What to do if baby comes too quickly

Recognize when birth may be imminent

Precipitous labor generally refers to labor culminating in birth within approximately three hours of contractions beginning. The defining feature is not simply that contractions are uncomfortable or close together, but that cervical dilation, descent, and delivery progress unusually quickly. A person may have little warning, especially if they have previously given birth, have had a rapid labor before, or are not yet accustomed to interpreting labor sensations.

Signs that delivery may be close include an intense and involuntary urge to push, pressure in the rectum or pelvis, a bulging perineum, the baby’s head becoming visible, or the sudden rupture of membranes followed by rapidly intensifying contractions. Heavy vaginal bleeding, severe constant abdominal pain, loss of consciousness, seizures, or concern that the baby is not moving normally are emergencies regardless of how advanced labor appears.

Do not rely on timing contractions alone. If the person feels that the baby is coming, treat the situation as urgent. Call emergency services even if the birth seems likely to occur before an ambulance arrives. The dispatcher can help determine the safest position and may connect you with instructions for an

unplanned out-of-hospital delivery.

Call for help and prepare a safe space

Call the local emergency number and state clearly that a baby may be born imminently. Give the exact location, including access information if responders must enter an apartment, gated property, or remote area. Tell the dispatcher the person's gestational age if known, whether this is a first or subsequent birth, whether the baby's head is visible, whether there is bleeding, and whether the person or baby has any known medical complications. Remain on the line unless instructed otherwise.

Place the phone on speaker. Send another adult to meet the ambulance if possible, but do not leave the birthing person alone. Unlock doors, turn on lights, secure pets, and gather clean towels or blankets. A waterproof layer under the person may protect the surface, but do not delay the call or emergency transport while collecting supplies.

Help the birthing person into a stable position, such as lying supported on their side, reclining with knees bent, or sitting low with their back supported. Choose the position that reduces the risk of falling and allows the baby to emerge safely. If the person is on stairs, in a vehicle, or standing, assist them to a safer location when this can be done without force. Avoid placing pressure on the abdomen and do not attempt to examine the cervix.

Support the delivery without trying to control it

Follow the emergency dispatcher's instructions. Encourage slow, steady breathing and calm communication. If the person has an urge to push, do not attempt to physically restrain them. If the dispatcher advises panting or gentle breathing between contractions, support those instructions, but recognize that an involuntary expulsive effort may be difficult or impossible to suppress.

As the head emerges, place clean hands or a clean towel beneath it to prevent it from striking a surface. Do not pull on the head or rotate it. The head may turn spontaneously as the shoulders align. Once the head is born, check visually for a cord around the neck only if the dispatcher directs you and it

is easily visible. Never pull on a cord. If it is loose, a trained clinician or dispatcher may instruct how to gently ease it over the head; if it is tight, leave it in place and await instructions.

The shoulders and body usually follow with the next contraction. Support the newborn's weight as the body emerges, because a wet newborn is slippery. Do not pull on the arms, shoulders, or trunk. If the baby does not emerge after the head is born, tell the dispatcher immediately and follow their instructions; this can indicate shoulder dystocia and requires urgent professional management.

Do not attempt to cut or clamp the umbilical cord unless specifically instructed by emergency professionals. Do not pull on the cord or placenta. The placenta may deliver later, but the immediate focus is breathing, warmth, and the condition of the birthing person.

Immediate care for the newborn

Place the newborn directly on the birthing person's bare chest or abdomen if the baby is breathing normally and there is no immediate danger. Dry the baby thoroughly, including the head, with a clean towel, and replace wet towels with dry coverings. Skin-to-skin contact helps reduce heat loss and supports physiologic transition. Cover the baby's back and head while keeping the face visible.

Observe breathing, color, tone, and responsiveness. Normal transition can include irregular breathing, crying, and changes in color during the first moments. However, a newborn who is not breathing normally, is limp, or remains unresponsive needs immediate dispatcher-guided care. Tell emergency services exactly what you see. Clear only visible material from the mouth; do not perform blind finger sweeps. Do not shake the baby or attempt feeding.

