As Ob/Gyn Hospitalists, we may be put in the situation of having to resuscitate a newborn baby if its delivery is unexpected and the nursery team of providers is not immediately available to respond. This simulation drill will hopefully make this type of scenario much less intimidating.

**Initial Preparation:**
If possible, obtain relevant history (EGA, pregnancy complications or risk factors, color of amniotic fluid, antecedent events) and check equipment prior to the neonate being born. If not, obtain this information while doing the initial assessment of the baby.

**Initial Assessment:**
- Level of consciousness (alert/depressed/unconscious)
- Moving (yes/no)
- Breathing (yes/no)
- Crying (yes/no)
- Muscle tone (normal/diminished/absent)
- Anomalies (yes/no)
- Heart rate (> 100 bpm/< 100 bpm)
- Meconium (present/absent)

If abnormal findings are noted; Initiate code/alert (usually code “pink” or “blue” depending on the baby’s gender)/request additional help.

**Initial Resuscitation Steps:**

- Provide warmth (dry baby off with blankets/place baby on a warm blanket under a warming light/lamp)
- Provide stimulation (rub back and/or rub bottom of feet)
- Suction mouth/nose (with bulb syringe)---DeLee suctioning is no longer recommended in this situation unless an ET tube is in place
- If heart rate still < 100 bpm, baby is apneic or gasping, proceed with the following:
  - Secondary Resuscitation Steps - should be started by one minute of life
• initiate PPV (with mask) using room air for term baby/30% O2 for premies
• call for help, again, provider certified in NRP, nursery personnel, anesthesiologist, charge/staff nurse
• apply SPO2 monitor (target of at least 70% initially, 80% by 4-5 minutes of life)
• evaluate for chest movement with ventilation (present/absent)

If Ineffective - take corrective ventilator action (MRSOPA)

• M: Mask adjustment
• R: Reposition head
• S: Suction mouth/nose again, but this time, with:
  • O: Open mouth
  • P: Increased ventilator pressure (typically, about 50%)
  • A: Alternate airway (ET tube); this will typically be necessary if thick meconium is present in order to adequately suction the trachea
    • Consider CO2 detector with placement of ET Tube
  • Consider placing orogastric tub to reduce gastric distention

  o Request assessment of breath sounds via auscultation
  o Perform effective PPV for cycles of at least 30 seconds
  o Reevaluate HR after each cycle of PPV
    • If heart rate > 100 bpm, stop resuscitative efforts and provide post-resuscitative care and support.
    • If heart rate still < 100 bpm but > 60 bpm, continue with resuscitative efforts per above.

If, after above interventions are undertaken, bradycardia (HR < 60 bpm) is present;

Proceed with steps below:

**Advanced Resuscitative Steps:**
• Begin chest compressions/PPV with O2 @ 100% (for 45-60 seconds)
• Reevaluate HR/breathing/O2 saturation % after each cycle of chest compressions if still apneic/bradycardic
• Consider/attempt intubation after 2-3 cycles of chest compressions
• Administer epinephrine via ET tube: 1:10,000 concentration, dose of 0.5-1.0 cc/kg, repeat every five minutes if heart rate still < 60 bpm.
  If unsuccessful, continue with PPV/chest compressions
• Continue with resuscitative efforts until relieved by other providers
• Assist with family support after completion of resuscitative efforts, if needed

Debrief Comments: Start here:

REFERENCES

a. Toni Hurley RNC, MSN: Perinatal Nurse Educator St David’s Women’s Center of Texas
12221 Mopac Expwy. North Austin, Texas 78758; tonnyann.hurley@stdavids.com

b. Deona Bien, RN, BSN, CLC, LNC: Women and Children Service Line Director-Trident Health - Summerville Medical Center and NRP Instructor


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