DELIVERY ROOM/LABOR ROOM
STANDARD OPERATING PROCEDURE

POLICY NO: NSO-015

DIVISION: NURSING SERVICE DIVISION

SECTION: DELIVERY ROOM/ LABOR ROOM

POLICY REVIEW DATE: May 22, 2014

Reviewed by:		
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OBJECTIVES:

I. To encourage women to have constant labor and birthing companions of their choice.
II. To advise women to walk and move about during labor, if desired, and to assume the positions of their choice while giving birth, unless a restriction is specifically required for a complication and the reason is explained to the mother (not using invasive procedure)
III. To define the standard operating procedures in the area for compliance and implementation.
IV. To foster better mother-child relationship.

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COVERAGE:

All medical and non-medical personnel of the hospital, patients and their significant others.

RESPONSIBILITIES:

1. It shall be the responsibility of the **Head Nurse** to orient her staff with regard to this policy and to monitor the general activities in the unit.
2. It shall be the responsibility of all **Staff** of this section to observe and follow set standard operating procedures as written in this policy.
3. It shall be the responsibility of the DR/LR Nurses/ Midwives to:
    a. Closely monitor vital signs, FHT, and progress of labor
    b. DR Nurses perform IV insertion and administers medication

c. Properly document progress of labor and refer for any untoward signs and symptoms
d. Assist the doctor in the performance of vaginal deliveries.
e. Perform newborn care
f. Render health teaching and assist in early initiation of breastfeeding

POLICY:

1. To require that all shall abide with the guidelines incorporated into this policy.
2. This policy shall ensure timeliness and accuracy in the deliverance of only the best and quality service afforded by this institution.
3. To enforce the timeliness of release of any procedure done.

PROCEDURES:

1. LABOR ROOM ADMISSION

a. Primi Gravida/Segundi in active labor with 8 cm cervical dilatation and 6 cm cervical dilatation for multi-para.
b. High risk pregnancies in labor, for induction or augmentation of labor.
Considered high risk are the following:
- Elderly Primi-Gravida (35 years old and above)
young Primi-Gravida (15 years old and below)
- Toxemia of pregnancy (pre-eclampsia and eclampsia)
- Pre-maturity and Post maturity
- Early Rupture of Membrane (EROM),
Premature Rupture of Membrane (PROM)
- Multiple gestation
- Malpresentation (Frank breech), footling, shoulder and face presentation
- Polyhyramnios and oligohyramnios
- Intrauterine Fetal Growth Retardation (IUGR)
- Patients with moderate vaginal bleeding (e.g low lying placenta or placenta previa marginalis)

c. All pregnant patients with oxytocin drip regardless of the internal examination except for the blighted ovum, missed abortion and intra-uterine fetal death

Note:
LR maybe used for delayed CS, only that OR staff will be the one responsible for the patient.

d. Change street clothes to hospital gown.
e. Check patency of IVF/IV site
f. Monitor and record vital signs, FHT and progress of labor, refer to MO/MS for any signs of abnormalities:
-FHT of:
- LOW RISK patients – recorded every 15 minutes
- HIGH RISK patients - recorded every 5 minutes
Note: separate sheet provided for this purpose must be used.

Normal FHT: 120 -160 bpm

- Uterine contractions and blood pressure recorded every 30 minutes on the same monitoring sheet. (Normal BP <140/90 mmHg and 3-5 contractions every 30 minutes in < 90 seconds)

g. Transport patient to delivery room at 9 cm cervical dilatation and notify MO/MS

2. DELIVERY ROOM ADMISSION

a. Primi gravid and Segundi gravid client in active labor, 9 cm to fully dilated cervix.
b. Multi-para client, in active labor, 8 cm cervical dilatation.
c. Muliti-para client, BOW ruptured:
   - Change patient street clothes to hospital gown before entering Delivery Room
   - False teeth, nail polish, jewelries must be removed
   - Check for patient's record for complete laboratory results (CBC, blood typing, Hbs Ag, Ultrasound and other relevant data)
   - IVF insertion, monitoring of vital signs and FHT
d. For placental extraction but with IVF before admission

3. INTR-UTERINE DELIVERIES ROUTINE
   a. Check vital signs and FHT.
   b. Client should not be left unattended while on the DR table.
   c. Vaginal delivery must be attended by the Resident Doctor or by the Attending Physician.
   d. In case of emergency vaginal deliveries, the Nurse/Midwife attends to the delivery and may perform a right-media-lateral episiotomy and immediately inform the MO/MS. Repair shall be done only when verbal consent of the physician is given
   e. All patients whose deliveries are not directly supervised by the MO on duty MUST undergo I.E and/or rectal examination by the consenting physician prior to transfer of patients to ward.

4. POST-PARTUM ROUTINE
   a. Check vital signs, record and report signs of bleeding, uterine atony and abnormalities
   b. Perineal washing and application of adult diaper prior to ward transfer.
   c. ID wrist band for mother and baby should contain the following data:
      -Name of mother
      - Sex of baby
      - Date and time delivered
      - Type of delivery
      - Attending Physician
   d. Routine maternal boding should be done immediately after delivery of the newborn and to encourage mothers to breastfeed their babies while in the ward
   e.All post-partum patients must be assessed by the doctor prior to order for transfer to ward.
   f. Internal Exam by NOD/MO/MS prior to ward transfer.

5. ESSENTIAL NEWBORN CARE (DOH AO 2009-0025)
   This Administrative Order (AO) outlines specific policies and principles for health care providers with regards to the prescribed systematic implementation of interventions that

address health risks known to lead to preventable neonatal deaths. This AO is consistent with AO No. 2008-2009 on implementing Health Reforms for Rapid Reduction of Maternal and Newborn Mortality and support all DOH initiatives and programs for newborn and child health.

a. Within the first 30 seconds

Objective: Dry and provide warmth to the newborn and to prevent hypothermia

- Put on double gloves just before delivery.
- Use a clean, dry cloth to thoroughly dry the newborn by wiping the eyes, face, head, front and back, arms and legs.
- Remove wet cloth.
- Do a quick check of newborn's breathing while drying.
- Do not put the newborn on a cold or wet surface.
- Do not bathe the newborn earlier than 6 hours of life.
- If the newborn must be separated from his/her mother, put him/her on a warm surface, in a safe place close to the mother.

b. **After thorough drying**

Objective: Facilitate bonding between the mother and her newborn through skin-to-skin contact to reduce likelihood of infection and hypoglycaemia.

- Place the newborn prone on the mother's abdomen or chest, skin to skin.
- Cover the newborn's back with a blanket and head with a bonnet.
- Place the identification band on the ankle.
- Do not separate the newborn from the mother, as long as the newborn does not exhibit severe chest in-drawing, gasping or apnea and the mother does not need urgent medical/surgical stabilization e.g emergency hysterectomy.
- Do not wipeoff vernix if present

Check for multiple births as soon as newborn is securely positioned on the mother. Palpitate the mother's abdomen to check for a second baby or multiple births. If there is a second baby (or more), get help. De;liver the second newborn. Manage like the first baby.

c. While on skin-to-skin contact (up to 3 minutes post delivery)

Objective: reduce the incidence of anemia in term newborns and intraventricular hemorrhage in pre-term newborn by delaying or non-immediate cord clamping.

- Remove the first set of gloves immediately prior to cord clamping.
- Clamp and cut the cord after cord pulsation have stopped (typically at 1-3 minutes). Do not milk the cord towards the newborn.
  -Put ties tightly around the cord at 2 cm and 5 cm from the newborn's abdomen.
  -Cut between ties with sterile instrument.
  -Observe for oozing blood.
- After cord clamping, ensure 10 IU Oxytocin IM is given to the mother. Follow the protocol in PCPNC.

d. **Within 90 minutes of age**
Objective: Facilitate the newborn's early initiation to breastfeeding and transfer of colostrums through support and initiation of breastfeeding.

- Leave the newborn on the mother's chest in skin-to-skin contact. Health workers should not touch the newborn unless there is a medical indication.
- Observe the newborn. Advice the mother to start feeding the newborn once the newborn starts to show feeding cues (e.g opening of mouth, tonguing, licking, rooting). Make verbal suggestions to the mother to encourage her newborn to move toward the breast e.g nudging.
- Counsel on positioning and attachment. When the newborn is ready, advise the mother to position and attach her newborn.
- Advise the mother not throw away the colostrums.
- If the attachment or suckling is not good, try again and reassess.
- A small amount of breastmilk may be expressed before starting breastfeeding to soften the nipple area so that it is easier for the newborn to attach.

To prevent **opthalmia neonatorum** through proper eye care, administer erythromycin or tetracycline ointment or 2.5% povidone-iodine drops to both eyes after the newborn has located the breast. Do not wash away the eye antimicrobial.

6. NON-IMMEDIATE INTERVENTIONS

These interventions are usually given within 6 hours after birth, and should never be made to compete with the time-bound interventions.

a. Give Vitamin K prophylaxis
- Inject a single dose of Vitamin K 1mg IM (if parents decline intramuscular injections, offer oral Vitamin K as a 2nd line.

b. Inject Hepatitis B and BCG vaccinations
- Inject Hepatitis B vaccination IM and BCG intradermally.

c. Examine the newborn. Check for birth injuries, malformations or defects
- Weigh the newborn and record
- Look for possible birth injury and/ or malformation
- Refer for special treatment and/or evaluation if available
- If the newborn has feeding difficulties because of the injury/malformation, help the mother to breastfeed. If not successful, teach her alternative feeding methods.

d. Cord care
- Wash hands.
- Fold diaper below stump. Keep cord stump loosely covered with clean clothes.
- If stump is soiled, wash it with clean water and soap. Dry it thoroughly with clean cloth.
- Explain to the mother that she should seek care if umbilicus is red or draining with pus.
- Teach the mother to treat local umbilical infection three times a day.

7. NEWBORN RESUSCITATION
    a. Start resuscitation if the newborn is not breathing or is gasping after 30 seconds of drying or before 30 seconds of drying if the newborn is completely floppy and not breathing.
    b. Cut and clamp the cord immediately.
    c. Call for help.
    d. Transfer newborn to a dry, clean and warm surface. Keep the newborn wrapped or under a heat source if available.
    e. Inform the mother that the newborn needs help to breath.

8. ADDITIONAL CARE FOR A SMALL BABY OR TWIN

    If a newborn is preterm, 1-2 months early or weighing 1500-2499 g (or visibly small where a scale is not available)

    a. If the newborn is delivered 2 months earlier or weighs < 1500 g, refer to a specialized hospital.
    b. For a visibly small newborn born >1 month early;
        - Teach the mother how to keep the small newborn warm in skin-to-skin contact via Kangaroo Mother Care (KMC). Start KMC when:
            - The newborn is able to breathe on its own (no apneic episodes)
            - The newborn is free of life-threatening disease or malformations.
        - Provide extra blankets for the mother and the newborn, bonnet, mittens, and socks.
        - If the mother cannot keep the newborn skin-to-skin because of complications wrap the newborn in a clean, dry, warm cloth and place in a cot. Cover with a blanket. Use a radiant warm if the room is not warm or if the baby is small.
        - Give special support for breastfeeding: encourage the mother to breastfeed every 2 hours.
        - Weigh the newborn daily.
        - When the mother and newborn are separated, or if the newborn is not sucking effectively, use alternative feeding methods.

9. UNNECCESARY PROCEDURES
    a. Routine suctioning
    b. Early bathing/ washing
    c. Footprinting
    d. Giving sugar water, formula or other prelacteals and use the bottles or pacifiers
    e. Application of alcohol, medicine and other substances on the cord stump and bandaging the cord stump or abdomen.

10. DOCUMENTATION
    a. Check for complete patient record, including laboratory request and results (CBC, blood typing, HbsAg during endorsement)
    b. Accomplish Delivery Room and Newborn record and signed by the Attending Physician and Nurse on Duty.

11. ENDORSEMENT
    a. Inform the ward staff 5-10 minutes before sending the patient out from the delivery room.
    b. All staff should not leave the area without the proper endorsement to the incoming staff.
    c. Soiled linens should be sent to the linen section for linen replacement.
    d. Maintain cleanliness and orderliness of the area.

APPENDIX:

Summary of Parturition
Labor Record
Birth Practices Checklist
Client Survey on Breastfeeding

DATE OF IMPLEMENTATION:

This policy has been implemented since 1978, however, minor revision has been made 1994, 1998, 2001, 2003, 2006, 2011 and reviewed May 22, 2014.

SCHEDULE FOR POLICY REVIEW:

This policy shall be revised every three (3) years or as deemed necessary