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NEONATAL RESUSCITATION

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Next Revision: 6/2029

(Signature On-file)
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NEONATAL RESUSCITATION

PROTOCOL PROCEDURE: *Flow of protocol presumes that condition is continuing. If patient is in severe distress, immediate, rapid transport is preferred with treatment performed en route.*
Remember not to forget the mother in post-delivery resuscitations.

Basic Life Support

EMT

IF NEONATE-

- Is term,
- is breathing or crying, and
- has good muscle tone

THEN:

- Provide/maintain warmth, placing baby skin to skin with mother is good way to keep baby warm
- Dry vigorously including head and back. Use clean dry blankets or towels and continue drying until the baby is completely dry. Assess skin color.
- Routine suctioning of neonates **is not indicated**. Newborns without respiratory distress do not require any suctioning. Only **utilize suctioning for airway obstruction** and only use gentle anterior oropharyngeal bulb suction if suctioning is required. No deep or prolonged suctioning – even with meconium. If required, suction the mouth, then nose.
- Place with mother and monitor skin and vital signs.
- Calculate APGAR at 1 and 5 minutes.
- Routine use of oxygen **is not indicated** – see targeted SpO2 table*
- In newborns who do not require resuscitation, delaying cord clamping for 30-60 seconds reduces anemia, especially in preterm infants.

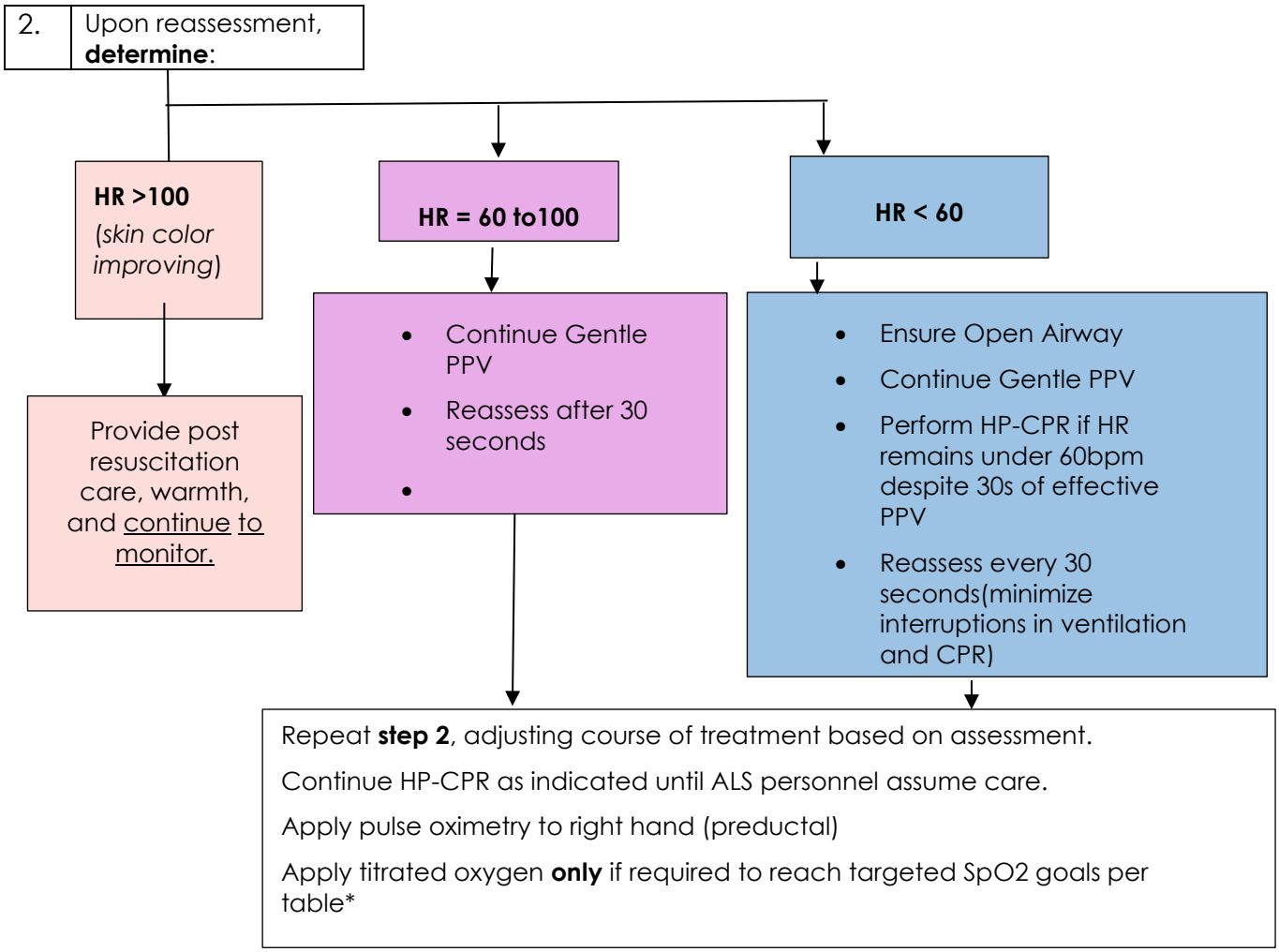
Preterm or low birth weight neonates are extremely susceptible to hypothermia and need aggressive warming measures and temp management during resuscitation.

