EMT Skill Sheet

Skill #8 - Pre-hospital Childbirth

Student Name: ____________________________ Pass date - ___________

Evaluator Name______________________ Signature: ___________________________________
(Sign if Student Passes Skill) Date

* Students may have pen, light pen, stethoscope, blank Note Book/Clipboard and First Out equipment

Dispatched:	Patient Contact:	Transport:	End of Call:	

Information on this skill can be found in the Text Book and on the class D2L website		**Comments**
SCENE SIZE-UP – Starts prior to Patient contact but continues throughout the call		
Uses body substance isolation precautions of Gloves and Eye Protection **(Critical Fail!)**		
Scene Size-up Evaluation (Information from Dispatch or EMRs) – **Safety (Critical Fail!)**, Mechanism of Injury (MOI) – C-spine needed, Nature of Illness (NOI), Additional Resources, # of Patients		
PRIMARY ASSESSMENT (Primary Survey/Initial Assessment) - Done on Scene		
General Impression of the scene, patient & gathers information from EMRs or bystanders. Must observe: ✓ Unusual Environmental Factors (Hazards, Odors/Temperature, Lighting, Entrances/Exits, People) ✓ Patient's approximate Age, Sex, and Mental Status/ LOC (Level of Consciousness) ✓ Patient's Positioning, Level of Distress (Breathing/Pain), and any Gross Injuries seen ✓ Looking for Arterial Bleeding and ≈***If necessary*** - applying bleeding control as soon as possible		
Considers C-spine (Spinal Motion Restriction) for the Patient **(Critical Fail!)** – When in doubt – C-spine EMT should evaluate the scene for MOI (Mechanism of Injury). Does patient meet any of the following; • Significant MOI (MVC at high speed, Falls>20 feet) with Neck/Back Pain or Neurological deficit • Unresponsive/AMS (Altered Mental Status or Drugs/ETOH) patients with unknown history of event • Water related accidents, head/neck injuries, hangings If Yes to the above - Tell patient not to move and directs an EMT to hold manual stabilization (Skill #4)		
Identifies self by Name, Level of Medical training, Agency & gets Patient's consent (Expressed/Implied)		
Determines responsiveness of Patient by AVPU - May visualize for signs of Breathing at this time ✓ Awake - If patient is Alert must ask Person, Place, Time and Event orientation questions ✓ Responses to Verbal – check to see if patient can follow commands or answer questions ✓ Physical then Pain - check to see if patient can follow commands, open eyes or answer questions ✓ Unresponsive – **NO** response to Painful stimulus (Do no harm – neck/ear pinch, push bone above eye)		
≈***If necessary*** - If patient is Unresponsive to Pain start with Circulation not Airway (2015 ECC BLS)		
Asks Patient – Name, Age and Chief Complaint • Determines patient's condition and considers calling for ALS if necessary		
Note: The Evaluator states patient complains of Labor Pains		
Continues to assess the need for C-spine – ✓ Ask patient/witnesses if they have had any trauma (falls, assaults, MVC, head injury) If Yes – ask patient if they have head/neck/back pain and/or weakness/numbness to their extremities? ➢ Hold manual stabilization on Trauma patients that have neck/back pain or neurological deficits		
<u>Airway</u> - Assesses and Fixes **(Critical Fail!)** ✓ Listen for noise – snoring, stridor, gurgling, wheeze ✓ Smell for odors – ETOH (alcohol), emesis, ketones, unusual odors (must be within 3 feet of Head) ✓ **Ask if patient if they are nauseated or had emesis if awake (Vomiting common in Labor)** Considers if Airway is Good (Adequate) or Bad (Inadequate) ➢ **Signs/Symptoms (s/s) that Airway is Patent/Adequate** – Patient is awake and maintaining their own airway, no abnormal noises heard (stridor, snoring, gurgling), Patient can speak clearly, No oral trauma or obstructions (blood, vomit, fluid, swelling) are noted ➢ **Signs/Symptoms that Airway is Inadequate** – Diminished level of responsiveness, Abnormal noises heard (stridor, snoring, gurgling), Drooling, Difficulty talking or speaking clearly, Actively vomiting If Airway is Inadequate or Patient with Altered Mental Status (AMS) - Open mouth and look for Obstruction – broken teeth, dentures, edema, emesis, blood (use light pen) ≈***If necessary*** – Fixes Airway (Skill #2) • Suctions patient as needed • Open and maintain airway with Head-Tilt Chin-Lift/Jaw-Thrust if patient is not maintaining Airway due to decreased mental status • Considers Airway Adjunct for all Patient's with AMS - OPA or NPA		

