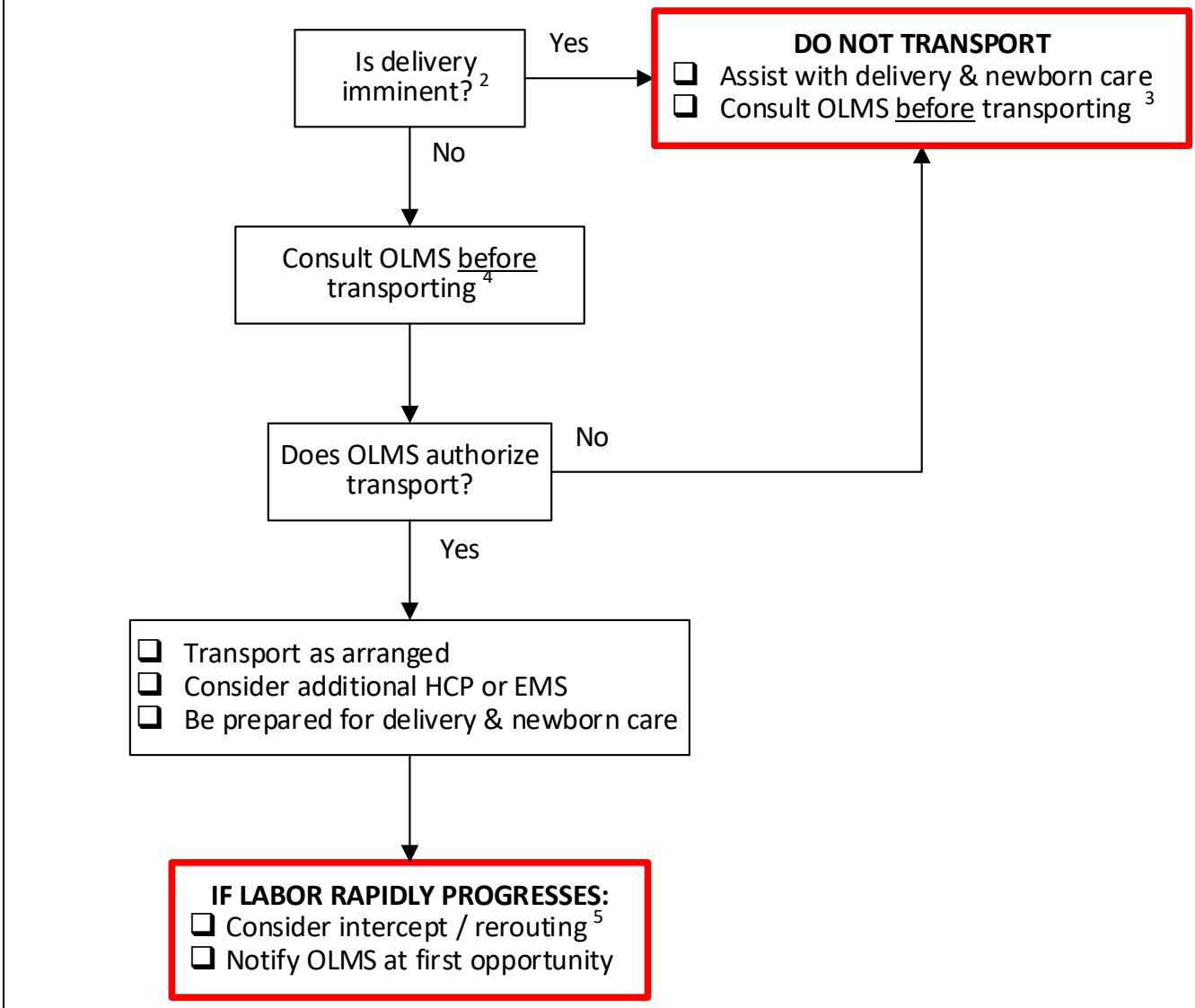
Shared health Soins communs Manitoba	**D01.2 - INTERFACILITY TRANSPORT DURING LABOR**
	MATERNAL & NEWBORN CARE
Version date: 2023-07-10	Effective date: 2024-02-13 (0700)



IDENTIFIER:	**EMR:** EMR only	**PCP:** PCP & ICP	**ICP:** ICP only	None - All providers

QRG: OBSTETRICAL FACILITIES

(*) Paramedics should call ahead to confirm that normal obstetrical services are currently available.

- 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) *

INDICATIONS

- Interfacility transport (IFT) of a patient in labor

CONTRAINDICATIONS

- None

NOTES

1. The onset of labor is usually identified by the beginning of regular painful uterine contractions. The *first stage* is the interval from the labor onset to full cervical dilatation. This stage is divided into latent and active phases. Vaginal examination can be helpful in differentiating the phases, but in practice has a wide margin of error.

   The *latent phase* is characterized by gradual cervical changes. The *active phase* is considered to begin when cervical dilatation reaches approximately half way. The transition usually occurs at about 5 centimeters in a term pregnancy, but can be less in preterm labor.

   The duration of each phase is highly variable and labor will generally be quicker after the first vaginal delivery.

2. Delivery should be considered *imminent* if the patient complains of an urge to "push", "bear down" or "have a bowel movement", the perineum is bulging, or the fetal head is crowning. Paramedics will not transport a patient when the patient is delivering or delivery is determined to be imminent regardless of the transport duration.
3. After delivery of the fetus consult for on-line medical support (OLMS) before transporting.
4. The decision to perform an interfacility transfer (IFT) with a patient in active labor is complex. OLMS will require the following information:
   - How many prior pregnancies (gravida) and deliveries (para)?
   - What is the gestational age of the pregnancy?
   - 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 regular prenatal care?
   - Has the patient had a vaginal examination in the last 30 minutes? Who performed the vaginal examination?
   - What is the station and dilatation on vaginal exam?

- 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 en route if necessary?
- What is the name and contact information for the referring health care provider (HCP)?
- What is the name and contact information for the receiving HCP?

5. **Birth in a non-obstetrical facility is preferable to delivery on the road**. Rerouting an emergency department (ED) along the way may become necessary. If rerouting, ensure appropriate pre-arrival notification of ED staff. Paramedics will over-ride a redirection (diversion) advisory if necessary.
6. If the patient should develop hypotension while supine during transport elevate the right hip 4 to 6 inches and manually displace the uterus to the patient's left side (appendix A).

LINKS
D02 – PREHOSPITAL DELIVERY D03 – NEWBORN CARE & RESUSCITATION

APPROVED BY	
	
EMS Medical Director	EMS Associate Medical Director

VERSION CHANGES (refer to X04 for change tracking)
• Identifier legend at bottom of flow chart replaces work scope statement in header

APPENDIX A: SUPINE HYPOTENSION SYNDROME

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

Supine hypotension is uncommon under twenty weeks gestational age because the uterus is not yet large enough to compress the inferior vena cava. Always consider all possible causes of hypotension.

FIGURE 1: VENA CAVAL COMPRESSION

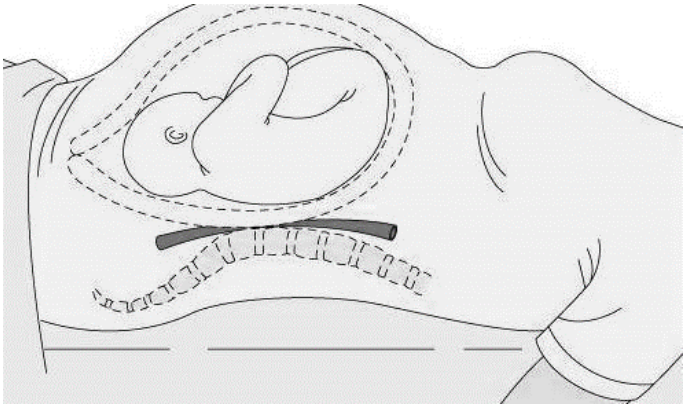


FIGURE 2: MANUAL UTERINE DISPLACEMENT