Emergent Delivery in the Emergency Department

POLICY:

It is the policy of Willapa Harbor Hospital to provide emergency services for the delivery of an infant in which it would be unsafe to transfer the patient. Willapa Harbor Hospital will follow EMTALA Guidelines as they relate to the patient in labor. A medical screening exam will be completed on all patients who present to the emergency department in questionable labor to determine whether an "emergency medical condition" exists. If an "emergency medical condition" exists or if the patient is in active labor, treatment must be instituted.

Stages of Labor:

First Stage: Onset of contractions to complete dilatation of cervix

Second Stage: Complete dilatation to delivery of baby

Third Stage: From delivery of baby to delivery of placenta

Equipment:

Infant Warmer	Sterile OB Pack	Sterile OB Basin
Infant Pack	Baby Blankets	Towels
Doppler	Fetal Monitor	Oxygen Tubing/Mask
Urinary Catheter	Personal Protective Equipment	

PROCEDURE:

1. Assist patient to ER room and assist patient to change into hospital gown.

2. Obtain complete vital signs, including fetal heart tones (FHT) using Doppler.

3. Set up patient on fetal monitor to monitor contractions and fetus.

4. Obtain urine sample to check for glucose and protein.

5. ER physician to do complete medical screening exam including vaginal exam to determine dilatation, station, effacement and to determine if delivery is imminent or not.

   A. If delivery is not imminent: minimal dilatation is found, minimal effacement, and patient considered not to be in active labor then prepare for transfer to a hospital where safe delivery can be completed.

   B. If delivery is imminent, don PPE (gown, gloves, face guard, open sterile birthing packs) and turn on infant warmer.

6. If delivery is imminent:

   A. Explain the course of labor and recovery phase as necessary to patient/family/support person.

   B. Have one RN available to aid with the mother and one dedicated to the baby. RN helping with the baby should be PALS certified. Notify RT and CRNA to come in to assist with resuscitation.

   C. Start maintenance IV and obtain medications as necessary.

   D. Have ready emergency medications including Oxytocin and Methergine.

E. Have and oxygen source and suction available for infant.

F. Have warmed blankets and towels available for baby.

G. Have blood collection tubes available (one red and one purple top, to be filled with cord blood after cord has been cut).

H. Have local anesthetic available in room as well as suture repair kit for lacerations.

I. Have light source available for laceration repairs.

J. Be prepared to assist with shoulder dystocia if necessary. Review in your mind the McRoberts Maneuver with suprapubic pressure (flex the mother's legs towards shoulders as she lays on her back to expand the pelvic outlet).

K. Have available a urinary catheter as needed for bladder drainage.

L. Open sterile birthing packs. Put on sterile gloves and set up sterile field.

M. Place sterile drape onto bend and position under buttocks.

N. Position patient for delivery as patient/provider desires (left side lying or lithotomy position are most common for delivery).

O. Continue to monitor FHT's every 5 minutes until delivery.

P. Assist physician with delivery as needed.

7. Assist with newborn:

A. Begin resuscitation procedure immediately if indicated.

B. Place on mother's abdomen, skin to skin or place in infant warmer. Do initial assessment. Dry infant thoroughly.

C. Do Apgar scores at 1 and 5 minutes (see attached Apgar scoring form).

D. Cover with blankets and/or keep skin to skin.

E. Instill eye medication within 30 minutes (Erythroymycin eye ointment).

F. Encourage bonding, encourage breast feeding within first hour of delivery.

G. VS initially, then every 1 hour X 4 then every 4 hours if stable.

8. Assist with delivery of placenta. Inspect for number of vessels. Document, save placenta, and sent to pathology for these conditions: Apgar less than 6 at 5 minutes, severe preeclampsia, significant fetal distress, cord/placenta abnormalities, placenta weight of less than 500 grams, obvious fetal abnormalities.

9. Assist with vaginal repair. Begin every 30 minute post partum assessments including VS, fundal checks, and vaginal flow checks.

10. Clean up all soiled instruments and restock.

11. Document all aspects of care.

12. When required, prepare mother and baby for transfer to appropriate hospital with Obstetrical Services. Send copies of chart, placenta, and complete COBRA.