<u>Breathing</u> - Assesses and Fixes **(Critical Fail!)** – This may be done in Mental status assessment Considers if Breathing is Good (Adequate) or Bad (Inadequate) ✓ Looks for bilateral chest rise/listens for noisy breathing (Feels for chest rise in AMS patients) ➢ **Breathing is Adequate** – Equal rise and fall of chest bilaterally, Non-labored, Patient is Awake with good mental status, no abnormal noise heard, breathing is full, appears to be a good rate (12-20), Pink dry skin, patient can speak in full sentences ➢ **Breathing is Inadequate** – Labored breathing, Abnormal noises (stridor, wheezes, coughing, or noisy breathing), Bad rate (<12 or > 20), Shallow breathing, Patient is tripoding, using accessory muscles, Pale /cyanotic skin, unable to speak full sentences, (Nasal flaring, Grunting, Retractions, or Seesaw breathing - Kids) – patients with Decreased mental status should be carefully assessed • **If Breathing is labored - Describes level of Dyspnea as Mild, Moderate or Severe** (**get SpO2**)		
Considers Ventilation and Oxygen for the Patient –- **(Critical Fail!)** *** Prehospital Childbirth O2 should be given because EMTs cannot assess the Neonate** Directs an EMT to provide O2 therapy and place SpO2 on patient (**keep SpO2 at or above 94%**) ✓ NC 1-6 LPM – Little Sick without Life threating Complaints or only mild Respiratory distress ✓ NRM 15 LPM – Big Sick, Hypoxic, AMS, CO poisoning, Shock, or Respiratory distress (>Mild) ➢ **Provide as much Oxygen as the Patient will tolerate**		
<u>Circulation</u> - Assesses and Fixes **(Critical Fail!)** ✓ Pulse **(Considers the Strength, Speed-fast/slow, and Regularity)** assess for up to 10 seconds ✓ Checks Skin signs (**Moisture/Color/Temperature**) and Cap Refill • Signs or symptoms of Shock must be treated in Primary Assessment (Skill #5)		
≈If necessary - Considers CPR and AED placement if there is no pulse in patient		
<u>Deformities</u> - Rapid Scan in all Patients (30-60 seconds) *(Trauma or AMS Patients use Skill #9)* ✓ Head – Visualize for deformities. Visualize ears, nose and mouth for edema, trauma, bleeding or ecchymosis, and facial symmetry (ask patient to smile as needed) ✓ Neck – Visualize for JVD, swelling or bleeding ✓ Chest – Visualize equal rise & fall of chest and ask Patient to take deep breath and move (non-trauma) for pleuritic pain • *EMT may check Lung Sounds (Bases & Apexes) for Dyspneic or Chest Pain patients* ✓ Abdomen – Ask patient if they have abdominal pain. Expose if patient complains of abdominal Pain • *EMT may palpate 4 quadrants of abdominal in assessment as needed* ✓ Pelvis – Visualize for incontinence (urine/feces) – Note Blood or Water breaking ✓ Extremities – (non-trauma) ask patient to move all extremities and check CMS* in all extremities ✓ Posterior – Visualize for abnormalities, rash or Trauma and ask about neck/back pain ***≈If necessary*** - **Provides bleeding control** (Skill #5) **or occlusive dressing (Critical Fail!)** ➢ Some EMTs just do a quick visual scan without palpation on awake medical/trauma Patients ➢ Some EMTs expose and exam patient's chief complaint area in Primary Assessment * CMS – Circulation, Motor and Sensory Function (also called Neurovascular Function and PMS – Pulse/Motor/Sensory)		
<u>Expose and Examine</u> - To the appropriate level (Age, Mental status, Injury, Environment) ✓ Head and Chest should be exposed in Critical Patients (Head Coverings/Shirt)		
Ask Patient about signs and symptoms for impending delivery and other questions associated with labor (must state at least 6) ✓ Is the Patient under a Doctor's care – Obstetrician (OB) ✓ Does she expect multiple babies ✓ Past medical history ✓ History of Drugs, Smoking or Alcohol ✓ When is the Due Date of the baby ✓ Any complications with her Labor (placenta previa, gestational diabetes, preeclampsia) ✓ Has her water broke (signs of meconium or bleeding) Signs of Impending Birth (name all)– ✓ Is she multipara (Para/gravida) ✓ Does mom feel the baby coming ✓ Does mom feel the urge to push or move her bowels or go to the bathroom ✓ Are contractions less than a few minutes apart – Directs EMT/EMR to time contractions		
Moves Patient to floor for further assessment and treatments		
Informs Patient the need to check for crowning due to possibility of Impending birth – get consent		
Exposes and checks for crowning		
Note: The patient is crowning with baby's head presenting and transport time is 45 minutes to closest Hospital		

