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Background

The American College of Obstetricians and Gynecologists (2018) released a position statement on practice considerations for rural and low-volume obstetric settings. “The provision of safe obstetric care requires a commitment to lifelong learning and maintenance of knowledge and skills. Rural settings, low-volume settings, or both may present challenges in maintain clinician and nursing skills because of limited volume and, therefore limited opportunity to participate in various aspects of care” (The American College of Obstetricians and Gynecologists, 2018, para. 1). The facility should have the ability to maintain skills and patient safety certain activities. The first activity would be to have an established contract with policies and procedures that handle a timely transfer for a woman that presents and needs an urgent or emergent delivery or a cesarean delivery with an accepting physician and facility. The second activity would be to have obstetric medications, supplies, and equipment on hand in the event the transfer cannot happen prior to the emergent delivery of mother and baby (The American College of Obstetricians and Gynecologists, 2018).

Educational Plan

The goal of the educational plan is to provide a guide for rural and critical access hospitals to base their facilities education for staff on the delivery of an emergent obstetric patient. The plan will be documented within each facility per their policy and procedure.

OBJECTIVE : To be able to safely delivery baby by an emergency vaginal delivery.	
BACKGROUND	1. An emergent vaginal delivery or precipitous delivery occurs quickly and typically under 3 hours of labor. 2. The nurse needs to be prepared to assist the physician with the delivery. 3. The goals of an emergent delivery are : • Establish a clean, safe, private area for the birth • Facilitate a controlled delivery • Prevent maternal and fetal complications • After delivery, transport mother and neonate to the appropriate level of care
EQUIPMENT	1. Have on hand and in working condition: • Vital signs monitoring equipment; blood pressure cuffs available for mother and neonate • Stethoscope, adult and pediatric • Sterile gloves • Sterile gowns • PPE: shoe coverings, caps, mask with face shield or mask and googles, gloves • Fluid impermeable pads • Sterile towels • Sterile Kelly clamps or cord clamps, minimum of 2 • Sterile scissors • Bulb syringe

	• Warm blankets • Basins • Neonatal hat, gown, blankets • Adult and Neonatal resuscitation equipment • Identifications bracelets for mother, father, and neonate • Peri bottle with warm water; perineal pads; ice packs • Facility approved cleansing solution or wipes • Bedpan • Additional linens and towels • Facility approved antiseptic solution • Blood sampling supplies • Optional but nice to have: • additional light source, sterile gauze, oxytocin, IV administration equipment and supplies, doppler device 2. The facility may have on hand a pre-packaged Obstetrics delivery kit that would have necessary supplies and equipment 3. Equipment and supplies need to be inspected on a routine schedule to make sure it is not compromised or expired.
DELIVERY	1. Confirm patient's identity using facility approved policy 2. Perform hand hygiene 3. Have another team member call the physician and other emergency personnel; you should always remain with the patient 4. The other team member gathers equipment and supplies and readies the room for delivery 5. Explain the procedure to the patient and the significant other 6. Complete history as time allows to include estimated due date, prenatal care received, any pregnancy complications, the time of membrane rupture and a description of the amniotic fluid, pertinent medical conditions to include group B streptococcus status, number of pregnancies, and types of previous deliveries

	7. Assist the patient to pant during contractions and to rest and breath normal between contractions 8. Assist the patient into a gown and remove any clothing that obscures the perineum 9. Position the patient on the bed or cart in a dorsal recumbent, squatting, or side-lying position; this will promote uteroplacental blood flow; do not place patient in supine position as this will compromise blood flow 10. Assess the patient for signs of an imminent delivery which can include a bulging perineum, vaginal bleeding, urgency to push, and crowning of the presenting part; if the cord presents before the head, the cord has prolapsed; if the presenting fetal part if not a head, the fetus may be in a breech position 11. Assess feta heart tones using either the stethoscope or doppler device 12. Monitor patient vital signs, if possible 13. As delivery draws closer, don in the PPE to include gloves, cap, shoe covers, and mask with googles or mask with face shield 14. Cleanse the perineum with the approved antiseptic solution 15. Remove gloves and perform hand hygiene and don in sterile gown and gloves; assist physician with sterile donning of PPE prior to donning in your sterile gown and gloves If the delivery is progressing faster than anticipated and the physician is not present at the time the fetus is coming, complete the following: 1. As the fetal head descend in the birth canal, instruct the patient to pant or blow through the contractions; instruct patient not to forceful bear down to help avoid with tearing 2. Place one of your hands on the perineum to help support the fetal head and control the speed of the expulsion; do not stop fetal descent as this can cause injury

