Assisted Vaginal Birth UHL Obstetric Guideline

University Hospitals of Leicester NHS
NHS Trust

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Contents

1. Introduction and who the guideline applies to:

This guideline applies to all members of staff within the Maternity Unit who provide peripartum care for patients undergoing assisted vaginal birth. It is an adaptation of the RCOG Green Top Guideline on Operative (Instrumental) Vaginal Delivery.

Related documents:

Consent to Examination or Treatment UHL Policy.pdf Trust ref: B34/2024

Resuscitation at Birth UHL Neonatal Guideline.pdf Trust ref: B35/2008

Bladder Care During and After Labour and Delivery UHL Obstetric Guideline.pdf Trust ref: C67/2004

Perineal or Genital Trauma Following Childbirth UHL Obstetric Guideline.pdf Trust ref: C99/2008

Surgical Swabs Instruments Needles and Accountable Items UHL Policy.pdf Trust ref: B35/2007

Safer Surgery UHL Policy.pdf Trust ref: B40/2010

What's New:
This guideline has received extensive updates in the following;

- Flow Chart of Management
- How to avoid assisted Vaginal Birth
- Ultrasound role in assessment prior to assisted vaginal birth
- Consent for assisted vaginal birth
- When should attempted forceps birth be discontinued and how should a discontinued forceps procedure be managed
- When should vacuum-assisted birth be discontinued and how should a discontinued vacuum procedure be managed
- The use of a vacuum is not contraindicated following a fetal blood sampling procedure or application of a fetal scalp electrode.
- Blood borne viral infections are not an absolute contraindication to assisted vaginal birth.
- The evidence to support use of mediolateral episiotomy at assisted vaginal birth in terms of preventing OASI is stronger for nulliparous birthing women and birthing people and for birth via forceps.
- OASI Care Bundle
- Governance issues
- Reducing psychological morbidity for the birthing woman or birthing person

Background:

Assisted vaginal birth carries a risk of morbidity for both the mother and the baby, particularly where rotational procedures are performed, although with careful practice overall rates of morbidity are low. Additionally, there has been an increase in litigation relating to assisted vaginal birth.

The goal should be to minimise the need for assisted vaginal birth and where such a birth is indicated, to minimise the risk of morbidity to both mother and baby. Obstetricians should be confident and competent in the use of both vacuum extractor and forceps and should be able to safely conduct rotational and non-rotational deliveries.

How to avoid assisted Vaginal Birth:

Where possible, steps should be taken to reduce the likelihood of birthing women and people requiring an assisted vaginal birth.

These steps should include[1]

- Offering all birthing women and people continuous support during labour
- Inform birthing women and people that administering epidural analgesia in the latent phase of labour compared to the active phase of labour does not increase the risk of assisted vaginal birth.
- The use of a partogram
- Use of upright or lateral positions in second stage of labour without an epidural or lying down lateral positions with an epidural
- *Extreme caution* should be used in multipara
- Oxytocin augmentation should not be started without an assessment by an experienced Obstetrician.
- Passive 2nd stage/Delayed pushing in primipara with an epidural (1-2 hours after diagnosis of second stage)

Flow Chart of Management

Safety criteria for Assisted Vaginal Birth met?

No → C section

Yes

Pre-requisites and Indications:

1: Operator has appropriate skills to carry out Operative Vaginal Delivery or appropriately supervised
2: Patient understands and consents to the procedure
3: Appropriate analgesia
4: Cephalic Presentation, Cervix fully dilated, membranes ruptures, Regular contractions
5: Exact position of Fetal head can be determined on examination +/- Uss
6: Fetal head no more than 1/5th palpable abdominally
7: Maintain Aseptic technique
8: Bladder Empty
9: person trained in neonatal resuscitation must be present

Room or Theatre?

Room if station Allows

Outlet: If fetal skull visible without separating the labia, fetal skull at pelvic floor >+2cm, sagittal suture is in maternal AP diameter without ≤45 degrees rotation.

Low: Leading part of skull (not Caput) is at least +2cm station with rotation of ≤45 degrees

Consider theatre if:

Mid Cavity and or head ≥1/5 palpable abdominally, that does not qualify as an outlet or low instrumental birth.

