Subject: Prolapsed Umbilical Cord Management	
REVISION DATE: May 2013, 04/2007 REPLACES: Prolapsed Cord	WRITTEN: November 1990 SUPERSEDES DATE: June 2012

Purpose: The goal of this guideline is to establish a process of care to reduce neonatal hypoxia in the event of a prolapsed umbilical cord.

Summary of Changes: References/content updated to reflect most current standards of practice.

1. References:

1.1. Lippincott, Williams, and Wilkins (2012). Prolapsed umbilical cord assessment and management. Retrieved from http://procedures.lww.com/lnp/view.do?pId=951584&s=p&fromSearch=true&searchQuery=prolapsed+cord.

2. Responsibilities:

2.1. Credentialed delivering provider.

2.1.1. Manage and assume responsibility for patient care administered.

2.1.2. Place appropriate medical orders in patient's Electronic Health Record (EHR) based on comprehensive patient assessment.

2.2. Nurse:

2.2.1. Provide recognized nursing standard of care to patients in coordination with provider's orders.

2.2.2. Acknowledge and carry-out all provider orders in the (EHR).

2.2.3. Report all assessment findings out of expected range to provider.

3. General

3.1 A prolapsed umbilical cord is defined as a portion of the umbilical cord that hangs below the fetal presenting part and is an obstetric emergency that requires immediate intervention. Delay in management increases fetal hypoxia and is associated with increased infant morbidity and mortality (Lippincott, 2013).

3.2. Risk factors include low birth weight, transverse lie, breech presentation, preterm labor, polyhydramnios, amniotomy, preterm rupture of membranes, placenta previa, long cord, and multiple gestation (Lippincott, 2013).

3.3. Cesarean section is the recommended mode of delivery if vaginal delivery is not imminent.

4. Standards of Practice/Guidelines for Care:

4.1. Monitor fetal heart rate pattern for any abnormalities associated with fetal cord compression (see Fetal Heart Rate Monitoring Guidelines). Close monitoring for suspected prolapsed cord should occur after membrane rupture.

4.2. If cord compression is suspected:

4.2.1. Call for help. Utilize emergency call button to immediately obtain staff assistance. Notify provider and other members of the nursing staff team to come to room for assistance.

4.2.2. Assist patient with position change to relieve pressure on the cord (knee to chest, trendelenburg, or lateral Sims with buttocks elevated)

4.2.3. Administer oxygen to the mother via face mask at 10L/min to improve fetal oxygenation.

4.2.4. **Don sterile gloves and place gloved hand in the vagina to elevate the presenting part**. **Do not remove hand until the neonate can be delivered by emergency cesarean birth (Lippincott, 2013).** Avoid manipulation or contact with the cord; this can cause vasospasm.

4.2.4.1. Do not reinsert an exposed cord as this could add to the compression (Lippincott, 2013).

4.2.5. Members of the nursing and medical staff not elevating the presenting part will:

4.2.5.1. Monitor fetal heart rate.

4.2.5.2. Notify anesthesia and the certified scrub technician to prepare the OR for an emergency operative delivery.

4.2.5.3. Notify the pediatrician, NICU and newborn nursery nurse to present to the OR for delivery.

4.2.5.4. Prepare the patient for immediate transport to the OR.

4.2.5.4.1. If not already obtained, serve as a witness for verbal consent for cesarean delivery to be obtained by the provider and document.

4.2.5.4.2. If cervical dilation is complete the physician may deliver quickly using forceps (Lippincott, 2013).

4.2.6. Keep patient and family members informed of the plan of care with explanations and rationale and provide emotional support.

5. Recommended Documentation:

5.1. Time of the cord prolapse and of all interventions performed.

5.2. Time provider notified and present in room.

5.3. Fetal heart rate monitoring per Electronic Fetal Heart Monitoring Guidelines.

5.4. Notification and time of arrival of anesthesia and pediatrician.

5.4. Time of transport to the OR.

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