- 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

Old's (2020)

Content of Precipitous Pack

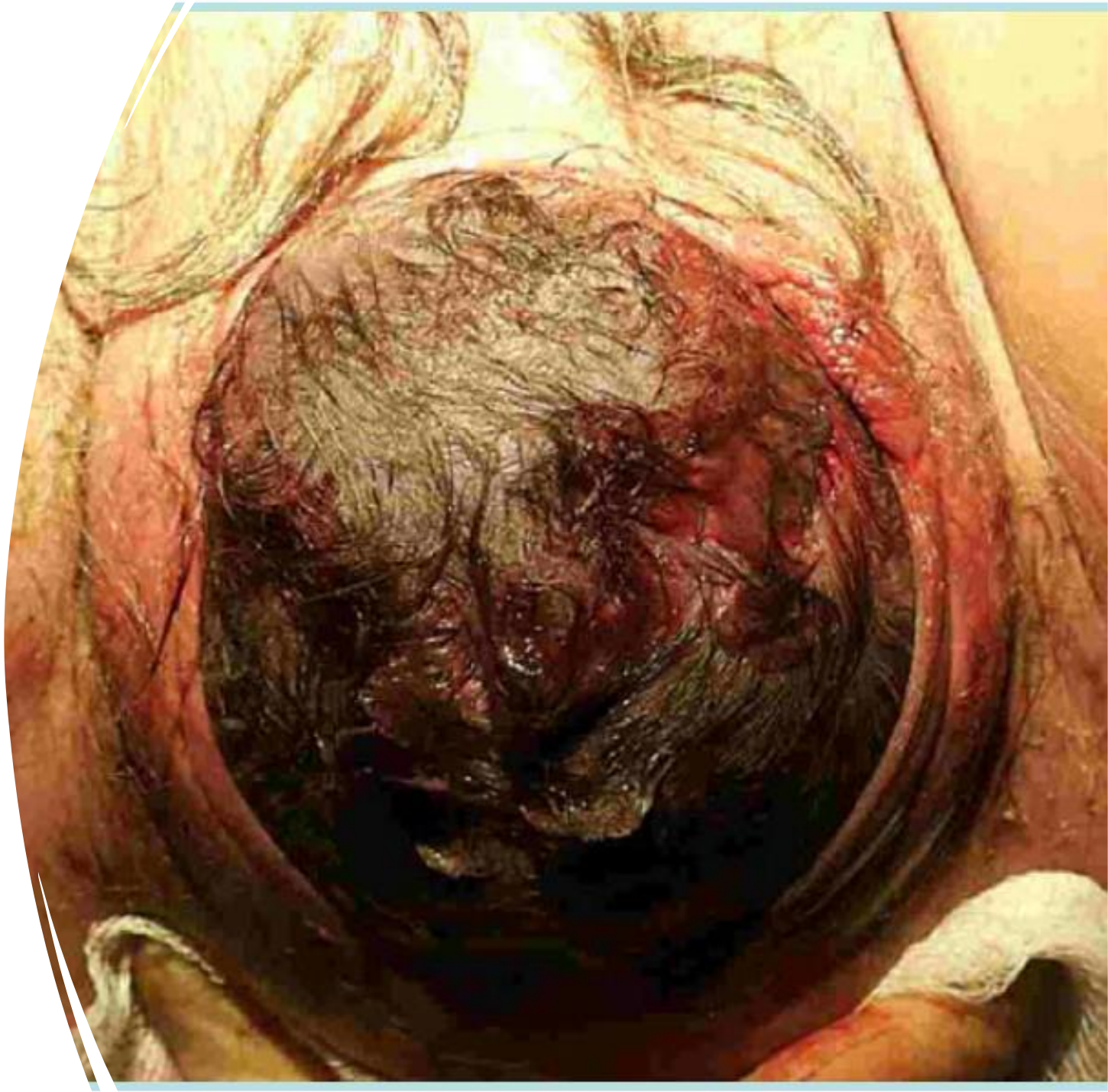
- Sterile basin to hold the following contents:
  - Small under buttocks drape
  - Bulb syringe
  - Two sterile Kelly clamps
  - Sterile scissors
  - Sterile umbilical clamp
  - Package of 4X4 ratex sponges
    - MUST count after opening package and after delivery
- Have sterile gloves and warm towels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

Old's (2020)

Crowning of the Fetal Head

- Support the perineum with one hand
- With the other hand, apply gentle pressure against the fetal head to maintain flexion and to prevent the head from delivering too rapidly
    - Do not hold the infant head too firmly to prevent delivery

