LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

SUBJECT: BIRTH OUTSIDE OF LABOR, DELIVERY BOA (BIRTH OUT OF ASEPSIS), AND NEONATAL DEATH **POLICY NO.** 306B

CATEGORY: Provision of Care	**EFFECTIVE DATE:** 10/07
POLICY CONTACT: Patricia Padlipsky, MD	**UPDATE/REVISION DATE:** 3/23
REVIEWED BY COMMITTEE(S): Pediatric Acute and Critical Care Committee	

PURPOSE:
To coordinate and provide care for mothers who give birth outside of the Labor and Delivery (L&D) unit and their infants; to coordinate continued care of the mother/birthing person while allowing for baby bonding after the death of a neonate soon after delivery.

DEFINITIONS:
Neonatal death: Newborn that completed 20 0/7th week of intrauterine gestation or more (or a weight of greater than or equal to 350 grams if gestational age is not known) that shows one or more sign-of life but expires at birth to 28 days (gets both birth and death certificate).
Stillborn: Newborn that has completed the 20 0/7th week of intrauterine gestation and has no signs of life (respirations or heartbeat at birth) or if gestational age is unknown, use weight of $\geq$ to 350 grams that has no signs of life (respirations or heartbeat at birth).
Spontaneous abortion (Miscarriage): Fetus did not complete 20 0/7 weeks of intrauterine gestation or if gestational age unknown, weighs less than 350 grams.

POLICY:
Harbor-UCLA Medical Center shall ensure the safety of the mothers/birthing people and their infants (dyad) when birth is outside of the L&D unit by the following procedures:

SITUATIONS:
A. *Newborn Delivered at Home or in an Ambulance*

1. Paramedics will call the Emergency Department radio room.
2. Mobile Intensive Care Nurse (MICN) or Physician will direct the paramedics to take the mother and baby to the Pediatric Emergency Department (PED). The MICN or Base Physician taking the call will notify an Adult Emergency Department (AED) team and the PED team of the anticipated arrival of the mother and infant.
3. The MICN or his/her designee will activate the OB Batch Pager for assistance in the care of the mother/birthing person and infant.

REVISED: 1/12, 3/12, 10/14, 4/18, 5/18, 11/22, 3/23
REVIEWED: 1/12, 12/12, 10/14, 4/18, 11/22, 3/23

APPROVED BY:

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B. *Delivery of a Newborn in the PED*

If paramedics transport a pregnant patient who is crowning, meaning delivery is imminent, they will be instructed to transport the mother to the PED. Pregnant patients presenting to the router desk with the urge to push will be escorted to the PED. PED team will evaluate the pregnant patient for crowning and will determine if birth is imminent.

If it is deemed that birth is not imminent, then the pregnant patient will be transported to L&D. If it is deemed delivery is imminent, then PED Charge RN or their designee will notify an AED team to come care for the pregnant patient and they will activate the OB Batch Pager for assistance in the delivery and/or resuscitation of the dyad.

C. *Delivery of a Newborn in the AED*

If a pregnant patient in labor delivers inadvertently in the AED, AED Charge RN or their designee will activate the OB Batch Pager and call the PED team for assistance in the care of the dyad.

PROCEDURE FOR INFANTS BORN OUT-OF-HOSPITAL, IN THE PED OR AED

1. If the infant is stable, the parent and infant dyad will be placed in the same room. If the baby requires resuscitation, the baby will be placed in a separate room nearby. The Birth out of Asepsis (BOA) cart and baby warmer will be brought to the room with the baby.
2. The AED team will evaluate and care for the mother until the OB team arrives. The OB team and the AED team will work together to care for the mother/birthing person until transfer to the 7th-floor ward.
3. The PED attending of record is responsible for all aspects of patient care until the NICU attending arrives or patient is admitted to the NICU. The PED attending will be the incident commander and perform or delegate procedures to the most appropriate provider.
4. Banding and registration of the mother and newborn(s) will be done in the PED. If the infant is born in the AED, banding and registration of parent(s) and newborn will be done in the AED, unless the newborn's condition dictates immediate transfer to the PED, in which case the newborn will be banded in the PED.
5. The OB Team is expected to evaluate the mother and ensure her stability before the team leaves the ED. (This includes checking for complete delivery of the placenta and administration of uterotonics, evaluation for any placental tears and postpartum bleeding.) Until the dyad is transferred to 7E L&D, ED nursing staff is expected to monitor the mother for any concerning signs postpartum, including vital sign abnormalities and excessive bleeding, that would warrant more urgent transfer.
6. Once stabilized, the dyad will be transferred to 7E L&D together if infant is deemed appropriate for Level 1 nursery by NICU/Nursery team. While waiting in the PED, L&D will assign a baby nurse to initiate live birth general care per the BOA Protocol (Appendix 1A).
7. If the infant requires admission to Level 2 or 3, the infant will be transported by the NICU/Nursery team to Level 2 or 3 NICU in a transport isolette.
8. PED staff will call L&D and the appropriate Nursery or NICU prior to transport. A nurse-to-nurse sign-out should be done prior to mother and baby being moved.