EFW > 4 kg

BMI >30

Malposition at ≤+2 station. Including occiput transverse or posterior or requiring g >45 degrees rotation

Extensive Caput and moulding

Theatre (Trial of instrumental Delivery)

If high index of Failure, where there is an immediate recourse to c section.

An experienced operator must be present for all rotational/mid cavity vaginal and 2nd stage c section.

Be prepared to abandon assisted vaginal birth for an immediate emergency c section if there is no descent after 2 to 3 appropriately directed tractions of a correctly applied instrument, be alert and conscious to maternal and fetal well-being and the time that has elapsed between decision, commencement, duration of instrument application and birth.

Following instrumental Birth successful or otherwise:

1: Stat dose of IV antibiotics
2: Cord Gases
3: Complete swab, Needles and instruments count
4: Assessing perineum, including rectal examination
5: consider inserting Foley's catheter
6: Explicit documentation
7: where required Datix (PPH, shoulder dystocia, 3rd/4th degree tear)
8: Debriefing when appropriate

All instrumental assisted births should have single stat dose of antibiotics within 2 hours of delivery
Please refer to: Women's antimicrobial summary (sharepoint.com)

A standard classification of instrumental delivery should be used:

Classification of assisted vaginal birth **(ACOG 2015)**[7]

Term	Definition
Outlet	- Fetal scalp visible without separating labia - Fetal head has reached the perineum - Rotation not exceeding 45 degrees
Low	- Leading point of presenting part (skull, not caput) is at station spines +2 or lower, but not on the perineum - Subdivisions: a) Rotation 45 degrees or less (non-rotational) b) Rotation greater than 45 degrees
Mid	- Fetal head is no more than 1/5 palpable per abdomen - Leading point of skull is at spines 0 or +1 but not above the spines - Subdivisions: a) Rotation 45 degrees or less (non-rotational) b) Rotation greater than 45 degrees

2. Guideline procedures and standards

2.1 Procedure competence:

The procedure should only be carried out by an appropriately trained or supervised clinician[1];

- Obstetric trainees should have their competence in assisted vaginal birth assessed (e.g. OSATS) prior to conducting unsupervised procedures

- The complexity of the delivery is related to its classification (see above). Complex, mid cavity or rotational deliveries, irrespective of the instrument used, must be performed by an operator who has received adequate training in these procedures

- An experienced operator should be present from the outset for mid cavity or rotational deliveries.

2.2 Clinical assessment

Careful clinical assessment by a trained operator should be performed before every assisted vaginal birth;

- Abdominal and vaginal examination must always be performed as part of the assessment.

- The following are **pre-requisites** for a safe vaginal delivery.

1) There should be no maternal or fetal contraindication to operative vaginal delivery or the use of a particular instrument (e.g. ventouse in prematurity <32 weeks, caution 32-36 weeks).
2) The head should be ≤1/5 palpable per abdomen.
3) Confirm the fetus is presenting by the vertex (although forceps delivery may be considered in a mento-anterior face presentation by a senior obstetrician).
4) The cervix should be fully dilated and membranes absent.
5) The exact position of the fetal head should be determined, and ultrasound should be used if any uncertainty following clinical examination. The operator should be trained in determining the fetal head position using abdominal ultrasound.
6) There must be no evidence of obstructed labour.
7) Maternal informed consent, even if verbal, should be obtained and documented in the notes.
8) Where the delivery is being performed as a trial in theatre, written consent should be obtained where possible [1,8]. When midpelvic or rotational birth is indicated, the risks and benefits of assisted vaginal birth should be compared with the risks and benefits of second stage caesarean birth for the given circumstances and skills of the operator.
9) Appropriate analgesia should be in place (regional or pudendal block, depending on urgency and anticipated complexity of delivery).
10) The maternal bladder should have been emptied recently- where an indwelling catheter is present the balloon should be deflated during delivery.
11) There should be a back-up plan in case of failed instrumental delivery, with adequate staffing including availability of anaesthetist.
12) Personnel should be present who are competent in neonatal resuscitation.

2.3 Indications

The indication for assisted vaginal birth should be documented in the patient's health record by the clinician performing the procedure[1,8]

- Operators should be aware that no indication is absolute and should be able to distinguish 'standard' from 'special' indications.

