Unanticipated Birth

Outside the Birthing Unit

Guidelines for Labour Assessment, Imminent Birth, Immediate Newborn Care and Transfer

Reproductive Care Program of Nova Scotia

RCP

Revised: May 2025

This is a clinical practice guideline only, intended for use by regulated health professionals. Practices may differ across facilities and practice environments, depending on available resources and prescriber preference. All policies and procedures must be approved by the appropriate processes within each facility / Nova Scotia Health (e.g., Maternal/Child or Perinatal Committee, Medical Advisory Committee, etc.).

The information in this guideline is intended to be inclusive of all childbearing persons including those who do not identify as a woman or female. Some of the content may include gendered language to reflect the populations studied and reported by researchers. However, RCP continually strives to shift the culture and improve our use of language in perinatal health to better reflect all persons and childbearing families, and we encourage all perinatal health professionals to do the same.

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Introduction

Most births in Nova Scotia (NS) occur in a hospital with an active obstetrical service. Occasionally, pregnant persons arrive in active labour in the Emergency or Outpatient area of a facility where an obstetrical service is unavailable. Health care professionals must be able to accurately assess these situations to determine the safest and most effective way to care for labouring persons. In some cases, the assessment may indicate that there is enough time for transfer to the nearest facility with an active obstetrical service. When it is likely that birth will occur, transfer may not be appropriate. Local clinicians must have the basic knowledge and skills required to support labour and birth to optimize healthy outcomes for both the parent and newborn. **Transfer should not be attempted if it is suspected that birth may occur on route.**

This document has been developed to support health care professionals who do not deliver babies as part of their usual practice. It is intended to provide guidance and support to safely and effectively assess and care for labouring/birthing persons. Included are guidelines for:

- ✓ Obstetrical and fetal assessment
- ✓ Indications for transfer and the transfer process, including a provincial directory of all facilities offering an obstetrical service and details regarding EHS LifeFlight
- ✓ Care and documentation during labour and birth when transfer is not possible
- ✓ Basic neonatal resuscitation (NRP) skills
- ✓ Postpartum/postnatal assessment and care
- ✓ Equipment
- ✓ Stock Medications for obstetrical emergencies and routine birth
- ✓ Laboratory tests

Roles of the Emergency Team

The value of multidisciplinary assessment and care by the emergency department team should never be underestimated. It is, however, the physician's responsibility to make a final decision regarding the laboring person's care. Where time and circumstances permit, it is always advisable to **seek support and advice from a referral centre or from the transport team/EHS LifeFlight Medical Control Physician (MCP).**

Emergency Health Services NS – EHS LifeFlight – 1-800-743-1334

Physicians transferring pregnant persons via regular EHS ground transport (i.e. not LifeFlight ambulances) retain and assume clinical responsibility until they reach a facility with an active obstetrical service. Pregnant persons who are clinically unstable and not suitable for transport without the support and expertise of the obstetrical or neonatal LifeFlight team, should remain onsite until the LifeFlight team is available and able to assume care.

Clinicians in ambulatory care or outpatient/emergency settings should be able to recognize labour and perform basic assessments of maternal, fetal, and newborn well-being. To complete a comprehensive assessment and provide reassurance to the pregnant person, and their partners and family.

The following skills are required:

- ✓ Assessing frequency, strength, and duration of contractions
- ✓ Helping pregnant persons in early labour with decision-making (e.g.to consider the potential need for travel or transfer to the most appropriate facility for labour and birth)
- ✓ Auscultating the fetal heart rate with a doppler or stethoscope

- ✓ Recognizing a normal (or abnormal) fetal heart rate
- ✓ Providing initial stabilization in consultation with referral centre colleagues until care is transferred
- ✓ Recognizing signs of rapidly progressing labour and birth
- ✓ Assisting and supporting pregnant persons during labour and birth
- ✓ Providing appropriate postpartum and newborn assessment and care, including:
    - first steps of newborn resuscitation (providing warmth and establishing effective ventilation if necessary)
    - supporting skin to skin and the initiation of breastfeeding

Assessment of Well-Being

The pregnant person is the best source of information about their obstetrical and medical history and presenting concerns. Some pregnant persons, particularly after 36 weeks' gestation, will carry a copy of their Nova Scotia Prenatal Record (PNR) with them; this will provide valuable information about the pregnancy. In addition to the information gained from the PNR, a discussion and description of personal health history can be obtained with key questions.

When **birth is imminent** and there is little time to do a comprehensive assessment, it is most important to assess:

- the **GA** of the newborn (determines the urgency of the transfer process, and the most appropriate referral centre for transfer)
- the **presentation** of the newborn (i.e. is the newborn coming out headfirst or breech – buttocks or feet. Cesarean birth is recommended for some breech presentations.)
- **whether or not the amniotic membranes have ruptured**. It is best not to artificially rupture the membranes unless 1) instructed to do so by an obstetrician at the referral centre; or 2) the newborn is born.

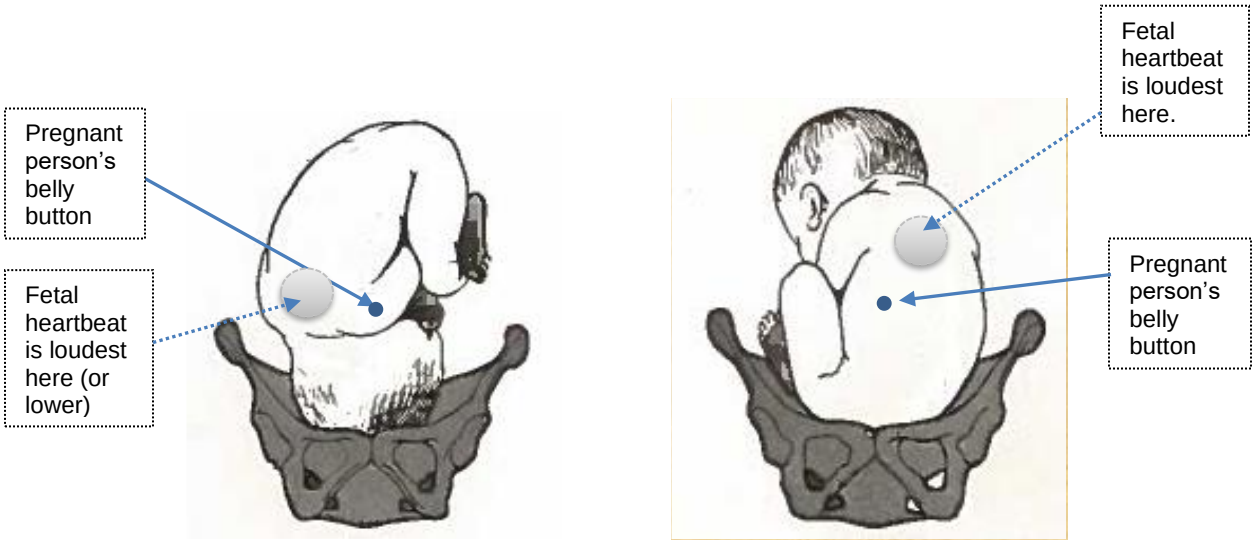
Key Questions to Assess Well-Being

Questions about the Pregnant Patients Current Status	Consideration
✓ Are you pregnant?	Confirm pregnancy and that viability has been achieved (> 20 weeks)
✓ When is your due date? ***OR*** ✓ How many weeks pregnant are you? ***OR*** ✓ When is your newborn due?	< 37 weeks = preterm Neonatal transport should be arranged as soon as possible if birth is imminent and in-utero transport is not an option.
✓ Is this your first newborn?	If **NO**, have they experienced vaginal birth before, or cesarean birth? **Previous vaginal birth:** expect a faster labour and delivery than experienced before. **Previous cesarean birth:** discuss with LifeFlight MD (MCP).
✓ Do you have any health concerns? ***OR*** ✓ Do you have any medical conditions?	Some pre-existing health conditions (e.g. diabetes, hypertension, obesity) may increase risk for adverse perinatal outcomes.
✓ Have there been any concerns with this pregnancy?	Conditions which have resulted in increased fetal or maternal surveillance (multiple gestations or breech presentation) should be discussed with a referral centre.

Questions about Fetal Status	Consideration
✓ Have there been any concerns with the newborn's health during this pregnancy?	The LifeFlight MCP will collaborate with the referring physician regarding decisions about transfer.
✓ Has your baby been less active today? ***AND*** ✓ When did you last feel your baby move?	Further assessment is indicated to confirm fetal wellbeing (i.e. confirmation of a fetal heartbeat via auscultation or POC ultrasound) **If a compromised newborn is anticipated** and birth is imminent, arrange neonatal transport immediately. If birth is not imminent, arrange transport.
Questions About Labour	**Consideration**
✓ Describe what you are feeling now. ✓ When did this start?	Consider how the symptoms have changed over time and what made them decide to come to hospital.
✓ Can you describe the pain? ○ Frequency ○ Duration ○ Strength or intensity ○ Constant or intermittent ○ Location	• Frequency = time from beginning of one contraction to beginning of next • Duration = how long does the contraction last from beginning to end? • Strength = How firm is the uterus with contractions? • How does pain rate on a scale of 1 to 10?
✓ Do you have any pelvic or vaginal pressure?	Pelvic or vaginal pressure may indicate imminent birth or less urgent conditions. Further assessment is required (e.g. urge to push vs urinary frequency)
✓ Has your water broken? ○ If so, when? ○ Is it clear in colour? ○ Is there a foul odour?	May be felt as a gush, trickle, or wetness Inspect leaking fluid for presence of blood or meconium (newborn's first stool: green, yellow, brown or black)
✓ Is there any vaginal bleeding? ✓ When did this start?	Note: amount, colour (bright vs dark), consistency

Auscultation of Fetal Heart Rate

The fetal heart rate (FHR) is most easily heard through the fetal back, with the pregnant person in a semi-recumbent or lateral lying position. When unsure of the fetal position, you may consider asking the pregnant person on which side they most frequently feel their baby kicking. Assuming this to be the location of the fetal limbs, you would auscultate on the opposite side of the abdomen, midway between the umbilicus and symphysis pubis. The FHR will be heard lower in the abdomen as the fetus moves down into the pelvis as labour progresses.



Listen to the FHR for a full minute, following a contraction. The rhythm should be regular, and the normal range is between 110 – 160 bpm. It is common to hear a deceleration that quickly recovers, so reposition the pregnant person (e.g. to opposite side-lying) and listen again following the next contraction.

Signs and Symptoms of Labour

- Regular contractions and/or back pain not relieved with rest or other comfort measures.
- Pelvic or vaginal pressure.
- Increased vaginal discharge, including but not limited to bloody show.
- Ruptured membranes with or without contractions (this may be indicated by slow leaking of fluid, wetness, 'popping' sensation accompanied by fluid, or a larger gush of fluid).
- Cervical change (someone who is skilled at cervical assessment may perform a pelvic exam only after careful assessment, consideration, and consultation regarding GA and membrane status; or if birth is imminent).

Do not perform a pelvic exam if the pregnancy is less than 36 weeks' gestation or if you are unaware of placental location, unless birth appears imminent, or you have consulted with a physician from a regional or tertiary hospital.

Signs and Symptoms of Imminent Birth

- Birthing person exclaims, "The baby is coming!"
- Uncontrollable urge to push (they may express a need to defecate)
- Separation of the labia, bulging perineum and rectum
- Bloody show
- Uncontrollable passage of stool
- Difficulty maintaining calm, or expression of panic
- Sudden nausea and vomiting
- Crowning of the fetal presenting part (typically the head)

Planning for Care

The presence or absence of labour, other concerns for the birthing person or fetus, or other safety factors such as time, distance and travel conditions will influence your decision to:

- Discharge home.
- Transfer to a referral centre or facility with an active obstetrical service.
- Provide care in your facility.

If the pregnant person is in labor, transfer should take place as soon as possible if birth is not imminent. Every effort must be made to avoid birth during transport.

Guidelines for discharge home:

If the pregnant person is not considered to be in labour, their symptoms are not concerning, or if they are in the early/latent stage of labour, reassure and offer these options:

- return home, **OR**
- travel to the hospital where birth was intended, considering distance and travel conditions. You may seek the recommendations of the birth hospital (e.g. if there is suspected or confirmed rupture of membranes).

Discuss the signs of labour as well as supportive care/comfort measures. Encourage them to return if they can't get to a facility with an active obstetrical service.