Please refer to the current BOA algorithm (Appendix 1A) for detailed instructions depending on the mother's COVID status.

9. **Live Birth General Care (See Appendix 1B)**

    1. All live births require banding prior to separation of mother/birthing person and newborn, except if the newborn is so unstable that immediate care must be given prior to banding.
    2. APGAR Score: Assign 1-minute and 5-minute APGAR scores. If the APGAR score is below 7 at 5 minutes assign a 10-minute APGAR score.
    3. Weigh infant if condition permits.
    4. Provide as much documentation as possible regarding birth time, cord clamping, who was present, any resuscitation efforts provided, other care provided, etc.
    5. Follow updated BOA Algorithm for newborn care within the first hour.

NEONATAL DEATH, STILLBORN, OR SPONTANEOUS ABORTION IN THE EMERGENCY DEPARTMENT

A. Stillborn/Neonatal Death After Delivery:

1. An attending Physician is responsible for pronouncing the newborn dead. If the NICU attending is present, s/he should pronounce the infant. However, if the NICU attending is not present the PED attending should pronounce the infant dead.
2. The physician (PED attending or NICU attending) will notify the birthing person/mother (and family if applicable) that the newborn was stillborn or died and answer any questions. The physician will discuss the request for an autopsy with the mother/family, if appropriate.
3. Quick registration for stillborn/neonatal death to obtain a medical record number (MRUN) and create a chart.
4. PED to consult Social Work to provide family support.
5. PED Team to notify the organ and tissue procurement agency and the coroner that a death has occurred (See Hospital Policy #316 Tissue and Organ Donations).
6. Encourage birthing person/mother and/or family to see and hold the infant (it is known that the grieving process is resolved much earlier if there has been some contact with the infant).
7. Unplug the infant from all monitors but leave lines and tubes intact if cause of death unknown.
8. L&D team should determine location for the ongoing care of the mother/birthing person. (See Appendix 2 for information on baby bonding after death). There is no limit to the amount of time family spends with the deceased infant.
9. The bonding of the mother and baby should continue if the family desires, even if mother/ birthing person is moved to L&D. If bonding continues in L&D, then the L&D staff will follow their policy L/D 1180.
10. Documentation of the stillborn at birth or the neonatal death should be done as completely as possible for all deliveries. For neonatal deaths, include a description of the resuscitation and time of expiration.
11. Death packet should be filled out.
12. Prepare the infant for the morgue (see Appendix 3 for procedure).
13. Placenta should be sent to Pathology in its container properly labeled with a completed Pathology request as we do for live births.
14. Document as appropriate.

B. Spontaneous Abortion (Miscarriage):

1. The physician (PED attending or NICU attending) will notify the birthing person/mother (and family if applicable) that the birthing person/mother had a spontaneous miscarriage and answer any questions.

2. PED to consult Social Work to provide family support.
3. Birthing person/family bonding with the fetus should be discussed on an individual basis (based on gestational age of the fetus). If bonding is desired by birthing person/family, it should be done as discussed above under neonatal death/stillborn (Appendix 2).
4. Once bonding is completed, the fetus is treated as a tissue specimen and disposed of by the laboratory in the same way (cremation) as other specimens.
5. Label as a specimen with birthing person/mother's name and MRUN number.
6. Place in a formalin container with a label on the container.
7. Enter order in laboratory system and send to the Pathology Lab.
8. Document as appropriate.

