| Shared health Soins communs Manitoba | D01.2 - INTERFACILITY TRANSPORT DURING LABOR | |
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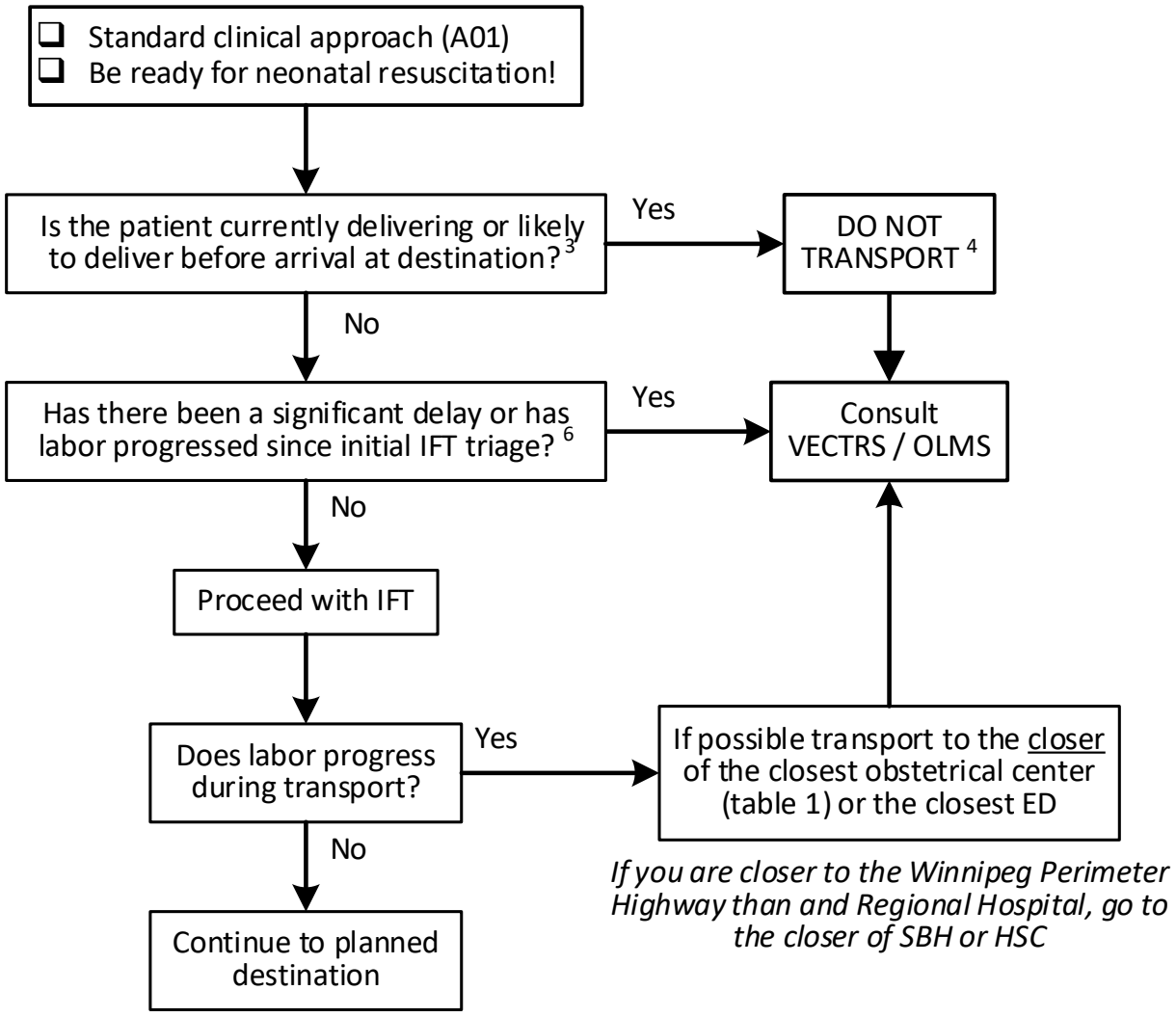
| | Version date: 2025-04-22 | Effective date: 2025-04-30 (07:00) |
| EMR / PCP / ICP / ACP | | |




