Special Delivery: Be Prepared to Assist in Emergency Childbirth

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Objectives

1: Review the stages of labor and emergency delivery process

2: Explain the needed preparation and equipment for an unplanned birth in a correctional facility

3: Describe how to assess for and respond to common obstetric complications

DO NOT FEAR CHILDBIRTH, THAT'S THE EASY PART. THERE IS NO EPIDURAL FOR MOTHERHOOD

@mum_probs

Patient Case

- 24 y/o female was admitted to the county jail facility 10 days prior
- No prenatal care and refusing to acknowledge her pregnancy
- Suspected to be about 28 weeks

Patient Case

- PMH- hypertension
- Social Hx- reports THC use since age 15, started heroin at age 18
- Gyn/OB Hx- previously in sex work, no known STDs
- 1 spontaneous and 2 therapeutic abortions

Patient Case

- Examined by medical and mental health clinicians
- Refusing all medications and treatments including prenatal care

Pregnancy

- A full term pregnancy lasts approximately 40 weeks (280 days)
- Majority of pregnancies proceed with minimal risks
- Patients in uncomplicated labor usually only need supportive care, but the ABCs are to be observed
- Nursing staff are to be prepared to deal with all types of pregnancies and possible complications that may develop
- Labor is the process of childbirth, starting with contractions and ending with delivery.

Labor

- Labor can present as the following:
  - Braxton-Hicks contractions
    - Usually painless, irregular timed contractions of the uterus
  - True labor
    - Is the dilatation of the cervix and contractions occur one right after the other.
  - False labor
    - Is irregular, brief contractions confined to the lower abdomen and can stop with walking or rest
- Labor can be divided into three stages

Labor: How to tell the Difference

	Braxton-Hicks contractions	Real contractions
When do they start?	As early as the second trimester, but more often in the third trimester	After your 37th week of pregnancy (if they come earlier, this can be a sign of preterm labor)
How often do they come?	From time to time, in no regular pattern	At regular intervals, getting closer and closer together in time
How long do they last?	From less than 30 seconds to 2 minutes	From 30 to 70 seconds
How do they feel?	Like a tightening or squeezing, but not usually painful	Like a tightening or cramping that comes in waves, starting in the back and moving to the front, getting more intense and painful over time.

Atypical Labor

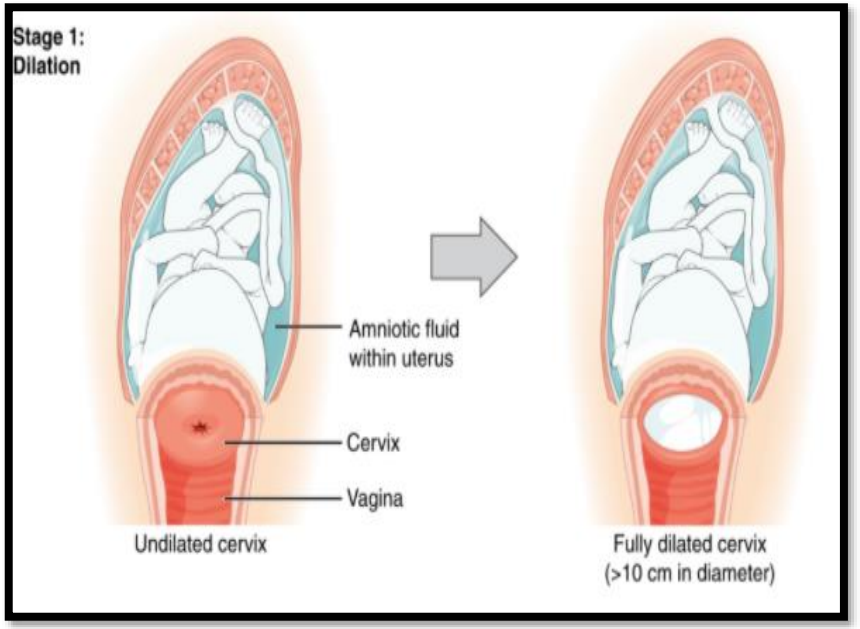
- Each woman’s labor is unique to her and each pregnancy can be different from one to another
- Every woman’s contractions differ and the placement of the placenta determines how a woman labors
- Each woman will need to be evaluated to determine how her labor is progressing
- Do not dismiss the patient if her labor is not “typical”

Uncommon Signs of Labor

- Just feeling off
- Dreaming of labor
- Diarrhea
- Feeling like you have the flu
- Insomnia
- Emotional breakdowns
- Moody
- Sudden weight loss
- Sudden loss of appetite
- Vaginal edema

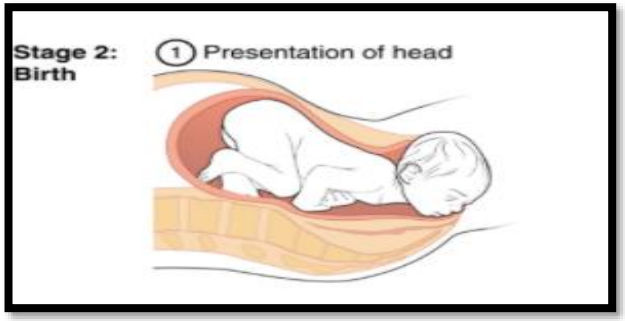
Three Stages of Labor

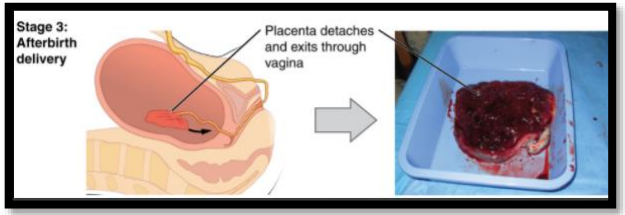
- The three stages of labor are as follows:
  - The first stage has three phases
    - Early labor, active labor, and transition to second stage



Three Stages of Labor

- The second stage
  - The baby moves into the birth canal
- The third stage
  - Afterbirth is delivered





First Stage of Labor

- The first stage of labor is from the onset of labor to the dilatation of the cervix
- At this time the patient releases the mucus plug, however, not all women have a mucus plug or notice its release
- The mucus plug covers the cervical os and with the amniotic fluid helps reduce the risk of infection and protects the fetus

Cervical Dilation

- a visual guide -

Cheerio®

1 cm

Slice of Banana

3 cm

Cracker

4 cm

Soda Can

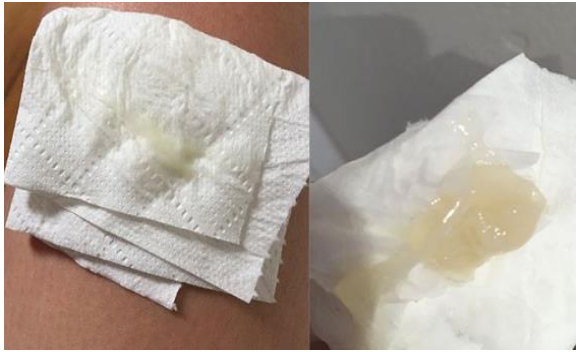
7 cm

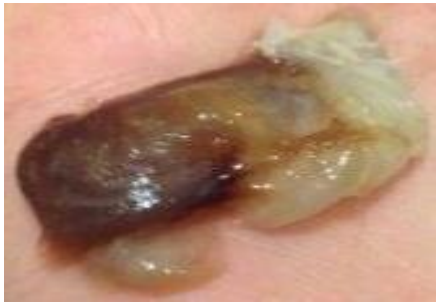
Bagel

10 cm

First Stage of Labor

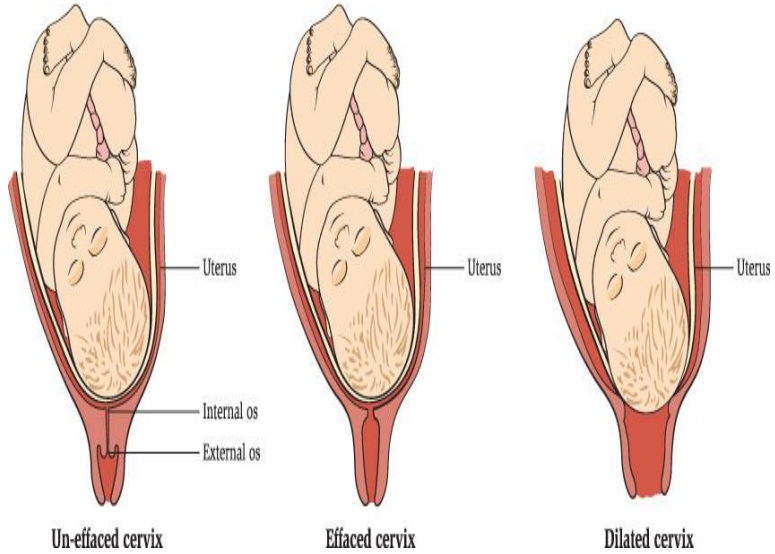
- The mucus plug should be clear in color but it can also be yellow or brown.
- It should never be bright or dark red and this can be a sign of an emergency.





