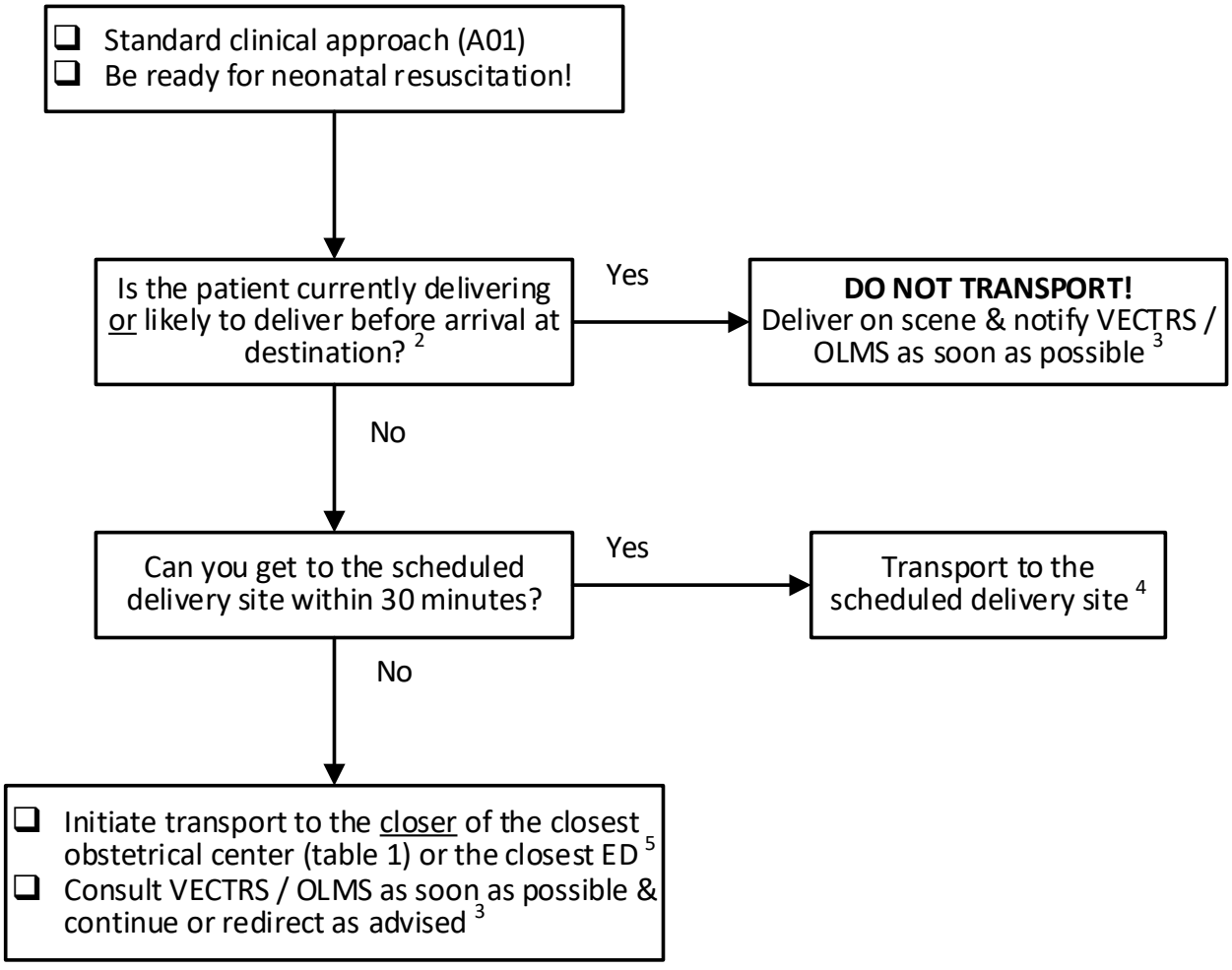
Shared health Soins communs Manitoba	D01.1 - PRIMARY TRANSPORT DURING LABOR	
	Version date: 2025-03-17	Effective date: 2025-04-30 (07:00)
EMR / PCP / ICP / ACP		



If you are closer to the Winnipeg Perimeter Highway than any Regional hospital, transport to the closer of SBH or HSC

VECTRS / OLMS: (204) 949-4000

TABLE 1: OBSTETRICAL CENTERS & OBSTETRICS-CAPABLE FACILITIES IN OR NEAR MANITOBA

- Bethesda Regional Health Centre (Steinbach)
- Boundary Trails Health Centre (Winkler)
- Brandon Regional Hospital
- Dauphin Regional Health Centre
- Health Sciences Centre (Winnipeg)
- Lake of the Woods District Hospital (Kenora, ON) *
- Neepawa Health Centre
- Portage District General Hospital (Portage La Prairie)
- Selkirk Regional Health Centre (Selkirk)
- St. Anthony's General Hospital (The Pas)
- St. Boniface Hospital (Winnipeg)
- Thompson General Hospital
- Yorkton Regional Health Centre (Yorkton, SK) *