**VECTRS / OLMS: (2024) 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**

- Interfacility transport of a patient in labor

**WARNINGS**

- Not applicable

**NOTES**

1. Transporting 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. VECTRS / OLMS can conference in the on-call transport obstetrician and Child Health Transport Team (CHTT) if required.
2. The duration of labor can be difficult to accurately predict (appendix A). Be ready for delivery if labor progresses, and be prepared for neonatal resuscitation if delivery occurs.
3. 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.
4. Assist local staff with delivery, newborn care, and postpartum maternal care. Call VECTRS / OLMS as soon as possible after delivery.
5. Before you are dispatched, VECTRS will triage the request for an interfacility transfer (IFT) to confirm safety, determine urgency, and establish priority. The following information will be obtained during triage.
   - How many prior pregnancies (gravida) and deliveries (para)?
   - Has the patient had regular prenatal care?
   - Is there one or multiple fetuses?
   - Is the patient having regular, painful contractions?
     - If so, how far apart are the contractions?
   - What has been the duration of previous labors?

- Has the patient had a vaginal examination, when was it performed, and who performed it?
- What is the presentation, station and dilatation on the examination?
- Are the membranes ruptured?
  - If so, is there meconium in the amniotic fluid?
- What is the expected transport duration?
- Are there enough qualified personnel available for transfer?
  - Is EMS intercept possible?
  - Are there alternative facilities along the way if necessary?
- What is the name and contact information for the referring and receiving health care providers (HCP)?
- Is the patient going directly to the labor floor or stopping in the emergency department (ED)?

6. If labor has progressed or there has been a significant delay since the initial triage, consult VECTRS / OLMS before transporting.

   VECTRS / OLMS may request a repeat vaginal examination to determine labor progression, and may request that the referring facility send additional personnel to assist with delivery and newborn care, should it occur during transport. And, VECTRS / OLMS may recommend transport to a closer obstetrical facility (table 1).

7. 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 |
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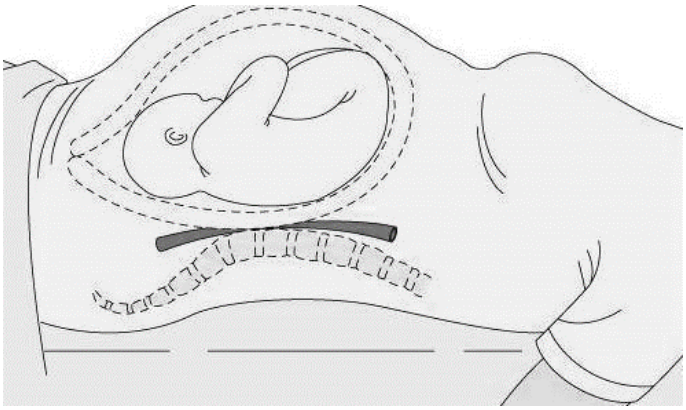
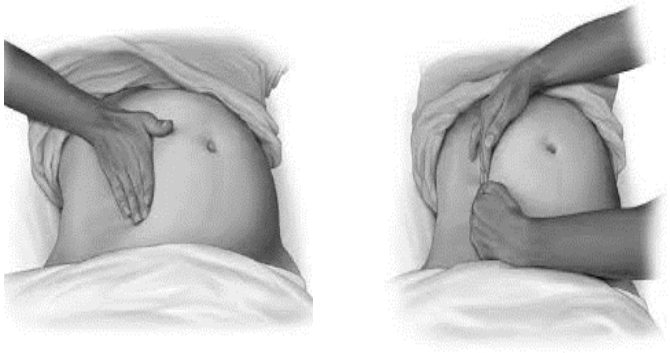
|  |  |

| LINKS |
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| • A01 - Standard Clinical Approach<br>• D02 – Prehospital Delivery<br>• D03 – Newborn Care & Resuscitation |

| APPROVED BY | |
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|  |  |
| EMS Medical Director | EMS Associate Medical Director |

| VERSION CHANGES (refer to X04 for change tracking) |
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| • Addition of advanced work scope<br>• Revised flow chart & notes for greater clarity & ease of use |

## APPENDIX A: LABOR DURATION

The onset of labor is identified by the beginning of regular painful uterine contractions. Once the cervix has dilated approximately half-way, **active labor** begins and can then progress rapidly. The duration of labor is quite variable between individuals and their pregnancies, but generally becomes shorter after each birth.

Active labor usually begins at about 5 centimeters of dilation in a term pregnancy, but can be less with preterm labor or a smaller fetus. Vaginal examination by an experienced health care provider (HCP) can be helpful in determining the onset of active labor, but has a wide margin of error with inexperienced hands.