User's Guide:
The Delivery Room Communication Checklist

USE OF THE CHECKLIST:
The checklist is multifunctional and can be used: 1) to educate novice learners on important information that should be communicated before, during and after deliveries, 2) to evaluate the performance of teams during simulated and actual deliveries, and 3) to assist in handoff communication during patient care as a standardized tool.

Target learners and users include all healthcare professionals who provide either maternal or newborn care during deliveries, either via vaginal delivery or cesarean section. Such individuals typically include medical, nursing and allied health members of the Obstetric and Pediatric teams. This checklist may also be appropriate for healthcare providers on the Anesthesiology and Emergency Medicine teams, depending on the location (e.g., operating room, trauma bay, etc.) and type of delivery (cesarean or vaginal delivery).

Educators may use the checklist as an assessment tool to evaluate the communication skills of learners. This may occur by either direct observation or review of videos of either simulated or actual deliveries. When the checklist is used as an assessment tool, the educator should assign one point for each item performed by the learner.

PERFORMANCE OF CHECKLIST ITEMS:
Effective communication in the delivery room is a function of team performance. Thus, all involved teams are equally responsible for the comprehensive communication of vital information to provide safe and timely patient care. For example, communication of maternal and fetal history to the pediatric team can be accomplished either by the Obstetric team providing information to the Pediatric team, as in a handoff, or by the Pediatric team asking for specific information from the Obstetric team if not provided.

ORGANIZATION OF THE CHECKLIST:
The checklist is divided into four sections. Each section represents a different occasion before, during and immediately after deliveries when information should be exchanged either between different teams, or between teams and the maternal patient and/or family members:

- During the initial call by the obstetric team requesting the pediatric team's presence at the delivery
- With the arrival of the pediatric team to the delivery room
- After stabilization of the newborn by the pediatric team

DESCRIPTION OF CHECKLIST ITEMS WITHIN EACH SECTION:
A printable version of the entire checklist is provided at the end of this document, on page 8. A description of each item of the checklist is detailed below, on pages 2-7. Examples of delivery room communication are provided after each section of the checklist.

Section 1 of the Checklist:
Information exchanged between the Obstetric and Pediatric teams, when the Obstetric team calls and asks the Pediatric team to attend a delivery

This first section of the checklist represents the time when the Obstetric team notifies the Pediatric team about the delivery and asks the Pediatric team to assist in newborn care. A member of the Obstetric team usually calls the Pediatric team to convey this information. However, in some institutions, the pediatric team may be text-paged instead. For many deliveries, the information conveyed during this period is the first communication between teams about the details of the mother and fetus. Information conveyed during this time is essential for the Pediatric team to decide what resources (personnel and equipment) are needed for the delivery.

CHECKLIST ITEMS	DESCRIPTION OF ITEMS
Brief reason why the pediatric team is called	The reason may be related to a known maternal or fetal risk factor (e.g., insulin-dependent diabetic mother, congenital diaphragmatic hernia, etc.). The reason may also be due to an intra-partum maternal or fetal complication (e.g., maternal vaginal bleeding, fetal bradycardia, etc.).
Infant's gestational age	The age should be expressed in weeks and days.
Pertinent maternal and fetal risk factors	These include additional maternal or fetal risk factors that are not a part of the primary reason why the pediatric team is called to the delivery, but may be important in helping the Pediatric team provide newborn care during delivery (e.g., mother given magnesium sulfate for a history of pre-eclampsia, intrauterine growth restriction, etc.)