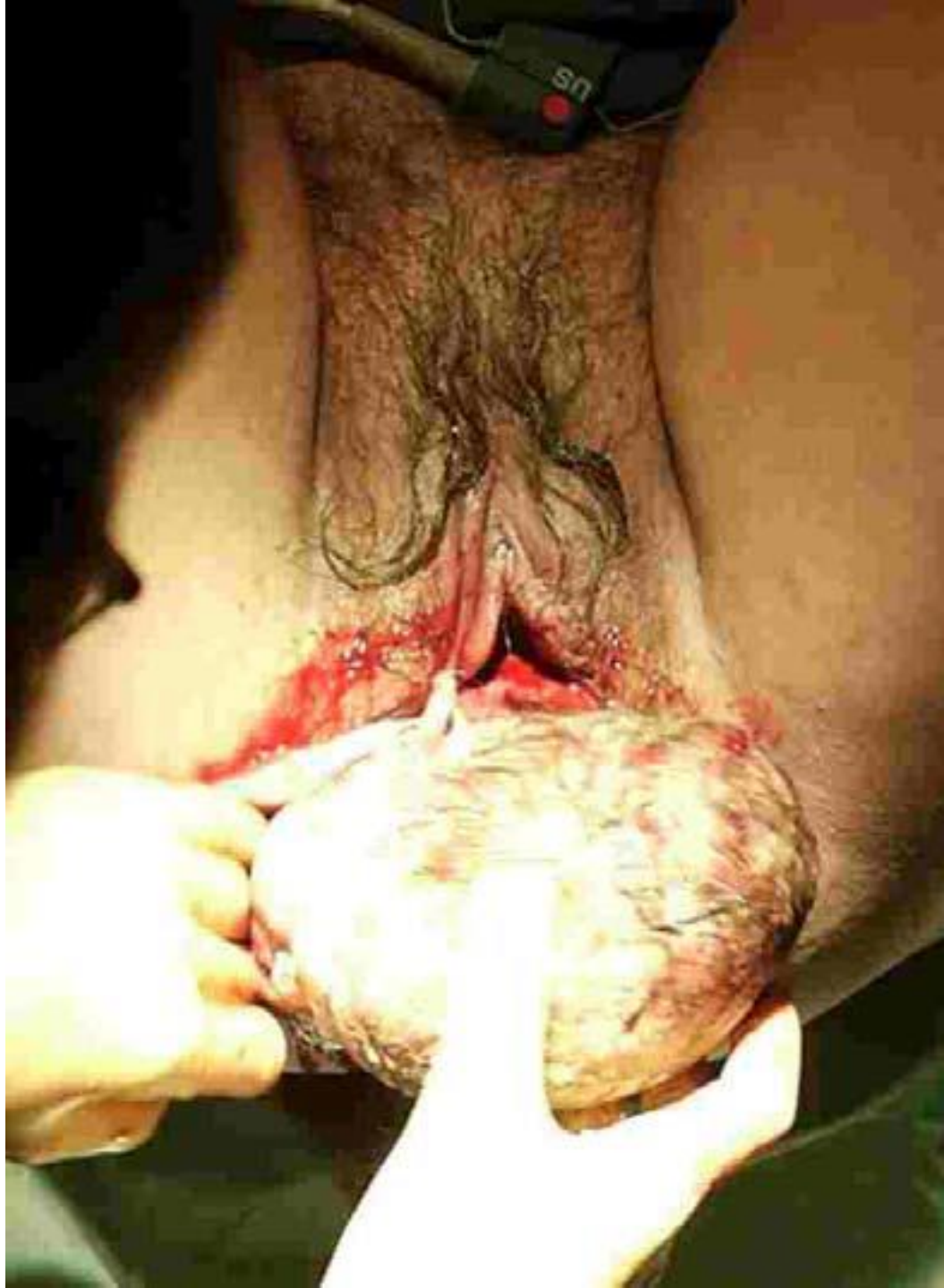
Old's(2020)

