COCHISE REGIONAL HOSPITAL

OB / GYNE POLICIES & PROCEDURES
ADMISSION OF NEWBORN

PROTOCOL

• Routine newborn care shall be carried out in the mother’s room while rooming in or the Newborn Nursery.

• Identification bands will be placed on baby, mother and a person of her choice, in Labor, Delivery, Recovery, Postpartum (LDRP) or Operating Room. In the case of multiple births, each infant will have own identification bands indicating sequence of birth (A or B etc.)

• Notify Admitting Office of infant’s birth, including well, sick or low birth weight status.

• Notify pediatrician/pediatrician’s office of infant’s birth and status (If notifying office staff, make notation of staff member’s name).

• The pediatrician shall examine well newborns within 24 hours after birth, within 24 hours prior to discharge and as indicated by the infant’s condition.

• Obtain Vital signs and Apgar scores.

• Obtain measurements and footprints.

• Weigh infant and record on Newborn admit record and nursery flow record.

• Complete the gestational age assessment and plot findings as AGA, SGA or LGA.

• Perform head to toe assessment and document on admission record.

• Give vitamin K injection 1.0 mg (0.5 mg if with is less than 1500 grams - 3 lb 5 oz) intramuscularly to anterior thigh, within one hour of birth.

• Administer Hepatitis B vaccine prior to discharge. Follow orders for the newborn born to a woman positive or unknown Hepatitis B surface antigen status.

• Instill ophthalmic antibiotic ointment into each eye within one hour of birth (first allow for bonding with parents)

• Assist mother to initiate breast or formula feeding within the first hour, if possible.
• Prior to feeding, assess for airway patency, including cleft lip and palate, and mother’s readiness to hold and feed newborn.

• Bathe infant if VS are stable and temperature is greater or equal to 98 degrees F.

• Keep newborn under radiant warmer with servo control or skin-to-skin for thermoregulation.

• Attach security bracelet transmitter and enter baby into Security System.

• Take newborn to mother’s room in crib. Orient parents to baby crib supplies, safety and security measures.

**DOCUMENTATION**

• Document all findings and report abnormal findings to physician.

• Document infant’s response to care and procedures in nurse’s notes.

• Documentation of parent refusal of Vitamin K, ophthalmic ointment, Hepatitis B vaccine and / or genetic screening will be noted in the medical record and the physician notified.

• Record newborn data in Nursery Log Book

• For preterm or sick newborns, refer to the Levels of Care protocol.

**REFERENCE**

**APGAR SCORE**

**PURPOSE**  Apgar scores will be performed on all newborns

**AFFECTED PARTIES**  Newborns, nursing and medical staff

**POLICY**

1. The Apgar score provides a rapid reporting of the status of the newborn and response to resuscitation.
2. The pediatrician will be notified as soon as possible of any Apgar score of less than or equal to 6 at five minutes.

<table>
<thead>
<tr>
<th>Sign</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Rate</td>
<td>Absent</td>
<td>Below 100</td>
<td>Over 100</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Absent</td>
<td>Weak cry, Hypoventilation</td>
<td>Good, crying</td>
</tr>
<tr>
<td>Effort</td>
<td>Limp</td>
<td>Some flexion</td>
<td>Active motion</td>
</tr>
<tr>
<td>Muscle Tone</td>
<td>No response</td>
<td>Grimace</td>
<td>Cry or active withdrawal</td>
</tr>
<tr>
<td>Reflex Irritability</td>
<td>Blue or pale</td>
<td>Acrocyanotic</td>
<td>Completely pink</td>
</tr>
</tbody>
</table>

**PROCEDURE**

1. A score of 0 to 2 is assigned to each item. The Apgar score is comprised from the total.
   1.1. A total score of 0 to 2 represents severe distress.
   1.2. A total score of 3 to 6 signifies moderate difficulty.
   1.3. A total score of 7 to 10 indicates absence of stress or only the mildest difficulty.

2. Evaluations are completed at one and five minutes after delivery of the entire body.

3. If a score of 7 or less is assigned at five minutes, evaluations are repeated every five minutes until the score is equal to or greater than 7 or until 20 minutes after the birth.

**DOCUMENTATION**

Apgar scores are documented on the Newborn Admission form and the Delivery Summary Record.

**REFERENCE**

DELIVERY NURSE PRIMARY VAGINAL DELIVERY

PURPOSE To provide safe care for birthing mothers and their support persons according to their birth plans, individual beliefs, values, culture, maternal-fetal condition, and stage of labor.