	3. As the head begins to emerge, support the head with one hand and support the perineum with the other hand using a sterile towel or gauze; as the fetus emerges cover the faces with the towel or gauze to prevent fecal contamination to the face 4. Carefully support the head of the fetus with both hands at the head rotates to one side 5. If the amniotic sac is intact, break the sac by inserting your finger into the fetus's mouth or snipping it with sterile scissors at the nape of the fetus neck; carefully pull the membrane away for the fetus's face 6. Locate the umbilical cord by placing one or two fingers along the back of the emerging head to make sure the cord is not around the neonate's neck 7. If the cord is loosely around the neck, slip it gently over the head; if the cord is tightly wrapped around the neck, the cord must be clamped in 2 places using the Kelly clams and then using the sterile scissors to the cut the cord between the clamps 8. Instruct the patient to bear down with the next contraction to aid in the delivery of the shoulders; position your hand on either side of the head and support the neonate's neck; exert a gently downward pressure to deliver the anterior shoulder, then exert a gently upward pressure to deliver the posterior shoulder 9. Use a sterile towel to receive the neonate; the neonate will be slippery due to the amniotic fluid and vernix; take extra care to securely support the neonate's body after the shoulders are freed 10. Note the time of delivery 11. Position the neonate in a slightly head down position to facilitate drainage of mucus; wipe the excess mucus from the face; if the neonate doesn't spontaneously breathe, flick the bottom of the feet or rub the back to stimulation the neonate; do not suspend the neonate by the feet 12. If warranted, use the bulb syringe to suction the neonate's mouth and then nares; do not deep suction the neonate

	13. Pat the neonate's back and hair with a towel and place the hat the on the head 14. If time allows, place the neonate on the mother's abdomen and cover with a warm blanket to foster bonding and thermoregulation of the neonate 15. Maintain the neonate at the level of the maternal uterus until the umbilical cord stops pulsating; delay cord clamping for at least 30 seconds 16. To clamp the cord, place a clamp in the umbilical cord several inches from the neonate's abdomen and place a second clamp several inches closer to the mother; cut the umbilical cord between the 2 clamps using sterile scissors 17. Collect blood sample from the placental end of the cord in the appropriate blood collection tube and arrange for transfer to the laboratory to determine neonate's blood type 18. Assess the neonate's Apgar score at 1- and 5-minute intervals and document 19. Monitor for signs of placenta separation such as a gush of vaginal blood, cord lengthening, and a firm uterus rising in the mother's abdomen; the placenta will usually separate within 5 to 30 minutes after delivery 20. When placenta separation is noted, instruct the mother to bear down to expel the placenta; if needed gentle traction can be applied to the cord to aid in delivery 21. Assess the placenta for intactness; place the placenta in a basin or container for later examination 22. After delivery of the placenta, gently massage the patient's fundus with one hand while supporting the uterus with the other hand to contract the uterus and prevent maternal hemorrhage; the uterus will feel like a grapefruit and be palpable at the umbilicus when contracted 23. Assess the perineum for lacerations; if noted, apply pressure until bleeding slows and they can be repaired 24. Cleanse the area with the peri bottle filled with warm water and apply the ice pack and perineal pad

	25. Apply the identification bands to mother, neonate, and father before prepping them for transport 26. Encourage and assist with breastfeeding if time allows; this will also help with uterine contraction and prevent maternal hemorrhage 27. Monitor maternal vital signs, fundal status, and vaginal bleeding every 15 minutes or at the frequency determined by facility policy until mother is transferred to the appropriate level of care 28. Monitor neonate vital signs, color, tone, activity, and respiratory effort every 30 minutes or at a frequency determined by facility policy until neonate is transferred to the appropriate level of care 29. Prepare mother, neonate, documents, and placenta for transfer and provide hand off communication to the transfer team and the receiving facility on the mother and neonate. 30. Clean up the room per facility policy
POSSIBLE COMPLICATIONS AFTER BIRTH	1. If the neonate doesn't have good tone or isn't breathing or crying, move the neonate from mother to a radiant warmer; make sure the airway is clear of secretions and nothing is blocking the airway; dry and stimulate the neonate; if the neonate fails to breathe spontaneously after birth, ventilate and oxygenate thee neonate and initiate chest compressions 2. Maternal complications could include infection, retained placenta, postpartum hemorrhage, amniotic fluid embolism, and/or cervical, vaginal, or perineal lacerations 3. Neonate complications could include meconium aspiration, a birth injury, hypovolemia, hypervolemia, and/or respiratory distress
DOCUMENTATION	1. Document the care and delivery per your facility policy 2. Items that must be documented are: • Initial time of maternal presentation • Initial and ongoing assessment and findings • Presentation and position of fetus • Characteristics of amniotic fluid • Record time of delivery and any complications

	• Note time of placenta expulsion, placenta appearance and intactness, amount of postpartum bleeding, status if uterine tone, contractions, and lacerations • Interventions provided and patient's response to interventions • Medications administered; document all details on the medication administration record • Evidence of maternal bonding • Neonate's gender, Apgar scores, assessment findings, and if any resuscitation measures were used • Breastfeeding • Teaching provided to patient, family, and their understanding of the teaching

Note. Lippincott. (2020, February). Emergency delivery. Retrieved from

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