

SUBJECT:		ADMISSION TO INPATIENT OB PROCEDURE				NO: 701-0009	
POLICY:		PROCEDURE:	X	GUIDELINE:		PROTOCOL:	
Supersedes:						Effective Date:	09-01-02
Development Team/Authors(s):		Susan McCoy RNC					
Committee Approval/Review:							
Administrative Approval:							
Audit Review:	Initials:	TM	LA	SD	LK	PM	JF
	Date:	4/9/03	5/5/05	4/10/06	9/5/07	11/11/09	08/6/2010

POLICY

PURPOSE: **A Perinatal Registered Nurse will perform assessment and direct the antepartum, intrapartum and postpartum care management of women experiencing pregnancy and childbirth.**

SUPPORTIVE DATA

- EFM Protocol
- Documentation Guidelines
- Standard Precautions
- Urine Testing for protein
- Infant Security

SUPPLIES

- CPSI charting access for Outpatient OB, Initial Interview, Admission Assessment, Labor Flowsheet
- Specimen cup, clean wipes
- EFM t
- Floor scale, Thermometer, B/P cuff, Stethoscope
- Patient gown and monitor belts

STEPS

1. Escort woman to triage or labor room. Weigh on floor scale. Instruct her to obtain clean catch urine, remove personal clothing, and don hospital gown. Provide bag for personal items if needed.
2. Orient to room, nurse call, bathroom, routines, and plans for care.
3. Do not leave alone in presence of frequent and strong contractions, pelvic pressure, or extreme anxiety.
4. Review procedures for woman concerning her progress through labor management.
5. Review prenatal history.
 - ❖ Obtain Blood type and Rh factor, VDRL status, Hepatitis screen, Rubella titer, GBS status. Determine Gravity, Parity, and EDC. Confirm Allergies and coexisting medical conditions.
6. Place EFM to begin baseline and /or ongoing assessment of fetal heart rate and uterine activity. Routine 30-minute strip on admission.

7. Perform Vaginal exam if indicated
 - a. Do not perform vaginal exam in presence of heavy vaginal bleeding or preterm labor
 - b. Update physician on status and obtain orders.
 - c. Determine cervical status, status of membranes
8. Complete Outpatient OB Patient on CPSI and determine disposition. Admit to labor, or discharge to home per Dr's order.
9. Determine educational needs for woman during labor management, delivery and postpartum care and newborn care and breastfeeding.
10. Initiate routine labor/delivery management orders and protocols, or other orders as indicated by Healthcare provider.
11. Determine expected outcomes and initiate plan of care

DOCUMENTATION

12. Document exceptions, reportable concerns, and patient responses in the medical record. Include all communications with the health care provider.

PROSSER MEMORIAL HOSPITAL

723 Memorial Street, Prosser, WA 99350

SUBJECT:		ADMISSION TO OUTPATIENT OB PROCEDURE				NO: 701.0010			
POLICY:		PROCEDURE:	X	GUIDELINE:		PROTOCOL:		OTHER (SPECIFY):	
Supersedes:							Effective Date:	04-02-02	
Development Team/Authors(s):			Susan McCoy RNC						
Committee Approval/Review:									
Administrative Approval:									
Audit Review:		Initials:	TM	LA	SD	LK	PM	JF	
		Date:	4/8/03	5/05	4/10/06	5/10/07	11/11/09	8/6/10	

POLICY

PURPOSE:

To outline the nursing management and responsibilities of scheduling and processing outpatient obstetrical procedures.

SUPPORTIVE

DATA:

Outpatient procedures to be scheduled include, but not limited to:

- Antepartal testing – NST – CST
- Cervical Ripening
- External versions
- Uterine Activity Monitoring – (UAM), assess for preterm labor
- Assess for rupture of membranes
- Assess for active labor
- Presurgical Admission Testing
- Pre Delivery Assessment
- Postdischarge Assessment (mother)
- Newborn assessment post discharge

APPOINTMENTS

1. Appointments are scheduled according to the patient need and staff utilization.
2. Orders for the procedures may be obtained at the time the appointment is scheduled.
3. Appointments are recorded in the Daily Schedule Book with the following information included:
 - Patient Name, time & type of procedure,
 - Health Care Provider (HCP),
 - Reason for procedure.
 - If orders were orders given
4. All patients register at the Admitting Desk.
5. If a patient does not keep a scheduled appointment, the HCP will be notified and “NS” for no show is placed in the schedule book.
6. The HCP will be responsible to reschedule the procedure.
7. Follow up procedures will be coordinated by the Perinatal RN.

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8. The attending HCP will be notified when the procedure is completed and will be given a verbal report.
 9. Forward all charts to the medical records.
 10. After any prenatal outpatient visits, the chart is coded and it is returned to the Birthplace for the Prenatal Outpatient File.

