HENDRICKS REGIONAL HEALTH

Obstetric and Pediatric Service
Rules and Regulations

1.0 PROTOCOLS FOR INFANT/NEWBORN TRANSFER

The newborn's physician will determine if an infant is in need of services, or expertise outside of capabilities of our hospital or medical staff. The newborn's physician will then call the hospital selected for transporting the infant to, discuss this with the parents, and write the order to transfer. The physician will remain present, or be immediately available, until the transport team arrives. When the team from the receiving hospital arrives to transport the newborn, that physician's responsibility is then transferred to the physician of the receiving team.

2.0 PROTOCOL FOR MATERNAL TRANSPORT

If it is deemed by the mother's physician that the mother or the fetus is going to require care outside of the capability of our hospital or medical staff, that physician will then accept responsibility to initiate transport. Anytime a pregnancy is at risk for delivery at less than 32 weeks or <1500 grams, transport will be initiated, as long as mother and fetus are stable, and it appears that there is adequate time for transport prior to delivery.

Whenever possible, the mother will be transported to the tertiary care facility with infant in utero. If she is stable, she may be transported by local ambulance service or helicopter service. That physician's responsibility includes accessibility for communication until the physician on the receiving end actually has received the patient on their unit. Accompanying information for mother or infant will be sent by fax or with the transport team, as well as any forms, which the receiving hospital requires.

3.0 PERSONNEL REQUIREMENTS FOR DELIVERY

Personnel present at delivery will be determined through the multidisciplinary policy for Neonatal Resuscitation: Management at Deliveries.

3.1 NEONATAL RESUSCITATION CERTIFICATION

1. All providers are required to maintain ongoing NRP certification per American Heart Association and American Academy of Pediatrics guidelines.

4.0 VACUUM EXTRACTOR CRITERIA

1. Full dilation and effacement of the cervix.
2. Engaged vertex presentation.
3. Ruptured membranes.
4. No demonstrable clinical cephalopelvic disproportion.
5. Fetus must be 34 weeks gestation or later

4.1 CONTRAINDICATIONS FOR VACUUM EXTRACTOR APPLICATION

1. Pregnancy less than 34 weeks gestation
2. Known cephalopelvic disproportion, macrosomia or risk of shoulder dystocia
3. All non-vertex presentations
4. Delivery requiring unusual amount of traction or rotational forceps.
5. Incomplete cervical dilation.
6. Unengaged or unknown fetal presenting part.
7. Disengagement of vacuum extractor three times.
8. Known fetal bone demineralization condition (e.g. osteogenesis imperfecta)
9. Fetal bleeding disorder (e.g. alloimmune thrombocytopenia, hemophilia, von Willebrand's disease

4.2 FAILURE OF THE PROCEDURE

The procedure should be discontinued if any of the following occur:

1. Fetus does not move when appropriate traction is applied to vacuum during contractions.
2. Total time of traction including all pulls exceeds 5 minutes.
3. Extractor cup becomes disengaged three times for any reason (pop-offs).
4. Total vacuum application time exceeds 15 minutes.
5. Evidence of scalp trauma during the procedure.

* Once failure of the vacuum delivery is diagnosed, the physician should move promptly to Cesarean Delivery. Further expectant management or use of other operative vaginal delivery techniques (e.g., use of different vacuum, forceps) increases risks of complications.

5.0 REQUIREMENTS FOR DELIVERY SUMMARIES/DISCHARGE SUMMARIES ON ALL ADMITTED PATIENTS

1. Delivery Summaries must be completed within 24 hours using electronic documentation.
2. All admitted and observation patients discharged from the CBC require appropriate discharge documentation within 48 (forty-eighty) hours of discharge.

6.0 FETAL MONITORING

6.1 INTRAPARTUM FETAL MONITORING

All intrapartum patients will have contractions and fetal heart rate monitored. Monitoring may be continuous or intermittent, depending on the physician's order.

6.2 INTERMITTENT FETAL MONITORING

In Preparation During Labor: The fetal heart rate should be auscultated every 30 minutes. Second stage of labor: Fetal heart rate should be recorded and evaluated at least every 15 minutes. In preparation for delivery: The fetal heart rate should be recorded and evaluated every 10 minutes.

If the number of patients exceeds the number of electronic fetal monitors available, then the patient will be evaluated by the phase of labor and their risk status in order to prioritize monitor

use. Patients in active phase of labor and/or with risk factors in their prenatal/intrapartum history will take precedence over patients in the latent phase of labor and/or at low risk for complications.

