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A Complimentary Publication

2005 REVISED NEONATAL RESUSCITATION GUIDELINES

In every delivery there are 2 patients involved, the mother and the infant. Each needs at least one person that is primarily responsible for them, therefore every delivery needs to have a qualified person with the skills needed to complete neonatal resuscitation whose primary responsibility is the infant. Some facilities or providers have decided not to have NRP [neonatal resuscitation protocol] certified providers, but the standard of care is the same and providers are still held to the NRP certification guidelines. Appropriate equipment and supplies also need to be readily available and accessible. At a minimum this includes oxygen, appropriately sized bag and mask and suctioning equipment.



At birth a rapid assessment should be done to see if the neonate is full term, is breathing, crying and has good muscle tone and if the amniotic fluid is clear.

Ventilation is required if the neonate is not breathing or breathing ineffectively. This is usually done with a bag/valve mask and 100% oxygen. After 30 seconds of ventilation the heart rate is checked. If it is less than 60, chest compressions should be started. Resuscitation is continued until the heart rate is consistently greater than 100. If the heart rate is not consistently over 60 within 30 seconds of starting chest compressions, Epinephrine should be given down an endotracheal tube and IV fluids given through an umbilical vein catheter. The neonate is reassessed every 30 seconds for improving color, spontaneous breathing and increasing muscle tone.

If you need assistance to evaluate a case involving neonatal resuscitation, give us a call.

Source: American Academy of Pediatrics Neonatal Resuscitation Guidelines.

Risk factors that put the mother or baby at risk for requiring resuscitation include [these are not all inclusive] :

- maternal age > 35
- maternal diabetes
- pregnancy induced hypertension
- maternal infection
- premature rupture of membranes [PROM]
- decreased fetal movement
- polyhydramnios/oligohydramnios [too much or too little amniotic fluid]
- drug therapy like magnesium sulfate
- no prenatal care
- breech or abnormal presentation
- premature labor
- nonreassuring fetal heart rate
- maternal general anesthesia
- maternal narcotics within 4 hrs of delivery
- known genetic problems
- congenital abnormalities

DECISION-TO-INCISION : CHALLENGING THE 30 MINUTE RULE

The National Institute of Child Health and Human Development (NICHD) Maternal-Fetal Medicine Units Network conducted a recent observational study to look at the outcomes from the time of a decision to perform a C-section to the time of incision.

The data came from only primagravid women [first child] in active labor who had an infant that weighed over 2500 gm. Indications for c-sections included: nonreassuring fetal heart rate, umbilical cord prolapse, placental abruption, placenta previa with hemorrhage and uterine rupture. Over 11,000 cases were analyzed over 2 years.

The data clearly showed that more than one third of all c-sections for these indications did not comply with the "30 minute rule".

The study also found that:

- when the decision-to-incision time was less than 30 minutes, the rates of fetal acidemia and intubation in the delivery room were higher
- 95% of infants delivered in more than 31 minutes did not experience any increase in the incidence of hypoxic-ischemic encephalopathy, fetal death or apgar scores <3 at 5 mins.
- only one in eight neonatal deaths occurred in the group of infants delivered after 31 mins.

Source: *OB Management: Vol.19, No 10.*

FDA NEWS... HALDOL

The FDA recently sent a “Dear Doctor” letter to healthcare providers warning them of the risk of sudden death, torsades de pointes and QT prolongation associated with the administration of the antipsychotic medication, Haldol. This risk is particularly associated with intravenous administration or when given at doses higher than recommended.



Injectable Haldol is approved by the FDA **only** for intramuscular injection, although there is a lot of evidence in the medical literature that IV administration is a common “off label” use for severe agitation in the hospital setting. EKG monitoring is recommended if Haldol is given intravenously. Source: www.medscape.com

IMPROVING HOSPITAL CARE FOR SURGICAL PATIENTS

In the last issue we discussed the “5 Million Lives Campaign”, that is aimed at reducing harm in US health care facilities. One part of this initiative is improving hospital care for surgical patients.

Issues being addressed are:

- preventing surgical site infections by appropriate use of prophylactic antibiotics and use of appropriate hair removal methods, glucose control in patients under going major cardiac surgery and maintaining normal body temperatures in patients undergoing colon surgery.
- avoiding adverse cardiac events by continuing beta-blocker therapy for all patients taking a beta-blocker before admission for surgery and during their hospitalization
- preventing VTEs [venous thrombotic events, this includes both deep vein thrombosis and pulmonary embolism] through use of intermittent pneumatic compression devices and graduated compression stockings and administration of low-dose unfractionated heparin, low-molecular weight heparin or Coumadin. Short trips to the bathroom and walks up and down the halls are not enough to prevent VTE.
- preventing VAP [ventilator acquired pneumonia] by elevating the head of bed to 30-45 degrees at all times except when care is being provided, allowing patients that are sedated to come up daily to assess their responsiveness and readiness to wean, and administering daily medication to prevent peptic ulcers.

Source: *Nursing 2007, August.*

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