UTILIZATION

11. Minimum increment of time allotted for each type of procedure is as follows:

NST	30	minutes
CST	60	minutes
External version	60–90	minutes
Assess ROM	30–60	minutes
Assess Uterine Activity	60	minutes
Assess Active Labor	60–90	minutes
Pre- admit assessment	60	minutes
Post discharge assess	60	minutes

DOCUMENTATION

- Document exceptions, reportable concerns, and patient responses in the medical record.
- Include all communications with the health care provider.
- Document all outpatient procedures in the outpatient log with all care time in minutes of service.
- Document all charges on Charge Sheet and submit to Information Systems (Data)

SUBJECT:	Induction of Labor				NO:	701-0004	
Supersedes:	New			Effective Date:	8/15/01		
Author(s):	Perinatal Committee		Distribution:				
Committee/Medical Director Approval				Department Manager Approval			
Administrative Approval				Policy Committee Approval			
Audit Review:	Initials:	LA	SMC	LA	SD	LK	JF
	Date:	2/03	7/13/04	5/5/05	4/10/06	9/5/07	09/10/10

POLICY:

- A specific obstetrical or medical problem must be present for an induction to be termed medically indicated.
- In order to provide a quality standard of care to patient undergoing induction there should be no more than one induction of labor in progress on a shift or scheduled per day unless additional 1:1 nursing can be provided.

INDICATIONS:

- a. Pregnancy induced hypertension
- b. Maternal diabetes
- c. Premature rupture of membranes
- d. Post maturity (more than 40-42 weeks of gestation)
- e. Suspected fetal jeopardy
- f. Intrauterine fetal demise

CONTRAINDICATIONS:

Maternal

- a. Classical cesarean incision
- b. Abnormalities of uterus, vagina, or pelvis
- c. Placental abnormalities – relative
- d. Active herpes type II in genital tract
- e. Invasive cervical carcinoma – relative

Fetal

- a. Fetal malpresentation
- b. Low birth weight or preterm fetus – relative
- c. Fetal distress shown by electronic fetal monitoring – relative

Bishop Score

A pelvic scoring using the assigned value of factors listed below will assess readiness for induction. Scores of 6 or more suggest the highest probability of successful induction.

ASSIGNED VALUES				
Factor	0	1	2	3
Cervical dilatation	0	1-2 cm	3-4 cm	5 cm or more
Cervical effacement	0% - 30%	40% - 50%	60% - 70%	80% or more
Fetal station	-3	-2	-1, 0	+1, +2
Cervical consistency	Firm	Medium	Soft	
Cervical position	Posterior	Midposition	Anterior	

/SUBJECT: OB Emergent Status		NO:	701-0023
<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Procedure <input type="checkbox"/> Protocol/Pre-Printed Order <input type="checkbox"/> Other:			
<input checked="" type="checkbox"/> New <input type="checkbox"/> Supersedes # ;		Effective Date	12/11/007
Author		Date of Electronic Distribution	12/11/2007
Dept. Manager	L. Kaur	Medical Director/ CAH Oversight	
Administrative		Policy Committee	
Committee		Other	
Audit Review:	Initials:	PM	JF
	Date:	11/11/09	08/09/10

GUIDELINES

FETAL EMERGENCY: Life threatening abruption, prolapsed cord, hemorrhage, acute cord accident, prolonged persistent decelerations less than 60 beats per minute lasting longer than one minute.

POLICY GOAL

To recognize and provide rapid, coordinated response to emergent conditions that pertain to fetal survival, such as prolapsed cord, placental abruption, or persistent fetal decelerations.

Parties that may or will become involved in this process are, but not limited to, OB provider, OB nurse(s), the Lead Nurse, and Staff nurses, OR crew, anesthesia Pediatrician, Respiratory Therapy and possibly outside NICU team.

PROCEDURE

On determination of emergent situation requiring possible surgical intervention for delivery of infant –

- 1) Lead Nurse or designee will call the OR crew, Anesthesia, RT and the Pediatrician on call.
 1. Assists OB nurse in preparing the patient for surgery.
 2. Assists transport of patient to OR as necessary.

- 2) The OB RN(s) will:
 1. Place oxygen on the mother via non-rebreather mask at 10 liters.
 2. Position her on her left side or position optimal for maternal and fetal well-being.
 3. Place Foley catheter.
 4. Establish IV access with # 18 gauges (preferably 2 sites).
 5. Obtain CBC, Type and Cross 2 units.
 6. Assist Physician in getting an Informed Consent signed.
 7. Give Bicitra 30 ml orally just prior to transfer to OR.
 8. Assure that patient has all undergarments off under her gown, jewelry removed, dentures or partial plates removed. Place surgical cap, boot covers, and SCD stockings on.
 9. Document events of actions on the OB monitor strip and medical record.

10. Transfer to OR on stretcher or may go on an OB bed as necessary. Take fetal monitor to OR with patient or monitor fetal heart tones every 5 minutes by Doppler in OR.

- 3) For night shift emergency (no OR staff present)
 1. OB nurse opens "Crash C/S" instruments on instrument table
 2. OB nurse and anesthetist position patient for surgery
 3. OB nurse assures infant radiant warmer and resuscitation supplies are available.
 4. OB nurse performs quick abdominal wash and assists physician with C/S as needed.

- 4) Upon arrival to OR during day shift, when OR staff is available. The patient will be cared for per OR protocol. The OB Nurse stays with the Pediatrician to care for the Baby.

PROSSER MEMORIAL HOSPITAL

723 Memorial Street, Prosser, WA 99350

SUBJECT: Termination of Pregnancy

NO: 873-0020

POLICY:	X	PROCEDURE:	X	GUIDELINE:		PROTOCOL:		OTHER (SPECIFY):	
Supersedes:	New			Effective Date:	7/13/2004				
Development Team/Authors(s):	Perinatal								
Committee Approval/Review:									
Administrative Approval:	Leann Anderson, RN Director of Patient Care Services								
Audit Review:	Initials:	la	LA	LA	SP	MF			
	Date:	8/10/2005	6/25/07	8/5/2010	8/16/12	4/10/14			

GENERAL INFORMATION:

- A. Abortion means any medical treatment intended to induce the termination of pregnancy except for the purpose of producing a live birth.
- B. Current legal precedent allows elective termination of pregnancy up to age of viability. It is also allowed at any gestational age, if the fetus is deemed incapable of viability or to protect the mother's health.
- C. Because of the comparatively low volume of OB services offered at PMH, elective terminations are rarely performed. As such, the hospital's ability to staff for this procedure is inconsistent. Prior to considering termination of pregnancy, it will be necessary for physicians to communicate with the OB clinical manager and OR manager to evaluate adequate staffing availability.

POLICY: Statute requires PMH, as a public hospital, to offer termination of pregnancy.

1. Pretermination

- A. Consultation: Physicians on staff are required to obtain a consult with another OB provider for patients who are to be admitted for termination of pregnancy.
- B. Team Consult: A team consult is encouraged to review and discuss the case to ensure that concerns of the patient, family and provider have been addressed; the alternatives have been explored, and the decision is based on informed consent. It is recommended the team consist of, but not be limited to, the primary provider, a pediatrician and Social Services.
- C. An informed consent with information from the above providers shall be documented in the chart. It will clearly reflect the patient's understanding of the procedure, alternatives and the risk thereof. The physician terminating the pregnancy, must fully document in the patient's chart the basis for his or her determination that the fetus is not viable or that the procedure is necessary to protect the health of the pregnant woman.
- D. It is requested that a minimum of 48 hours prior notification of the planned admission be provided to the Clinical manager of the OB department to determine if appropriate staffing can be arranged. The Clinical manager must then coordinate any services with the Surgery manager prior to proceeding.
- E. It is the hospital policy that a Social Service Referral be done on every patient.

2. Staffing:

- A. No physician, member of the PMH staff or PMH employee shall be required to participate in the performance of any termination of pregnancy, if the individual objects

to doing so.

- B. Any physician, member of the PMH staff or PMH employee may state their objection on a case-by-case basis or may provide PMH with a letter stating that they will not participate in any termination of pregnancy performed at PMH or any District-owned facility.
- C. No physician, member of the PMH staff or PMH employee shall be discriminated against in employment or professional privileges because of his or her participation or refusal of participation in the termination of pregnancy.
- D. If appropriate staff is not available, the pregnant woman seeking a termination of pregnancy, will be provided with a referral by her physician to an appropriate facility that provides service.

OF NOTE: WAC 246-490-100 Reporting of Pregnancy Terminations

Each hospital and facility where lawful induced abortions are performed during the first, second, or third trimester of pregnancy shall, on forms prescribed and supplied by the secretary, report to the department during the following month the number and dates of induced abortions performed during the previous month, giving for each abortion the age of the patient, geographic location of patient's residence, patient's previous pregnancy history, the duration of the pregnancy, the method of abortion, any complications, such as perforations, infections, and incomplete evacuations, the name of the physician or physicians performing or participating in the abortion and such other relevant information as may be required by the secretary. All physicians performing abortions in non-approved facilities when the physician has determined that termination of pregnancy was immediately necessary to meet a medical emergency, shall also report in the same manner, and shall additionally provide a clear and detailed statement of the facts upon which he or she based his or her judgment of medical emergency.