



- Precipitous Delivery
- What's A Nurse To Do?

# Definition

- Precipitous Labor
  - Usually refers to labor and birth less than or equal to 3 hours



## Attending Nurse's Responsibility

- Remain calm
- Stay with the patient
  - Request assistance from ancillary staff when able to contact provider
    - Retrieve emergency precipitous pack
      - Recommended content of pack on next slide
- Keep the patient and family informed
- Encourage the woman to breathe with you and focus
- Avoid placing woman in stirrups but rather lower the bottom of the bed
  - Babies are very slippery due to blood, vernix and amniotic fluid

# Content of Precipitous Pack

- Sterile basin to hold the following contents:
  - Small under buttocks drape
  - Bulb syringe
  - Two sterile Kelly clamps
  - Sterile scissors
  - Sterile umbilical clamp
  - Package of 4X4 ratex sponges
    - MUST count after opening package and after delivery
- Have sterile gloves and warm towels and blankets available

# Step One.....

- Remain calm and have the birthing person breathe keeping eyes opened and focused on either you or their partner



# Crowning of the Fetal Head

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- As the head crowns, it distends the labial and perineal tissues, and the anus is stretched sometimes causing feces to be expelled. The feces is wiped away posteriorly to avoid contamination of the vulva.
- The provider is not holding the head back but controlling its exit by using gentle pressure on the fetal occiput ( the back of the head).

Murray (2023)

Anderson (2014)



# Crowning of the Fetal Head

- Slight pressure is applied to the fetal chin through the perineal tissue at the same time slight pressure is applied to the occiput. This action aids in fetal extension as the fetal head comes under the symphysis allowing the head to gradually deliver. It also supports and minimizes perineal tissue trauma

Murray (2023)  
Anderson (2014)



# Check for Nuchal Cord

- Once the head is delivered:
  - Check for Nuchal Cord by slipping one or two fingers along the back of the fetal head
    - If the cord is present – bend a finger like a fishhook and slip the cord over the baby’s head
    - Check to see if more than one loop is around the baby’s neck
    - If unable to slip the cord around the baby’s head; place two clamps on the cord and cut between the two clamps

Murray (2023)

Anderson (2014)



# After checking or eliminating for the presence of a nuchal cord.....

- Wipe the fetal mouth and nose to avoid aspiration of secretions when the infant takes the first breath
- Routine use of a bulb syringe and or vigorous suctioning of the baby's mouth and nose is no longer recommended
  - If bulb syringe is utilized, suction the mouth first followed by suctioning of the nose





# Rotation of the Fetal Head

- Typically, the fetal head will rotate (restitutes) to either the right or left side to align the shoulders

Murray (2023)

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# The Head is Out What Now?

- Place hands on either side of the infant's head and instruct the woman to push gently to deliver the rest of the body
- Typically, the provider will gently push the fetal head toward the client's perineum to deliver the anterior shoulder and then pushes the fetal head upwards toward the client's symphysis to allow delivery of the posterior shoulder



Murray (2023)

Anderson (2014)












- Support the newborn as it is delivered
  - Newborns are very slippery due to blood and amniotic fluid
- Cradle the baby's head in one hand and the buttocks in the other
- Keep the baby's head lower than the rest of the baby's body to facilitate drainage of mucus.
  - Use a bulb syringe only if need to remove mucous from the mouth first and then the nose.

- Try and keep the newborn at the level of the uterus to facilitate blood flow from the umbilical cord until the cord has stopped pulsating
- Keep baby warm and dry
- After cord has stopped pulsating – clamp in two places (up to 3 minutes)
  - Instruct Dad or support person to cut between the two clamps




# Documentation

- Assign Apgar score to infant
  - 1 minute
  - 5 minutes
  - 15 minutes

	Score 0	Score 1	Score 2
Appearance			
Pulse	No pulse	<100/min.	>100/min.
Grimace			
Activity			
Respirations	No respirations	Weak, slow	Strong cry

apgar [www.fotosearch.com](http://www.fotosearch.com)



# Place Baby Immediately Skin to Skin

- Place directly onto mom's chest, and continue to dry baby off and remove any wet linens
  - Rub back to stimulate
    - Tactile stimulation
- Loosely Cover baby with warm blankets and hat.

Lowdermilk , et.al ( 2024)

# Steps for Safe Skin to Skin



- Skin to skin provides numerous benefits for moms and their babies.

