ALS
(Placenta Abruptio)

OVERVIEW:

Abruptio placenta (placental abruption) refers to premature separation of the normally implanted placenta from the uterine wall after the 20th week of gestation and prior to birth.

Patients with abruptio placenta typically present with bleeding, uterine contractions, and fetal distress.

A significant cause of third-trimester bleeding associated with both fetal and maternal morbidity and mortality, abruptio placenta must be considered whenever bleeding is encountered in the second half of pregnancy.

The frequency of placental abruption in the United States is approximately 1% of all pregnancies, and a severe abruption leading to fetal death occurs in 0.12% of pregnancies (1:830). This mortality rate approaches 100% when > 50% of the placenta is involved.

Placental Abruption begins with arterial hemorrhaging into the deciduas basalis. A hematoma is formed and progresses in size causing the expanding abruption. As the abruption continues, more vessels become involved, further contributing to the expanding retro-placental hematoma.

Abruptio placenta is a surgical emergency and should be transported without delay with interventions completed during transport.

Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes - ROM
        xv. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Frequency of Pain – Need to time intervals.
            4. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST
    f. MOI – NOI
    g. Need for ALS.
    h. Pulse Ox
    i. End Tidal CO_2

   j. Place on Cardiac Monitor/Obtain 12 lead EKG.
   k. IV Access
   l. Primary Assessment
      i. XABCDE Format
   m. Life Threat Bleeding
      i. Assessment
      ii. Correction
   n. Airway
      i. Assessment
      ii. Correction
   o. Breathing
      i. Assessment
      ii. Correction
   p. Circulation
      i. Assessment
      ii. Correction
   q. Disability
      i. Assessment
      ii. Correction
   r. Exposure
      i. Assessment
      ii. Correction
2. Demonstrates the following skills.
   a. Proper Physical Exam
      i. Head to toe format
      ii. All major body parts/systems
      iii. Vital Signs / Documentation
   b. Frequently assess for Vaginal Bleeding/Shock
      i. If Shock Symptoms Present
         1. Refer to Shock Hypotension Protocol
      ii. ALS
   c. Position Mother in position of comfort
      i. Preferred Position is on the Patient's Left Side if possible.

d. Immediate Transport
e. Frequent Reassessment
f. Pulse Ox Measurement
g. Oxygen/Ventilation based on Assessment.
h. Demonstrates the appropriate transport mode and destination.
i. Transport as soon as safe to do so to the proper destination.

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Student's and FTO's signatures below signify that the student has demonstrated sufficient working knowledge and can perform such competency and has had the opportunity to ask and has had all questions and answers provided to their level of comfort.

Competency – ODEMSA – Regional Protocols – **OB/GYN – OB/GYN – Pregnancy-Related Emergencies – ALS - (Placenta Abruptio)**

Student's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ______________________________ Date_________

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OB/GYN – Pregnancy-Related Emergencies – ALS

(Placenta Previa)

OVERVIEW:

Placenta previa is an obstetric complication that occurs in the second and third trimesters of pregnancy and accounts for 20% of vaginal bleeding during these last trimesters.

Placenta previa occurs when the placenta is implanted low in the uterus and covers the cervical canal in varying amounts.
The placenta may be marginally, partially, or completely covering the internal cervical opening.

Risk factors for placenta previa include prior placenta previa, first pregnancy following a cesarean delivery, multi-parity, age > 30 years, multiple gestations, prior induced abortions, and smoking.

Abruptio placenta is an OB/GYN emergency and should be transported without delay with interventions completed during transport.

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Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Previous Placenta Previa
        xv. Previous Cesarean
        xvi. Maternal Age greater than 30 years of age
        xvii. Recent Vaginal Exam/Sexual Intercourse
        xviii. Rupture of Membranes - ROM
        xix. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Frequency of Pain – Need to time intervals.
            4. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST

    f. MOI – NOI
    g. Need for ALS.
    h. Pulse Ox
    i. End Tidal CO_2
    j. Place on Cardiac Monitor/Obtain 12 lead EKG.
    k. IV Access
    l. Primary Assessment
        i. XABCDE Format
    m. Life Threat Bleeding
        i. Assessment
        ii. Correction
    n. Airway
        i. Assessment
        ii. Correction
    o. Breathing
        i. Assessment
        ii. Correction
    p. Circulation
        i. Assessment
        ii. Correction
    q. Disability
        i. Assessment
        ii. Correction
    r. Exposure
        i. Assessment
        ii. Correction
2. Demonstrates the following skills.
    a. Proper Physical Exam
        i. Head to toe format
        ii. All major body parts/systems
        iii. Vital Signs / Documentation
    b. Frequently assess for Vaginal Bleeding/Shock
        i. If Shock Symptoms Present

1. Refer to Shock Hypotension Protocol

ii. ALS

c. Position Mother in position of comfort
    i. Preferred Position is on the Patients's Left Side if possible.
d. Immediate Transport
e. Frequent Reassessment
f. Pulse Ox Measurement
g. Oxygen/Ventilation based on Assessment.
h. Demonstrates the appropriate transport mode and destination.
i. Transport as soon as safe to do so to the proper destination.

The above is a very abbreviated summary of the Protocol.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – OB/GYN – Pregnancy-Related Emergencies – ALS - (Placenta Previa)**

Student's Name and Signature – date below:

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OB/GYN – Pregnancy-Related Emergencies – ALS

(Prolapsed Umbilical Cord)

OVERVIEW:

Although most babies are born without difficulty, complications may occur.

Umbilical Cord Prolapse (UCP) is a condition when the umbilical cord presents through the birth canal after the amniotic sac ruptures before delivery of the head.

If the umbilical cord presents in front of the fetal presenting part and the membranes rupture, the risk that the cord will prolapse through the cervix into the vagina is significant.

Occult prolapse occurs when the cord lies alongside the presenting part.

The risk is increased with abnormal fetal presentations, especially when the presenting part does not fill the lower uterine segment, as is the case with incomplete breech presentations, premature infants, and multi-parous women (mother has delivered previously).

This presents a serious medical emergency, endangering the life of the unborn fetus.

In this situation, the umbilical cord may get compressed against the vaginal walls by the pressure of the infant's head. As a result, the infant's supply of oxygenated blood can be cut off.

Goal – to restore/maintain fetal circulation via the Umbilical cord by relieving pressure on the Umbilical Cord.

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Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes - ROM
        xv. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Fundal Harding noted
            4. Frequency of Pain – Need to time intervals.
            5. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST
    f. MOI – NOI
    g. Pulse Ox
    h. Need for ALS.

i. End Tidal CO_2
j. Place on Cardiac Monitor/Obtain 12 lead EKG.
k. IV Access
l. Primary Assessment
    i. XABCDE Format
m. Life Threat Bleeding
    i. Assessment
    ii. Correction
n. Airway
    i. Assessment
    ii. Correction
o. Breathing
    i. Assessment
    ii. Correction
p. Circulation
    i. Assessment
    ii. Correction
q. Disability
    i. Assessment
    ii. Correction
r. Exposure
    i. Assessment
    ii. Correction

2. Demonstrates the following skills.
    a. Proper Physical Exam
        i. Head to toe format
        ii. All major body parts/systems
        iii. Vital Signs / Documentation
    b. Frequently assess for Crowning/Vaginal Bleeding/Shock
        i. If shock develops follow the appropriate Shock Protocol
    c. If Delivery is imminent
        i. Position Mother
            1. **Place Mother in Knee to Chest Position**

2. **Facedown – on the Stretcher**
3. **Elevate Buttocks**
4. Determine position of Umbilical Cord – Move if needed.
    a. **Immediate Transport**
    b. ALS
    c. Cord Visible Upon Exam/Externally
        i. **2 Gloved** Fingers to reduce pressure on the cord to maintain pulsatile sensation of the cord.
        ii. **This MUST BE Maintained until Arrival at Hospital and care assumed by Hospital Staff.**
        iii. Keep Cord Warm and Moist
        iv. **Place Mother in Knee to Chest Position**
        v. Early Contact with Medical Control/Hospital
    d. Note time.

d. Pulse Ox Measurement
e. Oxygen/Ventilation based on Assessment.
f. Demonstrates the appropriate transport mode and destination.
g. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – OB/GYN – Pregnancy-Related Emergencies – ALS - (Prolapsed Umbilical Cord)**

Student's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

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OB/GYN – Pregnancy-Related Emergencies – ALS
(Hypertension/Eclampsia/HELLPS)

OVERVIEW:

Pre-eclampsia is characterized by elevated BP, proteinuria, and edema after the 20th week of pregnancy in a patient who previously has been normal in these respects.