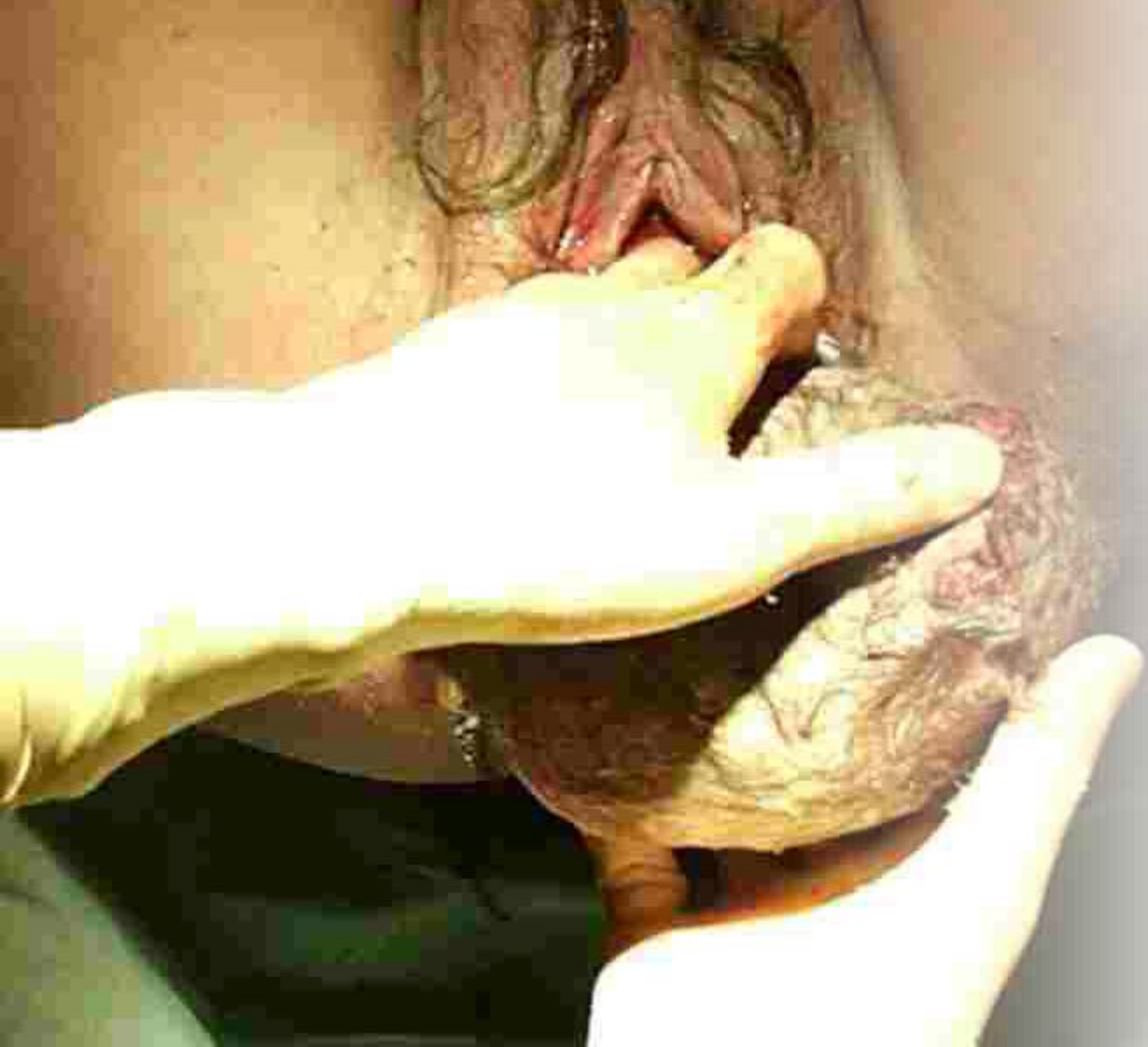


Check for Nuchal Cord

- 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

Old's (2020)





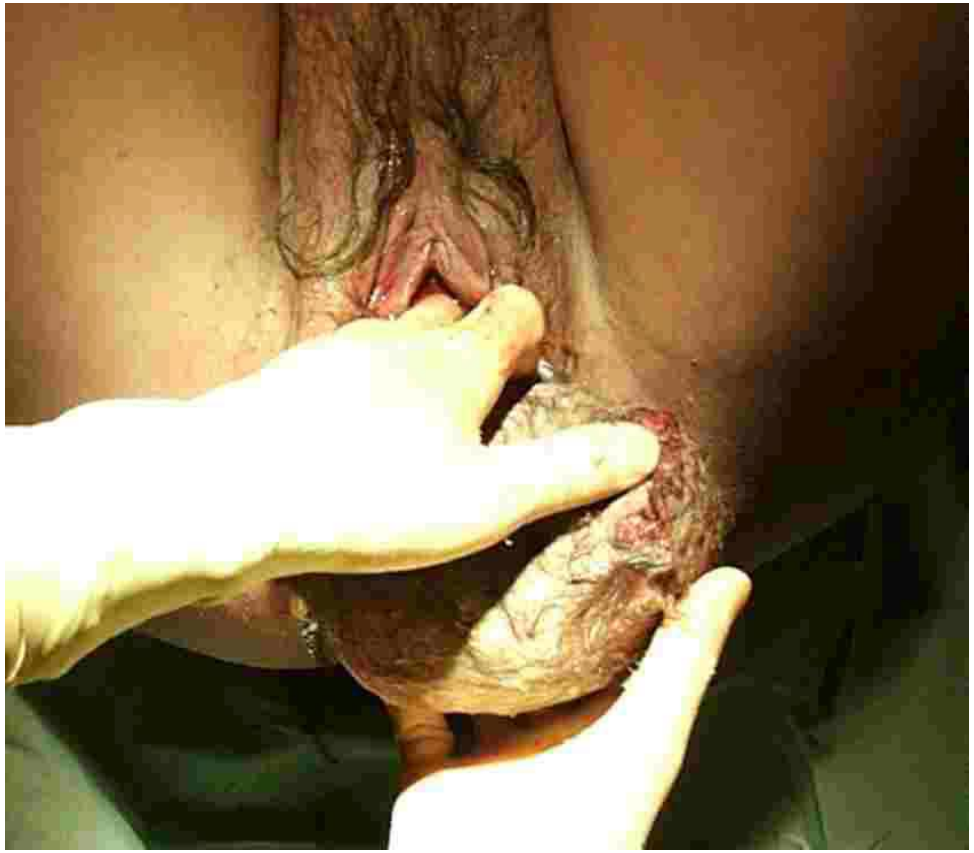
Rotation of the Fetal Head

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

Old's (2020)

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
- Support the newborn as it is delivered
- Hold onto the infant at the level of the uterus
  - Infants 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 body to facilitate drainage of mucus.
  - Use a bulb syringe only if need to remove mucous from the mouth first and then the nose.



Old's 2(020), Lowdermilk (2024)

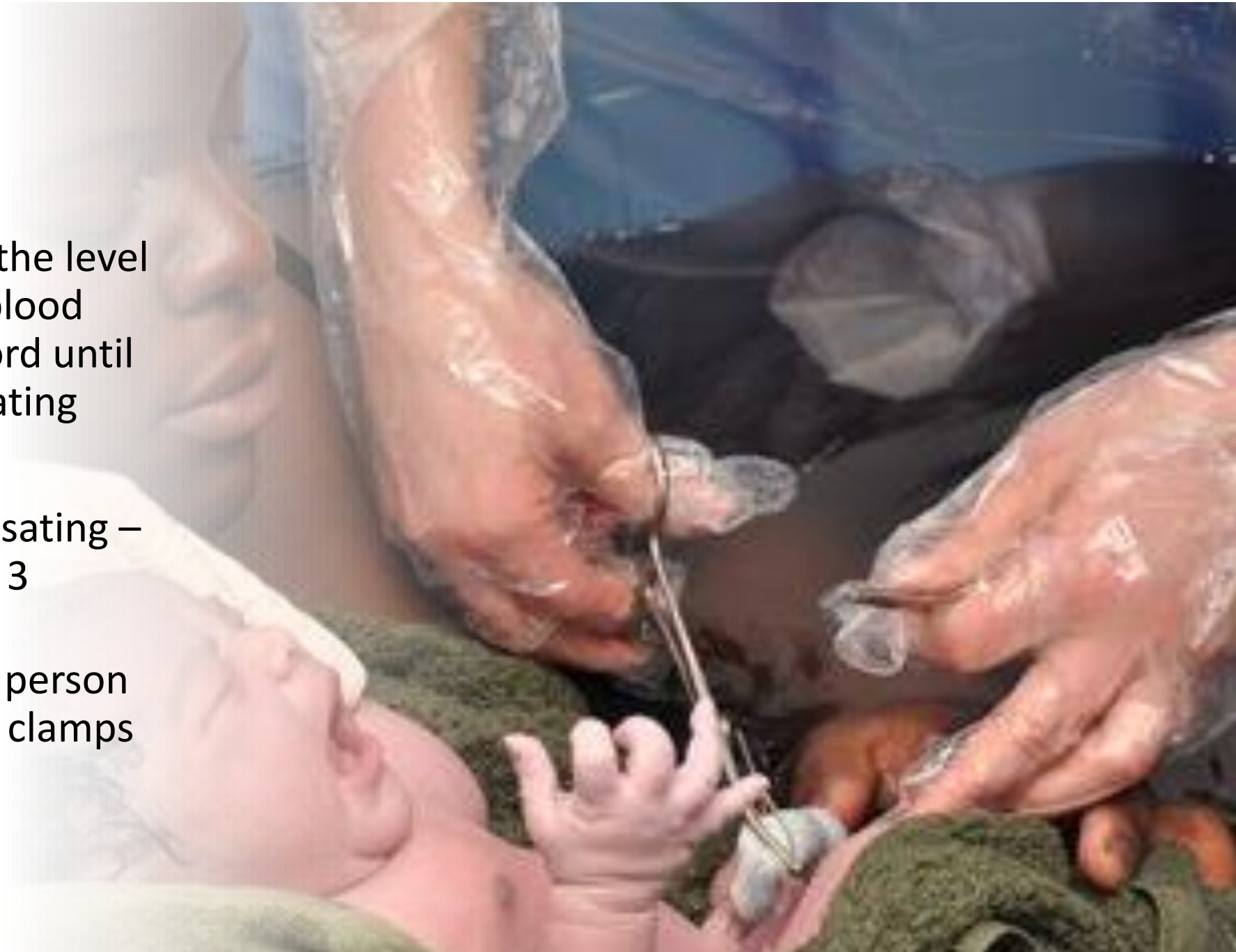
Place Baby Immediately Skin to Skin

- Place directly onto mom's chest or abdomen 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 (2020)

Delivery Continued

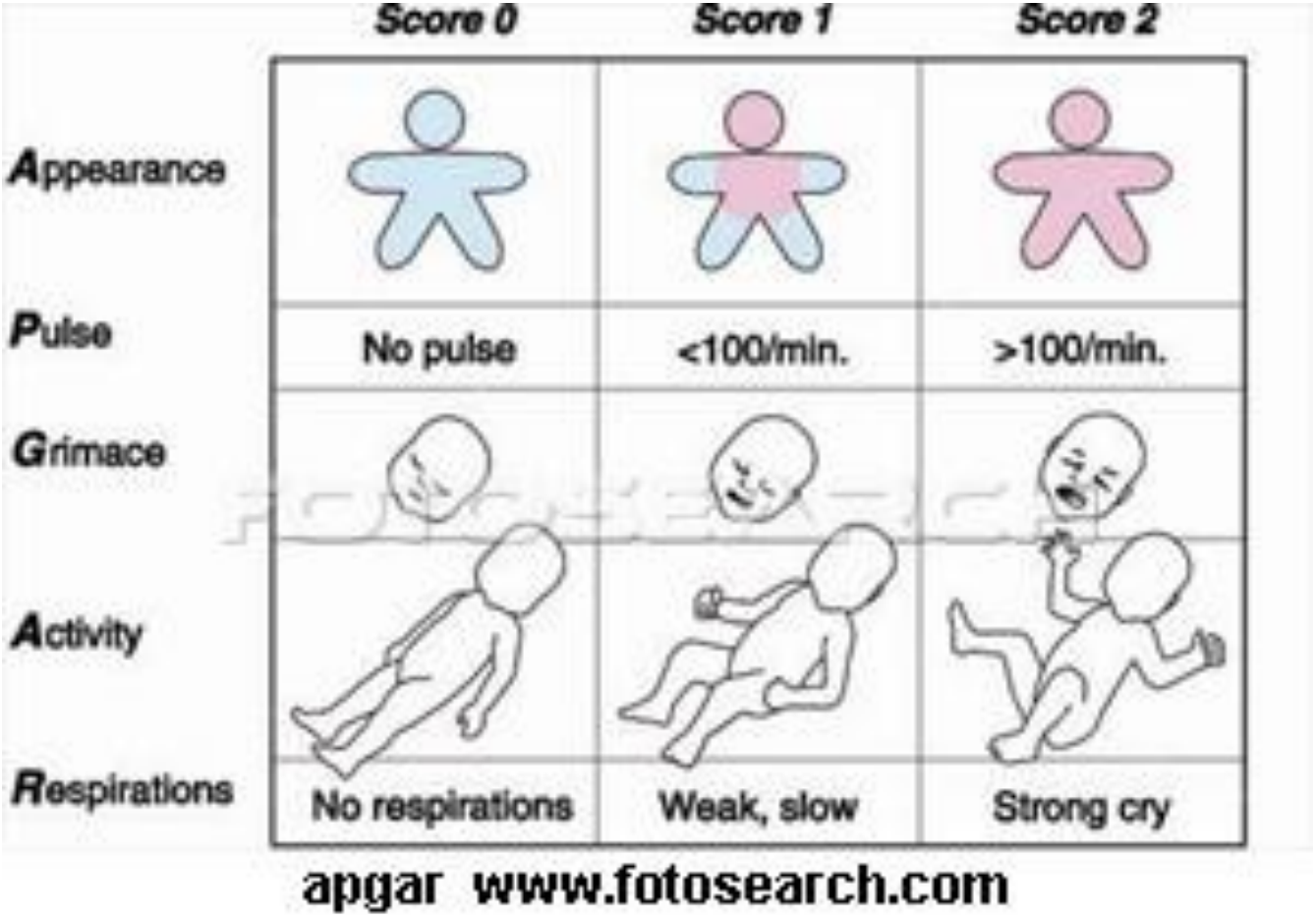
- Try and keep the infant at the level of the uterus to facilitate blood blow from the umbilical cord until the cord has stopped pulsating
- Keep baby warm and dry
- After cord has stopped pulsating – clamp in two places (up to 3 minutes)
  - Instruct Dad or support person to cut between the two clamps



Lowdermilk (2024)

