

**WASHINGTON ADVENTIST HOSPITAL  
WOMEN'S SERVICES  
LABOR AND DELIVERY  
COLLABORATIVE PRACTICE STANDARDS**

Effective Date: 5/79

Comments:

Reviewed: 7/92, 12/02

Revised: 5/79, 5/83, 4/89, 5/95, 12/95, 1/02, 6/04, 4/13

Policy: WWD 9502

Origin: L&D

Approved: 1/03

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**Admission and Care of the Patient on Labor and Delivery**

**SCOPE:** This policy applies to the Labor and Delivery Unit

**I. PURPOSE:**

To establish guidelines and criteria for the admission and care of patients admitted to the Labor and Delivery unit

**II. POLICY:**

- A. Patient will be admitted or placed in observation to the Labor and Delivery after either a triage evaluation or orders for direct admission are obtained.
- B. All patients admitted or placed in observation to the Labor and Delivery Unit have an initial assessment including but not limited to:
  1. Obstetrical History
  2. Medical History
  3. Social risk factors
  4. Fetal status
  5. Labor status including
    - a. Sterile vaginal exam
    - b. Contraction pattern
    - c. Membrane status
- C. All patients will be under the direct care of their primary LIP or the covering LIP. If a patient presents without having a LIP on staff the covering LIP will care for the patient.
- D. A patient may be kept in observation status for up to 72 hours without being admitted. The standard of care for observation patients is the same as those defined for the admitted patient.
- E. All patients <32 weeks or with high risk conditions require a maternal fetal medicine and Pediatric/Neonatology consult.
- F. On-going Maternal vital sign assessment will be done every 4 hours or sooner if patient status indicates (temperature will be assessed every 2 hours after rupture of membranes).
- G. On-going fetal assessment for low risk patients will include the following:
  1. Fetal heart rate will be evaluated and documented every 30 min during the active phase of the first stage of labor
  2. Fetal heart rate will be evaluated and documented every 15 min during the active pushing phase of the second stage of labor.
- H. On-going fetal assessment for high risk patients and patients receiving Pitocin for induction or augmentation of labor will include the following:
  1. Fetal heart rate will be evaluated and documented every 15 min during the active phase of the first stage of labor
  2. Fetal heart rate will be evaluated and documented every 5 min during the active pushing phase of the second stage of labor
- I. On-going uterine assessment should be done each time the fetal heart is assessed

**III. BY WHOM:**

A Registered Nurse with training and experience in Obstetrics.

**IV. PROCEDURE:**

- A. Patient registration will be notified once it has been established that the patient will be admitted or placed in observation status.

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- B. Admission orders will be written by the LIP caring for the patient.
- C. Prenatal records will be obtained.
- D. The patient will be assisted to a Labor room and instructed to remove all jewelry.
- E. Patient will be placed on the Electronic Fetal Monitor per LIP orders.
- F. An admission assessment will be completed.
- G. Procedure and plan of care will be discussed with patient by LIP and patient will sign consent form for procedure.
- H. Blood work will be drawn according to the orders, and IV will be started if ordered.
- I. Continue with ongoing assessment

**REFERENCE:**

AAP/ACOG 2012. Guidelines for Perinatal Care. 7<sup>th</sup> Ed.

AWHONN: Fetal Heart Monitoring Principles & Practices. 4<sup>th</sup> Ed.

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POLICY AND PROCEDURE**

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**Admission and Newborn Care: Regular Nursery**

**I. PURPOSE**

1. To provide standards of care for well newborns transitioning from the delivery room to regular nursery
2. To provide guidelines(a) to recognize high risk conditions, (b) to report infant's condition to physician and (c) to develop a nursing plan of care
3. To provide standards for reassessing infants and implementing nursing plans of care

**II. POLICY**

**A. ADMISSION**

1. Well newborns should be transferred from Labor and Delivery (L&D) to Regular Nursery within 2 hours of birth. The nursery will be notified prior to transfer.
2. L&D staff bringing infant to the nursery
  - a. Identifies newborn per Infant Identification and Safety Collaborative Practice Standard (CPS).
  - b. Reports information including prenatal history and labs (maternal HIV, RPR, HB<sub>s</sub>Ag and GBS status), delivery events, and pertinent maternal and familial history
  - c. Provides copies of computerized Current Admission Record, Admission Record, LD-Infant Transfer Chart, and Delivery Summary
  - d. Obtains official birth weight and length from nursery staff
3. All infants will be weighed and measured on admission to the nursery and placed under radiant warmer at neutral thermal environment.
4. Admission measurements will be the official birth weight and length
5. Nursery staff
  - a. Initiates care and treatment per Admission to Regular Nursery CPS
  - a. Completes Admission Assessment-Newborn within 6 hours of life
  - b. Monitors blood glucose per Infant Blood Sugar Monitoring CPS
  - c. Maintains infant in a neutral thermal environment until placed into open crib
  - d. Administers eye prophylaxis within 2 hours of admission to nursery
  - e. Administers Vitamin K within 1 hour of admission to nursery. If mother is HB<sub>s</sub>Ag or HIV positive Vitamin K is given after bathing or thoroughly washing area of inoculation
  - f. Administers HBIG within 12 hours of birth to (a) HB<sub>s</sub>Ag positive mothers or (b) mothers with no prenatal care
  - g. Obtains results of prenatal labs if not available at delivery
  - h. Notifies Pediatrician or representative within 2 hours of admission to nursery, except for staff infants admitted between 10 pm and 8 am and selected pediatricians who request otherwise. The staff pediatrician will be notified by 8 am the following morning, and selected pediatricians will request in writing when they would like to be notified. The date, time, physician name, office or answering service is notified is documented on admission orders.

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**Admission and Newborn Care: Regular Nursery**

Documents verbal and telephone admission orders per hospital policy.

Notifies Pediatrician or representative of any change in condition felt to be significant including conditions requiring additional observation in the nursery.

Enters birth information into Admission Log

6. If the health care provider (HCP) determines there is a cardio-respiratory emergency, a Code Blue-Infant will be called and the pediatrician notified

7. All newborns will be examined by a physician within 24 hours of birth

8. Admission orders will be noted or given as telephone or verbal orders within 24 hours of admission

9. All newborns will have a Type and Coombs test on cord blood (or heelstick if not available) if mother is blood group O or Rh negative

10. Nursery staff may order a bilirubin test x1 if infant appears jaundiced. The results will be reported to the Pediatrician

11. Referrals/consults will be initiated per Admission Assessment Screens

12. Blood work should be drawn per Group B Streptococci – Infant CPS

13. All lab work and consultations ordered should be noted in red ink by order number (lab work) or date (consultation) on the physicians order sheet

14. Universal precautions will be observed when caring for infants

**B. CONTINUING CARE**

1. Infants will be weighed daily in grams and pounds (see WWS 9158)

2. Record all stools and voids

3. Infants will be assessed at regular intervals and assessments documented, dated and timed on the "Daily Flowsheet: Regular Newborn" (Form #650-132) and associated Nursing Notes

4. Assessments and daily care performed in the mother's room

5. Nursing staff will assist mother in selecting a follow up Pediatrician as needed

6. Nursing staff will follow up on referrals/consults initiated by the Admission Assessment Screens

7. All newborns will have a Newborn Metabolic Screening Test and Hearing Screening Test prior to discharge unless signed refusal by parent or unanticipated technical problems

8. All infants will have identification matched with mother's/significant other's band # per Infant Identification and Safety CPS

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**Admission and Newborn Care: Regular Nursery**

**III. PROCEDURE**

**A. ADMISSION**

**1. EQUIPMENT AND SUPPLIES**

- a. Radiant warmer or isolette
- b. Oxygen and suction source and setup
- c. Stethoscope
- d. Thermometer with probe cover
- e. Measuring tape
- f. Baby Scale
- g. Bulb syringe
- h. Accuchek
- i. Tenderfoot
- j. Alcohol wipes
- k. 2x2 gauze
- l. Band-aids
- m. Tuberculin syringe
- n. Eye prophylaxis (per physician order)
- o. Vitamin K (see physician order)

2. Verify infant's identity and identification bracelets with the L&D nurse per Infant Identification and Safety CPS. Verify ID band of significant other, if present
3. Weigh (grams and pounds) and measure (centimeter and inches) and record in Physical Assessment – Newborn
4. Nursery RN will sign Newborn Identification Sheet with L&D RN.
5. Place nude infant in bassinet under radiant warmer set on servo control at 36.5°C - 37°C
  - a. Remove excess vernix in RLQ abdomen with alcohol wipe to allow probe to adhere
  - b. Attach temperature probe
6. Receive report from L&D nurse including prenatal history and labs, delivery events, and pertinent maternal and familial history. Document in Admission Assessment – Newborn
7. Obtain and record vital signs (temperature, pulse, respiration) on admission, then every 30 – 60 minutes under radiant warmer, then one hour after placed in open crib. If within normal limits every 8 hours thereafter per physician order.