First stage of labor

- As the uterus contracts, the cervix dilates in preparation for the baby to pass into the birth canal
- As the cervix dilates, it then stretches out and thins, this is called effacement.
- Typically the cervix must dilate to ten centimeters before the fetal head can pass out of the uterus.



First Stage of Labor

- The fetal membranes are a protective barrier filled with amniotic fluid that aids in fetal development
- The rupture of membranes (ROM) usually occurs during the first stage of labor.
- If ROM does not begin within 24 hours of labor beginning; complications can occur

First Stage of Labor

- When the membranes rupture, the nursing staff will need to observe the amniotic fluid for:
  - Amount
    - Large – soaking 3 or more towels
    - Small – soaking only 1 towel
  - Color
    - Clear to pale yellow is normal and is odorless
    - Greenish brown color can indicate meconium is present
    - Red can be indicative of blood and can be a sign of abruption
    - Brown to dark yellow can be a sign of infection especially when accompanied by a foul smell
  - Document the amount, color and the presence of an odor
    - Report to the provider, EMS, and the hospital staff.

First Stage of Labor

- Stress before and during labor can cause meconium to be released into the uterus.
- Meconium is the infant’s first bowel movement
- Thick pea-soup discoloration indicates the meconium level is very high and can be a serious threat to the infant
- Remember to notify the hospital if the infant is born with meconium staining

Patient Case

- Patient notified custody staff of “stomach ache”.
- 2 LPNs were on the unit for med pass and intake, and asked to see the patient
- They noted she was leaking fluid and suspected SROM and preterm labor
- Contractions were timed at Q minute
- The patient continued to deny she was in labor

Second Stage of Labor

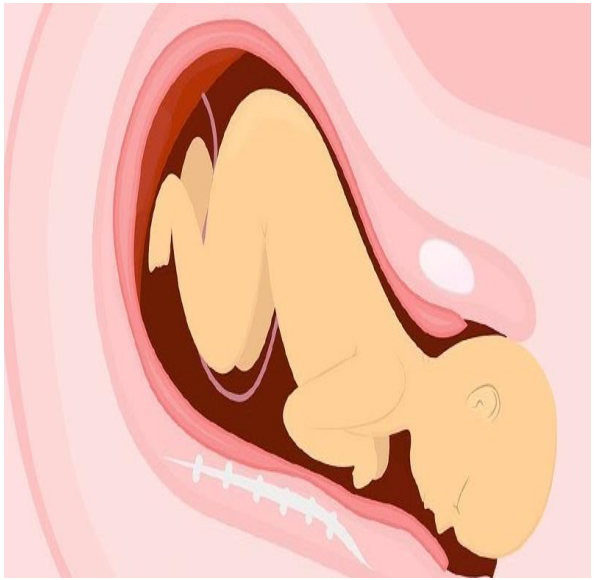
- The second stage of labor is the period from full dilatation of the cervix to the delivery of the fetus
- Contractions push the fetus down the birth canal
- Contractions can last 45-90 seconds at intervals of 3-5 minutes of rest in between.

Second Stage of Labor

- The delivery of the fetus is divided into 3 phases:
  - Delivery of the head
  - Delivery of the shoulders
  - Delivery of the body and legs
- At this stage the fetus’ head will become visible and this is called crowning.

Crowning

- There can be a burning and/or stinging sensation experienced during crowning
- Crowning is the deciding factor on whether or not to transport the patient.
- If crowning is present do not transport and notify EMS



Second Stage of Labor

- Prepare to deliver the baby
- The mother will look to the nursing staff for guidance, support and reassurance.
- Nursing staff must demonstrate confidence and an attitude of calm
- The mother does all the work and the nursing staff aids with guiding the infant out of the birth canal

Second Stage of Labor

- Multiparous patients frequently deliver their newborns quickly and unexpectedly. The nurses will need to take some extra precautions
  - Do not leave a woman in labor unattended
  - Do not leave a woman in stirrups unattended
  - The nurse should always place their hand on the perineum when they need to look away

Second Stage of Labor

- There will be strong pressure at the rectum
- The mother will feel the urge to have a bowel movement
- The urge is due to the infant’s head putting pressure on the rectum
- Do not allow the patient to go to the bathroom as the delivery may occur in the toilet.