Example dialogue:

Obstetric team: *This is Jane Evers, the nurse taking care of Madeleine Roberts, who is laboring in the Labor and Delivery Unit.*

Pediatric team: *Hi Jane, this is Mary Reed, the NICU[1] nurse manager.*

Obstetric team: *Ms. Roberts is ready to deliver vaginally, and we would like to your team to attend her delivery. The obstetrician noted meconium-stained fluid.*

Pediatric team: *What's the gestational age?*

Obstetric team: *She's term, at 38 weeks.*

Pediatric team: *Are there any other risk factors that we should know about? How does the fetal strip look?*

Obstetric team: *The mother is healthy with no other issues, and the fetal heart rate has been normal with a Category I tracing.*

Pediatric team: *Okay, I'll send the team to the delivery.*

[1]Abbreviation Key: NICU, Neonatal Intensive Care Unit

Section 2 of the Checklist:
Information exchanged between the Obstetric and Pediatric teams, when the Pediatric team arrives at the delivery

This section reflects communication during a brief huddle between at least one member of the Obstetric team with the Pediatric team when the Pediatric team arrives at the delivery. The Obstetric Anesthesiologist, if present, may also participate in the huddle. Information that was exchanged during the initial call (see Section 1) is repeated here, because the Pediatric provider who took the initial call may not be a part of the delivery room team and may not have conveyed all the information to the team. Other information that is important to how the Pediatric team may provide newborn care in the delivery room is also communicated at this time. In general, information communicated is more comprehensive in content.

CHECKLIST ITEMS	DESCRIPTION OF ITEMS
Obstetric team's acknowledgement or Pediatric team's announcement of arrival to delivery	There should be an acknowledgement of the Pediatric team's arrival to the delivery for communication between teams to begin. Sometimes situational awareness is lost during emergency or complicated deliveries when the Obstetric team is very focused on maternal care (e.g., STAT cesarean section, maternal code, etc.). During these times, Obstetric communication with the Pediatric team may be delayed and interfere with the team's ability to prepare adequately for the delivery.
Brief reason why the Pediatric team is called	See Section 1.
Infant's gestational age	See Section 1.
Pertinent maternal and fetal risk factors	See Section 1.
Maternal medications, including pertinent over-the-counter drugs	These are medications that may affect newborn status or care in the delivery room. Examples include antenatal corticosteroids, tocolytics, insulin and oral hypoglycemic agents, antibiotics, narcotics, etc. For certain medications, timing in relation to the delivery, dosing, or length of therapy is important to specify.
Time of infant's birth, or how old the infant is in minutes during hand-off (if applicable)	This needs to be specified if the infant is cared for by the Obstetric team prior to the arrival of the pediatric team.
Any resuscitative measures done for the infant by the Obstetric team (if applicable)	A general guide for information sharing can follow interventions to improve the "ABCs" (airway, breathing, circulation) of resuscitation. Examples include administration of free-flow oxygen, positive pressure ventilation, intubation, chest compressions and medications. If only routine care (drying, stimulation and warming) was provided, it should be stated.
Assignment of APGAR[2] scores by the Obstetric team prior to the arrival of Pediatric team (if	This needs to be specified if the infant was cared for by the Obstetric team for greater than 1 minute prior to the arrival of the pediatric team.

[2] Abbreviation Key: APGAR, an acronym (Appearance, Pulse, Grimace, Activity, Respirations) representing five criteria used to evaluate the clinical status of newborn infants.

applicable)	

Example dialogue:

Obstetric team: *Hi, I'm Jane Evers, the nurse taking care of Madeleine Roberts. She's a 30-year-old G4-P3 woman at 38 weeks' gestation with good prenatal care and no pregnancy complications. She ruptured her membranes about 2 hours ago, with meconium-stained fluid. Fetal tracings have been normal at Category I.*

Pediatric team: *Great. What is the GBS status? And did she get any medications?*

Obstetric team: Her GBS is negative. *She got 1 dose of nalbuphine for pain.*

Pediatric team: *How long ago did she get the morphine?*

Obstetric team: *About 2 hours ago.*

Pediatric team: *Okay, thanks. We'll get set-up for the delivery.*

Section 3 of the Checklist:
Information exchanged on infant status between the Obstetric and Pediatric teams, after the Pediatric team stabilizes the infant

After the Pediatric team stabilizes the infant, there should be communication back to the Obstetric team on the infant's clinical status and measures taken to stabilize the infant. The information is important to the Obstetric team, because it guides them in their communication with the infant's family, especially if the infant required extensive resuscitation. Information may also be communicated during the stabilization period, if there is ongoing, extensive resuscitation.

CHECKLIST ITEMS	DESCRIPTION OF ITEMS
Baby's current clinical status	This information is especially important when resuscitative measures are necessary to stabilize the infant.
Resuscitative efforts on the infant	A general guide for information sharing can follow interventions to improve the "ABCs" (airway, breathing, circulation) of resuscitation. Examples include administration of free-flow oxygen, positive pressure ventilation, intubation, chest compressions and medication administration. If only routine care (drying, stimulation and warming) was provided, it should be stated.
Where the baby will be admitted	Areas may include the mother's room, newborn nursery, special care nursery and the NICU. In some instances, the infant may need to be transferred to another institution for higher level of newborn care.
APGAR scores	At the minimum, the 1 and 5 minute APGAR scores should be communicated.

Example dialogue:

Pediatric team: *We initially suctioned a lot of meconium from the baby's airway and mouth. Afterwards, she immediately started breathing on her own, and her heart rate was normal the whole time. She's currently grunting and tachypneic, with a respiratory rate ranging 70-80. Her saturations in room air were borderline low-normal, in the 80s. So, we are giving her free-flow oxygen.*

Obstetric team: *Do you think she will need more respiratory support?*

Pediatric team: *It's hard to say at this point, but it may be a possibility if she starts having increased respiratory distress. So, we'll take her to the NICU and place her under an oxyhood or nasal cannula for now. If we need to do more, we'll let you know.*

Obstetric team: *Okay, thanks. What are her APGAR scores?*

Pediatric team: *They are 7 and 8.*

Obstetric team: *Okay, thanks.*

Section 4 of the Checklist:
Information communicated by the Pediatric team to the infant's family, either during or after infant stabilization

This is usually the first opportunity for the Pediatric team to begin establishing a relationship with parents and families. After the Pediatric team stabilizes the infant, there should be communication with the family on the infant's clinical status, measures taken to stabilize the infant, as well as some anticipatory guidance on what to expect next. This is an exciting moment for families, but families may also be anxious regarding the infant's well-being if the infant has difficulty transitioning after birth or has a complication (either expected or unexpected). Communication should be supportive and in understandable terms with no medical jargon.

CHECKLIST ITEMS	DESCRIPTION OF ITEMS
Introduce yourself to the mother and family	The Pediatric provider may be an attending, fellow, resident, nurse practitioner, physician assistant or nurse. Providers should introduce themselves by stating their name and position since families often meet many providers from different services. If possible, introductions should occur upon arrival of the Pediatric team to the delivery room. It there is insufficient time before delivery, then it should occur as soon as possible after the infant is stabilized.
Discuss infant's current clinical status	If the baby required resuscitative measures, it is helpful for parents to know how their baby responded to those measures.
State measures done to help the baby transition	Unlike the information relayed back to the Obstetric team, information given to the parents may not need to be as specific. Communication to the parents should be in easily understandable language. (e.g., "We needed to help your baby breathe by placing a breathing tube.")
Communicate where the baby will be admitted	Areas may include the mother's room, newborn nursery, special care nursery or the NICU. In some instances, the infant may need to be transferred to another institution if a higher level of care is needed.
Discuss why special care nursery or NICU care is required (if applicable)	The reason may relate to specific maternal or fetal risk factors (e.g., monitoring blood glucose levels in an infant of a diabetic mother). Providing a general sense of how long the infant may need to stay in the special care nursery or NICU can be helpful to the parents.
Offer to answer any questions	Family members usually have additional questions to ask, but may be distracted or shy. By encouraging questions, providers can often alleviate any anxiety that families may have about their baby.
Offer to let the family see, touch, and/or hold the baby	Sometimes the mother may be under general anesthesia. Letting the mother's support person know when she can see her baby is helpful.

Example dialogue:

Pediatric team: *Hi, I'm Dr. Sweet, the pediatrician taking care of your baby. Congratulations, you have a beautiful baby girl! Do you have a name for her?*

Parents: *Oh, thank you! We named her Emily. Can we see her? How is she doing?*

Pediatric team: *Sure! As you can see, she's lying under the warmer to stay warm, but we will bring her to you in a moment. In the meantime, I can tell you how she is doing… Right*

after she was born, we suctioned a lot of thick fluid, called meconium, from her airway and mouth. Did your obstetrician talk about meconium to you?

Parents: *Oh, yes, that's her first stool?*

Pediatric team: *Yes, that's correct. Sometimes babies pass their first stool before they are born. Because it is thick and sticky, we suctioned as much of it as we could so that Emily did not inhale it into her lungs. After we suctioned the meconium, she started crying normally, but she is currently breathing a little fast. You can probably hear her breathe from the warmer.*

Parents: *Oh, yes. Is that sound normal?*

Pediatric team: *That noise that she is making is helping her open up her lungs to breathe better. We are also helping her by giving some oxygen.*

Parents: *Will she be okay? How long does she need the oxygen?*

Pediatric team: *Emily is currently doing a great job breathing on her own; she just needs some oxygen right now. It's possible that she may have inhaled some of the meconium into her lungs. If that is the case, it's hard to say at this point how long she will need the oxygen since it can take some time for the meconium to fully go away. We would like to bring her to the Neonatal ICU to watch her and support her with oxygen until her breathing improves. After a few hours, we may be able to give you a better sense of how long we think she will need to stay with us.*

Parents: *Okay, thank you.*

Pediatric team: *I just gave you a lot of information about Emily. Do you have any questions right now?*

Parents: *Will we be able to see her in the Neonatal ICU?*

Pediatric team: *Absolutely. As soon as you are all settled, your nurse can show you where we are located. When you get to the NICU, we can give you an update on how she is doing… It looks like my team is ready to bring her over to meet you. Do you have any other questions, or is there anything I can do for you at this time?*

Parents: *No, we can't think of any other questions right now. Thank you.*

Pediatric team: *Okay, congratulations again! We will take good care of Emily and see you soon.*

DELIVERY ROOM COMMUNICATION CHECKLIST

This checklist is a communication guide for Obstetric (OB) and Pediatric (Peds) teams who provide maternal or newborn care during deliveries. Please review the communication items below.

CHECKLIST ITEMS *(Items should either be stated or determined by asking.)*	**Item performed?**
Information exchanged between OB and Peds, when OB calls and asks the Peds to attend a delivery - *OB: State each checklist item in this section to the Peds team.* - *Peds: Ask the OB team for information that was either not communicated or needs clarification.*	
Brief reason why the pediatric team is needed	
Infant's gestational age	
Pertinent maternal risk factors (If there are none, it should be stated.)	
Information exchanged between OB and Peds when Peds team arrives at the delivery - *OB: State checklist items in this section to the Peds team.* - *Peds: Ask the OB team for information that was not communicated or needs clarification.*	
Peds team's announcement of their arrival at the delivery	
Brief reason why the pediatric team is needed	
Gestational age	
Pertinent maternal risk factors (If there are none, it should be stated.)	
Maternal medications, including pertinent over-the-counter drugs (If there are none, it should be	
Time of infant's birth, or how old the infant is in minutes during hand-off	
Any resuscitation measures done for the infant by the obstetric team (if applicable)	
Peds team's communication that they either require additional support, or have sufficient resources to continue resuscitation on their own	
APGAR score assignment by OB team prior to arrival of pediatric team (if applicable)	
Information exchanged on infant status between OB and Peds, after Peds stabilizes the infant - *Peds: State checklist items in this section to the OB teams.* - *OB: Ask the Peds team for information that was not communicated or needs clarification.*	
Resuscitative efforts on infant	
Infant's current clinical status	
Where the infant will be admitted	
APGAR scores	
Information communicated by Peds to the infant's family, either during or after infant stabilization - *Peds: Perform checklist items in this section as specified when communicating with the family.*	
Introduce yourself to the mother and family	
Discuss infant's current clinical status	
State measures done to help the infant transition	
Communicate where the infant will be admitted	
Discuss why NICU care is required (if applicable)	
Offer to answer any questions	
Offer to let the mother see, touch, and/or hold the baby	

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If you have any questions or comments on the use of this checklist, please contact:
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