When an electronic fetal heart monitor is not available, the contractions and fetal heart rate will be monitored using palpation and a Doptone or Fetoscope.

7.0 PATHOLOGY EXCLUSIONS

7.1 There must be a physician's order on the chart for submitting placentas to the laboratory to satisfy the third-party payor requirements.

7.2 Foreskin removed from newborn males via circumcision or tissue removed during obstetric scar revision may be discarded or sent to the laboratory for pathological examination at the discretion of the physician.

8.0 PROTOCOL FOR INDUCTION

Inductions are to be scheduled in advance, if possible. A provider or nurse must evaluate the patient prior to the initiation of the induction.

The provider will be immediately available by phone or pager. If the provider cannot be readily available, the primary provider is responsible for arranging OB coverage during his/her absence and must communicate this to the nurse.

1. Induction may be initiated if cephalic presentation is established.

2. The patient must be evaluated by a provider within 24 hours of admission.

3. If the induction is discontinued for failure to establish labor, the provider must re-evaluate the patient prior to discharge.

8.1 **PROTOCOL FOR AUGMENTATION OF LABOR**

If the patient is noted to be in established labor (spontaneous rupture of membranes or progressive cervical change) Pitocin augmentation may be initiated. The physician must evaluate the patient within 12 hours.

8.2 **ELECTIVE INDUCTIONS AND C-SECTIONS**

Elective induction of labor and c-sections are not performed prior to 39 weeks estimated gestational age (EGA). Gestational age is determined by criteria also delineated in ACOG Practice Bulletin 107 and ACOG Committee Opinion Number 700 which includes the following:

a. Ultrasound at less than 20 weeks EGA supports gestational age of 39 weeks or greater.
b. Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography.
c. It has been 36 weeks since a positive serum or urine HCG pregnancy test.
d. ART-derived EGA

8.3 **NON-ELECTIVE INDUCTIONS AND C-SECTIONS**

When induction or c-section is planned after 37 + 0 weeks and prior to 39 weeks EGA, the physician must document the reason(s) plainly in the medical record and the correct ICD 10 diagnosis codes must be included in the medical record. Acceptable indications for inductions of labor are included in the ACOG Practice Bulletin 107, “Induction of Labor” and in the Joint Commission National Quality Measures current version. Acceptable diagnosis codes are found in Appendix A, Table 11.07 of the Specifications Manual for Joint Commission National Quality Measures.

8.4 **INDUCTIONS OF LABOR LESS THAN 37 WEEKS ESTIMATED GESTATIONAL AGE:**

Inductions of labor less than 37 weeks EGA will require review by the OB Chief/designee. The scheduler is not allowed to schedule inductions of less than 37 weeks and will inform the obstetrician to notify the OB Chief or designee.

Quality review of induced deliveries is part of the Quality Assurance Program. Physicians who deviate from these policies or whose practice varies from practice of other obstetricians will be notified and if necessary will be counseled regarding induction practices.

9.0 **ADMISSION TO CHILDBIRTH CENTER - NON-VIABLE FETUS**

The Childbirth Center will accept all non-viable perinatal losses on an individual/physician ordered basis at any stage of non-viability greater than or equal to 14 weeks gestation. Such clients will be automatically referred to our resolve-through-sharing grief counselor.

10.0 **ADMISSION TO CHILDBIRTH CENTER - VIABLE FETUS**

Childbirth Center medical and nursing staff will facilitate maternal transfer to a tertiary center of any viable gestation of less than 32 weeks, unless the mother of the fetus has medical problems necessitating delivery. The transport will not occur until the physician has evaluated the mother and both she and the fetus are both deemed to be in stable condition for transport. Childbirth Center nursing staff may initiate tocolytic therapy per protocol, by physician's order, for pre-term labor prior to actual transfer of the mother.

11.0 **CONSULTATION REQUIREMENT – Requirement to consult an OB physician**

The following situations require consultation by an OB/GYN physician:

1. Application of any forceps/vacuum to affect vaginal delivery

2. Probability of maternal transfer to another facility, 32 weeks or less with viable fetus.

3. C-section to be performed

11.1 CONSULTATION REQUIREMENT – OB Physician for Outside Consultation

1. OB patients transferred to ICU, whether antepartum or postpartum, require consultation with a Maternal Fetal Medicine physician.

12.0 **ATTENDANCE OF SIGNIFICANT OTHERS AT BIRTH**

Clients of our Childbirth Center may elect to have significant others present for her labor/ birth, so long as the following criteria are met:

1. Attending physician (s) approval.
2. Significant other's behavior complies with Childbirth Center visitation policies.

Priorities for care will be to the mother and infant, and the significant other in attendance will be expected to comply with any reasonable request to leave, should an emergency situation arise.

13.0 **OXYTOCIN CHALLENGE TEST**

A physician should be readily available, otherwise, principles of the Pitocin Induction Policy (notify nurse if another physician is covering) apply. Pitocin is to be delivered at 0.5 mu/min Then increase every 30 minutes by 1.0 mu/min, until 3 cx within 10 minutes is achieved.

The monitor strip must be reviewed by a physician prior to discontinuation of the Pitocin.

14.0 **ADOPTION PROCEDURES**

The physician will notify Social Services and the Unit Manager of the Childbirth Center of any anticipated adoption during the prenatal period.

15.0 **VAGINAL EXAMINATIONS**

Registered nurses assigned to the Childbirth Center who have completed orientation and the appropriate skill checklist may perform medical screening examinations, including those for determination of active labor and progress of labor.

16.0 **STANDING ORDERS FOR HIGH-RISK INFANTS**

Standing orders are to provide for rapid intervention when an infant is at risk and the physician is not present.

The standing orders for high-risk infants may be implemented by a nurse on any infant that is determined to be at high-risk for respiratory distress and if the infant's physician is not present. The infant's physician is to be notified as soon as possible of the infant's condition and that the orders have been implemented.

17.0 **STANDING ORDERS TO RELIEVE FETAL DISTRESS**

In the event of demonstrated fetal distress, the nurse will deliver an IV bolus and oxygen to the mother per mask if oxygen saturation is <92% and position patient to attempt to relieve the distress. If on Pitocin, discontinue.

18.0 **HYDROTHERAPY DURING LABOR**

If rupture of membranes has not occurred and fetal heart rate are stable, hydrotherapy may be initiated at the nurse's discretion. If rupture of membranes has occurred, a physician's order should be obtained.

19.0 **SPONTANEOUS RUPTURE OF MEMBRANES WITHOUT LABOR**

When a patient is admitted to the Childbirth Center with possible ruptured membranes and no firm, regular contractions, the nurse is NOT to check for cervical dilation until he/she has a specific order to do so from the physician for the care of said patient. This policy applies regardless of the patient's expected date of confinement.

To assure increased accuracy in determining the status of the membranes, it is recommended that an appropriate test to confirm be done unless amniotic fluid is present in amounts that assure an accurate diagnosis without these tests.

20.0 **ASSESSMENT OF NEWBORNS AND OBSTETRIC PATIENTS**

The physician will be expected to assess all newborns within 24 hours of birth, and the physician will be expected to assess all obstetric patients within 24 hours or less of admission to the obstetrical unit.

21.0 **PEDIATRIC ROLE AS A CONSULTANT**

For pediatric (<18) surgery cases (ENT, Surgery, Orthopedics) admitted to Hendricks Regional Hospital, consultation with pediatric hospitalist is encouraged, especially for children < 40 kg or < 16 years of age. Advantages of consultation include specialized familiarity with fluid and nutritional requirements, medication dosing, and medical pediatric emergencies. In addition, pediatric service presence may improve family centered communication, physician presence, and overall patient satisfaction.

- For surgical pediatric patients < 18 years old requiring ICU care, please see Pediatric ICU guidelines.
- Except for uncomplicated soft tissue infections, surgery team will serve as primary team to manage all surgery related conditions and inquiries (e.g. diet advancement, wound management), as well as admission and discharge.
- Expectations for pediatric service would include:
    - Coordination and assistance with medications including antibiotics and analgesics.
    - Management of IV fluid requirements
    - Medical Conditions/Comorbidities
    - Coordination and communication with Primary Care Pediatrician

- Coordination and assistance with access to pediatric subspecialty consultation, when needed
- Coordinating transfer to tertiary facility, when medically indicated
- The pediatric team will respond to any emergency code called on the patient as they would for any pediatric patient.

Approved by OB/Peds Committee: 01/15/2024
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Supercedes: 01/2015, 07/2013, 07/2009, 5/2015, 03/2017, 02/2019,1/2020, 1/2021,01/2022, 02/2023