Referenced Documents

Reference Type		Title	Notes

Effective	03/24/2014	Document Owner	Halsan, Carole

Policy:

Emergency Contraceptive Pills (ECP) are an important option for women who have recently had unprotected intercourse or a contraceptive accident who do not want to become pregnant.

Procedure:

Indications:

1. In case of sexual assault or other non-consensual sex when the woman was not protected by a reliable contraceptive method.
2. When no contraception has been used.
3. When there is a contraceptive accident or misuse.

Contraindications:

The only contraindication to ECP is confirmed pregnancy, because ECP cannot achieve their intended purpose if an established pregnancy already exists. ECPs may be given when pregnancy status is unclear and pregnancy testing is not available, as there is no evidence suggesting harm to the woman or to an existing pregnancy. There are no other known medical contraindications to the use of ECPs.

Consideration:

1. Breast Feeding: ECPs may be used by lactating women. There is no evidence of danger to the woman or the nursing infant.
2. Previous ECP use: ECP may be used on multiple serial occasions, but the patient should be informed that ongoing, correct use of the contraceptive methods provide more effective protection over time.
3. More than one unprotected act: One ECP regimen may be given to cover all unprotected acts, but the patient should understand that efficacy to prevent pregnancy from acts more than 72 hours prior to ingestion will be low.
4. ECPs effectiveness: Beyond 72 hours after intercourse is not well demonstrated. The earlier it is administered, the more effective it is. However, some women may elect to try ECPs beyond 72 hours (up to 120 hours), even though their efficacy may be less.
5. Nausea: Occurs in approximately 25% and vomiting in about 5% of women using levonorgestrel only.
6. Regimen:

   Levonorgestrel only regimen: 1.5 mg levonorgestrel as soon as possible, optimally within 72 hours after unprotected intercourse (Plan B one-step)

Referenced Documents

Reference Type	Title	Notes

Signed by	(03/24/2014) Carole Halsan, Chief Executive Officer		
Effective	03/24/2014	**Document Owner**	Halsan, Carole

Willapa Harbor Hospital
Working together for a healthier community
Pacific County Hospital District No. 2

Policy/Procedure

Emergency Transfer Policy (EMTALA)

Nursing Services 10346 (Rev: 3)**Official**

Policy:

It is the policy of Willapa Harbor Hospital to identify conditions which require services not available to Willapa Harbor Hospital Patients and thus require transfer to another health care facility.

Procedure:

A. Patients presenting with the following conditions will be assessed, evaluated and stabilized in this Emergency Department then referred to another facility appropriate to the Patient's condition for definitive treatment.
   1. Psychiatric conditions requiring In-Patient psychiatric treatment.
   2. Conditions requiring immediate surgery if the scope of surgery is beyond what the Staff Surgeon can perform under his allowed privileges and if the surgeon is unavailable.
   3. Neonates or pediatric Patients requiring extensive or intensive services which are not provided at Willapa Harbor Hospital.
   4. Conditions requiring immediate neurologic work-up or neurosurgery.
   5. Patients who are determined to be in a high risk pregnancy and/or less than 20 weeks gestation and are not in an imminent stage of labor.
   6. Patient with emergent spinal cord injuries.
   7. Woman in active labor less then 5cm cervical dilation.
   8. Patients requiring surgery when a surgeon and/or anesthetist are not available.
   9. Patients requiring a higher level of care that WHH is not able to provide safely.

After stabilizing treatment is rendered, the Physician will make appropriate arrangements with the receiving Physician. Nursing staff will make arrangement for bed placement and transportation. Documentation of the arrangements made will be noted on the Patient's Emergency Room medical record.

The potential benefits and potential problems associated with transfer must be explained to the Patient or Patient's guardian or next of kin and the COBRA Transfer Consent Form completed and signed. The original stays with the Patient's ER record and a copy goes with the Patient. A report on the Patient's status should be called to the receiving facility Nursing Staff by the Nurse caring for the Patient to facilitate continuity of care.

Referenced Documents

Reference Type	Title	Notes

Signed by	(03/24/2014) Carole Halsan, Chief Executive Officer		
Effective	03/24/2014	**Document Owner**	Halsan, Carole