Obstetrical Kit

- The nursing staff will need to:
  - Have the obstetrical kit readily available
  - Ensure the obstetrical kit has not expired and is intact
  - Ensure the nursing staff is aware of the location of the obstetrical kit, its contents and the usage
  - Ensure that the emergency bag has a newborn ambu bag and face mask
  - Have the fetal Doppler in good working order
  - Ensure the nursing staff understand how to use it

Typical Contents of Obstetrical Kit

- 1 pair of sterile gloves
- 3 disposable sheet
- 4 alcohol pads
- 2 4 x 4s
- 2 cord clamps
- 2 over sponges
- 1 obstetrical pad
- 1 plastic bag
- 8 disposable towels
- 2 nylon tie-offs
- 1 pair eye protective gear
- 1 bulb aspirator

Obstetrical Kit Usage

- Open the OB kit and apply the PPE
  - Sterile gloves, face shield, and gown
- Open one of the sterile sheets and place under the hips
- Open the second sterile sheet and place under vagina
- Open and spread the third sterile sheet over the stomach

Obstetrical Kit Usage

- 4 x 4's are to aid in cleaning the mucus from the newborn's nose and mouth
- A bulb aspirator is used to gently suction the newborn's nose and mouth only if secretions are obstructing the newborn's breathing
  - It is inserted into the mouth ½ inch and suctions out the mucus and amniotic fluid
  - It is inserted into nares ¼ inch and suctions out the mucus and amniotic fluid
  - It is performed at least 3-4 times per orifice

Obstetrical Kit Usage

- In each kit there will be 2 plastic clamps and a pair of scissors in a plastic sealed bag
- The nursing staff will clamp the umbilical cord in 2 places and then cut the cord
- There are 2 nylon tie-offs in case the umbilical cord is to large for the clamps
- The plastic bag is for the placenta

Second Stage of Labor

- Once the OB kit is ready
- Place the mother as follows:
  - Supine with legs bent at the knee
  - Place a pillow/folded blanket under the buttocks
  - Ensure the patient is draped to protect her privacy
- The infant’s head will usually present facing down

Second Stage of Labor

- The nurse will place a gloved hand gently against the head of the infant to prevent an explosive delivery
- The forehead appears first, and then the face and chin
- If the umbilical cord is wrapped around the neck
  - Gently slip the cord over the head
  - If this can’t be performed easily
  - Place two clamps on the cord and cut between the clamps

Second Stage of Labor

- When the cord circles the neck it is call a “Nuchal Cord”
- It occurs in 20% of all deliveries
- Usually not life threatening
- The nursing staff will need act quickly to avoid any complications
- Assess the newborn for ABCs

Second Stage of Labor

- At this time the upper shoulder will be visible
- The head should be below the vagina to allow the shoulder to be guided out smoothly
- Once the shoulders are free; the body and legs are delivered by easy traction
- The newborn will be covered in vernix caseosa which insulates and waterproofs them but makes them slippery; a firm grasp is needed

Second Stage of Labor

- Nursing can use a towel or gown to aid the in safe delivery of the newborn
- By placing the towel or gown over their gloved hands it will reduce the risk of dropping the newborn
- Newborns can be comfortably held in one hand
  - The trunk supported by the palm
  - The head supported by the outstretched fingers
  - The body laid across the forearm
- If the newborn does slip, the nursing staff should bring the newborn close to their chest resembling a hug

Patient Case

- The LPNs called a “code” or emergency response
- The baby came quickly and unassisted before the rest of the team responded

Care of the Infant

- Hold the newborn’s head down to aid with further drainage of the mucus from the oropharynx
- Wipe the newborn’s face with the 4 x 4s to remove any excess secretions
- Place the newborn in a blanket with only the face exposed and ensure the infant is wrapped tightly

Care of the Infant

- Examine the cord for 2 arteries and 1 vein
- Wait for the cord to stop pulsating
- Clamp the cord midway between the placenta and the infant and place the second clamp 2-3 inches from the 1st clamp
- Using the sterile scissors; the nurse will cut the cord
- Cover the cord stump with a dry 4 x 4 and tape

Data

- The nursing staff will need to record the date and time of the birth
- The time of birth is when the newborn is completely delivered from the birth canal
- The time of the birth also aids in noting when complications arrive
- The APGAR score is completed now