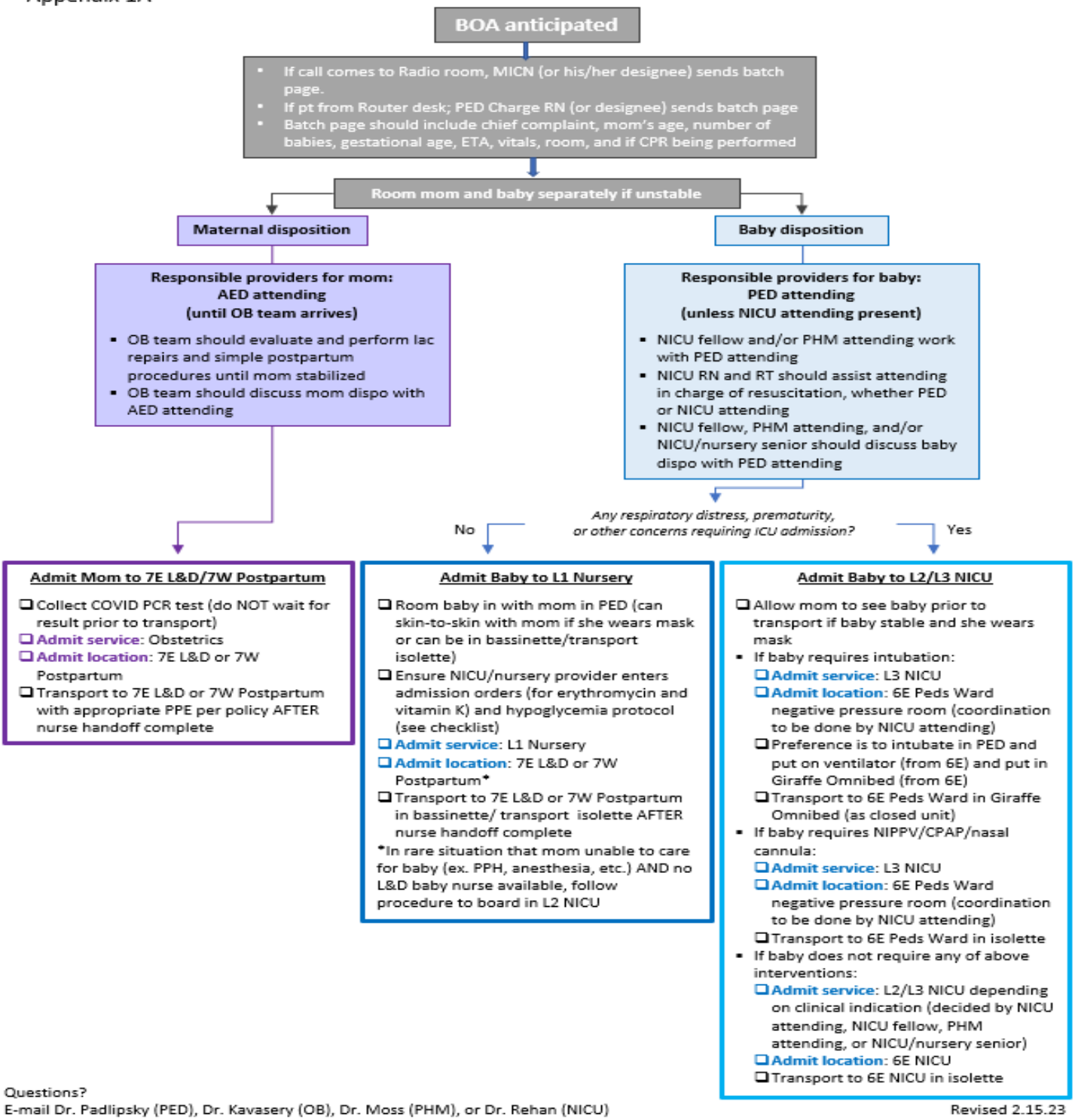
REFERENCE:
Nursing Policy Manual, Policy 315.0 Newborn Identification