Consider and verbalizes the following – Patient Priority (Life Threats) – 1. Appears – Stable (Little Sick) – Mental Status & ABCDs normal and no life threating complaint(s) 2. Appears - Potentially Unstable (possible Big Sick) – Mental Status and ABCD good but has life threating complaint(s) 3. Appears – Unstable (Big Sick) – Any abnormal Mental Status or abnormal ABCDs and/or has life threating complaint(s) ✓ Inform team of Transport Decision. Stay & Play or Load & Go (<10 min on scene - Critical patient) ✓ ALS needed or any additional resources ✓ Informs Dispatch of Impending delivery and ask to have car seat brought to the scene ✓ Assign Tasks to Team Members ➢ EMT #1 – Prepares for Delivery ➢ EMT #2 - Vital Signs, Time Contractions, provide Treatments and gets Patient History (Stays at Patients Head) – Documents History, Demographics, and Vital signs		
Note: The Patient states she feels the need to push and feels the baby coming		
Positions patient on firm surface. Exposes and cleanses patient with sterile water and iodine (allergies) ✓ Elevates patients hips 2” to 4” with towels/blanket to get view of vagina with patient in sitting position		
Drapes patient as necessary (chux and sterile sheets) and prepares for birth ✓ EMT puts on disposable gown, face shield, and verbalizes putting sterile gloves		
Prepares hands for delivery on baby’s head to prevent explosive birth (verbalizes noting the fontanels)		
Delivers baby head and checks for nuchal cord **(Critical Fail!)**		
➢ Delivers baby (do NOT Suctioning Baby Airway unless there is an airway obstruction – 2015 ECC)		
Note: The Evaluator states baby is active with a strong cry		
If baby is not crying and active after birth go immediately to Neonatal resuscitation (Critical Fail!)		
Warms and Dries baby - keeps baby at level of vagina until cord clamped **(Critical Fail!)**		
Keeps baby warm (wraps baby in dry blanket and covers head with cap) – keep AC off in ambulance		
Note: The Evaluator states baby active with a strong cry		
Does APGAR score at 1 minute and 5 minutes after birth – document time ✓ **A**ppearance – Skin Color: Pale or blue all over = 0 Pink color body but blue extremities = 1 Pink color in core and extremities = 2 ✓ **P**ulse - Heart Rate Absent heartbeat = 0 Slow heartbeat (less than 100 beats per minute) = 1 Adequate heartbeat (more than 100 beats per minute) = 2 ✓ **G**rimace - Response to Stimulation (also called Reflex Irritability): No response = 0 Weak cry to stimulus = 1 Vigorous cry or withdrawal = 2 ✓ **A**ctivity - Muscle Tone: Limp, flaccid = 0 Weak resistance to flexing or bending = 1 Resists attempts to straighten legs = 2 ✓ **R**espiration (neonates and infants often have irregular breathing rates): Not breathing = 0 Slow breathing = 1 Rapid Respirations = 2		
Documents Time of Birth		
Clamps and cuts cord with **sterile** equipment ✓ Delay clamping of the umbilical cord for 1 to 3 minutes for uncomplicated births (no resuscitation) ✓ First clamp 8 to 10 inches toward mother and then 2ed clamp 2 to 4 inches toward baby (minimum 6 inches from baby – some text books state 4 inches or fingers) – Umbilical cord is baby’s life line ✓ Checks for pulse in-between clamps, if pulse detected adjust clamps till pulse disappears ✓ Clamps and cuts cord with **sterile** equipment ✓ If no sterile equipment is available, the EMT must leave baby attached to placenta and keep baby and placenta at same level		
Gives baby to Mom – Skin to Skin Contact (baby to mom) and nurse if mom wants Must do 1st APGAR and clamp and cut cord prior to giving baby to Mom		
✓ Delivers the placenta and saves in plastic bag and transports with the baby (Third stage of labor) ✓ Does not pull on umbilical cord (Normally delivers in 5 – 10 minutes but may take up to 30 minutes)		