Documentation

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



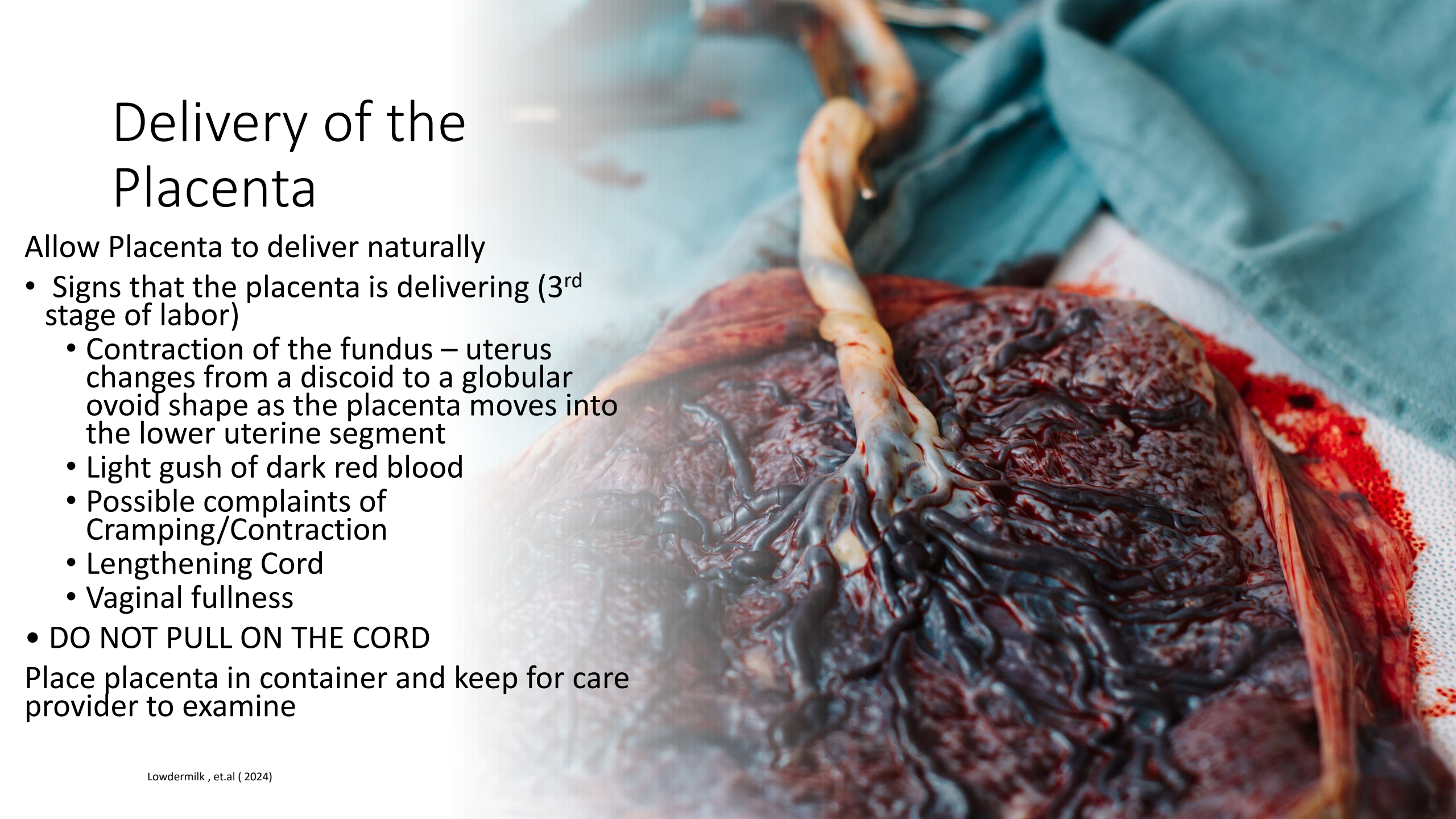
Delivery of the Placenta

Delivery of the Placenta

Allow Placenta to deliver naturally

- Signs that the placenta is delivering (3rd 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



Lowdermilk , et.al (2024)

Medication Guidelines

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

Prophylaxis	Treatment
Oxytocin infusion: ▸ Oxytocin 10-30 units in 500 mL or 20-60 units in 1000 mL controlled infusion with a standardized rate 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) **OR** ***Oxytocin bolus:*** ▸ 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) **OR** ***Oxytocin IM:*** ▸ Oxytocin 10 units IM when no IV access	*Administer first-line agent:* ▸ 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 • Avoid high doses of oxytocin infusion greater than 30-40 units/hour • Closely monitor maternal heart rate (using pulse oximeter) and blood pressure when delivering higher-rate oxytocin infusions or boluses for active hemorrhage ▸ 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

CMQCC Toolkit (2022) pgs. 115-116

Medication Guidelines Continued

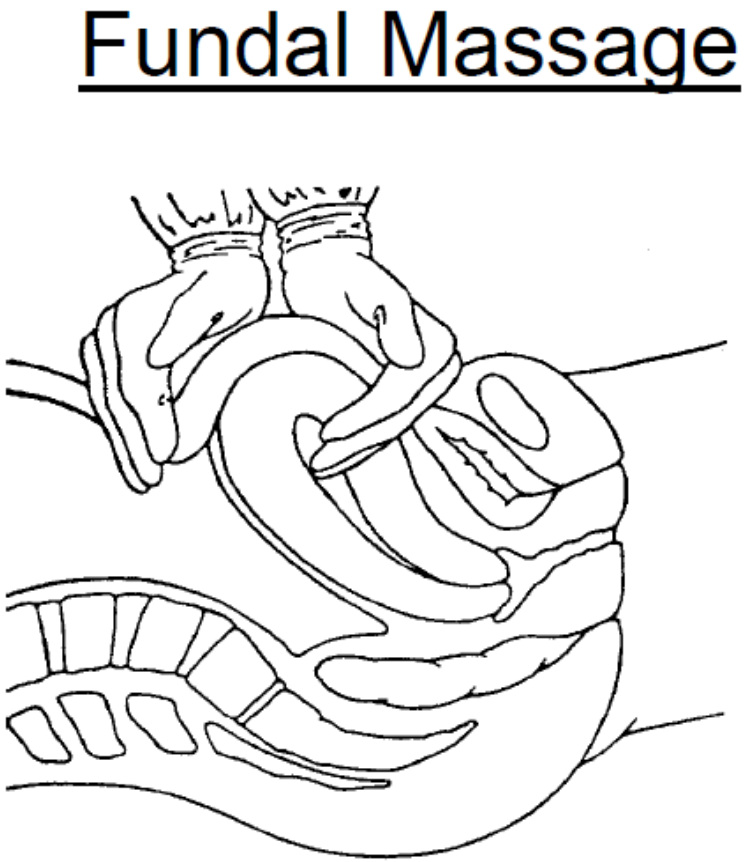
	Choose a standard second-line agent: ▸ Methylergonovine 0.2 mg IM ***or*** ▸ Carboprost 250 mcg IM **Consider misoprostol only for patients with asthma and hypertension (misoprostol is no longer recommended otherwise due to high rates of side effects and inconsistent efficacy)** ▸ Misoprostol 600 mcg orally or 800 mcg sublingually (*Rectal administration is no longer recommended due to the late onset of action*)
	Unresponsive to uterotonics: ▸ 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 ▸ 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

Improving Health Care Response to Obstetric Hemorrhage, a CMQCC Quality Improvement Toolkit, 2022

CMQCC Toolkit (2022) pgs. 115-116

Fundal Assessment and Massage

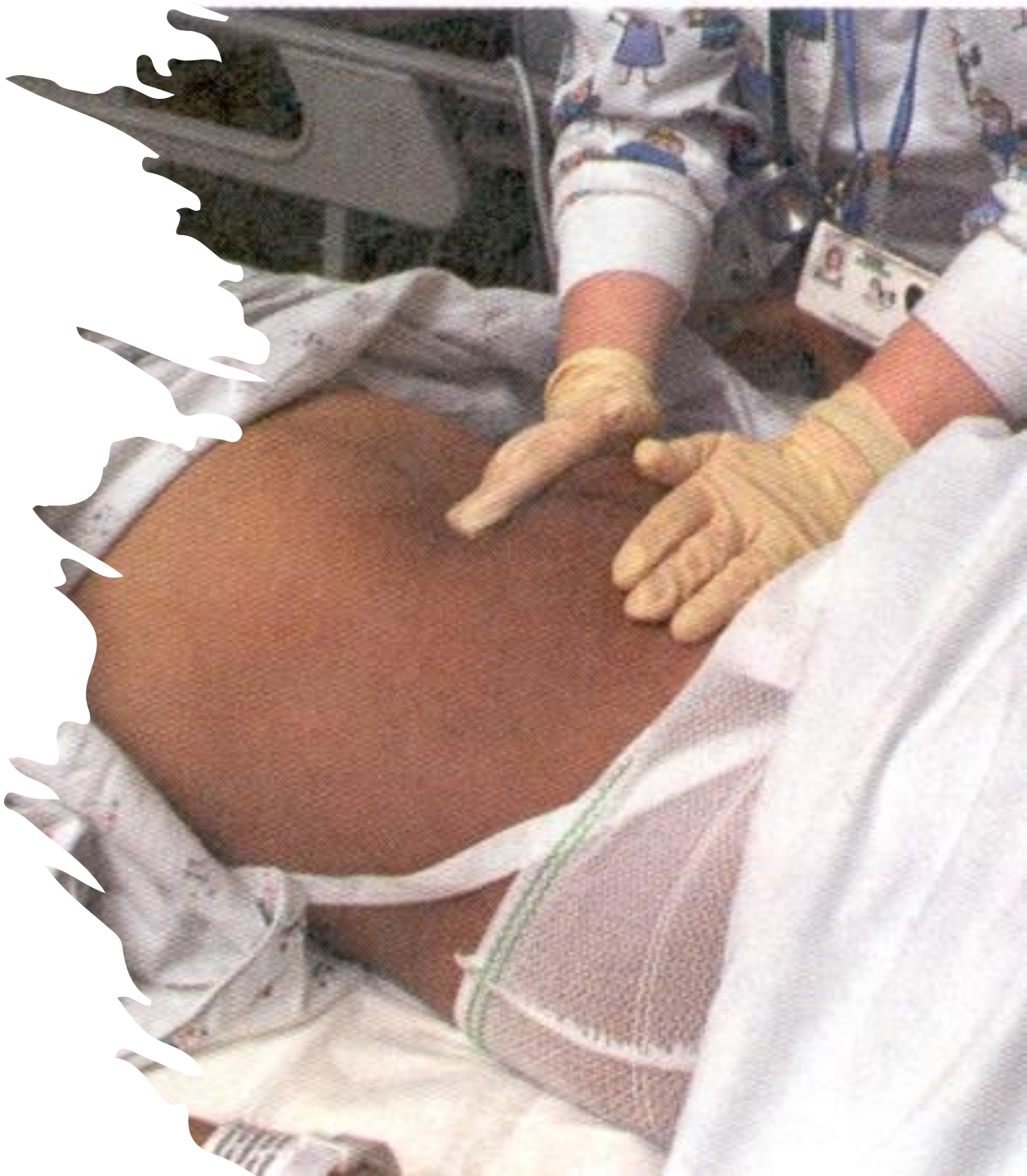
- Once the placenta is delivered and at least every 15 minutes for the first 2 hours perform fundal assessment and massage