APGAR Score

- The APGAR score is very important in assessing the status of the newborn
- The nursing staff will need to understand why this test is important to the newborn’s health assessment
- The nursing staff will need to understand how to complete the APGAR and demonstrate how to score the newborn

APGAR Score

- The APGAR is a test performed at the 1 and 5 minutes after birth.
- The 1 minute score determines how well the newborn tolerated the birth
- The 5 minute score determines how well the newborn is doing outside of the womb

APGAR Score

- APGAR is an acronym for the following:
  - A – Appearance (color)
  - P – Pulse
  - G – Grimace (reflex irritability)
  - A – Activity (muscle tone)
  - R - Respirations

APGAR Score

- The APGAR scoring system is a standardized component and comprises of the following 5 components:
  - Color of the body and extremities
  - Heart rate or pulse
  - Reflexes and irritability
  - Muscle tone
  - Respirations and crying
- Each is given a score of 0, 1, or 2

APGAR Score

- A – Appearance of color of the body and extremities
  - Entire newborn is pink = 2
  - Body is pink, extremities are blue = 1
  - Newborn is blue = 0
    - Immediate resuscitation is required

APGAR Score

- P – pulse rate of the newborn
  - Pulse rate greater than 100b/m = 2
  - Pulse rate less than 100b/m = 1
  - No pulse rate = 0
    - Immediate resuscitation of the newborn required

APGAR Score

- G – Grimace or reflex irritability is the newborn’s reaction to the snap of a finger on the sole of the foot
  - Cries and tries to move away = 2
  - Weak cry and minimal movement = 1
  - No cry or movement = 0

APGAR Score

- A – Activity or muscle tone is demonstrated with flexion of the knees and hips and resistance is to straightening
  - Strongly resists = 2
  - Weakly resists = 1
  - Completely limp = 0