AFFECTED PARTIES The Pregnant patient, her fetus/newborn, Nursing and Medical staff.

POLICY All vaginal deliveries will have a primary Registered Nurse (RN) present. The RN will be experienced in labor and delivery to provide a clean and safe environment for the mother and immediate care of the newborn.

EQUIPMENT

1. Delivery table
2. Infant warmer equipped with necessary resuscitative supplies and medications.
3. One liter warmed water
4. Betadine solution
5. 2% Lidocaine
6. LR 1000ml 20 or 30 mU pitocin, as per physician
7. Sutures specific to physician
8. Stool for physician
9. Step stool
10. PPE (Personal Protective Equipment)

PROCEDURE

11. Prepares equipment maintaining aseptic techniques

12. Ensures second person is available for newborn at delivery

13. Assists during delivery

   13.1. Removes foot of labor bed and positions patient in lithotomy position

   13.2. Pours saline/betadine mixture in appropriate basins on delivery table

   13.3. Pours lidocaine in labeled medicine cup on delivery table

   13.4. Positions family members for safe location

   13.5. Has pitocin readily available for use after delivery

14. Receives newborn at delivery on mom’s abdomen (if fetal status allows), and dries/stimulates newborn

15. Provides newborn resuscitation if indicated with the assist of nursery personnel
16. Bands newborn, mother and father or significant person after delivery

17. Ensures infusion of pitocin bolus after delivery of placenta

18. Assists physician with perineum repair

19. **Support breastfeeding initiation as soon as possible — within 30 minutes of birth.**

20. After Delivery
   20.1. Places peripad on patient and replaces foot of bed
   20.2. Provide patient with warm blankets
   20.3. Dispose of needles in appropriate sharps container
   20.4. Labels all specimens
   20.5. Removes dirty equipment and used supplies from room in appropriate red bags

21. Transfer patient to recovery status
   21.1. Place ice on perineum and medicate as needed/ordered
       21.2.1.1. Assess fundal height, uterine tone, amount of bleeding, and blood pressure every 15 minutes for one hour, every 30 minutes for the second hour.

22. Promote newborn/maternal/family bonding.

23. Complete birth documentation and charges.

**REFERENCES:**

GBBS DISEASE, MATERNAL & NEWBORN

PURPOSE  To treat intrapartum women at risk for carrying Group Beta Streptococcus (GBS) or those who are positive for GBS in order to reduce transmission of the organism to the newborn using current CDC guidelines.

AFFECTED PARTIES

POLICY

1. Prenatal screening for vaginal/rectal GBS colonization is recommended for all pregnant women at 35-37 weeks gestation.

2. Nursing will obtain a vaginal/rectal culture for GBS at 35-37 weeks without prenatal care or anyone in labor.

3. Women in labor with unknown or positive GBS cultures will receive antibiotic therapy according to the CDC GBS algorithm

4. Intrapartum antibiotic prophylaxis (IAP) is recommended for:
   4.1. Women who delivered a previous infant with GBS disease
   4.2. Women with GBS bacteriuria in the current pregnancy
   4.3. Women with a GBS-positive screening result in the current pregnancy
   4.4. Women with unknown GBS status who deliver at less than 37 weeks’ gestation, have an intrapartum temperature of 100.4°F or greater, or have rupture of membranes for 18 hours or longer.

5. Prophylactic antibiotics are not recommended for women with intact membranes undergoing cesarean section

6. Laboring women with unknown results will receive antibiotics according to risks factors:
   6.1. preterm labor (less than 37wks gestation),
   6.2. ROM greater than 18hrs,
   6.3. or temp greater than or equal to 100.4F).

7. Antibiotic therapy is not recommended for those women with a negative GBS culture during the current pregnancy despite a history of a positive GBS culture with a prior pregnancy UNLESS the prior pregnancy resulted in the delivery of an infant that became ill with GBS sepsis.

8. Penicillin remains the preferred agent with ampicillin an acceptable alternative.
PROCEDURE

9. Obtain vaginal/rectal culture for GBS colonization for women without prenatal care presenting to the maternal/child unit prior to the vaginal exam.

10. If patient not in labor, attempt to obtain culture prior to vaginal exam.

11. Give prophylactic treatment per physician’s orders for positive or unknown culture results (see chart below for CDC Recommendation).