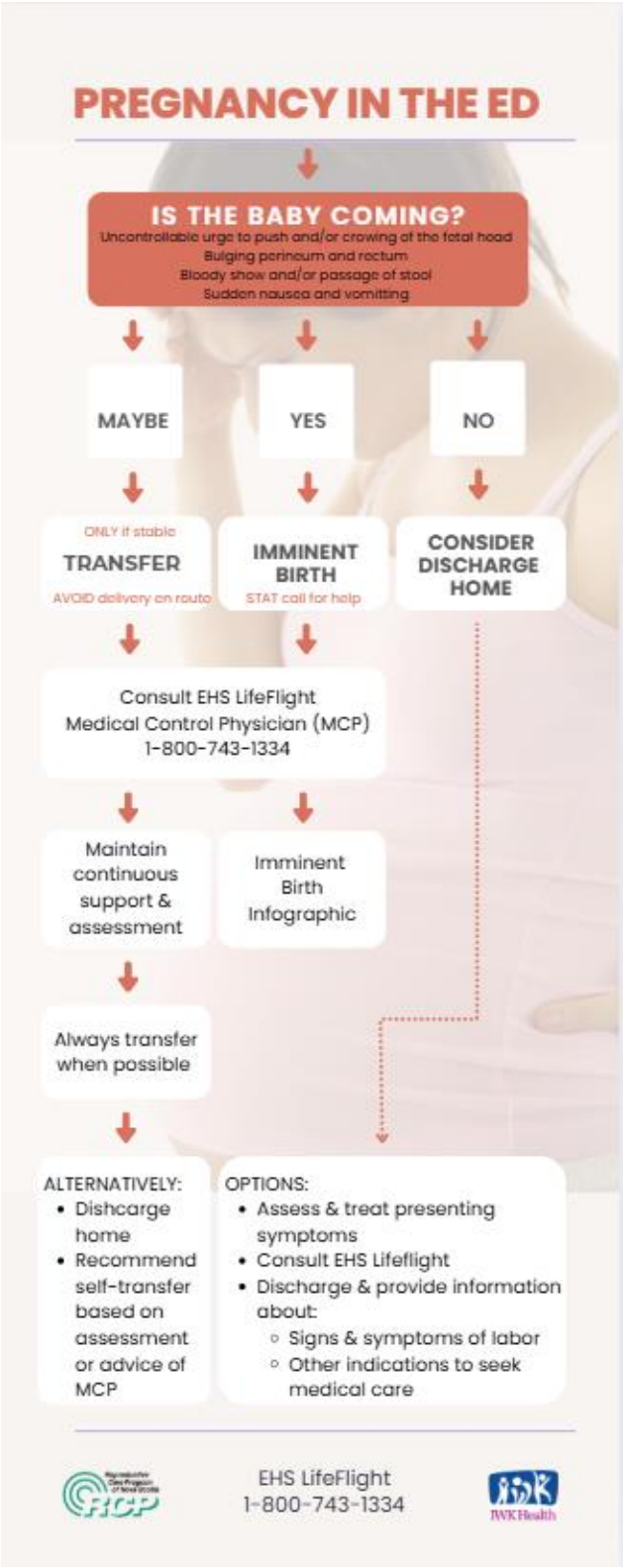
Guidelines for transfer to a referral centre:

- Consult with physician on call at the appropriate referral center or call LifeFlight to consult with the Medical Control Physician (MCP).
- Maintain continuous support and assessment.
- Consider safety of conditions for transfer (time before birth, weather).
- Ensure appropriate care providers are available to attend during transfer. If the pregnant person is to be transferred unattended, the transferring physician maintains responsibility until the pregnant person arrives at the intended destination and is taken into care.
- Reassess labour progress prior to transfer.
- If birth is imminent and the newborn is preterm (< 37 weeks) or if the newborn is anticipated to be compromised, contact LifeFlight to mobilize the neonatal team.

Guidelines for providing care in your facility:

- If unable to safely transfer due to imminent delivery or poor travel conditions, support the birth in your department and call for additional help as needed.
- All Emergency Department staff must be familiar with the location and use of equipment required to care for a labouring or birthing person.
- Provide a safe, comfortable, private environment with continuous support.

Labour/Birth Assessment: A Quick Reference



When Birth is Imminent

Birth is a natural process, and most of the time is uncomplicated, particularly when the pregnancy is at term (> 37 weeks). It is quite possible that most people who give birth in an emergency room will have had previous vaginal deliveries, hence the precipitous nature of the labour and inability to get to a facility with an active obstetrical service. A successful vaginal birth history gives a very good indication that this birth will go smoothly.

It is important to remain calm and provide both emotional and physical support to the labouring person, their partner and/or family. The goals of care are to prevent or minimize trauma by supporting the normal processes and movements of birth, and to create a positive lasting memory of the birth for the birthing person, partner, and family. **Healthcare professionals should:**

- Always remain with the labouring person.
- Ensure help is available to prepare for birth.
- Provide support and care to the pregnant person, partner, and family.
- Provide care for the newborn.

Ideally, a separate room should be available for the birth. All equipment should be kept in an area known to all staff and readily available for an imminent delivery.

Keep the newborn's body temperature between 36.5° and 37.5° C

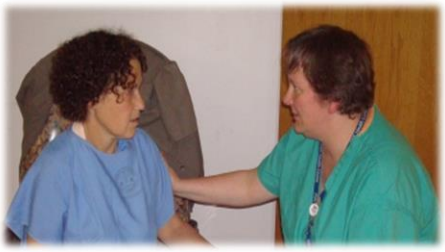
It is **very important** to keep the newborn's body temperature in the normal range (normothermia: between 36.5° and 37.5° C), and to avoid both hypothermia

(<36.5° C) and hyperthermia (>38° C)[1]. The environment should be warm to minimize potential heat loss for the newborn. Additional ways to maintain normothermia include:

- immediate skin-to-skin contact of either parent with the newborn,
- using warmed towels or blankets when drying or covering newborn,
- closing windows and keeping the newborn away from windows, outside walls, or any other potential sources of cold or drafts (e.g. vents), &
- If the newborn is placed in a warmer or incubator, it must be servo-controlled with a temperature sensor to ensure newborn's temperature is maintained in the normal range.

Standard provincial documentation forms for labour and birth will help prompt your care; samples of these are in Appendix C and can be requested from the RCP office or via the RCP online order form.

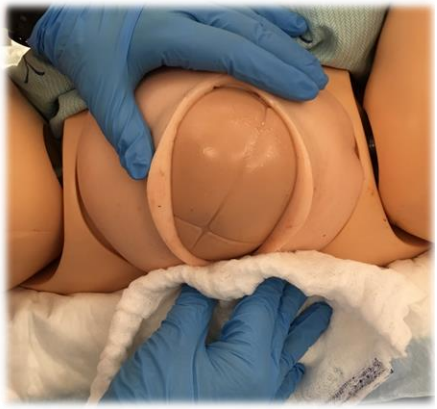
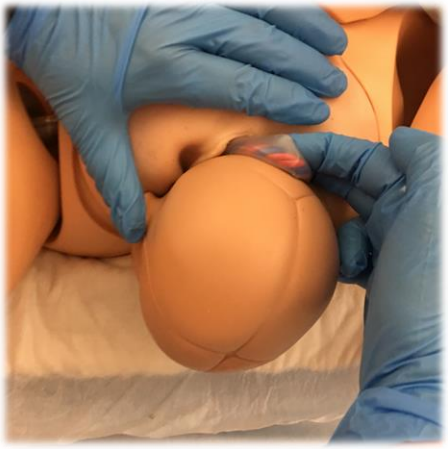
Assisting with Birth[2]: Step by Step…

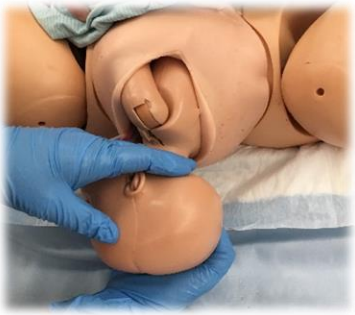
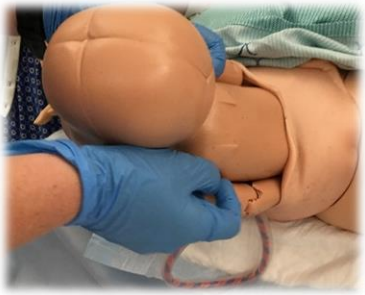
Call for Assistance	
	There are at least **two** persons requiring assessment and care at each birth – the birthing person, and the newborn. **Both require a care provider**.
Sound Confident and Reassuring	
	✓ Close up eye contact ✓ Make a physical connection e.g. touch their shoulder or arm. ✓ Speak in a quiet confident voice. ✓ Call them by name used and use gender-inclusive language. ✓ Minimize distraction and noise in the room ✓ Provide privacy

1 Boulton, J. E., Coughlin, K., O'Flaherty, D., & Solimano, A. (2021). *ACoRN, acute care of at-risk newborns: A resource and learning tool for health care professionals. The Canadian Pediatric Society* (2nd ed.). Oxford University Press.
2 Society of Obstetricians and Gynecologists of Canada (2024). ALARM Course manual. Advances in labour and risk management (31st ed. 2024-2025).

Labor & Pushing Techniques	
	✓ Support the birthing person into a position that is comfortable and allows visibility of the perineum. ✓ Encourage bearing down/pushing according to the patient's own preference (spontaneous with natural urges or directed with Valsalva Maneuver (i.e. holding breath and counting). Spontaneous pushing is recognized as best clinical practice. Spontaneous pushing follows natural urges, which is often 3-5 pushes per contraction. ✓ There may be times when directed pushing (i.e. holding breath and counting) is required. For example, in times of fetal distress and ineffective spontaneous pushing. ✓ Wash hands and wear gloves. ✓ Get equipment ready

Scan to view RCP's simulation of an uncomplicated vaginal birth

Birth of the Head	
	✓ If the amniotic membranes have not yet ruptured and are bulging through the vagina, consider breaking them with your fingers, or leave them intact. Note the color, quantity, and odour of the fluid. ✓ Hold a towel or sponge between the vagina and the anus and apply gentle pressure to support the perineum. ✓ Apply light pressure with the opposite hand on the back of the fetal head to maintain flexion. ✓ Delivery of the fetal head is advised at the end or between contractions by light panting and gentle, short pushes to prevent perineal trauma. ✓ **Do not pull** on the fetal head.
Check for the Cord	
	✓ Once the head is born the birthing person will feel some relief and often will naturally pause before continuing to push. ✓ Feel for the umbilical cord around the fetal neck. ✓ If you feel cord: o try to gently loosen the cord and bring it out over the fetal head. Sweep again in case it is looped twice and repeat this step if needed. ✓ If you cannot loosen the cord, **DO NOT CUT THE CORD** until after the fetal shoulders are delivered, and: o gently push the cord back over the fetal shoulder allowing the shoulder to slip under it as the fetus delivers. **OR** o keep the fetal head close to the perineum allowing the remainder of

	the body to deliver or "somersault out". After birth remove the cord from the newborn's neck and body as required.
Restitution	
	✓ Allow the fetal head to spontaneously turn (restitute) to face left or right. ✓ Let the uterine contractions do the work of turning the fetus through the pelvis once the head is born. ✓ As the fetus restitutes (i.e. turns to one side or the other), the shoulders are lining up to move through the pelvic bones. ✓ If needed, a helper on each side can support both of the birthing person's legs to flex the hips while they bear down with the next contraction.
Support the Head and Guide the Body	
 	✓ Place a hand on either side of the fetal head for support. ✓ The 'pushing power' comes from the birthing person and their uterine contractions, **not** from the birth attendant pulling. ✓ Move hands downward with the fetal head as you guide the upper (anterior) shoulder under the pubic arch. ✓ Use a gentle downward motion; **never pull.** ✓ Once the upper shoulder is delivered, **gently guide the fetal body up (do not pull) in an upward direction *over*, not through, the perineum.** ✓ The contraction will assist the birthing person to push the fetus down and out ✓ To avoid forceful expulsion and perineal injury, encourage panting or easy grunting.

Newborn's Born!	
	✓ Lift the newborn onto the birthing person's abdomen or chest where they can see and hold their newborn. ✓ Keep the newborn warm by placing them 'skin-to-skin' with the birthing person: - page 27 for newborn assessment and care - page 31 for neonatal resuscitation ✓ As you gently dry the newborn with warm towels/blankets, they should begin to cry vigorously. ✓ Do not suction a vigorous newborn. ✓ Secretions are often present in a newborn's mouth and nose, and the newborn can usually clear these independently (e.g. 'spitting up' or sneezing) or these may be wiped away with a soft cloth. ✓ Cover both the birthing person and the newborn with warm, dry blankets. Replace wet blankets with dry warm ones. ✓ Give oxytocin 10 units IM to the birthing person. ✓ **Remember to record the time of birth!**
Congratulations!	
✓ Congratulate all and praise the birthing person's efforts!	

Clamping the Umbilical Cord and Collecting Cord Bloods

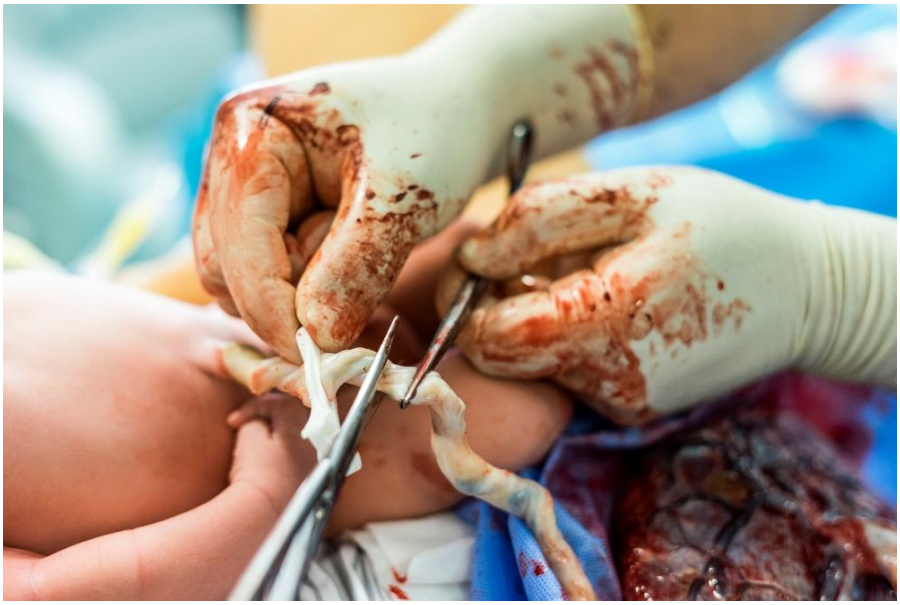
Preterm (<37 weeks) singletons: Deferred (delayed) umbilical cord clamping (DCC) is recommended for 60 to 120 seconds.

Term singletons: DCC is recommended for 60 seconds. DCC beyond 60 seconds increases the risk of hyperbilirubinemia requiring phototherapy.

- **When cord clamping cannot be deferred as recommended, then DCC for at least 30 seconds is superior to immediate clamping[3].**
- **DCC should be performed with the infant at or below the level of the introitus.**
- **Disrupted utero-placental circulation is a contraindication for DCC.**

✓ <u>Clamping the Umbilical Cord:</u>

To clamp the umbilical cord, place 2 metal clamps on the umbilical cord and cut in between.



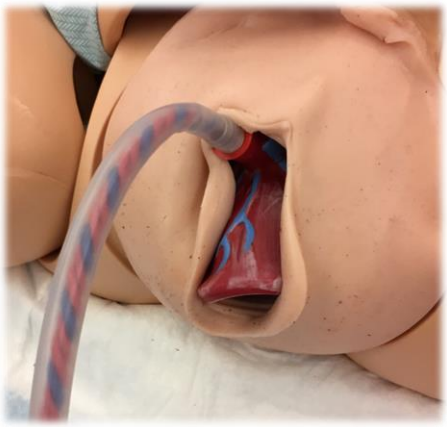
3 McDonald, S. D., Narvey, M., Ehman, W., Jain, V., Cassell, K., Obstetricians and Gynecologists of Canada, & Fetus and Newborn Committee. (2022, March 15). *Umbilical cord management in preterm and term infants*. Position Statement. https://cps.ca/documents/position/umbilical-cord-management-in-preterm-and-term-infants

- ✓ If possible, obtain Cord Blood Gases: (Note: the larger vessel in the cord is the umbilical vein, the two smaller vessels are the umbilical arteries). With the umbilical cord still clamped, first draw an arterial and then a venous cord gas specimen into two labeled pre-heparinized syringes; cord blood samples are most accurate and stable at room temperature for 60 minutes. If not analyzed within 60 minutes, store the samples at 4-8 °C and document the time of analysis. **A clamped blood-filled 20 cm segment of cord may alternatively be collected for analysis within 60 minutes.**

- ✓ Cord Blood: From the cord that is still attached to the placenta, release the clamp slowly to allow the flow of approximately 10 mL of cord blood into a medicine cup or a lavender topped EDTA collection tube. Ensure the clamp is closed securely around the umbilical cord.

- ✓ Remember to label the blood collection tube accordingly.

- ✓ Placing an Umbilical Cord Clamp: After the cord has been cut, the metal clamp that is attached to the newborn can be replaced with a plastic umbilical cord clamp. Leave 3-5cm length of cord between newborn and the plastic cord clamp. Ensure that the plastic clamp is tightly secured before removing the metal clamp.

Waiting for the Placenta	
 	✓ Ideally, one member of the care team is observing and caring for the newborn during skin-to-skin time, while another care provider assesses the birthing person's vaginal bleeding while awaiting placental delivery. The placenta should come within 20-30 minutes. ✓ It is normal to see a <u>small</u> trickle of bright blood from the vagina after the newborn is born but before the placenta is delivered. ✓ You may see small tears in the skin or vaginal tissue; not all will need repair. ✓ **DO NOT** massage the fundus (top of the uterus) or apply pressure to 'assist' the delivery of the placenta. ✓ Signs of placental separation include: ✓ Lengthening cord ✓ Gush of blood ✓ Rising of the uterus in the abdomen ✓ Uterus becoming firmer. ✓ Feeling of cramping ✓ Feeling vaginal/rectal pressure ✓ **AFTER** signs of placental separation gentle traction can be applied to the cord with the other hand supporting the uterus just above the pubic bone. ✓ Gentle traction using ring forceps, or maternal coughing can be used to

	ensure all amniotic membranes are delivered. ✓ **Massage** the fundus immediately after the placenta is delivered; it should be firm and palpable around the level of the umbilicus. ✓ **Examine the placenta** to note that it is intact, with no apparent sections missing. Retained placental parts lead to postpartum hemorrhage.

Assessment and Care of Birthing Person Following Birth

At a minimum, check vital signs, including pain, bleeding, fundal height and tone, bladder fullness, and perineum, for all postpartum person's:

- every 20 minutes for the first hour after birth,
- every hour for the next four hours, and then (if not transferred),
- every 12 hours until discharge.

Checks may be more frequent if indicated.

Bleeding

- Lochia will be red (rubra) and moderate to heavy within the first hour after delivery. Bleeding should not exceed the saturation of a pad within the first hour. You may have to check for pooling under the postpartum person's buttocks/back and weigh sanitary pads to fully appreciate the degree of blood loss.

- If the birthing person has any known risk factors for postpartum hemorrhage (e.g., previous history, precipitous birth, etc.) consider initiating a large bore IV (18 gauge) as soon as possible, ideally prior to the

birth. After the delivery of the placenta, consider starting a prophylactic oxytocin infusion by adding 20-40 units of oxytocin to 1000mL of 0.9 NaCl or Ringers lactate and infuse at a rate of 150mL/hr.

RCP Simulated Photo

- If the bleeding is excessive, treatment of postpartum hemorrhage is required. Massage the uterine fundus and start an oxytocin infusion; add 20-40 units of oxytocin to 1000mL of 0.9% NaCl or Ringers Lactate and infuse rapidly via IV infusion pump for 4+ minutes until a firm uterine tone is achieved[4]. The IV infusion rate should then be adjusted as outlined in the medication table for treatment of postpartum hemorrhage.
- If a continuous infusion or bolus of oxytocin IV and fundal massage do not control vaginal bleeding, start a second IV of NaCl (infuse wide open) and consider giving an alternate uterotonic and antifibrinolytic such as:
    - Ergonovine maleate (Ergot)
    - Carboprost tromethamine (Hemabate)
    - Misoprostol (Cytotec)
    - Tranexamic acid (TXA) (Cyklokapron)

See Medication Table (pages 38-41) for recommended dosages and routes.

Consult with a physician at your referral centre for advice with management of excessive bleeding.

4 Robinson, D., Basso, M., Chan, C., Duckitt, K., & Lett, R. (2022). Guideline no. 431: Postpartum hemorrhage and hemorrhagic shock. Journal of Obstetrics and Gynaecology Canada, 44(12). https://doi.org/10.1016/j.jogc.2022.10.002

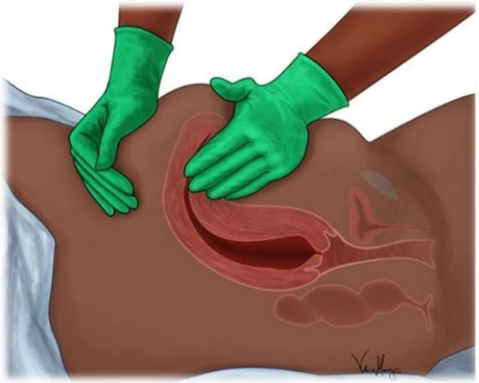
Vital Signs:

- BP
- Pulse
- Respirations
- Temperature
- Pain

Fundal Height and Tone

- The fundus should be firm and palpated at the level of the umbilicus and in the midline of the abdomen.
- The flat of the hand should be used to palpate the fundus, while supporting the lower portion of the uterus with the other hand.

Postpartum Uterine Massage



- If the fundus is higher than at the level of the umbilicus and/or is not midline, prompt intervention is required. This can be caused by a full bladder or clots forming in the uterus, both of which are common causes of postpartum hemorrhage.
- Ensure visualization of the perineum during fundal assessment. The amount and color of the blood (bright red, dark red) is important to assess.

Bladder

- The bladder should not be palpable.
- A distended bladder can interfere with uterine contractility leading to uterine atony and increased postpartum bleeding.
- If the bladder is distended encourage the postpartum person to void. If they are unable to void on their own, it is appropriate to recommend catheterization to prevent or control postpartum bleeding.

Perineum

- Perineal lacerations causing excessive bleeding should be repaired; small, minimal tears generally heal well.
- An ice pack is recommended to provide comfort and prevent or reduce swelling.

Assessment and Care of Newborn

First Impressions

- After birth the newborn should be placed directly on the birthing person's abdomen or chest for skin-to-skin care.
- Rapidly evaluate the newborn:
    - Is the newborn term?
    - Does the newborn have good muscle tone?
    - Is the newborn breathing and/or crying?
- If the answer is "No" to any of these questions the newborn should have the cord clamped and cut and be brought to a radiant warmer (if available) or a surface that resuscitation could be initiated. The 5 initial steps of newborn care should be completed immediately once placed on the resuscitation surface available.
- Otherwise, the newborn can remain skin-to-skin for the initial steps newborn care:
    - Provide warmth
    - Dry and stimulate
    - Position the head and neck to promote optimal airway position
    - Remove secretions from the airway needed (wipe mouth with dry towel or blanket)
- Healthy term newborns seldom require more than a clear airway and adequate warmth.
- **Routine suctioning is not recommended**. If the newborn has excessive secretions, it may be necessary to remove them by wiping the mouth and nose with a towel or by suctioning with a bulb syringe (*remember to depress the bulb before placing it in the mouth). Alternatively, you may consider using a large-bore (10-12 F) catheter to suction secretions from the mouth, then nose, if required. Suction pressure should be set at a maximum of 80-100 mmHg. Be careful not to suction vigorously or deeply

as this can produce a vagal response. Brief, gentle suctioning with a bulb syringe is usually adequate to remove secretions.

Apgar scores are assigned at 1, 5, and 10 minutes:

Assessment	0	1	2	1 min	5 min	10 min
Heart Rate	Absent	Below 100	Above 100			
Respiratory Effort	Absent	Slow irregular	Good crying			
Muscle Tone	Limp	Some flexion	Active motion			
Reflex Irritability	None	Grimace	Cough sneeze			
Colour	Blue Pale	Body Pink with blue extremities	All Pink			
			Total			

Newborn Assessment for Apgar Scoring:

Heart Rate (HR): absent/not detected → less than 100 bpm → greater than 100 bpm.

- Auscultate HR or feel pulse at base of cord.
- SPO2 monitor could applied on the **right** hand or wrist for assistance in assessing HR.
- ECG (if you have access) may be helpful to identify HR, especially if it is low or difficult to palpate.

Respiratory Effort: none → slow/irregular → vigorous crying

- Stimulate if respirations are absent or gasping.

Muscle Tone: limp → some flexion of limbs → active motion

Reflex Irritability: no response → facial grimace → coughing or sneezing

Colour: blue to pink

- The newborns central areas – lips, tongue and trunk- should turn pink shortly after birth, while hands and feet may remain pale or bluish for up to 24 hours. Be prepared to differentiate cyanosis from bruising.
- If the newborn is breathing but appears blue, be prepared to provide supplemental oxygen based on targeted preductal SpO_2 saturation levels. Avoid over- or under- oxygenation, as both can be harmful.
- Place an SpO_2 monitor on the newborn's right hand or wrist. If their SpO_2 is low and not improving, deliver just enough supplemental oxygen to reach the target for their age. This can be done by using your hand as a mask over the newborn's nose and mouth, holding the oxygen tubing between your fingers.

Targeted Preductal SpO_2 After Birth	
1 min	60% - 65%
2 min	65% - 70%
3 min	70% - 75%
4 min	75% - 80%
5 min	80% - 85%
10 min	85% - 95%

(AAP/CPS 2021)

Resuscitation

See page 31 for an overview of Neonatal Resuscitation, or Appendix A for the complete NRP Flow diagram and equipment list.

Medications

Universal screening for gonorrhea and chlamydia is recommended in pregnancy. In an emergency it's unlikely the birthing person's screening results will be known, and so erythromycin eye ointment is recommended[5].

Vitamin K 1mg IM (thigh) is recommended to administered to all newborns within the first 6 hours after birth. A dose of 0.5mg is appropriate for newborns weighing less than 1500g[6]. Skin-to-skin contact or breast(chest) feeding during administration is known to reduce the newborns pain experience.

Keeping the Newborn Warm

Maintaining the newborn's body temperature may become a major challenge because you are unlikely to have a radiant warmer readily available. It is essential for caregivers to provide warmth to newborns, as hypothermia and cold stress place a newborn at increased risk for morbidity and mortality. Overheating a newborn is also harmful but is less likely to happen. Aim to maintain a newborn (axillary) body temperature of 36.5° – 37.5° Celsius.

Means to promote newborn normothermia (all babies):

- **Direct skin to skin** care with a parent.
- Change wet blankets/towels and replace with dry blankets/towels that have been (ideally) warmed.
- Maintain room temperature at 23°C to 25°C.
- Check newborn's temperature (per axilla) every 30 minutes for the first two hours.
- Keep newborn away from sources of drafts (e.g. vents).

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5 Moore, D. L., MacDonald, N. E., Canadian Pediatric Society, & Infectious Diseases and Immunization Committee (2024). *Preventing Ophthalmia Neonatorum*. Canadian Paediatric Society. https://cps.ca/documents/position/ophthalmia-neonatorum

6 Ng, E., & Loewy, A. D., & Fetus and Newborn Committee (2024). *Guidelines for vitamin K prophylaxis in newborns.* Canadian Paediatric Society. https://cps.ca/documents/position/vitamin-k-prophylaxis-in-newborns

- Do not place newborn on, in or near cold equipment, or near walls or windows.
- If a hat is not available, a cap fashioned out of stockinette may be used.

Smaller or preterm newborns have more difficulty maintaining a normal body temperature, and it may be necessary to employ these supports **in addition to the above**:

- Clean food-grade plastic wrap or a bag may be used to prevent heat loss through evaporation if the newborn is less than 32 weeks gestational age (GA).
- Portable gel warming mattress.

Do not use outdated radiant warmers due to the risk of injury from improper or faulty operation. Alternatively, use gel warming mattresses, wrapped in a blanket or towel, to safely manage temperature regulation in at-risk newborns. Never microwave IV bags for newborn warming.

Neonatal Resuscitation – An overview

Rapid Evaluation

- ✓ Term gestation?
- ✓ Breathing or crying?
- ✓ Good tone?

} If '**yes**' to all, newborn may remain skin to skin

If '**no**' to any of these questions the cord must be clamped and cut, and the newborn must be moved to a safe place to begin neonatal resuscitation. Newborns require a different approach to resuscitation than adults. When a newborn requires resuscitation, it is usually caused by ineffective respirations, leading to respiratory acidosis due to inadequate gas exchange.

The focus of neonatal resuscitation is effective ventilation!

Effective PPV =

- *Chest rise*
- *HR increasing to >100 bpm*
- *Improving tone and colour ("pinking up")*

A – Airway (30 seconds)

- Provide warmth.
- Dry with towel or blanket (discard/replace when wet), and stimulate (gently rub the newborn's back, truck, or extremities)
- Position the head and neck to open the airway (neutral or slightly extended position)
- Clear secretions if needed (e.g. use a blanket or towel to gently wipe inside the newborns mouth. If suction is required, use a bulb suction, suction mouth FIRST, then each of the nares)

B – Breathing (30 seconds)

- Evaluate respirations and heart rate.
- If apneic, gasping, or HR < 100 bpm:
    - start PPV at a rate of 40-60 bpm via bag and mask or neo puff (site dependent)
    - the goal is to start PPV before 1 minutes of life.
        - at an FiO_2 of 21% (room air) if the newborn is term.
        - at an FiO_2 of 30%, if the newborn is preterm (less than 37 weeks).
    - place an SpO_2 monitor on the newborn's right hand or wrist. Adjust FiO_2 to reach the target SpO_2 for their minutes of age.

- reassess HR after 15 seconds of PPV
- if there is no increase in HR and there is no chest rise with PPV begin corrective steps (MR. SOPA):

M: Mask adjustment

R: Reposition head and neck

- Give 5 breathes, if not chest movement

S: Suction mouth then nose

O: Open mouth

- Give 5 breathes, if not chest movement

P: Pressure increase

- 5-10 cm increments to a max of 40cm for term and 30 cm for preterm
- Give 5 breathes, if not chest movement

A: Alternate Airway

- LMA
- ETT (if trained to do so)

- **Increasing HR is the number one indicator of effective ventilation.**
- If the HR begins to rise and is >60 bpm but <100 bpm continue with PPV until the newborn begins to effectively breathe on their own.
- If the newborns HR is < 60 bpm after **30 seconds of effective PPV**, start chest compressions and provide 100% oxygen.

C – Circulation

- Ensure you have given at least 30 seconds of effective PPV before you consider beginning chest compressions.
- Coordinate effective PPV and chest compressions (ratio is 3 compressions: 1 breath).
- Continue to assess pre-ductal oxygenation status via the SpO_2 monitor on the newborn's right hand or wrist.
- Titrate oxygen to achieve target SpO_2 levels.

Targeted Preductal SpO_2 After Birth	
1 min	60% - 65%
2 min	65% - 70%
3 min	70% - 75%
4 min	75% - 80%
5 min	80% - 85%
10 min	85% - 95%

(AAP/CPS 2021)

- Discontinue chest compressions when HR > 60 bpm; discontinue PPV and transition to free-flow oxygen when HR > 100 bpm and newborn is breathing spontaneously.

Additional resuscitative measures are described in the NRP algorithm (Appendix A).
Consult the MRP for neonates through EHS LifeFlight 1-800-743-1334

Transfer

When possible, it is ideal to transfer the labouring person to a facility with an active obstetrical service. Furthermore, it is beneficial to transfer a fetus in utero, especially when the need for special care is anticipated. **Transfer should not be attempted if it is suspected that birth may occur on route.**

Consult with an obstetrician at your regional centre or directly through LifeFlight regarding management and/or transfer. If the newborn is expected to need special care and prenatal transfer is not an option, the neonatal transport team (through contact with LifeFlight) should be notified to facilitate their presence at the birth or as soon as possible thereafter to care for the newborn.

If it is necessary to transfer the newborn after birth, parents will need information about transfer, parent rooms or courtesy rooms in the referral hospital. Staff should check with the receiving centre to ensure the availability of a room, as space is sometimes limited. If a parent room is not available, staff in referring hospitals should provide information about alternate accommodations for parents.

Regardless of where postpartum/postnatal care is provided, when they are both stable the newborn should always remain with the birthing parent.

Active Obstetrical Service Directory

Emergency Health Services – EHS LifeFlight – 1-800-743-1334
(For Prenatal/Postpartum and Newborn Transfer)

***Tertiary Centres*:**

Halifax: *IWK Health, Birth Unit*	902-470-6670
Sydney: *Cape Breton Regional Health Care Complex* Labour and Delivery Unit	902-567-7834

***Regional Centres*:**

Amherst: *Cumberland Regional Health Care Centre*	902-667-5400 Ext.6144
Antigonish: *St. Martha's Regional Hospital* Children's and Women's Health Unit	902-867-4200
Bridgewater: *South Shore Regional Hospital*	902-527-5214
Kentville: *Valley Regional Hospital*	902-678-7381 Ext. 3050
New Glasgow: *Aberdeen Hospital*	902-752-7600 Ext. 2530
Truro: *Colchester East Hants Health Centre*	902-898-2918
Yarmouth: *Yarmouth Regional Hospital*	902-742-3541 Ext. 130

Equipment

Ideally, a warm separate area or private room should be available for labour and birth

- Keep all equipment in a designated area, where it is readily available for an imminent birth.
- A copy of standard provincial documentation for labour and birth will help prompt your assessments (see appendix B).

Sterile emergency delivery tray contents:	
✓	4 clamps (it is useful to have at least one pair of Kochers or an Allis clamp to rupture membranes if needed)
✓	1 pair curved scissors
✓	1 pair suture scissors
✓	Blood Bank collection tube and stopper to indicate clotted specimen
✓	1 umbilical cord clamp
✓	1 small bowl
✓	1 towel
✓	1 drape
✓	1 large pad suitable to place under the birthing person's buttocks
✓	Sponges
✓	Gloves
* *Disposable emergency delivery trays are available. These are often more practical in a community hospital that does not provide obstetric services.*	

You will also need:

1. Several *warm* flannel blankets/towels to dry the newborn. The newborn should be placed skin-to-skin with the birthing parent (abdomen or chest), and both covered with clean, dry, warm linens. The newborn should always be dried immediately; this can be done while skin-to-skin. Alternatively, the newborn can be held skin-to-skin with the partner or other support people. If skin to skin is not possible you may also bundle the newborn in 2 or 3 warm blankets/towels.
2. Warm, sterile water (to wash the perineum following birth)
3. Suction catheters (#6,8,10)
4. Sanitary pads
5. Ice pack for perineum (provides comfort and prevents swelling; can be made and stored ahead by soaking a sanitary pad in water and placing it in the freezer. They must be wrapped in a light cloth to protect the perineum from the direct contact with ice).
6. Plastic bags for placenta (2)
7. Identification bracelets: 1 for birthing parent, 1 for newborn
8. Folder with RCP chart form package & necessary hospital laboratory requisitions
9. Newborn resuscitation equipment (Appendix A) and a neonatal resuscitation record (Appendix D)

Medications for Vaginal Birth and Obstetrical Emergencies: Recommended for Stock in the ED						
Prevention of PPH[7,8]						
Drug Name / Level of Care	**Agent/Class**	**Indications**	**Contraindications**	**Dosage**	**Storage**	**Potential Adverse Effects**
Oxytocin ***(All hospitals)***	**UTEROTONIC AGENT** **CLASS:** OXYTOCICS	**Active Third Stage Management:** **Prevention:** of PPH is **always** Oxytocin	Hypersensitivity to Oxytocin	• 10 IU IM, **OR** • 3 IU IV with the delivery of the anterior shoulder or immediately after the newborn is delivered, **OR** • 20-40IU in 1000mL of Ringer's Lactate or NaCl at 150 mL/hr. *Individuals at high risk of PPH may receive both an initial bolus of dose of 10IU IM or 3IU IV after the newborn is delivered **AND** a prophylactic infusion after delivery of the placenta.	Room temperature	-Hypotension -Tachycardia -Water intoxication -ECG changes have been observed following the administration of concentrated solutions.
Tranexamic Acid (TXA) (Cyklokapron) ***(All hospitals)***	ANTIFIBRINOLYTIC	**Prevention** of PPH in **VERY HIGH-RISK** births.	Hypersensitivity to TXA or any component of the formulation. Injection: active intravascular clotting; subarachnoid hemorrhage	• 1 g IV over 30 - 60 seconds. - Within 10 min after birth. - May repeat x 1 in 30 min. *Provincial drug manuals guide care providers to administer TXA IV over 10 min.	Room temperature	-N&V -Diarrhea -Dizziness -Hypotension -Visual color disturbances -Thrombo-Embolic event

7 IWK Drug Information Resource. (n.d.). https://www.dir.iwk.nshealth.ca/
8 LibGuides at Nova Scotia Health. (n.d.). https://library.nshealth.ca/Nurses/PharmacyResources

<table>
<tr><th colspan="7">Medications for Vaginal Birth and Obstetrical Emergencies: Recommended for Stock in the ED</th></tr>
<tr><th colspan="7">Treatment of PPH</th></tr>
<tr><th>Drug Name / Level of Care</th><th>Agent/Class</th><th>Indications</th><th>Contraindications</th><th>Dosage</th><th>Storage</th><th>Potential Adverse Effects</th></tr>
<tr>
<td>Oxytocin

(All hospitals)</td>
<td>UTEROTONIC AGENT

CLASS:
OXYTOCICS</td>
<td>Treatment
of PPH

*if required after placental delivery for uterine atony.</td>
<td>Hypersensitivity to Oxytocin</td>
<td>• Add 20-40 IU to 1000 mL of Ringer’s Lactate or NaCl.
- Rapid infusion over 4 min
• Then run at a MAX infusion of 15IU/hr.

<table><tr><th>IU of Oxytocin per Liter of IV Fluid</th><th>Infusion rate to delivery 15 IU/hr.</th></tr><tr><td>20</td><td>750</td></tr><tr><td>30</td><td>500</td></tr><tr><td>40</td><td>375</td></tr></table></td>
<td>Room temperature</td>
<td>-Hypotension
-Tachycardia
-Water intoxication
-ECG changes have been observed following the administration of concentrated solutions.</td>
</tr>
<tr>
<td>Carboprost (Hemabate)

(Regional & Tertiary hospitals)</td>
<td>UTEROTONIC AGENT

CLASS:
PROSTAGLANDIN</td>
<td>Treatment
of PPH

*if required after placental delivery for uterine atony.</td>
<td>-Cardiovascular, pulmonary, renal or hepatic disease
-Known hypersensitivity to the preparation.</td>
<td>• 250 mcg IM or IMM (intra-myometrial)
• *May repeat every 15 min, maximum 8 doses (2 grams)</td>
<td>Refrigerate at 2 to 8° C</td>
<td>-N&V
-Diarrhea
-Hypertension
-Pyrexia
-Headache
-Flushing
-Diaphoresis
-Restlessness</td>
</tr>
<tr>
<td>Ergonovine maleate (Ergometrine)

(All hospitals)</td>
<td>UTERONTONIC AGENT

CLASS:
ERGOT ALKALOID</td>
<td>Treatment
of PPH

*if required after placental delivery for uterine atony.</td>
<td>Should not be used with any of the HDP:
-Chronic HTN
-Gestational HTN
-Preeclampsia
-Eclampsia</td>
<td>• 0.25 mg IM
• May repeat every 2 hours

*(slow IV injection ONLY in life-saving circumstances)</td>
<td>Refrigerate at 2 to 8° C; Stable 60 days without refrigeration</td>
<td>-Peripheral vasospasm
-Hypertension
-Nausea
-Vomiting</td>
</tr>
</table>

Medications for Vaginal Birth and Obstetrical Emergencies: Recommended for Stock in the ED						
Treatment of PPH						
Drug Name / Level of Care	**Agent/Class**	**Indications**	**Contraindications**	**Dosage**	**Storage**	**Potential Adverse Effects**
Misoprostol (Cytotec) ***(All hospitals)***	**UTEROTONIC AGENT** **CLASS:** PROSTAGLANDIN	**Treatment** of PPH ***if** required after placental delivery for uterine atony.	Use caution with history of cardiovascular disease	• 400 mcg sublingual or oral *There is no evidence for a second misoprostol dose	Room temperature	-Nausea -Vomiting -Diarrhea -Shivering -Pyrexia
Tranexamic Acid (TXA) (Cyklokapron) ***(All hospitals)***	ANTIFIBRINOLYTIC	**Treatment** of PPH ***if** required after placental delivery with increased fibrinolysis (>500 mL blood loss after vaginal birth, or blood loss causing hemodynamic instability).	Hypersensitivity to TXA or any component of the formulation. Injection: active intravascular clotting;	• 1 g 1 g IV over 30 - 60 seconds. - Initiated as soon as possible after the diagnosis of PPH. - May repeat x 1 in 30 min - If IV access is not established, IM TXA may be reasonable. - No benefit when given >3 hours from onset of PPH *Provincial drug manuals guide care providers to administer TXA IV over 10 min.	Room temperature	-Nausea -Vomiting -Diarrhea -Dizziness -Hypotension -Visual color disturbances -Thrombo-Embolic event
Fibrinogen ***(All hospitals)***	**CLASS:** BLOOD COAGULATION FACTOR	Treat or prevent severe PPH due to hypo-fibrinogenemia	-Active thromboembolism	• START with 4 g IV (60mg/kg)	Refrigerate at 2 to 8° C; follow blood bank policy	-Allergic reaction -Fever/Chills -Headache

Laboratory Tests

TIP: *Keep corresponding requisitions with the emergency delivery equipment and chart forms.*

Cord Blood (collect if possible):

- ABO, Rh type and DAT (Direct Antiglobulin Test)
    - Following birth, collect at least 1 mL into a 10 mL lavender topped EDTA tube.
- Carefully label and refrigerate.
- Forward to Laboratory with the appropriate requisition as soon as possible.

PRN Bloodwork:

- Consider obtaining CBC, ABO/Rh and type and crossmatch if any identified risk factors for postpartum haemorrhage exist.
- Consider Rubella or Varicella Titre if immunization status unknown or unsure.

Rh Negative or Rh Unknown:[9,10]

- Collect the following within 12 hours of birth:
    - ABO, Rh type & Antibody screen into a lavender topped EDTA tube.
    - Kleihauer-Betke into a lavender topped EDTA tube (Central Zone prefers a purple top EDA tube)
- Complete appropriate requisition.

***Note: If specimen is from a non NSH *Central Zone Hospital*; Do not accession and send directly to the IWK Haematology Lab.**

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9 *Rh program of Nova Scotia*. Rh Program of Nova Scotia | Reproductive Care Program of Nova Scotia. https://rcp.nshealth.ca/rh

10 Fung-Kee-Fung, K., Wong, K., Walsh, J., Hamel, C., & Clarke, G. (2024). Guideline no. 448: Prevention of rh D alloimmunization. Journal of Obstetrics and Gynaecology Canada, 46(4), 102449. https://doi.org/10.1016/j.jogc.2024.102449

Newborn Bloodwork:

Laboratory screening tests routinely done for full term healthy newborns include metabolic and endocrine screening (e.g. PKU screening), and a screen for bilirubin level. Blood samples are typically collected at 24-48 hours of age.

Documentation

Documenting the events of an unexpected birth in an emergency or outpatient department can be overwhelming. Even for experienced caregivers who routinely attend births it can be challenging to maintain accurate and contemporaneous documentation. Much of the documentation of the birth can be done after the birth has occurred and all are assessed to be healthy and safe in the immediate postpartum/postnatal period. Noting and remembering the time of birth is one important aspect of care and can be documented on the birth record as soon as circumstances permit.

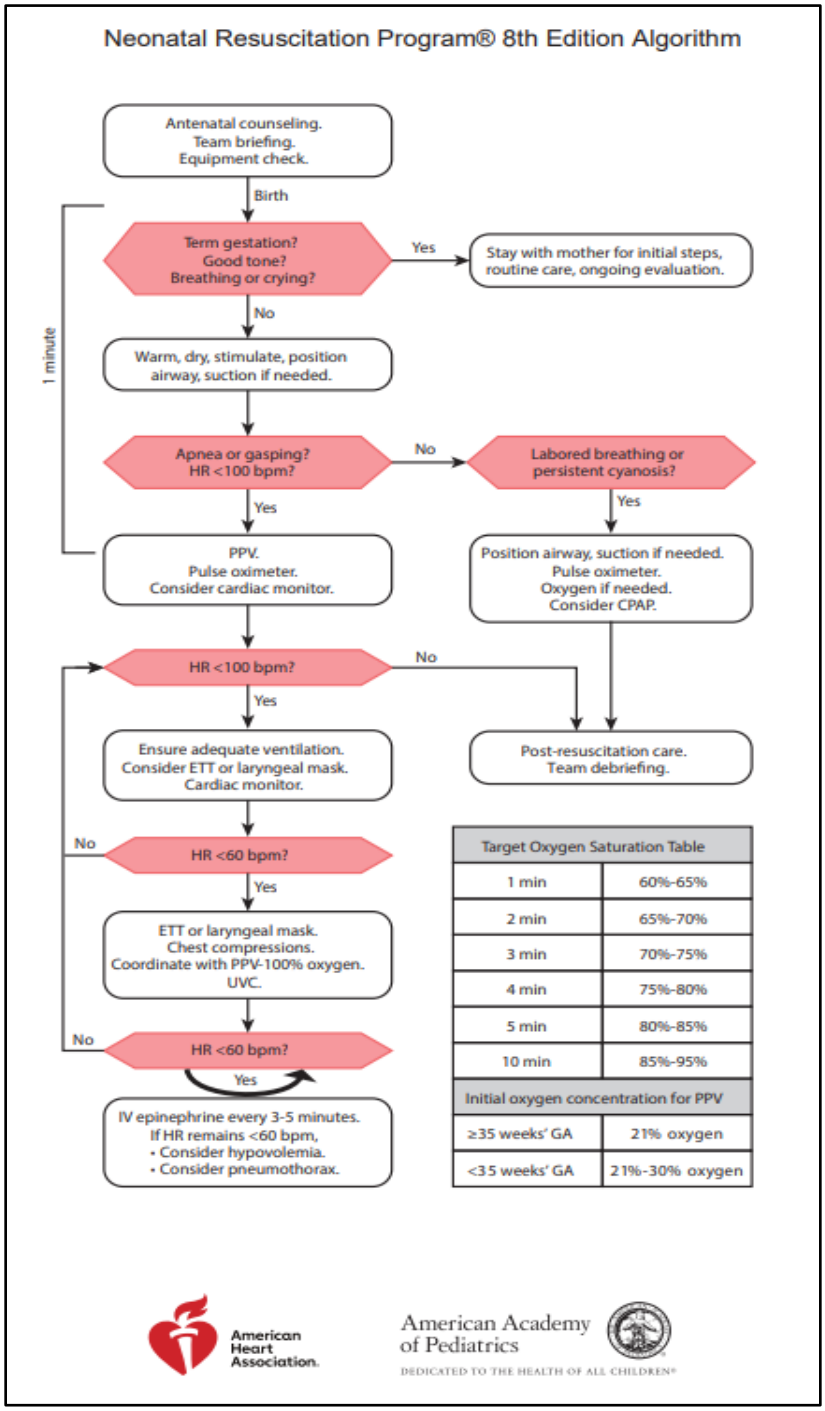
Keeping a small stock of RCP forms for use during unexpected births can help promote the best care possible. These forms can help prompt caregivers to initiate appropriate assessments and treatments such as the timing of routine intrapartum/postpartum and neonatal assessments and the administration of medications routinely used in care. While some of the forms may not be applicable, depending on the duration of stay, the maternal assessment forms, partogram, birth record, and newborn assessment forms will be helpful and necessary to use for any birth even if a transfer is indicated shortly thereafter.

RCP provides standard documentation forms for NS hospitals to support the documentation of perinatal care. **Images *of these forms are in Appendix C. Forms can be requested from the RCP office or via the RCP online order form.***

RCP/01: Preadmission Maternity Assessment
RCP/02: Maternal Assessment
RCP/03: Labour Partogram
RCP/04: Birth Record
RCP/07: Maternal & Newborn Progress Notes
RCP/08: Newborn Admission/Discharge
RCP/09: Newborn Nursing Assessment
RCP/10: Newborn TPR

Appendix A

Flow Diagram for NRP[11]



11 Textbook of Neonatal Resuscitation, 8th Ed. By American Academy of Pediatrics and American Heart Association. Edited by Gary M. Weiner and Jeanette Zaichkin (2021)

Equipment for Neonatal Resuscitation

Item	***Community Site***	***Regional Site***
Newborn warmer		✓
Means to keep newborn warm in lieu of skin-to-skin contact (e.g. gel warming mattress, cap, warm blankets/towels)	✓	✓
Oxygen supply	✓	✓
Appropriate size masks for term/preterm babies	✓	✓
Self-inflating neonatal resuscitation bag and tubing to connect to an oxygen source	✓	✓
O_2 blender (or means to blend air with O_2; e.g. Y-connector)	✓	✓
Manometer	✓	✓
Endotracheal tubes (sizes 2.5 to 4)	✓	✓
Tape and scissors	✓	✓
Laryngoscope (0 and 1 sized blades) with extra bulbs and batteries ***(*Requires specific training to achieve and maintain competency. Not to be used otherwise)***	✓	✓
T-piece resuscitator (e.g. Neopuff™ Infant Resuscitator)		✓
CO_2 detector	✓	✓
Laryngeal Mask Airway (LMA) size 1 ***(*Requires specific training to achieve and maintain competency. Not to be used otherwise.)***	✓	✓
Bulb syringe	✓	✓
Regulated mechanical suction	✓	✓
Suction catheters (6F, 8F, 10F, 12F)	✓	✓
Suction tubing and canister	✓	✓
Feeding tube (8F catheter)	✓	✓
Syringe, catheter tipped, 20 mL	✓	✓
Meconium aspirator		✓
IV catheters (22 g)		✓
Tape and sterile dressing material	✓	✓

Item	***Community Site***	***Regional Site***
D10W	✓	✓
Isotonic saline solution	✓	✓
Syringes, assorted (1-20 mL)	✓	✓
Epinephrine (0.1 mg/mL)	✓	✓
Umbilical catheters (3.5F, 5F)		✓
Chest tube (10F catheter)		✓
20 g IV catheter with 3-way stopcock (in lieu of chest tube)	✓	✓
Sterile procedure trays (e.g., scalpels, hemostats, forceps)	✓	✓

Canadian Pediatric Society's Neonatal Resuscitation Record[12]

NeoLog

Document every 1-2 minutes (if possible)

American Academy of Pediatrics | American Heart Association

Adapted with permission from Jane Germano, DO, FAAP

Name: GA: Date/time of birth: Date/Time: Wt/EFW:

Maternal risk factors/events leading to resus:

Location: ☐ Delivery Rm ☐ OR ☐ NICU ☐ Nursery ☐ Other | Thermoregulation (if preterm): ☐ Plastic wrap ☐ Thermal mattress Room temp:

☐ Preheat warmer ☐ Check PPV device with mask ☐ Prep pulse oximeter ☐ Check laryngoscope ☐ Prep ETT ☐ Access ECG leads ☐ Prep UVC ☐ Prep epinephrine ☐ Prep volume

MR. SOPA MR: Mask adjustment & Reposition airway SO: Suction & Open mouth P: Pressure increase A: Alternative airway

Time	Breathing: Yes / No / Assisted	HR: HR Auscultated	HR: HR on Monitor	O_2 Saturation	O2 Concentration	CPAP Pressure	PIP/PEEP	Chest Movement	CO2 Detector Color	Airway	Compressions O2 increase to 100%	Access	Preferred IV Epi 0.1mg/mL (0.1 - 0.3mL/kg)	ET Epi 0.1 mg/mL (0.5 - 1mL/kg)	Volume 10mL/kg	Notes (color, tone, ETT size and insertion depth, OG tube, total volume infused, transillumination, etc.)
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	

Outcome: Admission Temperature: ☐ Stabilized/remained on unit ☐ Transferred to: Time:

☐ Expired Time: Notification: ☐ Family Time: ☐ OB provider: Time:

☐ Baby's physician: Time:

Team Leader:

Scribe (print name): Scribe: (sign name): Date/Time:

Key: EFW = estimated fetal weight Epi = epinephrine ETT = endotracheal tube GA = gestational age IO = intraosseous IV = peripheral IV LM = laryngeal mask
NS = Normal Saline PIP/PEEP = positive inspiratory pressure/positive end expiratory pressure PRBC = packed red blood cells U = umbilical venous catheter

Page 1 of ____ (more recording space on next page)

Rev. 3/20

NeoLog Continued

Document every 1-2 minutes (if possible)

Name:

MR. SOPA MR: Mask adjustment & Reposition airway SO: Suction & Open mouth P: Pressure increase A: Alternative airway

Time	Breathing: Yes / No / Assisted	HR: HR Auscultated	HR: HR on Monitor	O_2 Saturation	O2 Concentration	CPAP Pressure	PIP/PEEP	Chest Movement	CO2 Detector Color	Airway	Compressions O2 increase to 100%	Access	Preferred IV Epi 0.1mg/mL (0.1 - 0.3mL/kg)	ET Epi 0.1 mg/mL (0.5 - 1mL/kg)	Volume 10mL/kg	Notes (color, tone, ETT size and insertion depth, OG tube, total volume infused, transillumination, etc.)
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	
	☐Y ☐N ☐A							☐		☐LM ☐ETT	☐	☐U ☐IO ☐IV	_____mL	_____mL	☐NS ☐PRBC	

Scribe (print name):

Scribe: (sign name): Date/Time:

Key: EFW = estimated fetal weight Epi = epinephrine ETT = endotracheal tube GA = gestational age IO = intraosseous IV = peripheral IV LM = laryngeal mask
NS = Normal Saline PIP/PEEP = positive inspiratory pressure/positive end expiratory pressure PRBC = packed red blood cells U = umbilical venous catheter

page ____ of ____

12 Neonatal critical event log. (2020) https://cps.ca/uploads/nrp/NRP_8th_ed_ITK_NeoLog.pdf

Appendix B:

Infographics for Birth, Postpartum and the Newborn

After Birth:

- Administer 10 IU Oxytocin IM to the birthing person

The placenta may take up to 30 minutes to deliver

Watch for Signs of Placental Separation:

- Gush of blood
- Lengthening of the cord

Did the placenta deliver?

- Massage the top of the uterus (fundus) immediately after placental delivery.
- Encourage emptying of the bladder

- Do not massage the fundus
- Do not pull on the cord
- Assess vaginal bleeding
- Assess maternal vital signs

EHS LifeFlight
1-800-743-1334

IMMEDIATE

- Place baby skin-to-skin
- Provide warmth
- Position the head and neck to maximize the airway
- Suction secretions from mouth then nose if needed

30 sec

Is baby breathing and/or crying ?

- Keep baby warm
- Place skin-to-skin
- Delay cord clamping:

Preterm (<37 weeks): 60-120 seconds

Term (≥37 weeks): 60 seconds

- Clamp and cut the cord after delayed clamping

- Clamp & Cut the cord
- Call for help
- Keep baby Warm
- Ventilate

Ventilation Rate 40-60 BPM

"**1** AND **2** AND **3** AND **BREATHE**"

EHS LifeFlight
1-800-743-1334

Appendix C

Samples of Standard Documentation for Labour and Birth

Images of the RCP chart forms are listed in order of their chart form number:

RCP/01:	Preadmission Maternity Assessment
RCP/02:	Maternal Assessment
RCP/03:	Labour Partogram
RCP/04:	Birth Record
RCP/07:	Maternal & Newborn Progress Notes
RCP/08:	Newborn Admission/Discharge
RCP/09:	Newborn Nursing Assessment
RCP/10:	Newborn TPR

PREADMISSION MATERNITY ASSESSMENT

To be used only for labour assessment prior to or upon admission to labour/delivery area, provided the prenatal record is present on the chart and record has been reviewed. Otherwise the regular Medical History and Physical format should be used.

Date (YYYY/MON/DD): _____ Time (HH:MM): _____

Gravida (G): _____ Term (T): _____ Preterm (P): _____ Abortus (A): _____ Living children (L): _____ Stillbirth (S): _____

Best estimate of gestational age: _____ weeks If uncertain, describe: _____

SUMMARY OF SIGNIFICANT PROBLEMS in current pregnancy and past history: _____

LABOUR ASSESSMENT

Estimate of when regular contractions became established Date (YYYY/MON/DD): _____ Time (HH:MM): _____

Membranes ruptured: ❑ Yes ❑ No ❑ Questionable Date (YYYY/MON/DD): _____ Time (HH:MM): _____

Meconium present: ❑ Yes ❑ No

PHYSICAL ASSESSMENT

Blood pressure: _____ Cardiopulmonary status: ❑ Normal ❑ Abnormal Describe: _____

Fundal height: _____ cm Presentation: _____ Engagement: ❑ Yes ❑ No

Estimated fetal weight: _____ ❑ Grams ❑ Lbs. Fetal heart rate (FHR): _____

PELVIC EXAM	0	1	2	3
Dilatation	0	1-2	3-4	5-6
Effacement %	30	40-50	60-70	80
Station	-3	-2	-1, 0	+1, +2
Consistency	firm	med.	soft	
Position	post.	mid.	ant.	

BISHOP SCORE: _____

ADDITIONAL HISTORY OR CLINICAL EVALUATION: _____

SIGNATURE/STATUS/PRINT NAME: _____

MATERNAL ASSESSMENT

Date _____ Time _____

Reason for assessment _____

Gravida (G) _____ Term (T) _____ Preterm(P) _____

Abortus (A) _____ Living Children (L) _____ Stillbirth (S) _____

Blood Group/Rh _____ 28 wk Pho(D) inj. received ❑ No ❑ Yes

Support Person(s) _____

Primary Care Provider _____

LMP _____ ❑ Known ❑ Unsure

EDD _____ by ❑ LMP or ❑ U/S @ _____ weeks

Gestation _____ weeks

Current Health and History

Immunizations Received in Pregnancy
(e.g.; Influenza, TDap, Hepatitis B and COVID-19)

Previous Pregnancy/Delivery

Medical History

Substance Use

Smoking ❑ No ❑ Yes Amt/day _____

Alcohol ❑ No ❑ Yes Amt/week _____

Cannabis ❑ No ❑ Yes Frequency _____

Other ❑ No ❑ Yes Describe _____

Initimate Partner Violence ❑ No ❑ Yes

Psychosocial Concerns ❑ No ❑ Yes

Describe _____

Labour and Birth Plan ❑ Written ❑ Verbal

Key Points _____

Pain Relief Choices

❑ Non-Pharmacological _____

❑ Pharmacological _____

Prenatal Education

❑ Classes ❑ Other _____

Infant Feeding Choices

❑ Breast ❑ Antenatal Colostrum collection ❑ Other _____

Previous BF experiences ❑ No ❑ Yes

Describe _____

Allergies _____

Current Medications _____

Rubella	❑ Immune	❑ Non-immune	❑ Unknown
Varicella	❑ Immune	❑ Non-immune	❑ Unknown
HIV	❑ Negative	❑ Positive	❑ Unknown
Hepatatis B	❑ Negative	❑ Positive	❑ Unknown

GC/Chlamydia Screening

Date (most recent screen) _____

Gonorrhea	❑ Negative	❑ Positive	❑ Unknown
Chlamydia	❑ Negative	❑ Positive	❑ Unknown
GBS Status	❑ Negative	❑ Positive	❑ Unknown

Maternal Vitals TPR ____ / ____ / ____ BP _____

Pre-Preg. Wt _____ HT _____ BMI _____

Current Wt _____ Weight Gain _____

Lab Tests

Labour ❑ No ❑ Yes ❑ N/A

Contractions started _____

Frequency: # _____ in 10 minutes.

Palpated ❑ Mild ❑ Moderate ❑ Strong

fFN ❑ No ❑ Yes ❑ N/A ❑ Neg. ❑ Pos.

Cervix ____ cm ____ station ____ % eff. ____ position

Examined by _____

Membranes

SRM ❑ No ❑ Suspected ❑ Yes Date/time _____

Colour and volume of fluid _____

Ferning ❑ No ❑ Yes ❑ Not done

Fetal Presentation _____ Position _____ FH _____ cm

FM ❑ Active ❑ Decreased

FHR _____ bpm ❑ IA ❑ EFM Indication _____

Classification ❑ Normal ❑ Atypical ❑ Abnormal

Interpretation _____

NST (if indicated) ❑ Normal ❑ Atypical ❑ Abnormal

Plan of Care _____

BPP Score _____ U/S _____

Notes

Plan of Care

Attending Care Provider _____ notified @ _____ hr.

❑ Admitted to room # _____ Reason _____

Date _____ Time _____

❑ Transferred to _____ Date _____ Time _____

❑ Discharged home Date _____ Time _____

Signature/Status/Print Name _____

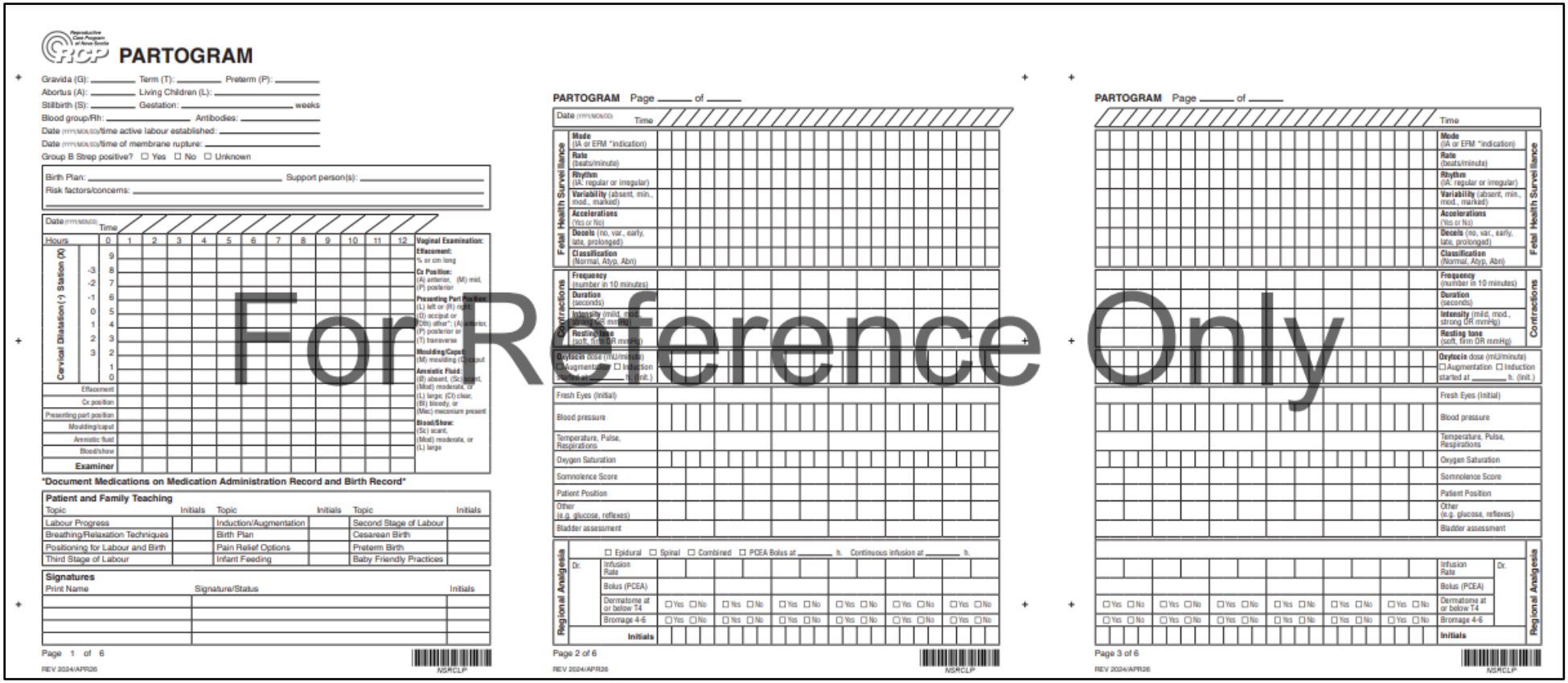
❑ **For Induction**

Indication _____

❑ **Booked C/S**

Indication _____

Date _____



PARTOGRAM

Gravida (G): _____ Term (T): _____ Preterm (P): _____
Abortus (A): _____ Living Children (L): _____
Stillbirth (S): _____ Gestation: _____ weeks
Blood group/Rh: _____ Antibodies: _____
Date (YYYY/MON/DD)/time active labour established: _____
Date (YYYY/MON/DD)/time of membrane rupture: _____
Group B Strep positive? ☐ Yes ☐ No ☐ Unknown

Birth Plan: _____ Support person(s): _____
Risk factors/concerns: _____

Date (YYYY/MON/DD) / Time

Hours	0	1	2	3	4	5	6	7	8	9	10	11	12
Cervical Dilatation (•) Station (X)	9												
	-3 8												
	-2 7												
	-1 6												
	0 5												
	1 4												
	2 3												
	3 2												
	1												
	0												
Effacement													
Cx position													
Presenting part position													
Moulding/caput													
Amniotic fluid													
Blood/show													
Examiner													

Vaginal Examination:
Effacement: % or cm long
Cx Position: (A) anterior, (M) mid, (P) posterior
Presenting Part Position: (L) left or (R) right; (O) occiput or (Sin) other*; (A) anterior, (P) posterior or (T) transverse
Moulding/Caput: (M) moulding (D) caput
Amniotic Fluid: (B) absent, (Sc) scant, (Mod) moderate, or (L) large; (Cl) clear, (Bl) bloody, or (Mec) meconium present
Blood/Show: (Sc) scant, (Mod) moderate, or (L) large

Document Medications on Medication Administration Record and Birth Record

Patient and Family Teaching

Topic	Initials	Topic	Initials	Topic	Initials
Labour Progress		Induction/Augmentation		Second Stage of Labour	
Breathing/Relaxation Techniques		Birth Plan		Cesarean Birth	
Positioning for Labour and Birth		Pain Relief Options		Preterm Birth	
Third Stage of Labour		Infant Feeding		Baby Friendly Practices	

Signatures

Print Name	Signature/Status	Initials

Page 1 of 6
REV 2024/APR26
NSMCLP

PARTOGRAM Page _____ of _____

Date (YYYY/MON/DD) / Time

Fetal Health Surveillance
- **Mode** (IA or EFM *indication)
- **Rate** (beats/minute)
- **Rhythm** (IA: regular or irregular)
- **Variability** (absent, min., mod., marked)
- **Accelerations** (Yes or No)
- **Decels** (no, var., early, late, prolonged)
- **Classification** (Normal, Atyp, Abn)

Contractions
- **Frequency** (number in 10 minutes)
- **Duration** (seconds)
- **Intensity** (mild, mod., strong OR mmHg)
- **Resting tone** (soft, firm OR mmHg)

Oxytocin dose (mU/minute) ☐ Augmentation ☐ Induction started at _____ h. (Init.)

- Fresh Eyes (Initial)
- Blood pressure
- Temperature, Pulse, Respirations
- Oxygen Saturation
- Somnolence Score
- Patient Position
- Other (e.g. glucose, reflexes)
- Bladder assessment

Regional Analgesia
☐ Epidural ☐ Spinal ☐ Combined ☐ PCEA Bolus at _____ h. Continuous infusion at _____ h.
Dr.
- Infusion Rate
- Bolus (PCEA)
- Dermatome at or below T4 — ☐ Yes ☐ No
- Bromage 4-6 — ☐ Yes ☐ No
- Initials

Page 2 of 6
REV 2024/APR26
NSMCLP

PARTOGRAM Page _____ of _____

Time

Fetal Health Surveillance
- **Mode** (IA or EFM *indication)
- **Rate** (beats/minute)
- **Rhythm** (IA: regular or irregular)
- **Variability** (absent, min., mod., marked)
- **Accelerations** (Yes or No)
- **Decels** (no, var., early, late, prolonged)
- **Classification** (Normal, Atyp, Abn)

Contractions
- **Frequency** (number in 10 minutes)
- **Duration** (seconds)
- **Intensity** (mild, mod., strong OR mmHg)
- **Resting tone** (soft, firm OR mmHg)

Oxytocin dose (mU/minute) ☐ Augmentation ☐ Induction started at _____ h. (Init.)

- Fresh Eyes (Initial)
- Blood pressure
- Temperature, Pulse, Respirations
- Oxygen Saturation
- Somnolence Score
- Patient Position
- Other (e.g. glucose, reflexes)
- Bladder assessment

Regional Analgesia
Dr.
- Infusion Rate
- Bolus (PCEA)
- Dermatome at or below T4 — ☐ Yes ☐ No
- Bromage 4-6 — ☐ Yes ☐ No
- Initials

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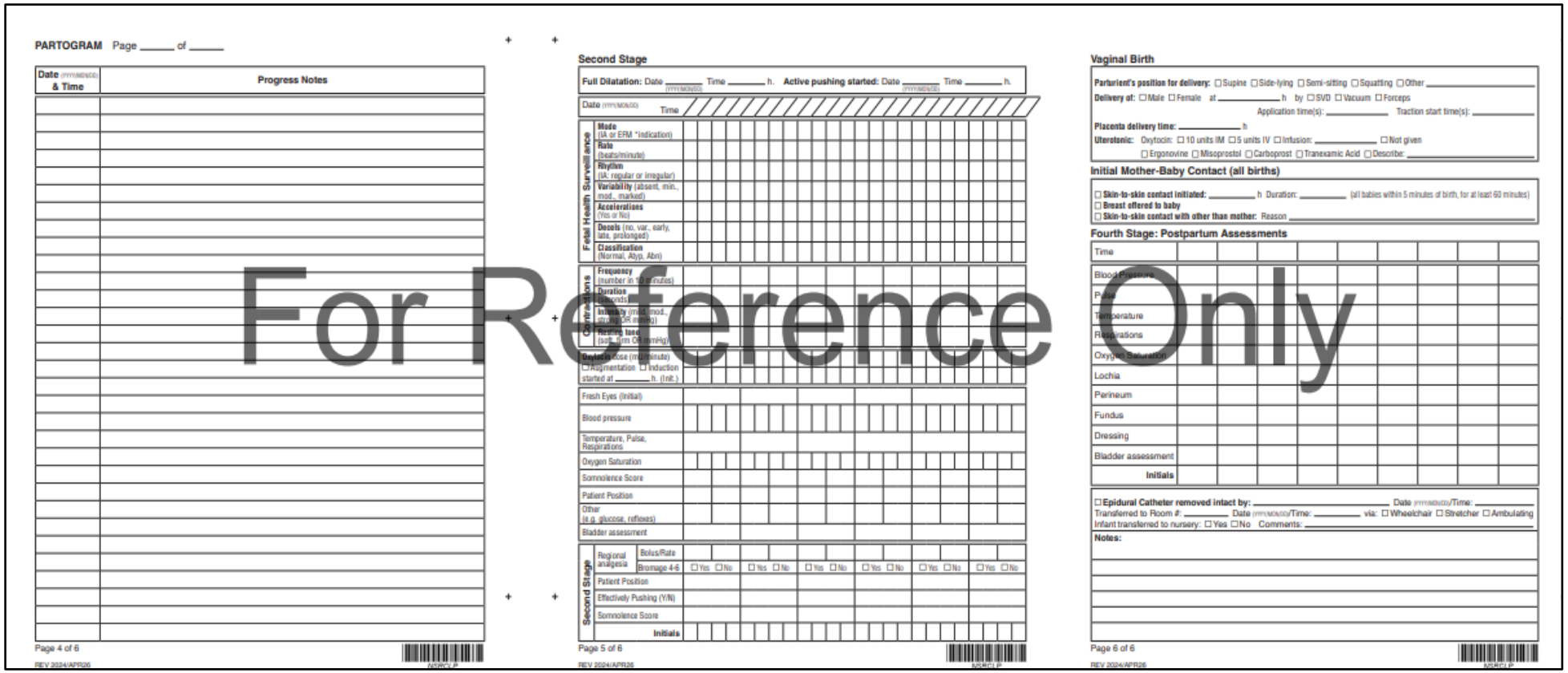
REV 2024/APR26
NSMCLP



PARTOGRAM Page _____ of _____

Date (YYYY/MON/DD) & Time	Progress Notes

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REV 2024/APR26

Second Stage

Full Dilatation: Date _____ (YYYY/MON/DD) Time _____ h. **Active pushing started:** Date _____ (YYYY/MON/DD) Time _____ h.

Date (YYYY/MON/DD) Time

Fetal Health Surveillance

- **Mode** (IA or ERM *indication)
- **Rate** (beats/minute)
- **Rhythm** (IA: regular or irregular)
- **Variability** (absent, min., mod., marked)
- **Accelerations** (Yes or No)
- **Decels** (no, var., early, late, prolonged)
- **Classification** (Normal, Abyp, Abn)

Contractions

- **Frequency** (number in 10 minutes)
- **Duration** (seconds)
- **Intensity** (mild, mod., strong (list marks))
- **Resting tone** (soft, firm OR mmHg)

Oxytocin Dose (ml/minute) ☐ Augmentation ☐ Induction started at _____ h. (Init.)

- Fresh Eyes (Initial)
- Blood pressure
- Temperature, Pulse, Respirations
- Oxygen Saturation
- Somnolence Score
- Patient Position
- Other (e.g. glucose, reflexes)
- Bladder assessment

Second Stage

- Regional analgesia — Bolus/Rate; Bromage 4-6 ☐Yes ☐No
- Patient Position
- Effectively Pushing (Y/N)
- Somnolence Score
- **Initials**

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REV 2024/APR26

Vaginal Birth

Parturient's position for delivery: ☐Supine ☐Side-lying ☐Semi-sitting ☐Squatting ☐Other _____

Delivery at: ☐Male ☐Female at _____ h by ☐SVD ☐Vacuum ☐Forceps

Application time(s): _____ Traction start time(s): _____

Placenta delivery time: _____ h

Uterotonic: Oxytocin: ☐10 units IM ☐5 units IV ☐Infusion: _____ ☐Not given

☐Ergonovine ☐Misoprostol ☐Carboprost ☐Tranexamic Acid ☐Describe: _____

Initial Mother-Baby Contact (all births)

☐ **Skin-to-skin contact initiated:** _____ h Duration: _____ (all babies within 5 minutes of birth, for at least 60 minutes)

☐ **Breast offered to baby**

☐ **Skin-to-skin contact with other than mother:** Reason _____

Fourth Stage: Postpartum Assessments

Time									
Blood Pressure									
Pulse									
Temperature									
Respirations									
Oxygen Saturation									
Lochia									
Perineum									
Fundus									
Dressing									
Bladder assessment									
Initials									

☐ **Epidural Catheter removed intact by:** _____ Date (YYYY/MON/DD)/Time: _____

Transferred to Room #: _____ Date (YYYY/MON/DD)/Time: _____ via: ☐Wheelchair ☐Stretcher ☐Ambulating

Infant transferred to nursery: ☐Yes ☐No Comments: _____

Notes:

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REV 2024/APR26

Reproductive Care Program of Nova Scotia

BIRTH RECORD

Gravida (G) ____ Term (T) ____
Preterm(P) ____ Abortus (A) ____
Living Children (L) ____
Stillbirth (S) ____
EDD ____ Gest ____ wks
GBS Status ☐ Neg. ☐ Pos. ☐ Unknown
Preg/Med complications

Membrane Rupture
☐ SRM Date ____
☐ Suspected Time ____
☐ ARM Duration ____
Meconium ☐ No ☐ Yes
Time first noted ____
☐ Maternal fever > 38˚ in labour

Initiation/Progress of Labour
☐ Spontaneous onset
☐ Oxytocin augmentation
☐ Induction Reason ____

Induction Method
☐ Cervical Ripening Type ____
☐ ARM
☐ Oxytocin
☐ Mechanical (catheter)

1st Stage Established Date ____ Time ____

2nd Stage Onset Date ____ Time ____

Birth Date ____ Time ____ Position at birth ____
☐ Spontaneous ☐ C/S Reason ____
☐ Vacuum (and/or) ☐ Forceps Reason ____
☐ Mid ☐ Low ☐ Outlet ☐ Attempted Only
☐ Mid ☐ Low ☐ Outlet ☐ Attempted Only
☐ Rotation ☐ Manual or ☐ Forceps
☐ Other Intervention (e.g. Breech Extraction) ____

Placental Delivery Date ____ Time ____
☐ Spontaneous ☐ Assisted ☐ Manual
Umbilical Vessels ☐ 3 ☐ 2 Cord pH done ☐ No ☐ Yes
Abnormalities Describe ____
Oxytocin ☐ No ☐ Yes Type ____ Dose ____ Route ____
Infusion postpartum ____
PPH ☐ No ☐ Yes
Estimated blood loss ☐ <500 mL ☐ 500–1000 mL ☐ > 1000 mL

Episiotomy
☐ None
☐ Midline
☐ Mediolateral

Lacerations
☐ None
☐ 1st (vaginal)
☐ 2nd (perineal)
☐ 3rd (anal sphincter) ☐ a ☐ b ☐ c
☐ 4th (rectal mucosa)
Suture required ☐ No ☐ Yes Count verified ☐ Sutures ☐ Sponges

Analgesia/Anaesthesia
☐ None ☐ Narcotic ☐ Spinal ☐ Epidural ☐ Nitrous Oxide ☐ General
☐ Other ____

Medications (to mother within 24 hours before birth)

Time	Drug	Dose	Route

Baby ☐ Female ☐ Male Weight ____ (g)

APGAR	0	1	2	1 Min	5 Min	10 Min
Heart Rate	Absent	Below 100	Above 100			
Resp. Effort	Absent	Slow irregular	Good crying			
Muscle Tone	Limp	Some flexion	Active motion			
Reflex Irritab.	None	Grimace	Cough sneeze			
Colour	Blue Pale	Body Pink Blue extrem	All pink			
APGAR Score			Totals			

Erythromycin Eye Ointment ____
(If indicated) Signature

Resuscitation

(Duration)	< 1 min.	1–3 min.	> 3 min.	Max. % or duration
02	☐	☐	☐	____
PPV	☐	☐	☐	____
ET tube (ventilation)	☐	☐	☐	____
LMA	☐	☐	☐	____
CPAP	☐	☐	☐	____
Chest compressions	☐	☐	☐	____

Tracheal suctioning ☐ No ☐ Yes
Meconium below cords ☐ No ☐ Yes Epinephrine ☐ No ☐ Yes
Other med ☐ No ☐ Yes ____

Delayed Cord Clamping
☐ < 30 sec.
☐ 30 to 60 sec.
☐ > 1 min. to 3 min.
☐ > 3 min.

Cord Milking
(if delayed cord clamping is not feasible)
☐ No
☐ Yes

☐ **Stillbirth** Date/Time last FHR ____
Date/Time last FM ____

Comments

Signature(s) of MD/MW attending birth ____ / ____
Signature(s) of RN attending birth ____ / ____

NSRCBIR

RCP/04 REV 2024AUG08 Copy Distribution White - Mother's Chart Yellow - Newborn's Chart Pink - Clinic

nova scotia health | IWK Health | Reproductive Care Program of Nova Scotia

MATERNAL AND NEWBORN PROGRESS NOTES

DATE (YYYY/MON/DD) & TIME (HH:MM)	PROGRESS NOTES	STATUS

NEWBORN ADMISSION/DISCHARGE

(Including stillbirths)

Initial Assessment

General Appearance:
☐ Transitioning Well ☐ If no, describe below:

Infant Surname, First name (if known) | Mother's Name

DOB | Time | Sex

Gest. Age by Assessment (weeks/days) | Gest. Age by Best Prenatal Estimate (weeks/days)

Delivery: ☐ SVD ☐ Vacuum ☐ Forceps ☐ Cesarean

Apgar: @1 ____ @5 ____ @10____ ☐ Resuscitation

☐ Admit to NICU/ Nursery (indication): _____

☐ At risk for complications

☐ Labour induced (indication): _____

Exam:	**<37 weeks (Preterm)**	**≥37 weeks (Term)**
Breast Tissue	☐ ≤3mm	☐ >3mm
Plantar Creases	☐ Smooth, single crease	☐ Cover anterior 1/3 or more
Ear Pinna	☐ Relatively flat, pliable	☐ Stiff cartilage, deep crease at outer aspect
Genitalia: Male	☐ Testes in canal	☐ Testes well within scrotum
Female	☐ Labia Minora visible	☐ Labia Majora cover Minora

GBS Status: _____ Rx >4hours: ☐ Yes ☐ No

Normal Prenatal Ultrasound: ☐ Yes ☐ No

Skin-to-skin first hour(s): ☐ Yes ☐ No, why: _____

Breastfeed first hour(s): ☐ Yes ☐ No, why: _____

Erythromycin eye prophylaxis: ☐ No ☐ Yes, why: _____

Vitamin K: _____ mg, ☐ IM ☐ PO

Comprehensive Physical Exam

Completed within 24h of birth *guide on reverse side of form

Birth Weight (g) Length (cm) Head Circ. (cm) ☐ SGA ☐ LGA

Describe findings other than normal:

Skin	☐ Normal	Soft tissue wasting: ☐ Moderate ☐ Severe
Head, Neck	☐ Normal	☐ Palate Intact
	☐ Red reflex: L___ R___	☐ Unable to obtain ☐ Follow-up req'd
Arms, Clavicles, Hands	☐ Normal	
Cardiac	☐ Normal	☐ Femoral pulses ☐ Murmur
Respiratory	☐ Normal	
Abdomen	☐ Normal	Cord: ☐ Single UA ☐ Double UA
	Spleen: _____ cm	Liver: _____ cm
Anus	☐ Normal	☐ Passed meconium
Genitourinary	☐ Normal	☐ Passed urine
Hips, Legs, Feet	☐ Normal	☐ Barlow/Ortolani: L___ R___
Back	☐ Normal	
Neurologic	☐ Normal	☐ Reflexes ☐ Unable to obtain reflexes

CCHD Screening final results: ☐ Pass ☐ Refer

Right hand	Foot	% Difference

Age when screened: _____ hours

☐ Declined ☐ Not clinically appropriate

Date: Time: Print Name: Signature/Status:

Discharge

☐ **Discharge Physical Completed** Discharge weight: _____(g)

Comments:

Feeding ☐ Breastfeeding ☐ EBM ☐ Exclusive ☐ with Supplementation ☐ Formula: _____ ☐ Medically Indicated

Indications for supplementation: _____

Feeding issues: _____

Discharge/Follow up plan: _____

Primary Care Provider appt: ☐ Booked: _____

(FP/NP/RM) ☐ Parent to arrange ☐ No provider

☐ PHN referral indicated ☐ Fax copy (if applicable) to: _____

Date/Time Print Name/Signature/Status

Newborn Screening:

☐ Bilirubin: last TSB ____µmol/L Date:_____ Time:_____

☐ To be repeated (date/time): _____

☐ Phototherapy (describe): _____

DAT: _____ Blood type: _____

☐ Newborn screening blot: Date:_____ ☐ To be arranged

Other test results: _____

☐ **Refer to Additional Dictation** ☐ **not applicable**

Consults: _____

NSHSC Hearing Screen: OAE / AABR Pass / Refer

☐ Hearing screen to be arranged

Date/Time Print Name/Signature/Status

NSRCPN

RCP/08 – Revised November/2020
WHITE – Hospital Chart / **YELLOW** – Primary Care Provider Office

NEWBORN EXAMINATION

A **brief examination** should occur within the first few minutes of life to:

- Assess for signs of successful transition to the extra- uterine environment
- Determine sex
- Identify significant congenital anomalies
- Reassure parents

In the healthy baby this examination should be undertaken while the baby maintains 'skin to skin' with the mother.

Every newborn baby should receive a comprehensive physical examination within 24h of birth. **If the baby is unwell or premature, this examination may be staged as clinically indicated**. If baby is preterm use the New Ballard Score for maturation assessment of gestational age. Findings should be documented and the results discussed with parents. A follow up comprehensive examination is recommended within the first 7-10 days of birth. All parents are contacted within 1-3 days of discharge to determine ongoing needs/supports required.

Components of the Comprehensive Newborn Physical Exam:

General Appearance

- Skin color
- State of Alertness
- Activity
- Range and symmetry of spontaneous movement
- Posture
- Muscle Tone

Growth Status

- Weight and Length
- Head Circumference

Skin

- Colour
- Texture
- Integrity
- Anomalies

Head

- Shape and symmetry
- Scalp
  - Caput
  - Cephalohematoma
- Anterior and posterior fontanels
- Sutures

Face

- Symmetry of structure, features and movement
- Eyes
  - Size and structure
  - Position in relation to the nasal bridge
  - Red Reflex
- Ears
  - Position and structure
- Nose:
  - Position and symmetry of nares and septum
  - Patency of nares bilaterally
- Mouth
  - Size
  - Symmetry of movement
  - Shape and structure - lips, palate, tongue
- Jaw size

Neck

- Structure/ Lymph nodes/ Thyroid palpable
- Symmetry of movement
- Range of movement

Clavicles, Arms and Hands

- Length
- Proportion
- Symmetry
- Hand creases
- Structure and number of digits

Chest/Cardiorespiratory

- Chest
  - Chest size, shape, symmetry
  - Breast tissue
  - Number and position of nipples
- Respiratory
  - Chest movement and effort with respiration
  - Breath sounds/Airway
  - Respiratory rate
- Cardiac
  - Skin colour - central/peripheral
  - Heart sounds
  - Heart rate
  - Heart rhythm
  - Pulse Oximetry
  - Pulses: brachial, femoral

Abdomen

- Shape and symmetry
- Major organs (liver and spleen, palpable, size)
- Umbilicus (number of vessels)

Genitourinary

- Has the baby passed urine?
- Inguinal hernia , Lymph nodes
- Genitalia: Male, female, ambiguous
  - Male: penis, foreskin, testes
  - Female: clitoris, labia, hymen

Anus

- Position
- Patency - Has the baby passed meconium?

Hips, Legs and Feet

- Use Ortolani and Barlow's maneuvers to assess hips for stability
- Legs and feet:
  - Length and proportion
  - Symmetry
  - Anomalies (e.g. club feet)
  - Structure and number of digits

Back

- Spinal column /Ribs
- Scapulae and buttocks for symmetry
- Skin (sacral dimple/sinus)

Neurologic

- Behavior
- Posture
- Muscle tone
- Movements
- Cry
- Reflexes: Babinski, grasp, moro ,rooting, stepping, suck

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NEWBORN NURSING ASSESSMENT

Birth Date (YYYY-MM-DD)	Birth Time	Sex	Band #
Birth Wt. (g)	Head Circ. (cm)	Length (cm)	
Blood Group Mother / Baby / Coombs	Feeding ❑ Breast ❑ With Suppl.	❑ Exclusive ❑ Formula	

GESTATIONAL AGE ASSESSMENT

	Less than 37 WEEKS (Preterm)	More than or equal to 37 WEEKS (Term)
BREAST TISSUE	❑ Less than or equal to 3mm	❑ Greater than or equal to 3mm
PLANTAR CREASES	❑ Smooth, Single Crease	❑ Covering Ant. 1/3 or More
EAR	❑ Relatively Flat, Pliable	❑ Stiff Cartilage, Deep Crease at Outer Aspect
GENITALIA	Male ❑ Testes In Canal	❑ Testes well within Scrotum
	Female ❑ Labia Minora Visible	❑ Labia Majora cover Minora

GESTATIONAL AGE
By Dates _____wks.
By Assessment _____wks.

HEAD TO TOE ASSESSMENT

	NORMAL	ABNORMAL (Comment on Abnormalities)		
1. GENERAL APPEARANCE	❑	❑		
2. SKIN	❑	❑ Bruising ❑ Petechiae ❑ Meconium Stain ❑ Edema ❑ Soft tissue wasting	❑ Peeling ❑ Jaundice ❑ Other ❑ Moderate	❑ Severe
3. HEAD	❑	❑ Overriding Suture ❑ Hematoma	❑ Molding ❑ Other	❑ Caput
4. EENT	❑	❑ Cleft Lip/Palate ❑ Suspected Choanal Atresia	❑ Other	
5. RESP	❑	❑ Grunting ❑ Nasal Flaring ❑ Retracting	❑ ↓ Breath Sounds ❑ Tachypnea ❑ Other	
6. CVS	❑	❑ Murmur ❑ Arrhythmia ❑ Tachycardia	❑ Central Cyanosis ❑ Absent Femoral Pulses ❑ Other	
7. ABDOMEN	❑	❑ Scaphoid ❑ Distended	❑ Other	
8. UMBILICAL CORD	❑	❑ Meconium Stain ❑ 2 Vessels	❑ Thin ❑ Other	
9. MUSCULO-SKELETAL	❑	❑ Spine ❑ Hip abnormal ❑ Clavicle	❑ Foot abnormal ❑ Other	
10. GENITO-RECTAL	❑	❑ Hydrocele ❑ Hypospadias ❑ Undescended testes	❑ Imperforate anus ❑ Other	
11. CNS	❑	❑ ↓ Tone ❑ Abnormal Cry	❑ ↑ Tone ❑ Jittery	❑ Other

Date (YYYY-MM-DD): _____ Time: _____
Signature: _____

❑ Erythromycin eye ointment given ❑ Yes ❑ No
❑ Vitamin K Dose/Route
Given by _____

Newborn Screening: ❑ Discussed ❑ Done ❑ Arranged

CCHD Screening:
Age at initial screen: _____ hours

R. Hand	Foot	% Diff	Action
			P / R / F
			P / R / F
			P / F

P=Pass / R=Repeat / F=Fail

❑ Further assessment required ❑ See Notes
❑ Screening declined
❑ Not clinically appropriate
Date (YYYY-MM-DD): _____ Time: _____
Signature _____

DISCHARGE Weight _____g
❑ Physician assessment completed
❑ Order for discharge written
Feeding: ❑ Breast ❑ Exclusive ❑ With Suppl.
Formula _____
❑ Medically Indicated
❑ Well Established
❑ Problems Ongoing
Follow-up Plan _____

COMMENTS

Date (YYYY-MM-DD): _____ Time: _____
Signature: _____

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NEWBORN T.P.R.