The risk of pre-eclampsia/eclampsia is thought to continue through six (6) weeks post-partum.
Unless the pre-eclamptic process is halted, seizure activity (eclampsia) may occur.
Once the first eclamptic seizure occurs, the infant / fetal mortality rate soars.

Once the seizure process is established, the ultimate patient outcome can be coma and death.

The actual cause of the disease process is unknown.
HELLP Syndrome (HELLPS) is a variant of severe PIH in which hematologic abnormalities exist with severe pre-eclampsia or eclampsia.
HELLP is an acronym for **H**emolysis, **E**levated **L**iver enzymes, and **L**ow **P**latelets, which are the hallmark signs of this syndrome.

Definitive treatment can only be accomplished through the delivery of the fetus(es).

Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes – ROM
        xv. Edema
        xvi. Headache
        xvii. Visual Disturbances/Visual Changes
        xviii. Hypertension
        xix. Hyperreflexia
        xx. Seizures
        xxi. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Fundal Harding noted
            4. Frequency of Pain – Need to time intervals.
            5. Duration – Need to time

   c. Signs and Symptoms
   d. SAMPLE
   e. OPQRST
   f. MOI – NOI
   g. Pulse Ox
   h. Need for ALS.
   i. **Patient is not to Physically exert – No ambulation – EMS Must do all moving of the Patient.**
   j. Primary Assessment
      i. XABCDE Format
   k. Life Threat Bleeding
      i. Assessment
      ii. Correction
   l. Airway
      i. Assessment
      ii. Correction
   m. Breathing
      i. Assessment
      ii. Correction
   n. Circulation
      i. Assessment
      ii. Correction
   o. Disability
      i. Assessment
      ii. Correction
   p. Exposure
      i. Assessment
      ii. Correction
2. Demonstrates the following skills.
   a. Proper Physical Exam
      i. Head to toe format
      ii. All major body parts/systems
      iii. Vital Signs / Documentation

- b. If shock develops follow the appropriate Shock Protocol
- c. Obtain Blood Glucose
  - i. Treat based on Assessment/Test Results
- d. If Seizure occurs
  - i. Magnesium Sulfate 2-4 Gm IV over 5-10 mins – 4 Gm is preferred dose
  - ii. Maintain Airway/Ventilation
  - iii. Immediate Transport
  - iv. If seizure continues
    1. Benzodiazepine
  - v. Refer to the Seizure Protocol.
- e. Pulse Ox Measurement
- f. Oxygen/Ventilation based on Assessment.
- g. Demonstrates the appropriate transport mode and destination.
- h. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – OB/GYN – Pregnancy-Related Emergencies – ALS - (Hypertension/Eclampsia/HELLPS)**

Student's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ______________________________ Date_________

Printed Name Signature

OB/GYN – Pregnancy-Related Emergencies – ALS

(Premature Rupture of Membranes (PROM))

OVERVIEW:

Premature Rupture of Membranes (PROM) is the leakage of amniotic fluid at least one (1) hour before the onset of labor.

This can occur at any gestational age and occurs in approximately 10% of all pregnancies.

The exact cause of PROM is not known and can lead to premature labor, umbilical cord prolapse, and intrauterine infection.

The patient usually reports a gush of fluid from the vagina. There may also be a continual leak of fluid, suggestive of a small tear in the amniotic sac.

Student Can demonstrate the following competencies without prompting and can explain the clinical reasoning for each listed below:

1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes – ROM
        xv. Edema
        xvi. Hypertension
        xvii. External Vaginal Drainage
        xviii. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Fundal Harding noted
            4. Frequency of Pain – Need to time intervals.
            5. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST

f. MOI – NOI
g. Need for ALS.
h. Pulse Ox
i. End Tidal CO_2
j. Place on Cardiac Monitor/Obtain 12 lead EKG.
k. IV Access
l. **Patient is not to Physically exert – No ambulation – EMS Must do all moving of the Patient.**
m. Primary Assessment
    i. XABCDE Format
n. Life Threat Bleeding
    i. Assessment
    ii. Correction
o. Airway
    i. Assessment
    ii. Correction
p. Breathing
    i. Assessment
    ii. Correction
q. Circulation
    i. Assessment
    ii. Correction
r. Disability
    i. Assessment
    ii. Correction
s. Exposure
    i. Assessment
    ii. Correction

2. Demonstrates the following skills.
    a. Proper Physical Exam
        i. Head to toe format
        ii. All major body parts/systems
        iii. Vital Signs / Documentation

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b. Position Patient – Left Lateral Recumbent
c. Observe for Signs of Labor
    i. Refer to Pre-Term Labor Protocol
d. If shock develops follow the appropriate Shock Protocol
e. Obtain Blood Glucose
    i. Treat based on Assessment/Test Results
f. Pulse Ox Measurement
g. Oxygen/Ventilation based on Assessment.
h. Demonstrates the appropriate transport mode and destination.
i. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – OB/GYN – Pregnancy-Related Emergencies – ALS - (Premature Rupture of Membranes (PROM))**

Student's Name and Signature – date below:

____________________________ ___________________________ Date________

Printed Name Signature

FTO's Name and Signature – date below:

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Printed Name Signature

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OB/GYN – Pregnancy-Related Emergencies – ALS

(Pre-term Labor)

OVERVIEW:

Pre-term labor is defined as regular and rhythmic contractions of the uterus that produce cervical changes after the 20th week of gestation but prior to the 36th week of gestation.

Of all pregnant patients, some patients will experience contractions without being in preterm labor, known as **Braxton-Hicks** contractions.

Regular uterine contractions with rupture of the membranes are the hallmark sign for pre-term labor diagnosis.

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1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Fetal Movement
        xii. Multiple Gestation
        xiii. Number of Previous Pregnancies
        xiv. Rupture of Membranes – ROM
        xv. Edema
        xvi. Hypertension
        xvii. External Vaginal Drainage
        xviii. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Fundal Harding noted
            4. Frequency of Pain – Need to time intervals.
            5. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST

f. MOI – NOI
g. Need for ALS.
h. Pulse Ox
i. End Tidal CO_2
j. Place on Cardiac Monitor/Obtain 12 lead EKG.
k. IV Access
l. Primary Assessment
    i. XABCDE Format
m. Life Threat Bleeding
    i. Assessment
    ii. Correction
n. Airway
    i. Assessment
    ii. Correction
o. Breathing
    i. Assessment
    ii. Correction
p. Circulation
    i. Assessment
    ii. Correction
q. Disability
    i. Assessment
    ii. Correction
r. Exposure
    i. Assessment
    ii. Correction

2. Demonstrates the following skills.
    a. Proper Physical Exam
        i. Head to toe format
        ii. All major body parts/systems
        iii. Vital Signs / Documentation
    b. Observe for Signs of Labor
    c. Frequently assess for Crowning/Vaginal Bleeding/Shock

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i. If shock develops follow the appropriate Shock Protocol

d. If Delivery is imminent
   i. Stop Ambulance if Applicable.
   ii. Call for manpower if Applicable.
   iii. PPE
   iv. OB Kit
      1. Layout contents in orderly fashion.
      2. ID all needed components.
   v. Position Mother
      1. Supine – Knees drawn up towards head as much as possible.
      2. Elevate Buttocks
      3. Create workspace – Sterile is Best Practice
      4. Child(ern) Delivery
         a. IF the Amniotic Sac remains intact – break with blunt object.
         b. Remove from Head/Nose/Mouth
         c. Back Pressure on Skull – Gentle
         d. Determine position of Umbilical Cord – Move if needed.
         e. Support Head and Neck
         f. As reminder of baby presents support the entire child with both hands/arms as needed
         g. Wipe Fluids from mouth and nose – sterile gauze
            i. Evaluate need to suction Mouth then Nose.
         h. Keep child level with the Vagina until Cord is cut
         i. Note time.
         j. Evaluate Need for Resuscitation
         k. If Newborn requires Immediate Resuscitation
            i. Clamp and Cut cord
               1. Clamp approx. 4 inches from Newborn
               2. Clamp 2nd approx. 6 inches from Newborn
               3. Refer to Newborn/Neonatal Resuscitation Protocol
               4. ALS

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5. Evaluate Mother
6. APGAR Scores
   a. 1 minute
   b. 5 Minute
7. Immediate Transport to the proper Facility as Soon as Possible

l. If Newborn does not require Immediate Resuscitation
   i. Clamp and Cut cord
      1. Clamp approx. 4 inches from Newborn
      2. Clamp 2nd approx. 6 inches from Newborn
      3. APGAR Scores
         a. 1 minute
         b. 5 Minute
         c. Evaluate Need for Resuscitation

3. Can Delay Clamping and Cutting cord if Newborn not Critical for approx. 1 minute.
   a. Keep Newborn Warm
   b. Place Newborn on Chest/Breast
   c. Prepare for Delivery of Placental Tissue
      i. Collect in Supplied Bag from OB Kit
   d. Place Sterile Pad over the Vaginal Opening of Mother
      i. Lower mothers Legs
      ii. Ask Mother to hold legs together (reduce bleeding)
   e. If mother is noted to exhibit signs of shock
      i. Refer to Shock Protocol.
      ii. IV Bolus
   f. **Do Not Separate Mother and Child(ern) unless Life Threat Present**
   g. Pulse Ox Measurement
   h. Oxygen/Ventilation based on Assessment.
   i. Demonstrates the appropriate transport mode and destination.
   j. Transport as soon as safe to do so to the proper destination.

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Competency – ODEMSA – Regional Protocols – **OB/GYN – OB/GYN – Pregnancy-Related Emergencies – ALS - (Pre-term Labor)**

Student's Name and Signature – date below:

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Printed Name Signature

FTO's Name and Signature – date below:

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OB/GYN – Post-Partum Hemorrhage – ALS

OVERVIEW:

Post-partum hemorrhage is defined as the loss of more than 500 mL of blood loss following a vaginal delivery or more than 1,000 mL following a Cesarean delivery.

However, many women tolerate losses of up to 1,000 mL of blood.

It can cause debilitation and diminished immunity, which can subsequently lead to post-partum infection, another leading cause of maternal death.

Post-partum hemorrhage can occur up to 6 weeks after delivery.

It is imperative that hemorrhage is diagnosed early and treated aggressively.

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1. Demonstrates proper assessment techniques / Physical skills.
    a. Scene Survey
    b. HPI – Complete
        i. EDC – Due date
        ii. LMP – Date
        iii. Number of living births
        iv. Number of abortions
        v. Number of times pregnant
        vi. High Risk
        vii. OB MD/Clinic/Preferred Hospital
        viii. Routine OB Care
        ix. Last Clinic visit
        x. Vaginal Bleeding/Spotting
        xi. Number of Previous Pregnancies
        xii. Edema
        xiii. Hypertension
        xiv. Contractions/Pain
            1. Time of Onset
            2. Where is the discomfort?
            3. Frequency of Pain – Need to time intervals.
            4. Duration – Need to time
    c. Signs and Symptoms
    d. SAMPLE
    e. OPQRST
    f. MOI – NOI
    g. Need for ALS.
    h. Pulse Ox
    i. End Tidal CO_2
    j. Place on Cardiac Monitor/Obtain 12 lead EKG.

- k. IV Access
- l. Primary Assessment
    - i. XABCDE Format
- m. Life Threat Bleeding
    - i. Assessment
    - ii. Correction
- n. Airway
    - i. Assessment
    - ii. Correction
- o. Breathing
    - i. Assessment
    - ii. Correction
- p. Circulation
    - i. Assessment
    - ii. Correction
- q. Disability
    - i. Assessment
    - ii. Correction
- r. Exposure
    - i. Assessment
    - ii. Correction

2. Demonstrates the following skills.
    - a. Proper Physical Exam
        - i. Head to toe format
        - ii. All major body parts/systems
        - iii. Vital Signs / Documentation
    - b. Frequently assess for Vaginal Bleeding/Shock
        - i. Place Sterile Gauze/Pad from OB Kit over the vaginal opening
          Do Not Insert Anything into the Vagina
        - ii. If shock develops follow the appropriate Shock Protocol
        - iii. If Uterus fails to contract.
            1. Firmly Massage fundus
        - iv. IV Bolus

c. Pulse Ox Measurement
d. Oxygen/Ventilation based on Assessment.
e. Demonstrates the appropriate transport mode and destination.
f. Transport as soon as safe to do so to the proper destination.

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Student's and FTO's signatures below signify that the student has demonstrated sufficient working knowledge and can perform such competency and has had the opportunity to ask and has had all questions and answers provided to their level of comfort.

Competency – ODEMSA – Regional Protocols - **OB/GYN – Post-Partum Hemorrhage – ALS**

Student's Name and Signature – date below:

______________________________ ____________________________ Date_________

Printed Name Signature

FTO's Name and Signature – date below:

______________________________ ____________________________ Date_________

Printed Name Signature

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