<table>
<thead>
<tr>
<th>Reason</th>
<th>Medication</th>
<th>Load Dose</th>
<th>Maintenance</th>
<th>Interval of Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>No PCN allergy</td>
<td>Penicillin</td>
<td>5 Million Units IV</td>
<td>3.0 Million Units IV</td>
<td>Every 4 hours while in labor</td>
</tr>
<tr>
<td>No PCN allergy (If PCN unavailable)</td>
<td>Ampicillin</td>
<td>2 Grams IV</td>
<td>1 Gram IV</td>
<td>Every 4 hours while in labor</td>
</tr>
<tr>
<td>Allergy to PCN with low risk for</td>
<td>Cefazolin</td>
<td>2 Grams IV</td>
<td>1 Gram IV</td>
<td>Every 8 hours while in labor</td>
</tr>
<tr>
<td>Allergy to PCN with High risk for anaphylaxis and documented culture sensitivity to both clindamycin and erythromycin</td>
<td>Clindamycin</td>
<td>900 mg IV</td>
<td>900 mg</td>
<td>Every 8 hours while in labor</td>
</tr>
<tr>
<td>+GBBS with known resistance to Clindamycin and Erythromycin</td>
<td>Vancomycin</td>
<td>1 Gram IV</td>
<td>1 Gram IV</td>
<td>Every 12 hours while in labor</td>
</tr>
</tbody>
</table>


13. Report to nursery
   13.1. Maternal risk factors,
   13.2. Time antibiotic therapy was initiated
   13.3. Number of antibiotic doses administered during labor.

14. Care of the Neonate will follow CDC recommendations. See algorithm below.

**Neonatal Management Algorithm**

Figure 4. Sample algorithm for management of a newborn whose mother received intrapartum antimicrobial agents for prevention of early-onset group B streptococcal disease* or suspected
chorioamnionitis. This algorithm is not an exclusive course of management. Variations that incorporate individual circumstances or institutional preferences may be appropriate.

Maternal IAP For GBS?

- Yes

  Signs of neonatal sepsis?

  - Yes
    
    Full diagnostic evaluation†
    
    Empiric therapy*
  
  - No

  Gestational age < 35 weeks?

  - Yes
    
    Limited evaluation⁻
    
    Observe ≥48 hours
    
    If sepsis is suspected, full diagnostic evaluation and empiric therapy⁷
  
  - No

  Duration of IAP before Delivery <4 hrs?

  - Yes
    
    No evaluation
    
    No therapy
    
    Observe ≥48 hours⁺
  
  - No

*If no maternal intrapartum prophylaxis for GBS was administered despite an indication being present, data are insufficient on which to recommend a single management strategy.

†Includes complete blood cell count and differential, blood culture, and chest radiograph if respiratory abnormalities are present. When signs of sepsis are present, a lumbar puncture, if feasible, should be performed.

‡Duration of therapy varies depending on results of blood culture, cerebrospinal fluid findings, if obtained, and the clinical course of the infant. If laboratory results and clinical course do not indicate bacterial infection, duration may be as short as 48 hours.⁺⁺CBC with differential and blood culture. ••Applies only to penicillin, ampicillin, or cefazolin and assumes recommended dosing regimens (Box 2)

¶A healthy-appearing infant who was ≥ 38 weeks’ gestation at delivery and whose mother received ≥ 4 hours of intrapartum prophylaxis before delivery may be discharged home after 24 hours if other discharge criteria have been met and a person able to comply fully with instructions for home observation will be present. If any one of these conditions is not met, the infant should be observed in the hospital for at least 48 hours and until criteria for discharge is achieved.
REFERENCES:

CDC - GBS Prevention Guidelines Algorithms and Tables - Group B Strep Hospitals and Healthcare Providers
http://www.cdc.gov/groupbstrep/guidelines/algorithms-tables.html
GLUCOSE MONITORING

PURPOSE    To provide guidelines to identify and/or treat the Late Preterm and Term newborn with hypoglycemia.

Definitions:
Normal blood glucose (WNL) less than 24 hours of age = greater than 40mg/dl
Normal blood glucose (WNL) greater than 24 hours of age = greater than 45mg/dl

AFFECTED PARTIES    Newborns meeting one or more of the following criteria will be screened.

1. At-Risk Newborns:
   1.1. Late Preterm newborns (34-36 6/7 weeks of gestation)
   1.2. Small for gestational age (SGA)
   1.3. Large for gestational age (LGA)
   1.4. Intrauterine growth restriction (IUGR)
   1.5. Infants born to a diabetic mother (pre-gestational or gestational)

2. Symptomatic Newborns:
   2.1. Jitteriness, tremors, irritability
   2.2. Hypotonia, lethargy, stupor
   2.3. Poor suck or poor feeding
   2.4. Exaggerated Moro reflex
   2.5. High-pitched cry
   2.6. Seizures
   2.7. Apnea, cyanosis
   2.8. Temperature instability

PROCEDURE:

3. To prevent hypoglycemia in all newborns, the nurse will:
   3.1. Encourage early (within the first hour) feeds via breast or formula feeding
   3.2. Maintain/establish normothermoregulation
   3.3. Identify at risk newborns – review maternal history
   3.4. Initiate AT RISK screening protocol (after birth)

4. At-risk newborns will have an initial glucose screen within one hour of age, preferable after a feeding

5. A second screen will be performed prior to the second feeding or by two hours of age.

6. If these two values are WNL and the newborn is asymptomatic, screening may be discontinued

7. If the blood sugar is between 25-40mg/dl on either test, the nurse will:
7.1. Verify the low value with a stat laboratory glucose
7.2. Provide feeding by breast milk or formula
7.3. Recheck glucose value in one hour after the feeding
7.4. Notify the provider if the repeat glucose remains less than 40mg/dl

8. Obtain specific IV fluid and blood sugar orders from the provider for low blood sugars not responding to feedings.
   8.1. IV glucose dose = Dextrose 10% (bolus at 2ml/kg over 1ml/min) and/or IV infusion at 80-100ml/kg/day).
   8.2. Achieve plasma glucose level of 40-50mg/dl.
   8.3. Obtain hourly glucose values until WNL x2.
   8.4. Obtain specific glucose orders from provider for continuous IV fluid therapy and for weaning IV fluids rates.

9. Identify signs of hypoglycemia (at any time) Initiate SYMPTOMATIC screening protocol.
   9.1.1. Obtain blood glucose
   9.1.1.1. If initial glucose value is WNL, discontinue screening protocol.
   9.1.2. Notify provider if symptoms persist
   9.1.3. Confirm with lab glucose if the initial glucose is low.
   9.1.4. Feed the newborn by breast or bottle if in no distress
   9.1.5. Report a poor suck or mild tachypnea (respiratory rate of 60-80 per minute). The provider may order gavage feedings of breastmilk and/or formula (2-5 ml/kg) to correct hypoglycemia
   9.1.6. Repeat glucose 30 minutes after feeding.
   9.1.6.1. If repeat glucose is WNL, repeat glucose prior to feeds until WNL X2.
   9.1.7. If glucose value is less than WNL after feeding, notify provider for IV fluid orders
   9.1.8. Keep NPO in the presence of tachypnea (respiratory rate >80/min),

10. Obtain specific IV fluid and blood sugar orders from the provider for low blood sugars not responding to feedings or NPO status
    10.1. IV glucose dose = Dextrose 10% (bolus at 2ml/kg over 1ml/min) and/or IV infusion at 80-100ml/kg/day).
    10.2. Achieve plasma glucose level of at least 40-50mg/dl.
    10.3. Obtain hourly glucose values until WNL x2.
    10.4. Obtain specific glucose orders from provider for continuous IV fluid therapy and for weaning IV fluids rates.
REFERENCES:

Adamkin, DH. Committee on Fetus and Newborn, Postnatal glucose homeostasis in late-preterm and term infants. *Pediatrics.* 2011; 127; 575-579

NEWBORN ASSESSMENT

PURPOSE  To complete and record appropriate assessments in order to document physical health, determine gestational age, and evaluate any abnormalities.

AFFECTED PARTIES  The newborn, parents, nursing and medical staff.

PROCEDURE

1. Care at Birth
   1.1. Assemble and check newborn resuscitation supplies and equipment.
   1.2. Review the mother’s admission history and labor course for any risk factors.
   1.3. Dry and stimulate the newborn immediately after birth on the mother’s chest or under the radiant warmer as indicated.
   1.4. Follow NRP guidelines for stabilization of the newborn.
   1.5. Promote newborn thermoregulation with skin-to-skin contact.
   1.6. Determine the infant’s Apgar score at 1 and 5 minutes of age.
   1.7. Obtain an axillary temperature, apical heart rate, and respiratory rate.
      1.7.1. Obtain a pulse oximeter reading if:
               1.7.1.1. oxygen has been administered
               1.7.1.2. respiratory complications are noted
               1.7.1.3. or per physician order.
   1.8. Weigh and measure the newborn’s length and head circumference.
   1.9. Obtain footprints and complete newborn identification form
   1.10. Apply identification bands before the mother and infant are separated.
   1.11. Allow the newborn to remain with the mother continuously, unless the infant’s clinical condition requires transfer to Level II nursery.
   1.12. The physician will be notified immediately for life-threatening conditions.