- Skin to skin time is encouraged as soon as possible after delivery, frequently while in the hospital, and after discharge from the hospital during the first weeks of baby's life.

- If mom begins to feel tired and wants to sleep, it's extremely important to place baby in a bassinet or crib or with another support person who is awake and alert.

To ensure baby remains safe during skin to skin time, mom should sit in a semi-reclined position and hold baby using the following steps:

1 Face can be seen

2 Nose is slightly tilted upward, in a "sniffing" position

3 Mouth and nose aren't covered

4 Head is turned to one side

5 Neck is straight – not flexed or bent

6 Shoulders and chest face mother

7 Legs are flexed

8 Back is covered with a blanket



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# Delivery of the Placenta



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Allow Placenta to deliver naturally

- Signs that the placenta is delivering (3<sup>rd</sup> stage of labor)
  - Contraction of the fundus – uterus changes from a discoid to a globular ovoid shape as the placenta moves into the lower uterine segment
  - Light gush of dark red blood
  - Possible complaints of Cramping/Contraction
  - Lengthening Cord
  - Vaginal fullness
- **DO NOT PULL ON THE CORD**

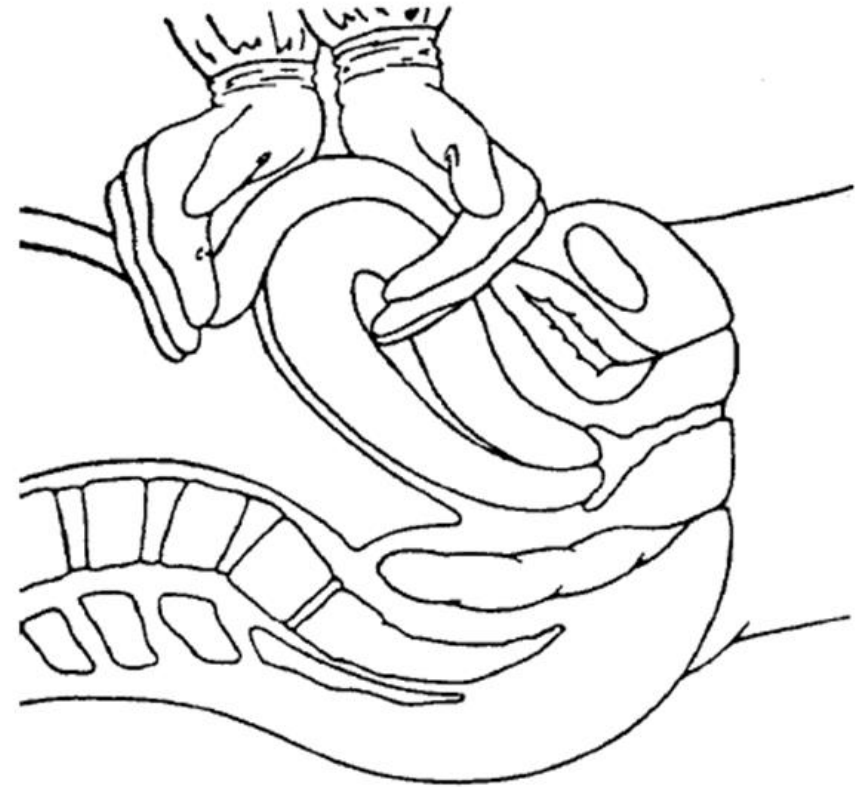
Place placenta in container and keep for care provider to examine



# Fundal Assessment and Massage

- Once the placenta is delivered and at least every 15 minutes for the first 2 hours perform fundal assessment and massage

## Fundal Massage



## Fundal Assessment and Massage

- Locate the Fundus w/Palm of the hand
- Cup the hand, place on lateral side of the hand slightly above fundus
- Place second hand above the symphysis pubis to support and stabilize the uterus during palpation
- Gently, but firmly, press into abdomen toward the spine and then slightly downward toward the perineum until a mass is felt in the palm of the hand.



# Fundus Assessment and Massage

- Determine whether the fundus is firm or boggy
  - If it is not firm – continue massage until it becomes firm
  - Note location in finger breaths
    - Above, Below or at the umbilicus
  - Determine the location of the fundus in relation to the midline of the body
    - A fundus may deviate from the midline if the bladder is full
  - Assess the amount of lochia and if clots are present



# Medication Guidelines

**Table 1:** Recommendations for oxytocin dosing regimens for atony prophylaxis and treatment

Prophylaxis	Treatment
<p><b><i>Oxytocin infusion:</i></b></p> <ul style="list-style-type: none"> <li>▶ Oxytocin 10-30 units in 500 mL or 20-60 units in 1000 mL controlled infusion with a standardized rate</li> </ul> <p>An example for a typical oxytocin regimen for atony prophylaxis is as follows: In 500 mL NS containing 30 units oxytocin – start with 334 mL/hour (10 u oxytocin given over 30 min). After 30 min, change to a maintenance rate 125 mL/hour, (7.5 u oxytocin over 60 min)</p> <p style="text-align: center;"><b>OR</b></p> <p><b><i>Oxytocin bolus:</i></b></p> <ul style="list-style-type: none"> <li>▶ Oxytocin IV bolus of 1-3 units to initiate adequate uterine tone followed by an infusion to maintain adequate tone (30 units in 500 mL; running at 125 mL/hour (7.5 u/hour)</li> </ul> <p style="text-align: center;"><b>OR</b></p> <p><b><i>Oxytocin IM:</i></b></p> <ul style="list-style-type: none"> <li>▶ Oxytocin 10 units IM when no IV access</li> </ul>	<p><b><u>Administer first-line agent:</u></b></p> <ul style="list-style-type: none"> <li>▶ Oxytocin 10-30 units in 500 mL or 20-60 units in 1000 mL, time-limited bolus infusion over 10-15 minutes, followed by maintenance infusion at a lower rate           <ul style="list-style-type: none"> <li>• Avoid high doses of oxytocin infusion greater than 30-40 units/hour</li> <li>• Closely monitor maternal heart rate (using pulse oximeter) and blood pressure when delivering higher-rate oxytocin infusions or boluses for active hemorrhage</li> </ul> </li> <li>▶ Call anesthesiology backup early and consider activating OB Rapid Response if you need assistance with monitoring maternal vital signs in women post-vaginal birth with evolving hemorrhage due to severe refractory uterine atony</li> </ul>

# Medication Guidelines Continued

	<p><u>Choose a standard second-line agent:</u></p> <ul style="list-style-type: none"><li>▶ Methylergonovine 0.2 mg IM</li><li><i>or</i></li><li>▶ Carboprost 250 mcg IM</li></ul> <p><b><u>Consider misoprostol only for patients with asthma and hypertension (misoprostol is no longer recommended otherwise due to high rates of side effects and inconsistent efficacy)</u></b></p> <ul style="list-style-type: none"><li>▶ Misoprostol 600 mcg orally or 800 mcg sublingually (<i>Rectal administration is no longer recommended due to the late onset of action</i>)</li></ul>
	<p><u>Unresponsive to uterotonics:</u></p> <ul style="list-style-type: none"><li>▶ Move quickly to non-pharmacologic methods of treatment based on etiology: e.g., uterine balloon tamponade; b-lynch suture; interventional radiology; trauma repair; dilation and curettage</li><li>▶ Consider tranexamic acid (TXA) 1 gm IV within 3 hours of recognition of PPH, may give a second dose of 1 gm if bleeding continues after 30 minutes or if bleeding stops and then restarts within 24 hours of completing the first dose</li></ul>

# References

- Anderson, R. & Bertone, A. Providence Sacred Heart Medical Center. *Emergency Childbirth “The Unexpected Delivery”* [Microsoft PowerPoint - Emergency Childbirth](#) June 2014 retrieved June 2026.
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- Davidson, M., London, M., & Ladewig, P. (2024) *OLDS’ Maternal-Newborn Nursing & Women’s Health Across the Lifespan*. (12<sup>th</sup> Ed.) Boston: Pearson
- Lowdermilk, D.L., Perry, S. E., Cashion, K. Alden, K. R., & Olshansky, E.F. (2024) *Maternity & Women’s Health Care*. (13<sup>th</sup> Ed.) *Chapter 19, Nursing Care of the Family During Labor and Birth*. St. Louis: Elsevier
- Murray, S., McKinney, E., Holub, K.S., Jones, R. & Scheffer, K.L. (2023) *Foundations of Maternal-Newborn and Women’s Health Nursing*. (8<sup>th</sup> Ed.) St. Louis: Elsevier
- Simpson, K.R., Creehan, P.A., O’Brien-Abel, N., Roth, C.K. & Rohan, A.,J. ( 2021). *Perinatal Nursing*.(5<sup>th</sup> Ed.) Philadelphia: Wolters Kluwer