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**Admission and Newborn Care: Regular Nursery**

8. Vital Signs should be taken every 4 hours times 24 hours if mother is GBS positive, heart murmur present, prolonged rupture of membranes greater than 18 hours, maternal temperature, intrauterine growth retardation or other risk factors per MD order
  - a. Normal values:
    - i. Apical pulse for one minute = 95 -160 bpm, regular, no murmur
    - ii. Breath sounds = 30-60 per minute, clear, symmetric, no flaring or grunting or retractions after 2 hours of age
    - iii. Axillary temperature = 36.5°C – 37.4°C (97.5° - 99°F)
  - b. Notify physician :
    - i. Temperature less than 97.5°F times 2 or greater than 99°F time 2 after 2 hours
    - ii. Heart Rate less than 95 bpm or greater than 160 bpm times 2
    - iii. Respiration greater than 100, or greater than 70 after 8 hours, or apnea greater than 15 seconds, or grunting, flaring or retractions after 2 hours of age
    - iv. Central cyanosis, irregular heart beat, heart murmur
    - v. Abdominal distension, bilious vomiting
9. Remove excess secretions or mucous with bulb syringe. Perform CPT and oral/gastric suctioning (use #8 Fr suction catheter) if coarse breath sounds. Document actions and response
10. Perform blood glucose with Accucheck per Infant Blood Sugar Monitoring CPS
11. Administer eye prophylaxis per physician order over lower conjunctival sac. Dose should be given within 2 hours of birth. Give at least 15 minutes before bath, or just after bath. Document in MAK
12. Administer Vitamin K per physician order IM LMAT, if HB<sub>s</sub>Ag negative. If HB<sub>s</sub>Ag positive or no prenatal care, give Vitamin K after bath. Document in MAK
13. Complete Physical Assessment – Newborn
  - a. Measure head, chest and abdominal circumference in centimeters and inches
  - b. Assess gestational age. If infant appears premature (less than 37 weeks) perform Ballard exam
  - c. Exam SkinColor
    - i. Pallor – pale color
    - ii. Cyanosis – central associated with hypoxemia

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Acrocyanosis – normal

- iii. Dusky – associated with hypoxemia, anemia
- iv. Plethora, ruddy – associated with polycythemia
- v. Jaundice – associated with elevated bilirubin
- vi. Mottled – associated with hypovolemia, hypothermia, sepsis
- vii. Lesions, rashes, birthmarks
- viii. Describe size and location (nevi, Mongolian spots, café au lait)

d. Turgor, Edema – Describe (peeling, laceration, abrasion, ecchymosis)

e. Exam Nervous System

- i. State – Asleep, quiet awake, active, crying, irritable, jittery, lethargic
- ii. Tone (for gestational age) – Normal, hypotonic, hypertonic
- iii. Motor behavior – symmetric, asymmetric
- iv. Reflexes ( grasp, suck, rooting, Moro ) – normal, weak, absent, equal
- v. Cry – lusty, weak, shrill

f. Exam Head and Facies

- i. Check size and shape – large head, small head, sutures (overriding), anterior and posterior fontanelles (flat, soft, tense, bulging, open, closed, large, small).
- ii. Note caput, cephalhematoma, molding, abrasions, forceps marks, facial symmetry

g. Exam Eyes

- i. Check corneas for cloudiness, subconjunctival hemorrhage
- ii. Red reflex – Hold ophthalmoscope 6-8 inches from the eye. Use the +10 diopter lens. Normal newborn transmits a clear red color back to the observer. In dark skinned babies, retina may appear orange or gray

h. Exam Ears

- i. Check position (low set?), shape of pinnae.
- ii. Note any preauricular tags or sinuses. Note canal patency

i. Exam Nose for flaring and patency and septum. If respiratory distress, may check for choanal atresia by passing a soft NG tube through each nostril to confirm patency

j. Exam Mouth

- i. Check lip, gum, hard and soft palate (intact, Epstein pearls, cysts)
- ii. Check teeth, sucking reflex, size and position of tongue

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- k. Exam Neck for masses (goiter, cysts) and webbing
  - l. Exam Chest and Lungs
  - m. Observe respiratory pattern (regular, shallow, periodic, apnea) and chest movement (symmetric, retractions). Listen for grunting, stridor, and breath sounds (clear, equal, rales, wheezes)
  - n. Exam Cardiovascular System
    - i. Check capillary refill (should be less than 3 seconds)
    - ii. Check femoral pulses and describe (equal, strong, weak)
    - iii. Palpate PMI (should be on left side of chest) to rule out Dextrocardia
    - iv. Auscultate for rhythm (regular, irregular) and murmurs. If present do 4 extremity blood pressure. Upper and lower MAP should be less than 10 mm Hg difference. Systolic BP should be greater than 50 mm Hg and less than 80 mm Hg
  - o. Exam Abdomen
    - i. Note shape (soft, distended, scaphoid, loopy, tense)
    - ii. Auscultate bowel sound in 4 quadrants (present, absent)
    - iii. Examine umbilical cord (record number of vessels)
    - iv. Examine anus for patency. Rectal temperature if patency questioned
  - p. Exam Genitalia
    - i. Male genitalia: Palpate testes and note if both have descended
    - ii. Female genitalia: Inspect labia, clitoris, urethral opening and external vaginal area
    - iii. Ambiguous: Notify physician
  - q. Exam Skeletal System
    - i. Examine and count fingers and toes (e.g., Simean crease, polydactaly)
    - ii. Check clavicles (e.g., crepitus, equal startle reflex)
    - iii. Examine spine (curvature, dimples)
    - iv. Examine hips using Ortolani and Barlow maneuvers (e.g., clicks, symmetric gluteal folds)
14. Bathe when vital signs are normal and temperature 98°F or above
- a. Bathe quickly
  - b. No soap on face
  - c. Not necessary to remove all vernix
  - d. Place in open crib when temperature is at least 98°F axillary and infant is stable
  - e. Check temperature after one hour in open crib
  - f. Dress with hat and double blanket in open crib



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15. Notes admission orders and enters all laboratory tests and procedures ordered into computer
16. Transfer care (i.e., give report) to Mother/Baby RN once:
  - a. Heart rate 95 – 160
  - b. Respirations 30 – 70
  - c. Temperature 98 - 99 degrees
  - d. Blood sugar is greater than 45

**B. CONTINUING CARE (Mother Baby RN)**

1. Educate Mother on the following:
  - a. Check identification bracelet every time baby is separated from and reunited with mother
  - b. Give baby only to personnel with WAH identification with red stripe on badge
  - c. Transport baby in bassinet only, do not hand carry
  - d. Never leave baby unattended or alone on bed
  - e. Call nurse to take baby to nursery or bring baby to nursery (mother or significant other with armband only)
  - f. Wash hands prior to and after diaper changes
  - g. What to do if baby chokes or changes color and how to use bulb syringe
  - h. Keep track of voids, stools, feedings, and communicate to nurse for documentation
  - i. Feedings – how often, how long, how to burp
  - j. Back to sleep
  - k. Review admission package
  - l. Review visiting hours of unit
  - m. Review and have patient sign all permits
  - n. Advise need to select follow-up Pediatrician by discharge and document
  - o. Advise and refer if needs assistance with Medical Assistance
2. Wash hands, per Hand Hygiene CPS, prior to and after handling of each infant.
3. Verify a match with mother's and infant's identification bracelets, each time baby is separated from and reunited with baby, with a minimum of q shift if baby remains in mother's room, see Infant Identification and Safety CPS
4. Assess infant's vital signs (apical pulse, respirations, and temperature) as follows:
  - a. every eight hours.
  - b. every 4 hours if mother is GBS positive, heart murmur present, prolonged rupture of membranes greater than 18 hours, maternal temperature, intrauterine growth retardation, no prenatal care, or other risk factors per MD order.

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- c. See normal values and when to notify physician in number 6 of Procedures, above
- 5. Console and assess infant's needs when cries
- 6. Use NIPS pain scale before, during, after procedures (e.g., circumcision, IV, lumbar puncture)
- 7. Provide circumcision care, using vaseline with each diaper change. See Infant Circumcision policy WWS 9151
- 8. Assess infant for signs/symptoms of hypoglycemia, per Infant Blood Sugar Monitoring CPS
- 9. Assess infant for signs of jaundice
- 10. Assess and chart infant's intake and output
  - a. Notify physician:
    - i. If no void within 24 hours of life
    - ii. No bowel movement within first 24 hours of birth
    - iii. Green emesis
    - iv. Abdominal distension
    - v. Poor skin turgor
    - vi. Dry mucous membranes or sunken fontanel
    - vii. Poor feeding after 24 hours of birth
- 11. Assist with infant breastfeeding support (see Breastfeeding policy WWS 9007)
- 12. Assist with Formula Fed babies
- 13. Provide dry cord care. Keep cord dry
- 14. Weigh infant each night, and assess difference in weight from preceding night and birth weight ( See weighing policy-WWS 9158)
- 15. Bath every other night after birth
- 16. Assess for parent bonding
- 17. Assess for support systems
- 18. Order Social Work consult, per Social Work Guidelines CPS
- 19. Order Pastoral Care consult, as needed
- 20. Refer infants for possible adoption:
  - a. The Social Work Department will be notified at the time of the admission of the baby
  - b. An outside agency will be notified by the Social Work Department
  - c. Mother will not be denied seeing her baby or caring for her baby if she wishes to do so
  - d. See Adoption CPS

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**Admission and Newborn Care: Regular Nursery**

**IV. DOCUMENTATION**

- A. Document, signature, and date/time:
- B. Newborn Identification Form
  - 1. Newborn Admission-Nursing Assessment
  - 2. Daily Newborn Flowsheet
  - 3. Regular Newborn Nurses' Notes and consents
- C. Document and report all remarkable findings to Pediatrician.  
Document when MD notified of admission

**REFERENCES:**

American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, 6<sup>th</sup> Ed. 2006. Library of Congress

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