- Put hat on baby, use provided blankets not wool grey blankets, or plastic wrap or bag for

very preterm infants, and avoid heat loss during transport. Also all infants can become cool quickly. Skin to skin is best.

IF NEONATE is gasping, apneic or HR<100 BPM-

1.	Provide **gentle room air positive-pressure ventilation (PPV)** at **40-60** breaths per minute. Avoid overinflation. If ventilation is ineffective: fix mask seal, reposition airway, suction only if obstructed, open mouth, increase pressure as needed, consider alternative airway. Reassess after 30 seconds



HP-CPR - Chest compressions are given using the 2 thumb-encircling hands technique. The ratio is 3 compressions to1 ventilation (3:1), with 90 compressions and 30 breaths to achieve approximately 120 events per minute. Do not ventilate and compress at the same time.

LOSOP

EMT working under Local Optional Scope

GLUCOSE LEVEL ASSESSMENT via finger stick

Treat per **GLYCEMIC EMERGENCY** protocol as indicated.

Advanced Life Support

Paramedic

AIRWAY

- Place SGA as indicated – Initiate with room air
- Monitor ETCO2 and pulse oximetry

CARDIAC MONITOR - for the rapid and accurate measurement of the newborn's heart rate

VASCULAR ACCESS – Establish IV/IO.

NORMAL SALINE - Consider bolus of 20 mL/kg.

GLUCOSE LEVEL ASSESSMENT - via finger stick or venipuncture.
Treat per **GLYCEMIC EMERGENCY** protocol as indicated.

OXYGEN – **Not routinely indicated and should be titrated only** if newborn demonstrates distress and does not meet the targeted preductal SpO2 after birth goals (see table*)

EPINEPHRINE – Initial and repeat doses; IV/IO: **0.01 mg/kg (1:10,000, 0.1 mL/kg**) every 5 minutes, until HR >60 BPM. A 3 mL Saline flush should follow every Epinephrine administration.
CONTACT BASE for additional orders as indicated

APGAR SCORE

	Sign	0 Points	1 Point	2 Points
A	Activity (Muscle Tone)	Absent	Arms and Legs Flexed	Active Movement
P	Pulse	Absent	Below 100 BPM	Above 100 BPM
G	Grimace (Reflex Irritability)	No Response	Grimace	Sneeze, cough, pulls away
A	Appearance (Skin Color)	Blue-gray, pale all over	Normal, except for extremities	Normal over entire body
R	Respiration	Absent	Slow, irregular	Good, crying

Targeted Preductal SpO_2 (Right Hand)	
1 min	60% - 65%
2 min	65% - 70%
3 min	70% - 75%
4 min	75% - 80%
5 min	80% - 85%
10 min	85% - 95%