Watch for signs of excessive bleeding (>500 ml) in mother (Bleeding control measures) **(Critical Fail!)** ✓ OB pad between mother's legs (keeps used pads for hospital) – always place OB pad for all patients ✓ Breast Feeding (oxytocin) ✓ Massage the fundus (Informs patient of treatment - painful)		
Verbalizes signs and/or symptoms of compensatory/early shock (Must state 6) **(Critical Fail!)** ✓ Agitation, Anxiety or Restlessness ✓ Feeling of Impending Doom ✓ Dizziness ✓ Weak, rapid (thready) pulses – tachycardia (narrow pulse pressure) ✓ Clammy (pale/cool/moist) skin signs ✓ Pallor and cyanosis at lips or distal extremities ✓ Rapid Breathing or Shortness of Breath ✓ Nausea or vomiting ✓ Delayed Capillary Refill ✓ Marked Thirst ✓ Altered mental Status (Confusion) • Treatment for Shock – keep warm, place supine if possible, high flow O2, and rapid transport		
Note: The Evaluator asks the steps of Neonatal resuscitation – Baby not breathing in 15-30 seconds after birth		
Students explains Neonatal resuscitation (Follow steps below 1 to 4 till baby is breathing and crying); Stimulate, Warm, and Dry all unresponsive and non-breathing babies for entire resuscitation 1. Immediately clamp and cut umbilical cord to start resuscitation 2. Stimulate, Warm, Dry and Suction with bulb syringe - oral then bilateral nares (30 seconds) 3. BVM with 20 ventilations in 30 seconds with Stimulate, Warm, Dry (30 seconds) 4. Check pulse for 6 seconds (Brachial, Umbilical, auscultates Apical) as you Warm/Dry/Stimulate ✓ Heart rates over 100 bpm continue to Stimulate, Warm, Dry and Suction with bulb syringe for airway compromised neonates (reassess every 30 seconds) ✓ Heart rates less than 100 bpm continue BVM at 40 to 60 ventilations per minute (Keep warm) (reassess every 30 seconds) – BVM full term neonates with Room Air. BVM premature neonates (<35 weeks) with supplemental Oxygen (set at only 5 LMP). ✓ Heart Rate less than 60 bpm start Neonatal resuscitation (3 compressions to 1 ventilation at 120 events per minute) – with warm, dry stimulate (reassess every 30 seconds) ➢ Compressions depth for a neonate is 1/3 the depth of the chest. 2 thumbs with the fingers encircling the chest and supporting the back (the 2-thumb technique)		
#2 EMT Obtains History, Vital Signs and Demographics – Done on Scene most of Time		
#2 EMT Gets and Documents SAMPLE and OPQRST		
#2 EMT Gets Get Patient's Demographical Info (legal name, age, birthday, full address, phone #, insurance/hospital) Patient ID and Insurance Cards (if at medical facility must get copy of patient's medical record)		
#2 EMT Documents 2 sets of Vital signs – Before and after birth		
Physical Assessment (Head to Toe) may be deferred till enroute		
Should begin transporting of the patients to the hospital (Car seat for baby) in 20 minutes or less after birth – Do Not delay Transport to deliver Placenta		
Contacts Medical Control and/or documents Standing Orders/Protocols followed		
More than 4 missed points results in Failure Total Missed Points		

✓	Actions performed and/or verbalized by student when doing skill
➢	Additional information on the procedure
•	Key Points that student should know but do not need to verbalized/do unless asked

Evaluator Comments: