Purpose:
To provide rapid, coordinated and appropriate response to obstetrical emergencies.

Policy:
The Code OB policy is designed to outline the training, roles, and responsibilities of the code responders and the procedure for Code OB activation.

Care of the patients experiencing an obstetrical emergency will be timely, consistent, and coordinated in order to obtain the best possible patient outcome.

A Code OB will be called for any Obstetric patient requiring urgent/emergent obstetrical care.

The Nurse/Physician/Midwife identifying an urgent/emergent situation where additional resources are required for an Obstetrical patient in the Obstetrical unit or other area in the hospital will activate a "CODE OB".

DEFINITIONS
Code OB: An organizational code that is used for any Obstetric patient experiencing an Obstetrical emergency.
Code OB Responders: Clinicians (RNs, RPNs, RMs, Physicians, RRTs, Anaesthetist, Surgeons, Lab Technician) who are assigned to respond to Code OB.
Mock Code OB: Periodically held sessions to practice the training, roles, and responsibilities of the people responding to Code OB.

Indications for calling a Code OB (including, but not limited to):

1. Maternal Cardiopulmonary Arrest
2. Cord Prolapse
3. Abnormal fetal surveillance not responding to intrauterine resuscitative measures and delivery not otherwise imminent

4. Severe maternal hemorrhage (evident or imminent)
5. Other maternal/fetal conditions for which emergent availability of the surgical team is indicated

Responsibility: Any Health Care Provider (HCP) providing direct patient care to an obstetrical patient will possess the knowledge, skill and judgement to recognize and respond to the clinical needs of an obstetric patient requiring emergency intervention.

Procedure:

Initial Staff Response:

1. Health Care Provider (HCP) identifies an obstetrical emergency.
2. The MRP will be notified immediately, if not already present.
3. The HCP **or Designate** will dial # 2333 at HDMH or x 3333 at SMMH from any phone, **stating:**
    a. **"Code OB"**
    b. **description of the issue (ie: cord prolapse, fetal bradycardia)**
    c. **location**
    d. **extension**
    e. **the MRP for the patient and whether they are already present.**
4. Switchboard will announce overhead "**Code OB**" and the location three times. Switchboard will also communicate this alert to the following people and will include the extension number of the room where the emergency is happening, and description of the issue (in order):
    a. OBS MRP
    b. Surgeon
    c. Anesthetist
    d. OR Assist
    e. OR Staff
    f. RRT
    g. Lab Technologist
    h. OB RN in department to report call out completed and estimated time of arrival of the team.
5. The following people will respond to the designated area (if in house) upon hearing the overhead page:
    a. Emergency Physician
    b. OB physicians
    c. OBS nurses
    d. Resource Nurse
    e. Registered Midwife

    f. Registered Respiratory Therapist
6. The person responsible for documentation must be assigned.
7. If the obstetrical emergency is in another area of the hospital, the OBS Nurse will designate which staff are needed to assist with the emergency and which staff are needed to ensure coverage for the remaining patients on their team.
8. Following the Code OB, the OB RNs will ensure any emergency carts used are checked and re-stocked as soon as possible (within 4-6 hours of completion of emergency).
9. After completion of the code, the provider assigned to documenting the code will review the documentation record for accuracy. The original Code OB documentation record will be placed in the patient's chart, a copy will be placed in the baby's chart, and a copy sent to Maternal/Newborn MQA Committee.
10. A post-Code OB debrief should be held as soon after the event as possible. The OB Nurse or any provider involved in the case facilitate the debrief using the Code OB Debriefing Tool (Appendix B). Any recommendations from this debrief will be forwarded to OBS Committee.

Code Responder Roles (will include but are not limited to)

1. OBS Nurses or Midwives
    a. Call "CODE OB" on appropriate extension (HDMH x2333, SMMH x3333)
    b. Remains with the patient
    c. Prepares the patient for surgery/delivery of newborn
        i. Ensure 1 IV #18 Gauge
        ii. Call lab to cross and type 2u pRBCs
        iii. Insert foley catheter (can be done in OR)
        iv. Take patient to OR. Bring delivery bundle
        v. Advise family to wait on the floor
        vi. prepare NRP equipment for possible Code Pink
    d. In the OR
        i. Assign recorder.
        ii. Ensures fetal monitoring continues until abdomen prepped. Document last auscultated fetal heart rate.
        iii. circulates for the Caesarean Section (if able and required)
        iv. confirm foley in
2. MRP:
    a. Remains with the patient
    b. Directs emergency efforts
    c. Provides case history out loud to OR staff, including: Gravida, Parity, Gestational age, and clinical scenario resulting in Code OB

d. Prior to commencement of Caesarean Section (if needed), confirms last fetal heart rate, fetal position, scalp clip removed.
e. Will assist Surgeon with surgery if Caesarean Section (if needed) prior to arrival of OR Assistant
f. Communicate anticipated critical events
g. Prepares for and directs care of the newborn upon delivery:
    i. review dating and risk factors
    ii. communicate anticipated critical events
    iii. check equipment is complete and functioning
    iv. review roles. Ensure recorder assigned.
    v. communicate readiness to other teams and the patient

3. Anaesthetist:
    a. Directs anaesthesia requirements. Assists with establishment of secured neonatal airway (if able and required)
4. First Assist in OR:
    a. Will assist Surgeon with surgery if Caesarean Section performed.
5. Registered Respiratory Therapist (RRT)
    a. Set up anaesthesia equipment as needed.
    b. Establishes and maintains patient airway if required
    c. Assists with intubation for newborn as required
    d. Remains in the OR until baby delivered
    e. Cares for baby in collaboration with MRP until stable or transport team arrives
6. OR Nurses:
    a. Scrub and circulate in the Caesarean Section as required.

DOCUMENTATION

1. Any events leading up to the emergency will be documented by the patient's assigned nurse and/or MRP in the Interdisciplinary Progress Notes, Labour and Delivery Partogram or Antenatal assessment form.
2. The events of resuscitation that occur during a Code OB situation will be documented at the time of the emergency by a designated provider on the Code OB Documentation Record (Appendix A) or Interdisciplinary Progress Notes. This documentation will present an accurate, clear and comprehensive picture of the patient assessments, interventions performed, and outcomes. Downtime laboratory requisitions will be used during the Code, if required.
3. RRT will ensure documentation of their activities and relevant information to the provision of care during these Code OB events (eg. Laboratory specimens collected, endotracheal intubation, baby care) has been completed.

4. Nurses will continue documenting on Interdisciplinary Progress Notes/L&D partogram until the beginning of Caesarean Section then the Circulating Nurse will document on the Perioperative Nursing Record.
5. Pre-operative Checklist will be initiated by nursing staff if applicable, and completed in as much detail as possible given the circumstances.
6. The individual who documents on the Code OB Documentation Tool is required to sign it.
7. The original Code OB Documentation Tool will be placed in the patient's chart, and copies will be placed in the baby's chart and sent to the Maternal/Newborn MQA Committee.
8. Notification of the next of kin and/or substitute decision maker will be documented by the MRP, as required/appropriate.

Special Consideration for Staff/Midwives/Physicians:
Staff to provide explanations of all procedures and reassurances as able to minimize anxiety for patient and her family.

Staff to provide information as needed to patient/family/substitute decision maker. Staff to provide opportunity for parents to interact with the baby ASAP and continually update on baby's condition. If baby transferred to the floor or another centre, have support person go with resuscitation team if able, and if not, keep support person/partner/family/substitute decision maker informed of baby's progress. Initiate infant contact as soon as possible.

ASSOCIATED DOCUMENTS
Accreditation Canada. (2016). *Qmentum Program 2010 – Standards: Effective Organization*. Ottawa,
Ontario: Accreditation Canada
MAHC Code OB Activation Protocol (2017)

Appendices:
Appendix A - Obstetrical Emergency (Code OB) Documentation
Appendix B – Debriefing Tool

REFERENCES:
Accreditation Canada. (2016). *Qmentum Program 2010 – Standards: Effective Organization*. Ottawa, Ontario: Accreditation Canada
Health Canada. Family Centered Maternity and Newborn Care: National Guidelines. Minister of Public Works and Government Services. Ottawa, 2000.

MORE OB Program Content (2010)
SOGC Guidelines-Policy Statement 379 (2019) *Attendance at and Resources for Delivery of Optimal Maternity Care.*
OSMH Code OB Policy and Procedure (2017)

APPENDIX A – Code OB Obstetrical Emergency (CodeOB) Documentation
Code Call: SMMH x3333/HDMH x2333

Date: _____ Time Called: _____ By: □ nurse □ midwife □ GP-OB □ _____

Reason for CodeOB: _____
_____
_____

Personnel present:	**Name**	**Designation**	**Arrival**
MRP	_____	_____	_____
Surgeon	_____	_____	_____
Physician	_____	_____	_____
L&D RN	_____	_____	_____
L&D RN	_____	_____	_____
Anaesthesia	_____	_____	_____
RRT:	_____	_____	_____
Other:	_____	_____	_____

Assessment

Time _____ Fetal Heart Rate _____ Contractions _____
Time _____ Vaginal exam: Dilated ____ effaced _____ station _____ presenting part _____
PV loss: □ none □ clear □ Meconium □ bloody Estimated Blood Loss _____

Interventions

Time _____Bloodwork □ CBC □ G+S □ LFTs □ Coag □ cross match ____units
Time _____IV#1 _____ solution _____ rate _____started by _____
Time _____IV#2 _____ solution _____ rate _____started by _____
Time _____Foley catheter _____ inserted by _____
Time _____Bedside ultrasound □ yes □ no
Time _____□ change of position (see progress notes)
Time _____□ Oxygen via Non-rebreather face mask _____L/min
Time _____□ scalp stimulation Fetal heart acceleration □ yes □ no
Time _____□ EFM applied
Time _____□ Fetal Scalp electrode □ yes □ no

APPENDIX A – Code OB (page 2) Obstetrical Emergency (CodeOB) Documentation

Medications

Time	Drug	Dose	Route

Time _____□ Prepped for OR □ Jewellery off □ Consent obtained □ NPO since _____
□ moved to L+D Room time _____

Outcome

C/S: □ emergent □ less urgent (refer to documentation on OR record)
Vaginal: □ Assisted vaginal delivery □ spontaneous vaginal delivery (refer to documentation on Labour Record)

Recorder name _____Signature _____
□ copy to baby chart and Maternal/Newborn MQA Committee

APPENDIX B – Code OB

Debriefing Tool

This format may be used to facilitate a debrief after a Code OB has occurred. Any recommendations arising from this debrief should be forwarded to the OBS Committee for review.

Questions to guide debrief:

What went well?

What could we have done better?

Recommendations/suggestions for improvement: