Labor and Delivery

Policy Title/Number: Emergent Resident Interventions


Categories:

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Review Responsibility: Clinical Unit Policy Committee

Effective Date:

Last Revised Date:

Team Members Performing:

- [x] RN
- [ ] LPN
- [ ] Care Partner/Patient Care Technician
- [x] Other licensed staff (specify): MD or CNM
- [ ] Other non-licensed staff (specify):

Guidelines Applicable to:
- [x] VUH
- [ ] VMG*
- [ ] VCH
- [ ] PHV
- [ ] Other (specify):
- [ ] Exceptions (specify):

*includes satellite sites unless otherwise specified.

Guidelines Applicable to:
- [ ] All patient care areas
- [ ] All inpatient areas
- [ ] Adult areas only
- [ ] Pediatric areas only
- [ ] Critical Care/Stepdown areas only
- [x] Selected areas (specify): Labor and Delivery
- [ ] Exceptions (Specify):

Specific Education Requirements: Yes No
Emergent Resident Interventions

I. **Outcome Goal:** To outline the procedures to be followed when residents must initiate treatments without the presence of an attending physician.

II. **Policy:** To ensure that there is no delay in performing urgent or emergent treatments and interventions when the attending physician is not available.

III. **Equipment/Supplies:** As needed.

IV. **Protocol:**

   In an urgent/emergent situation the most senior OB resident will make the decision regarding the performance of necessary treatments and interventions and will notify the attending physician of the decision. Notification of the attending physician may be delegated to the charge nurse as necessary.

V. **Procedure**

   The following procedures/interventions that may be performed in urgent/emergent situations include the following: cesarean sections, forceps assisted deliveries, and/or vacuum assisted deliveries.

   1. If the attending physician cannot be present, the senior resident or most senior OB resident available will be notified by the charge nurse to come to assess the situation.
   2. The most senior OB resident available will perform/supervise the procedure when the attending is not available contingent on their level of training.
   3. Any issue with the management of the patient or with the planned intervention will not be discussed in the presence of the patient or family. These discussions must occur outside of the patient’s room and in a private setting.
   4. The anesthesia attending will be called to be present for the planned intervention. If the OB anesthesia attending is not available the most senior OB anesthesia resident will be notified to come for the planned intervention. Some interventions, such as an emergent C/S, may include the need to administer anesthetic without the presence of the attending physician. This should be done as required. Lack of the attending presence should not delay the administration of anesthetics.
5. The charge nurse or the most experienced nurse available will be called to the room for the planned intervention. The role of the second nurse is to assist the assigned nurse during the intervention. She is not expected to supervise or instruct the resident.
6. Following any urgent/emergent interventions there will be a debriefing as soon as the attending is available. This will be no later than the end of the shift. All personnel who were present for the intervention will be expected to take part in the debriefing procedure.

VI. Patient/Family Education: The resident, attending physicians and nurse caring for the patient will discuss the interventions and plan of care with the patient and family. Whenever possible this will occur prior to the performance of the planned intervention. When the intervention is emergent discussions with the patient and family may occur following the debriefing.

VIII. Documentation: will be done by the providers and nurses caring for the patient in accordance with unit and hospital guidelines

IX. Cross References:

X. References:

XI. Web References:

XI. Contributors:

Dr. Bennett Spetalnick, Medical Director, Labor and Delivery

Donna Ruth, MSN Educator, Labor and Delivery

XII. Endorsement:

Clinical Unit Practice Committee – (month/year approved)

XIII. Approval:

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Chair of Obstetrics and Gynecology
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Administrative Director of Women’s Health  

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