Reviewed and approved by:
Medical Executive Committee - 3/2023

Beverley A. Petrie, M.D.
President, Professional Staff Association

Appendix 1A

Harbor-UCLA Medical Center BOA Protocol



Questions?
E-mail Dr. Padlipsky (PED), Dr. Kavasery (OB), Dr. Moss (PHM), or Dr. Rehan (NICU)

Revised 2.15.23

Appendix 1B

Checklist for Babies Being Admitted to L1 Nursery

- Until mom/baby transported to 7E L&D or 7W Postpartum:
  - ❑**Assign PED nurse or baby nurse from L&D to give baby care in PED**
  - ❑Room baby in with mom in PED with contact-eye-droplet precautions (baby can skin-to-skin with mom if she wears mask)
- ❑Ensure NICU/nursery provider enters *Level 1 Admit Order Set* and *Hypoglycemia Protocol*
  - ❑**Vitamin K** and **erythromycin ointment** (stocked in PED pharmacy) to be given by PED nurse or baby nurse (from L&D caring for baby in PED) within 1 hr of baby arrival
  - ❑**Hypoglycemia protocol** to be started by PED nurse or baby nurse (from L&D caring for baby in PED) within 1 hr of baby birth
  - ❑For **breastfeeding** moms:
    - If HIV positive, mom may NOT breastfeed; if HIV unknown, mom may express/pump milk until HIV results return
    - Until COVID status known, mom should wear mask and perform hand/breast hygiene before and after feeding
- ❑**Admit service**: L1 Nursery
- ❑**Admit location**: 7E L&D or 7W Postpartum*
- ❑**Nurse handoff**: PED nurse or baby nurse (from L&D caring for baby in PED) ➔ receiving baby/postpartum nurse on 7E/7W
- ❑Transport to 7E L&D or 7W Postpartum AFTER nurse handoff complete
- ❑Place contact-eye-droplet precautions once in room
- ❑For all babies, adjust isolation precautions once mom COVID PCR test result available
  - Positive: Continue contact-eye-droplet precautions
  - Negative: Change to standard precautions

Appendix 2: Bonding after the death of a newborn (neonatal death or stillborn infant)

- L&D team should determine location for the ongoing care of the birthing person.
    - The bonding of the birthing person and baby should continue even if mother is moved to L&D. If bonding continues in L&D, then the L&D staff will follow their policy L/D 1180.
- If bonding occurs in the PED, after the family has spent the desired amount of time with the infant, wrap the infant and remove from the room. There is no limit to amount of time family spends with the deceased infant.
- Documentation of the stillborn at birth or the neonatal death should be done as complete as possible for all deliveries. For neonatal deaths include a description of the resuscitation, and time of expiration.
- L&D/NICU/PED have bereavement boxes available to hold a lock of hair, footprint, photo, etc., if desired by mother/family.
- Consider moving family to a remote area if the PED is busy or if the family wishes to spend a prolonged period with the baby. Number of visitors to be based on current visitation guidelines.
- Wrap the infant and obtain a photo if family consents. Nursing and providers should document in the maternal record and infants record whether a bereavement box was prepared and if the photo was taken if it was placed in the box or included in the mother's medical record. If a photo was not obtained that should be stated in the medical record.
- L&D team should determine location for the ongoing care of the birthing person.
- The bonding of the birthing person and baby should continue even if the birthing person is moved to L&D.
- If bonding continues in L&D, then the L&D staff will follow their policy L/D 1180.

Appendix 3: Procedure for preparation of infant body before goes to the morgue (Infant death right after delivery or stillborn infant)

- Print 2 ID bands with the stillborn/deceased infant's information
- Place body on baby blanket or choux
- Place 1st ID band on one wrist and the 2nd ID band on the opposing ankle (opposing side of location of the ID placed on the wrist)
- Prepare 3 morgue tags by placing a baby label on each morgue tag
- Place the 1st morgue tag around one ankle
- Wrap the body with a blanket or choux. Tie the 2nd morgue tag around the wrapped body
- Place the wrapped body in the body bag
- Attach the 3rd morgue tag on the outside closure zipper of the bag
- Body transported to morgue by PED staff. Follow morgue log in procedures
- Placenta should be sent to pathology in its own container properly labeled with a completed Pathology request as we do for live births.