If the baby is not breathing normally, follow the dispatcher's instructions for stimulation and neonatal resuscitation. This may include drying and rubbing the back or soles briefly, positioning the airway, and starting rescue breaths or chest compressions if directed. Professional responders should take over as soon as they arrive. Keep monitoring the baby until help is present, because condition can change quickly.

If the baby is born in a sac, the sac must be opened promptly around the face so the baby can breathe. Tell the dispatcher if the membrane appears to cover the baby's face. A blue or gray color, persistent absence of breathing, severe limpness, or worsening responsiveness is an emergency.

Care for the birthing person after delivery

After the baby is stable, continue observing the birthing person. Keep them lying or reclined, warm, and supported. Note the amount and character of vaginal bleeding, level of alertness, breathing, pain, and any dizziness. Do not leave them alone, and do not encourage them to stand or walk, because blood loss and physiologic changes can cause sudden collapse.

Some bleeding is expected after birth, but rapidly increasing bleeding, repeated large clots, pallor, clammy skin, weakness, confusion, fainting, severe pelvic or abdominal pain, or difficulty breathing requires immediate communication with emergency services. These signs may indicate postpartum hemorrhage or another complication. Do not insert anything into the vagina, massage the abdomen unless instructed, or pull on the umbilical cord or placenta.

If the placenta delivers, place it in a clean container or bag for the clinical team. Do not try to remove tissue that remains attached. Retained placental tissue can contribute to hemorrhage and requires assessment by trained professionals. The newborn should remain warm and monitored while the birthing person is assessed.

Both patients need transport or evaluation after an unplanned birth. Clinicians may assess uterine tone and bleeding, genital tract injury, blood pressure, temperature, pain, and the completeness of placental delivery. The newborn may need evaluation of breathing, temperature, glucose risk, infection risk, injuries, and gestational maturity.

Why rapid labor needs medical follow-up

A sudden labor emergency can be physically and emotionally intense, even when the outcome is good. Rapid descent may increase the risk of perineal, vaginal, or cervical trauma, and the birthing person may have limited opportunity for

analgesia or planned support. The newborn may experience respiratory difficulty, temperature instability, or injury associated with a fast delivery. These risks cannot be ruled out by appearance alone.

Emergency clinicians will determine whether hospital transfer is needed and what monitoring is appropriate. Tell them about the timing of contractions, membrane rupture, medications, bleeding, the appearance and timing of the placenta, any resuscitation performed, and whether the baby passed urine or meconium if known. Do not worry about giving a perfect chronology; approximate times are useful.

After stabilization, ask the maternity team to explain what happened, what examinations were performed, and which warning signs should prompt a return to care. A postnatal debrief after emergency birth can help clarify events and address fear, guilt, or distress. Psychological support is clinically appropriate if the experience remains intrusive, causes sleep disturbance, or makes it difficult to care for yourself or the baby.

For a future pregnancy, discuss the rapid birth with an obstetrician, midwife, or other qualified maternity professional early in prenatal care. A previous precipitous labor may influence recommendations about when to call, transportation, proximity to the birth setting, and an individualized emergency plan. Do not make timing or medication decisions without professional advice.

Prevention and planning for a future rapid birth

No plan can guarantee that labor will progress at a predictable rate, but preparation can reduce delays. Keep emergency contact numbers accessible, know the quickest route to the intended birth setting, and identify backup transportation. If travel is necessary late in pregnancy, discuss location-specific access to maternity services with the care team.

Ask the maternity team when they want to be contacted based on your history and current pregnancy. People with a previous rapid labor may be advised to call earlier than standard contraction-timing thresholds. Make sure a support person knows the address, can provide gestational age and medical history, and understands how to call emergency services.

A practical birth plan can include clean towels, a charged phone, relevant medical records, prescribed medications, and a list of allergies. These supplies are secondary to calling for help. Avoid relying on online instructions in place of professional guidance, and never delay emergency care to complete a checklist.