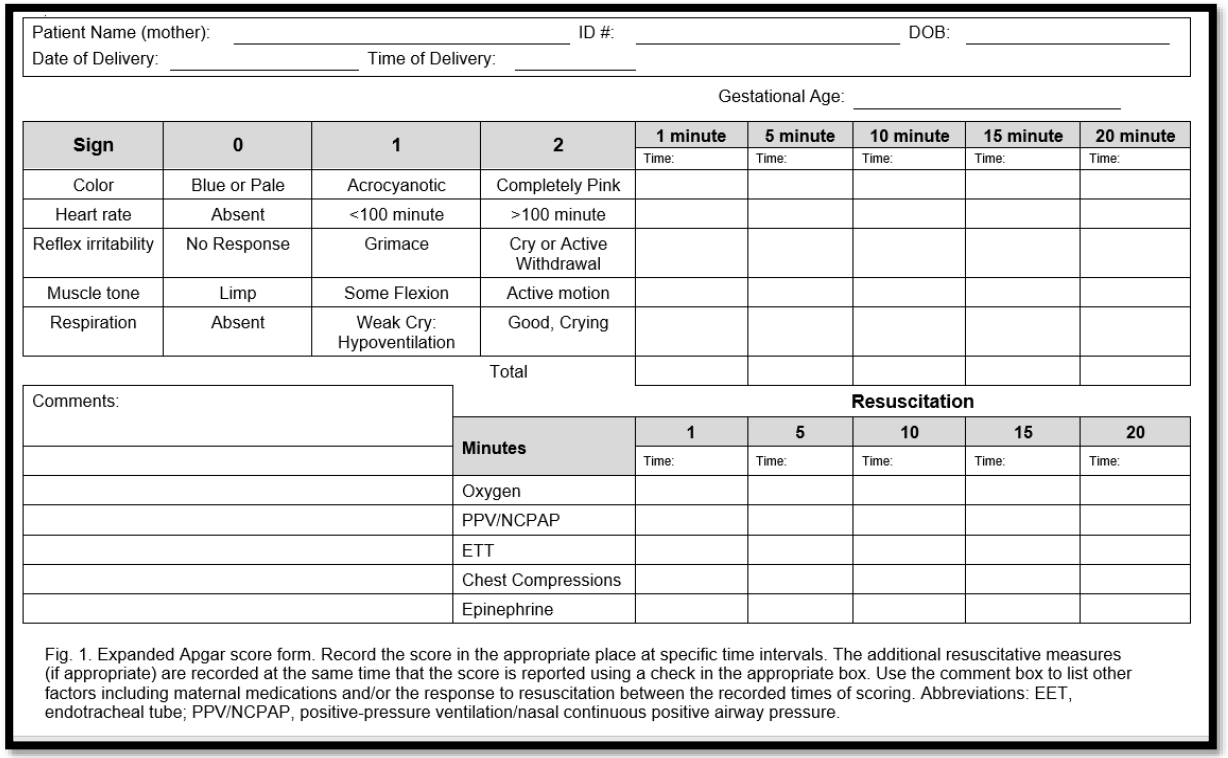
APGAR Score

- R – The respiratory rate of the newborn
  - Respiratory rate is greater than 20b/m = 2
  - Respiratory rate is less than 20b/m = 1
  - Respiratory rate is absent = 0
    - Immediate resuscitation is required

APGAR Score

- The numbers are then totaled.
- A perfectly healthy newborn will have a total score of 10
- The scores can change between the first minute and the fifth minute
- If the scores do not improve, stimulate the newborn by removing the blankets, vigorously rubbing until the newborn cries, re-wrap the newborn in dry blankets
- Repeat as needed

APGAR Score Chart



Patient Name (mother): _____ ID #: _____ DOB: _____

Date of Delivery: _____ Time of Delivery: _____

Gestational Age: _____

Sign	0	1	2	1 minute	5 minute	10 minute	15 minute	20 minute
				Time:	Time:	Time:	Time:	Time:
Color	Blue or Pale	Acrocyanotic	Completely Pink					
Heart rate	Absent	<100 minute	>100 minute					
Reflex irritability	No Response	Grimace	Cry or Active Withdrawal					
Muscle tone	Limp	Some Flexion	Active motion					
Respiration	Absent	Weak Cry: Hypoventilation	Good, Crying					
			Total					

Comments:

Resuscitation

Minutes	1	5	10	15	20
	Time:	Time:	Time:	Time:	Time:
Oxygen					
PPV/NCPAP					
ETT					
Chest Compressions					
Epinephrine					

Fig. 1. Expanded Apgar score form. Record the score in the appropriate place at specific time intervals. The additional resuscitative measures (if appropriate) are recorded at the same time that the score is reported using a check in the appropriate box. Use the comment box to list other factors including maternal medications and/or the response to resuscitation between the recorded times of scoring. Abbreviations: EET, endotracheal tube; PPV/NCPAP, positive-pressure ventilation/nasal continuous positive airway pressure.

Worsening APGAR

- The score should improve but if they are poor or worsen; immediate resuscitation will be required.
- Newborn compromise is usually due to ventilation difficulties
- Monitor chest rise and fall while monitoring respiratory rate
- Assess the airway for obstruction
- The airway will need to be cleared
- Provide oxygen as needed

Worsening APGAR

- The nursing staff will need to monitor the heart rate
- A heart rate less than 100 beats/minute requires respiratory support with mask and ambu bag to provide intermittent rescue breaths
- If the newborn’s heart rate is less than 60 beats/minute, initiate compressions and continue to ventilate newborn with mask/ambu bag
- If not effective, perform basic NRP if certified

Newborn Resuscitation

- Approximately 1% of all newborns will require some form of resuscitation
- Rapid intervention can aid in avoiding permanent damage.
- The thought of newborn resuscitation may increase the anxiety already present in the nursing staff.
- The Neonatal Resuscitation Program (NRP) works in tandem with the American Heart Association (AHA)

Newborn Resuscitation

- Basic NRP
  - Perform tactile stimulation
  - Dry newborn and replace with dry blanket
  - Keep newborn warm
  - Suction Airway as needed
  - Reassess airway and placement of Ambu bag to ensure proper ventilation of newborn

Patient Case

- The baby was wrapped in blankets and handed to the mother, but she refused
- The nurses dried the infant and monitored color, tone, and breathing
- EMS arrived three minutes after birth
- Mother and baby were transported to a local hospital for stabilization, and then a level 3 NICU.

Third Stage of Labor

- This is the last stage of labor
  - The placenta is delivered at this time
  - It is attached to the umbilical cord
  - The placenta delivers itself
  - The placenta is usually delivered a few minutes after birth
    - Can take as long as 20 – 30 minutes
  - Once the placenta is delivered, bleeding should decrease

Third Stage of Labor

- Inspect the placenta upon delivery
  - It will be round and about 1 inch thick
  - Measures about 7 inches in diameter
  - There are two surfaces
    - Smooth and covered in a shiny membrane
    - Rough and lobulated
  - Note if the whole placenta was delivered or if part is retained this can cause excessive bleeding, infection, or other unwanted side effects for the mother
- Place placenta in a bag with the cord and transport with the patient and the newborn to the hospital

Third Stage of Labor

- The following events are emergencies that can occur in the third stage of labor:
  - Cord avulsion or tearing of the umbilical cord from the placenta and makes delivery of the placenta difficult
  - More than 30 minutes have elapsed and the placenta has not spontaneously delivered
  - There is more than 250 ml of bleeding before the delivery of the placenta
  - If there is significant bleeding after the delivery of the placenta

Third Stage of Labor

- If any of the 3 emergency situations occur, while awaiting EMS; do the following:
  - Place the mother in the supine or left lying positions
  - Elevate her legs with a pillow/folded blanket
  - Administer O2 via nasal cannula
  - Monitor vital signs closely
  - If bleeding, place a sterile pad over the vagina
  - Never put anything into the vagina to stem the bleeding

COMPLICATIONS AND ABNORMAL DELIVERIES

Pre-Term Labor

- Pre-term labor is when labor begins before the 37th week of pregnancy
- Specific causes are unknown but certain factors can increase the risk for pre-term labor
- Can occur for no apparent reason

Pre-Term Labor

- It is important to educate the patient on symptoms of pre-term labor if they are pregnant with multiples, previous premature birth and/or uterine and cervical abnormalities
- It may be possible to prevent premature birth by recognizing the warning signs
- The following steps can aid in slowing down labor

Pre-Term Labor

- Attempt to slow down labor by using the following:
  - Have patient empty their bladder
  - Have patient lie down tilted towards left side
  - Have patient lie down in reverse Trendelenburg
  - Have patient get on hands and knees
  - Have patient avoid lying flat on their backs
  - Have patient drink several glasses of water
  - Have patient pant and avoid deep breaths

Failure of Amniotic Membrane Rupture

- Rupture of Membranes (ROM) is usually the first sign of labor and when the ROM does not occur spontaneously it can indicate complications
- The newborn can be born with the membrane covering the head and face.
- This is a medical emergency as the newborn will suffocate if the membrane is not removed immediately

Failure of Amniotic Membrane Rupture

- The nurse will break the membrane immediately using a gloved finger, sterile clamp or scissors
- Amniotic fluid will immediately rush out
- Clear the newborn’s mouth and nose with the bulb syringe and 4 x 4s found in the OB kit
- Monitor closely and continue with the delivery

Breech Delivery

- Breech delivery is when the buttocks, the feet or both are delivered first and occur 3-4% in full-term births
- Procedures for birth are as previously discussed and allow the delivery to occur spontaneously
- Prevent an explosive delivery by supporting the trunk and allowing the legs to dangle
- The head is delivered last making it more difficult to ease through the birth canal

Breech Delivery

- The nurse will need to place 1 gloved finger in the vagina to keep the vaginal walls from compressing the newborn's airway
- If a limb is the presenting part***, rush*** the patient to the hospital immediately.
- Notify EMS of the emergency to ensure the proper medical transfer, treatment, and facility can be arranged
- Cover the protruding limb with a sterile towel
- Do not push the limb back into the vagina

Prolapsed Umbilical Cord

- Prolapsed umbilical cord is the presentation of the umbilical cord before the newborn
- The presenting body part will compress the cord as it passes through the birth canal and stop the flow of oxygen to the newborn and this can lead to death
- This is a obstetrical emergency and the patient will need to be sent to the hospital immediately

Prolapsed Umbilical Cord

- Perform the following until EMS arrives:
  - Do not push the cord back into the vagina
  - Have the patient get on all fours with her head down
  - Observe the cord pulsations constantly
  - Gently place a gloved finger in the vagina and move the body part off the cord
  - Place a saline moistened towel over the exposed cord
  - Administer O2 vial nasal cannula to the patient

Excessive Bleeding

- Bleeding is normal with a vaginal delivery but excessive bleeding is over 250 ml
- 250 ml is equivalent to 5 soaked sterile pads
- Apply sterile pads to vaginal entrance
- Monitor closely and change as necessary
- Do not stem the blood flow by placing pads in the vagina

Excessive Bleeding

- Do not have the patient squeeze their legs together
- Start peripheral IV and administer IV fluids as ordered
- Administer O2 via nasal cannula
- Save any tissue that is passed
- Monitor vital signs closely, including oxygen saturations
- Transport the patient, newborn, placenta, any other tissue and soaked pads to the hospital emergently