Simpson, et.al (2021)

Fundal Assessment and Massage

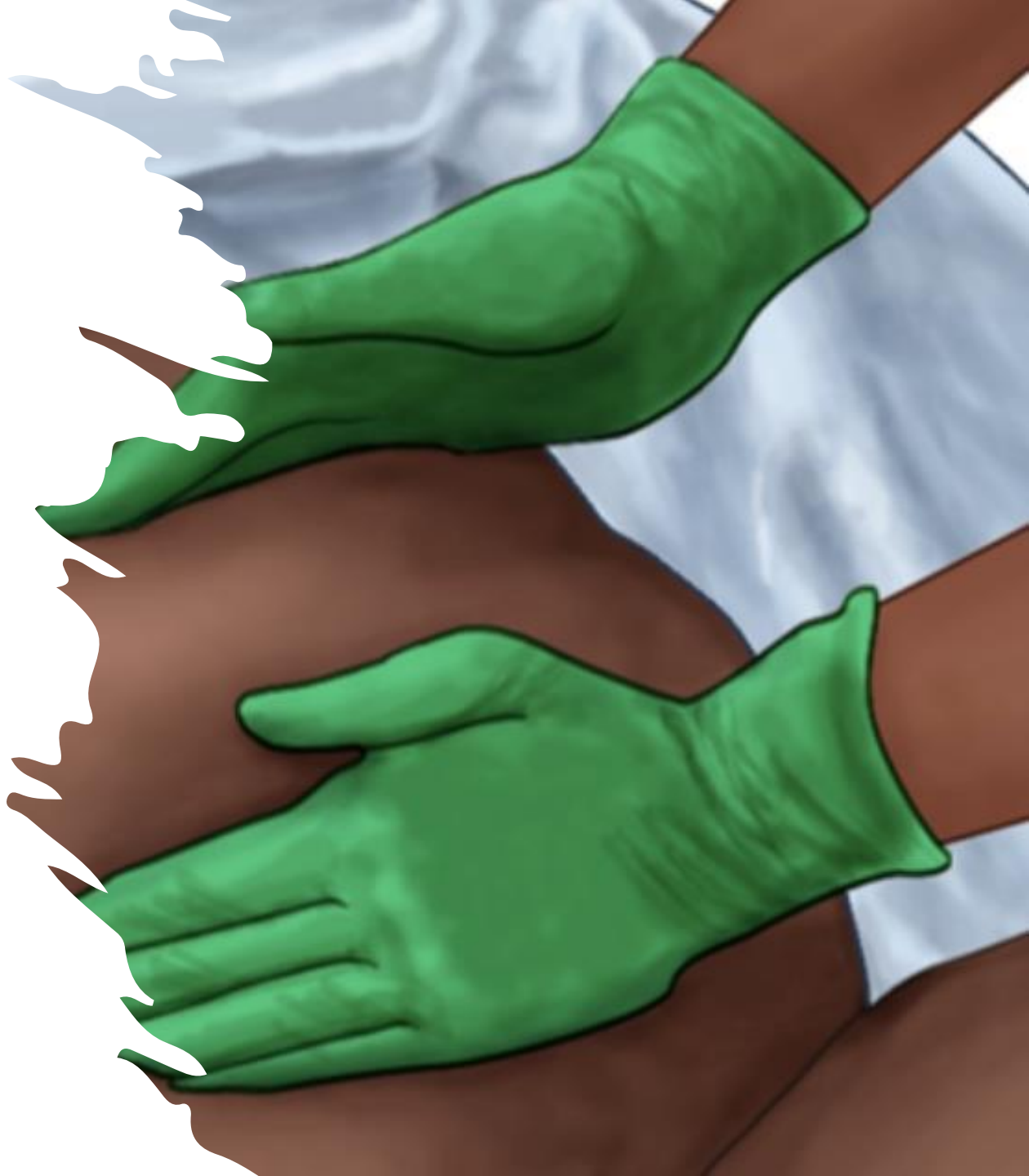
- Locate the Fundus w/Palm of the hand
- Cup the hand, place on lateral side of the hand slightly above fundus
- Place second hand above the symphysis pubis to support and stabilize the uterus during palpation
- Gently, but firmly, press into abdomen toward the spine and then slightly downward toward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



Simpson, et.al (2021)

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



Davidson, et.al (2020)

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