2. Transition Period. Begins after immediate stabilization and lasts until the newborn is stable for at least 2 hours. Notify physician for abnormal findings.
   2.1. Every 30 minutes, assess and document:
      2.1.1. Axillary temperature
      2.1.2. Apical heart rate
      2.1.3. Type of respiration and rate
      2.1.4. Skin color and peripheral circulation
      2.1.5. Activity level and level of consciousness
      2.1.6. Tone

   2.2. Assist the mother in breastfeeding without time limits
      2.2.1. Assist with positioning, latch and comfort measures
      2.2.2. Assess infant suck, swallow and breathing synchrony

   2.3. If the mother chooses to bottle-feed the infant, limit the first feeding to 5–15 ml.
2.3.1. Gradually increase formula feeding volume intake
2.3.2. Education the parents regarding the benefits of breastfeeding.

3. **Before the end of Transition**
   3.1. Administer eye prophylaxis and Vitamin K within 60 minutes of birth.
   3.2. Obtain a blood glucose level if indicated, per newborn hypoglycemia policy.
   3.3. Send cord blood sample to the laboratory for blood type and Rh if the mother’s blood type is O or Rh negative.
   3.4. Complete a full system assessment, including cardiovascular, respiratory, HEENT, neurological, genitourinary, gastrointestinal, musculoskeletal, and integumentary systems.
   3.5. Plot gestational age, weight, length, and head circumference on growth chart.
   3.6. Complete a gestational age assessment.
   3.7. Determine presence of anomalies or previously unsuspected diseases.
   3.8. Notify newborn’s health-care provider of birth, assessment, presence of risk factors, and current condition. These deviations include but are not limited to:
      3.8.1.1. Abnormal vital signs
      3.8.1.2. Cyanosis
      3.8.1.3. Jaundice and bilirubin levels greater than the 90th percentile
      3.8.1.4. Presence of birth defects or injury
      3.8.1.5. Jitteriness, lethargy, or excessive sleeping/lack of feeding
      3.8.1.6. Abdominal distention or bilious vomiting
      3.8.1.7. Lack of meconium stool passage within 24 hours after birth
      3.8.1.8. Lack of voiding within 24 hours after birth
   3.9. Bathe once temperature has stabilized, and as needed during hospital stay.

4. Attach security device and inform parents of locked unit
5. Obtain newborn photographs after obtaining parental consent.
6. **Ongoing Care.** Newborn should room in unless clinical condition warrants transfer to NICU, or mother requests nursery care.
   6.1. Assess temperature, pulse, and respirations at least every 4 hours.
   6.2. Assess color, respiratory effort, cardiac, nutritional intake, urinary and bowel elimination, and neuromuscular status at least every 4 hours.
   6.3. Any newborn with a persistent respiratory rate greater than 60, grunting, retracting, and/or with questionable color may be further assessed with oximetry.
      4.3.1 Hold oral feeding for newborns with a respiratory rate greater than 60 breaths per minute, while intervening to correct the tachypnea.
      4.3.2 Notify the physician
   6.4. The RN will complete a full system assessment once per every 12–hour shift.
   6.5. Weigh daily. Notify physician if weight is 10% less than birth weight.
   6.6. Administer hepatitis vaccine and HBIG as indicated in newborn orders
      6.6.1. Obtain signature on Vaccine Information Sheet prior to Hep B administration.
   6.7. Encourage and assist mothers to breastfeed on demand, or at least every 3 hours.
6.8. If the infant is formula-fed, feed on demand or at least every 3-4 hours, gradually increasing amounts as indicated by newborn hunger and satiation cues.

6.9. Keep umbilical cord stump clean and dry. Fold down the top of the diaper as needed to avoid irritation.

6.10. Assess and initiate discharge teaching plan and needs.

7. **Physician exam**

7.1. The physician will examine the well newborn within 24 hours of birth and then daily

REFERENCES: