HACKETTSTOWN REGIONAL MEDICAL CENTER

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MATERNAL SERVICES
(Scope)

TITLE: EMERGENCY MEASURES

PURPOSE: To provide the steps for initiating emergency care measures in the absence of a health care provider.

LEVEL: Interdependent

SUPPORTIVE DATA: In all cases, notify patient's obstetrical care provider immediately or ASAP. In all cases staff member to check OB/OR to verify availability of equipment and supplies. Any available privileged obstetrical provider may perform delivery. Maintain NPO unless otherwise ordered.

CONTENT:

Procedures included for Emergency Complications:

A. Precipitous labor and delivery
B. Cesarean Section patient admitted in active labor
C. Tetanic contractions
D. Hemorrhage
E. Prolapsed umbilical cord
F. Convulsions
G. Cardiac or Respiratory distress

A. Precipitous Labor and Deliver

1. Notify health care provider or midwife of impending birth
2. Notify any other health care provider or midwife in hospital if health care provider is not present
3. Ask for nursing assistance from OB nurses or Nursing Service
4. If time permits, wash perineum with betadine solution and set up for delivery
5. Have another nurse assemble quick set up or obtain midwife setup.
6. Encourage patient to blow through contractions to prevent pushing unless FH is low or birth is inevitable
7. Reassure patient
8. Slowly deliver head, support perineum to prevent tearing
9. When head emerges, suction mouth and nose to clear mucus.
10. Check neck to be sure cord is not wrapped around it, if so unwrap it.
11. Deliver anterior shoulder, posterior shoulder, and then rest of baby.
12. Clamp and cut cord
13. Place baby on mom's abdomen in warm blankets or under infant warmer. Second nurse to observe and provide care to infant.
14. Collect cord blood sample.
15. Wait for placenta to deliver – do not pull cord
16. Deliver placenta
17. After delivery of placenta add 10 units pitocin to existing IV solution and open chamber wide. Administer 10 units pitocin IM if no IV site available.

B. Scheduled Cesarean Section Patient Admitted In Active Labor

1. Call health care provider and notify him or her of patient's cervical dilation and labor pattern
2. Notify administrative coordinator will call anesthesia and OR team as directed by health care provider. Provider to call Pediatrician.
3. Admit patient and have CBC and type and screen drawn by lab STAT
4. Prepare patient for OR with abdominal perineal prep, as routinely ordered by individual health care provider. Start IV of L/R infusion first liter before OR. Place foley catheter, witness consents signed and remove all jewelry and artificial devices (including contact lenses).
5. Administer preop medicartions as ordered by provider and/or anesthesiologist.
6. Place OR cap on patient and be ready to transport her to OR Suite on call of the OR team.

C. Tetanic Contractions

1. Stop Pitocin if it is infusing, remove medication bag and accompanying tubing and open mainline IV.
2. Give 0_2 via NRB mask @ 8 liters and position patient on far left side, reposition patient of FH not improved.
3. Give Brethine (Terbutuline) 0.25 mg sc STAT and notify health care provider immediately.
4. Continuously monitor FH and contractions and be aware of fetal response to contractions.

D. Hemorrhage resulting in shock (placenta previa, abruption, uterine atony, and cervical and or vaginal lacerations, tearing of uterine arteries, uterine rupture, abnormal placenta, attachment or post-partum hemorrhage).

1. Notify health care provider immediately. Call "OB Emergency Response" via operator.
2. Start IV with #18 IV catheter and infuse Lactated Ringers solution.
3. Order CBC, type and cross match 2 units packed red cells.
4. O_2 via NRB mask, maintain patent airway; obtain vital signs especially blood pressure.
5. No vaginal exams (unless holding pressure on torn arteries or tissue to prevent further bleeding).
6. Trendelenburg position.
7. Have pitocin, methergine and hemabate on hand in room, verify blood pressure.
8. Notify nursing supervisor
9. Have OR on standby and consents available.

E. Prolapsed Umbilical Cord

1. If detected when doing vaginal exam, keep hand in place and call for help on bedside call bell while pushing gently upward on presenting fetal part.
2. Other nurses will call physician immediately while examining nurse assists patient to knee-chest position or Trendelenburg position while holding constant upward pressure on presenting part to prevent compression of umbilical cord. Notify on-call pediatrician.
3. Try to keep EFM on patient to pick up fetal heart (this may be difficult with patient in knee-chest position or Trendelenburg).
4. Apply 0_2 by NRB mask
5. Obtain OR consents and have another nurse prepare for an emergency cesarean section using cesarean section procedure described above (IV, foley).
6. If patient cannot sign in the position she is in to keep pressure off cord, husband may sign.
7. Transport patient to OR via stretcher when team is ready
8. Reassure patient about what you are doing and why.

F. Convulsions

1. O_2 via NRM mask; maintain patent airway; obtain vital signs.
2. Prevent self-injury by gentle assist, blankets and pillows.
3. Second nurse to call health care provider.
4. Prepare for IV insertion if not already in place.

G. Cardiac & Respiratory Distress

1. Apply O2 via NRB mask @ 8 liters.
2. Take vital signs and apply pulse oximeter
3. Call “OB Rapid Response” via operator
4. Apply fetal monitor and do a continuous strip
5. Call health care provider immediately

Reference: AWHONN Perinatal Nursing, Simpson and Creehan, 2001.