(*) Where indicated call ahead to confirm that normal obstetrical services are currently available

INDICATIONS

- Transport of a patient in labor from a primary response call

WARNINGS

- Not applicable

NOTES

1. Transporting a patient in active labor can be stressful. Paramedics should have a low threshold to call the Virtual Emergency Care & Transport Resource Service (VECTRS) and consult on-line medical support (OMS) for clinical assistance and destination decision support.

   Be ready for delivery if labor progresses, and be prepared for neonatal resuscitation if delivery occurs.

2. Consider that the patient is about to deliver if they complain of an urge to "push", "bear down" or "have a bowel movement". The patient is actively delivering if the perineum is bulging or the fetal head is crowning.

   Birth on scene or in any hospital (even a non-obstetrical facility) is considered much safer than birth during ambulance transport.

3. Call VECTRS / OLMS as soon as possible after delivery. They can access the Child Health Transport Team (CHTT), as well as the transport physician (TP) for consideration of air intercept. Should an obstetrical emergency develop, VECTRS / OLMS can conference in the on-call transport obstetrician.

4. If the situation allows, it is usually best for a patient to be delivered and receive postpartum and newborn care at their scheduled delivery site by a health care provider (HCP) familiar with their prenatal course.

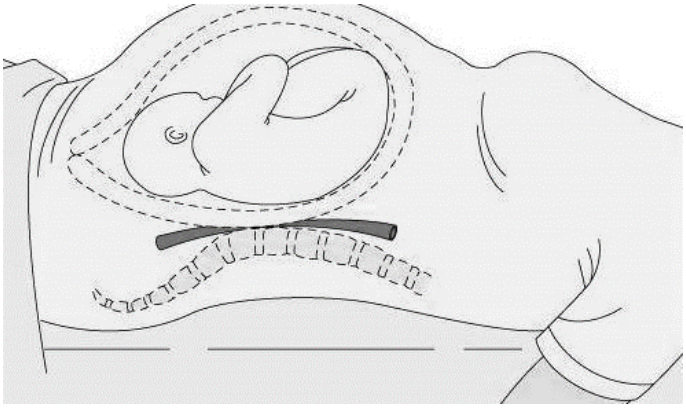
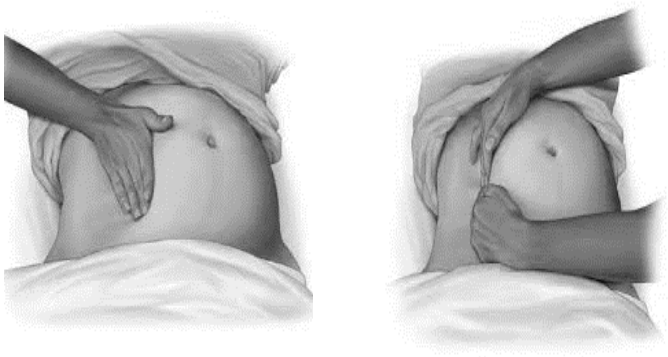
5. If the transport time to the scheduled delivery site will be excessive (either for clinical or operational reasons) transporting to an alternative location may be necessary. Further assessment there can help determine the most appropriate course of action, be it delivery at that site with a secondary interfacility transfer (IFT) or continued primary transport.

   if continuing to transport, additional personnel from the health care facility may potentially be available able to accompany and assist with delivery and newborn care, should it occur en route.

6. Some patients after 20 weeks gestation may experience hypotension when they lay down. Compression of the inferior vena cava by the gravid uterus will impede venous return to the heart resulting in hypotension.

   Unlike other causes of hypotension this may be accompanied by bradycardia due to an increase in vagal tone from pressure on the vena cava (figure 1). But, always consider all possible causes of hypotension.

   Elevating the patient's right side and manually displacing the uterus to the patient's left side will usually provide relief (figure 2).

FIGURE 1: VENA CAVA COMPRESSION	FIGURE 2: MANUAL UTERINE DISPLACEMENT
	

LINKS

- A01 - Standard Clinical Approach
- D02 - Prehospital Delivery
- D03 - Newborn Care & Neonatal Resuscitation

APPROVED BY	
EMS Medical Director	EMS Associate Medical Director

VERSION CHANGES (refer to X04 for change tracking)

- Addition of advanced work scope
- Revised flow chart & notes for greater clarity and ease of use