Miscarriage/Abortion

- The delivery of the fetus and placenta before 20 weeks is considered a miscarriage or abortion
- Abortion can be spontaneous or deliberate
  - Deliberate
    - Self-induced
    - Hospital/clinic setting

Miscarriage/Abortion

- Infection and hemorrhage are the two most serious complications of miscarriage and abortion
- Infection can be caused by improper sterile technique
- Incomplete delivery of the fetus, placenta or both
- Can develop as early as 24 hours after the event

Miscarriage (Abortion)

- Monitor for early signs of sepsis
  - Febrile, shivering, feeling cold
  - Diaphoresis
  - Tachycardia
  - Shortness of breath
- Monitor vital signs closely
- Administer O2 vial nasal cannula
- Administer IV fluids

Miscarriage (Abortion)

- Hemorrhage will be treated by:
  - Placing the patient supine
  - Elevate her legs with a pillow/folded blanket
  - Keep patient warm
  - Keep the patient talking and reassure her
  - Administer O2 vial nasal cannula
  - Monitor vital signs closely
  - Administer IV fluids
  - Massage the uterus in a circular motion

Miscarriage (Abortion)

- Both situations require immediate transfer to the hospital for further evaluation and treatment
- Notify EMS
  - Detailed report should be given to include
    - Onset of symptoms
    - Number of pads to estimate blood loss
    - Vital signs
    - Treatments with IV fluids and/or medications given

Restraint Use in Pregnant Patients

- The use of restraints is also called shackling and is defined as the use of any physical restraint or mechanical device to control the movement of a prisoner’s body or limbs.
- This includes handcuffs, leg shackles, and belly chains
- The use of restraints in pregnant and postpartum patients should only occur in exceptional circumstances.

Restraint Use in Pregnant Patients

- One of the most immediate concerns for all pregnant patients in a correctional setting is the use of restraints that require the patient to be restrained with her hands behind her back.
- Pregnant patients have altered centers of gravity which can increase risk of falling
- They are unable to protect themselves or the fetus if they fall
- This can cause harm to the patient and/or the fetus
- This can result in the patient requiring an emergent delivery

Restraint Use in Pregnant Patients

- The following agencies oppose the use of restraints for pregnant prisoners in labor, delivery, or post-delivery recuperation
  - 2007 the U.S. Marshall Service
  - 2008 the Federal Bureau of Prisons
  - 2008 American Correctional Association
  - 2010 National Commission on Correctional Health Care

Restraint Use in Pregnant Patients

- The standards adopted by the previous agencies serve as guidelines and are voluntary and not mandatory.
- 29 out of 50 states have adopted these standards but they are not always followed
- The Immigration and Customs Enforcement (ICE) agency, a division of the Department of Homeland Security does not support these standards

Restraint Use in Pregnant Patients

- Physical restraints reduces the ability to assess and evaluate the mother and fetus prior to birth by causing the following:
  - Interference with ultrasounds
  - Prompt and uninhibited assessment of vaginal bleeding
  - Seizures due to preeclampsia is difficult to treat while restrained
  - Increased risk of thrombus due to restraints
  - Inability to use the AED until restraints are removed, delaying the care to the mother and fetus

Restraint Use in Pregnant Patients

- The use of restraints interferes with labor and delivery
  - Inability to ambulate during first stage of labor
  - Inability to reposition patient to treat complications that arise during pregnancy or for comfort
  - Inability to prepare quickly for an emergent C-section
  - Inability for medical staff to have the proper access

Restraint Use in Pregnant Patients

- The use of restraints in the post-delivery phase
  - Can prevent mother-infant bonding
  - May prevent the mother from safely handling her baby
  - Inability to reposition self for comfort especially after a C-section or an episiotomy
  - Inability to participate in deep vein thrombosis protocol by ambulating freely

Emergency Childbirth

- Remember to listen to your pregnant patient
- Objectively evaluate their symptoms
- Understand normal and abnormal symptoms
- Empathy and compassion go a long way in supporting the patient
- Education at every step aids in keeping the patient calm and focused throughout the emergency

“When a woman births, not only is a baby being born but so is a mother. How we treat her will affect how she feels about herself as a mother and as a parent. Be gentle. Be kind. Listen.”

Ruth Ehrhardt

The Basic Needs of a Woman in Labour

References

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