- The aim of instrumental delivery is to shorten the second stage. There is some evidence that maternal morbidity may increase significantly after three hours in the second stage. The timing of intervention needs to involve balancing the risks and benefits of continuing active expulsive maternal efforts against those of instrumental delivery.

Indications for operative vaginal delivery:

Type	Indication
Fetal	Suspected fetal compromise (CTG pathological, abnormal FBS result, thick meconium)
Maternal medical	Medical indications to avoid Valsalva, such as Cardiac disease Class III or IV, cerebrovascular disease (e.g. uncorrected CV malformations, myasthenia gravis, spinal cord injury, proliferative retinopathy)
Labour-Delay in the second stage	Nulliparae: Lack of continuing progress in the second stage (total of passive and active second stage) of three hours with regional anaesthesia, or two hours without regional anaesthesia Multipara: Lack of continuing progress in the second stage (total of passive and active second stage) of two hours with regional anaesthesia, or one hour without regional anaesthesia Maternal exhaustion or distress

2.4 Contraindications and considerations

Vacuum extraction should be avoided below 32 weeks' gestation and used with caution from 32 weeks to 36 weeks' gestation, or where there is an increased risk of fetal haemorrhage [1, 2, 7]

- Vacuum extraction has potential added neonatal morbidity in the presence of prematurity. Evidence suggests it should be avoided below 32 weeks' gestation.
- Between 32- and 36-weeks' gestation vacuum extraction should be used with caution as there is an increased risk of subgaleal haemorrhage, intracranial haemorrhage and scalp trauma when compared with forceps but comparable long-term neurological outcomes.
- Difficult operative delivery should be avoided where fetal haemorrhage risk is potentially increased, such as maternal ITP / unexplained thrombocytopenia etc.
- Blood borne viral infections in the birthing woman or birthing person are not an absolute contraindication to assisted vaginal birth. However, it is sensible to avoid difficult assisted vaginal birth where there is an increased chance of fetal abrasion or scalp trauma, as it is to avoid fetal scalp electrodes or blood sampling during labour.
- The use of a vacuum is not contraindicated following a fetal blood sampling procedure or application of a fetal scalp electrode.

2.5 Management of assisted vaginal births with a higher risk of failure

Assisted vaginal births with a higher risk of failure should be performed as ‘trials’ in theatre where immediate recourse to Caesarean section is possible[1]

Higher failure rates are associated with:

- Maternal BMI ≥ 30
- Short maternal stature
- Clinically big baby / EFW > 4000g
- Head circumference over the 95th centile
- Occipito-posterior position and Occipito-transverse
- Station not below spines / 1/5 of head palpable abdominally
- Prolonged labour

In the presence of two or more of these risk factors (or other clinical uncertainty) a trial of instrumental delivery in theatre should be considered.

Where operative vaginal delivery is being performed in the presence of suspected fetal compromise, the risk of failed delivery in the room needs to be balanced with the delay in transfer time when conducting the delivery in theatre. As an aid to communication, the classification of urgency of caesarean section should be used for all operative deliveries, vaginal as well as abdominal. This should be communicated to all the MDT team involved with the patients care.

It is good practice to classify all instrumental births at the time of the decision to deliver, although it is recognised that instrumental deliveries in the delivery room usually proceed with minimal or no delay. However, where delivery is not achieved and transfer to theatre or second instrument is subsequently indicated an awareness of the urgency is helpful to all involved.

Classification of Instrumental Delivery

Take into account the condition of the birthing woman or birthing person and the unborn baby when making decisions about rapid delivery.

GRADE 1: Immediate threat to the life of the birthing woman, birthing person or unborn baby (as soon as possible or within 30 minutes)
GRADE 2: Maternal or fetal compromise that is not immediately life threatening (as soon as possible or within 75 minutes)

The time the decision for instrumental delivery should be documented in the patient's healthcare record.

Reasons for any deviation to this time frame, where applicable, should also be documented in the patient's electronic healthcare record.

2.6 Consent for assisted vaginal birth

For birth room procedures, verbal consent should be obtained prior to assisted vaginal birth and the discussion should be documented in the medical notes.

When midpelvic or rotational birth is indicated, the risks and benefits of assisted vaginal birth should be compared with the risks and benefits of second stage caesarean section birth for the given circumstances and skills of the operator.

Written consent should be obtained for a trial of assisted vaginal birth in an operating theatre.

The healthcare provider should clearly explain why an assisted vaginal birth is being considered, what the procedure is likely to involve, the benefits and risks of any available alternative treatments.

If there is a language barrier, the use of professional translation services is essential to enable effective and ethical consent taking. A professional medical interpreter should be involved to ensure accurate communication.

2.7 Instrument selection

The operator should choose the instrument most appropriate to clinical circumstances and their level of skill [1, 2, 4].

- Forceps and vacuum are associated with different risks and benefits. Vacuum extractor should be avoided below 32 weeks gestation and where fetal bleeding risk is increased.
- Rotational births should be performed by experienced operators; the choice of instrument depending on the clinical circumstances and expertise of the individual. The options include manual rotation followed by direct traction forceps or vacuum, and rotational vacuum extraction.

Vacuum extractor compared with forceps is:

More likely to fail at achieving vaginal delivery	OR 1.7; 95% CI 1.3–2.2
More likely to be associated with cephalhaematoma	OR 2.4; 95% CI 1.7–3.4
More likely to be associated with retinal haemorrhage	OR 2.0; 95% CI 1.3–3.0
More likely to be associated with maternal worries about baby	OR 2.2; 95% CI 1.2–3.9
Less likely to be associated with significant maternal perineal and vaginal trauma	OR 0.4; 95% CI 0.3–0.5
No more likely to be associated with delivery by caesarean section	OR 0.6; 95% CI 0.3–1.0
No more likely to be associated with low 5-minute Apgar scores	OR 1.7; 95% CI 1.0–2.1
No more likely to be associated with the need for phototherapy	OR 1.1; 95% CI 0.7–1.8.

Risks are summarised below:

Maternal outcomes:

- Episiotomy; vacuum, 50–60%; and forceps, more than or equal to 90%.
- Significant vulvo–vaginal tear; vacuum, 10%; and forceps, 20%.
- OASI; vacuum, 1–4%; and forceps, 8–12%.
- Postpartum haemorrhage; vacuum and forceps, 10–40%.
- Urinary or bowel incontinence; common at 6 weeks, improves over time.

Perinatal outcomes:

- Cephalhematoma; predominantly vacuum, 1–12%.
- Facial or scalp lacerations; vacuum and forceps, 10%.
- Retinal haemorrhage; more common with vacuum than forceps, variable 17–38%.
- Jaundice or hyperbilirubinemia; vacuum and forceps, 5–15%.
- Subgaleal haemorrhage; predominantly vacuum, 3 to 6 in 1000.
- Intracranial haemorrhage; vacuum and forceps, 5 to 15 in 10 000.
- Cervical spine injury; mainly Keillands rotational forceps, rare.
- Skull fracture; mainly forceps, rare.
- Facial nerve palsy; mainly forceps, rare.
- Fetal death; very rare.

2.8 When to consider abandoning the procedure

The bulk of malpractice litigation results from failure to abandon the procedure at the appropriate time, particularly the failure to avoid prolonged, repeated or excessive traction efforts in the presence of poor progress.

When should vacuum-assisted birth be discontinued and how should a discontinued vacuum procedure be managed?

1: Discontinue vacuum-assisted birth where there is no evidence of progressive descent with moderate traction during each pull of a correctly applied instrument by an experienced operator.
2: Complete vacuum-assisted birth in most cases with a maximum of three pulls to bring the fetal head on to the perineum. Three additional gentle pulls can be used to ease the head out of the perineum
3: If there is minimal descent with the first two pulls of a vacuum, the operator should consider whether the application is suboptimal, the fetal position has been incorrectly diagnosed or there is cephalopelvic disproportion. Less experienced operators should stop and seek a second opinion. Experienced operators should re-evaluate the clinical findings and either change approach or discontinue the procedure.
4: Discontinue vacuum-assisted birth if there have been two ‘pop-offs’ of the instrument. Less experienced operators should seek senior support after one ‘pop-off’ to ensure the woman has the best chance of a successful assisted vaginal birth.
5: Obstetricians should be aware of the increased neonatal morbidity following failed vacuum-assisted birth and/or sequential use of instruments, and should inform the neonatologist when this occurs to ensure appropriate care of the baby.

When should attempted forceps birth be discontinued and how should a discontinued forceps procedure be managed?

1: Discontinue attempted forceps birth where the forceps cannot be applied easily, the handles do not approximate easily or if there is a lack of progressive descent with moderate traction.
2: Discontinue attempted forceps birth if birth is not imminent following three pulls of a correctly applied instrument by an experienced operator.
3: If there is minimal descent with the first one or two pulls of the forceps, the operator should consider whether the application is suboptimal, the position has been incorrectly diagnosed or there is cephalopelvic disproportion. Less experienced operators should stop and seek a second opinion. Experienced operators should re-evaluate the clinical findings and either change approach or discontinue the procedure.
4: Obstetricians should be aware of the potential neonatal morbidity following a failed attempt at forceps birth and should inform the neonatologist when this occurs to ensure appropriate management of the baby.
5: Obstetricians should be aware of the increased risk of fetal head impaction at caesarean birth following a failed attempt at birth via forceps and should be prepared to dis-impact the fetal head using recognised manoeuvres.

Sequential application of instruments is associated with a higher morbidity (risk of intracranial haemorrhage is 1 in 256 deliveries for two instruments compared to 1 in 334 for failed single instrument proceeding to caesarean section). The use of forceps after failed vacuum extraction must therefore be judiciously balanced with the risk of a second stage Caesarean section. This decision should be made by an experienced Obstetrician [1, 5]. Obstetricians should be aware of the increased risk of obstetric anal sphincter injury (OASI) following sequential use of instruments.

- Operative vaginal delivery should be abandoned, and caesarean section considered where there is no evidence of progressive descent with moderate traction during each contraction or where delivery is not imminent following three contractions of a correctly applied instrument by an experienced operator. If the fetal head is at the perineum a further 3 gentle pulls using vacuum-assisted birth to ease the head out of the perineum can be used.

- The total number of contractions over which instrumental delivery was conducted should be confirmed after the birth of the baby by the Obstetrician and the Midwife and documented in the operative delivery notes.

2.9 Episiotomy

The evidence to support use of mediolateral episiotomy at assisted vaginal birth in terms of preventing OASI is stronger for nulliparous women and for birth via forceps.

- Mediolateral episiotomy should be discussed with the woman as part of the preparation for assisted vaginal birth.
- In the absence of robust evidence to support either routine or restrictive use of episiotomy at assisted vaginal birth, the decision should be tailored to the circumstances at the time and the preferences of the birthing woman or birthing person. The evidence to support use of mediolateral episiotomy at assisted vaginal birth in terms of preventing OASI is stronger for nulliparous birthing women or birthing people and for birth via forceps. When performing a mediolateral episiotomy, the cut should be at a 60-degree angle initiated when the head is distending the perineum.

2.9: OASI Care Bundle:

OASI's has tripled over the last decade from 1.8% to 5.9% among singleton, term, cephalic, vaginal first births. Overall incidence of OASI in the UK is 2.9%, with an incidence of 6.1% and 1.7% in primiparous and multiparous birthing women or birthing people respectively.
There are four key elements of Care Bundle:

1. Inform the birthing woman or person about OASI and what steps can be taken to minimize their risk. They should be given a copy of the OASI Care Bundle information leaflet at their antenatal appointment which takes place between 32-36 weeks.

2. When indicated, episiotomy should be performed mediolaterally at a 60-degree angle at crowning.

3. Documented use of manual perineal protection (MPP).

- For spontaneous births, manual perineal protection should be used unless the birthing woman or person objects, or their chosen position for birth doesn't allow MPP.
- For assisted births, manual perineal protection should be used. Continue MPP throughout the birth of the shoulders by moving your non-dominant hand to support the baby's body. If two clinicians are available during an instrumental birth, the assistant will apply support from one hand on the perineum during the birth of the fetal head (including after the episiotomy) by the instrument of choice. On crowning, the clinician should control the speed of the birth of the head. If only one clinician is available it may be possible to use one hand to support the perineum and use the other to operate the instrument, provided this does not risk harming the birthing woman, birthing person or their baby.

4. Following birth, the perineum should be examined, and any tears graded according to the RCOG guidance. The examination should include a per rectum (PR) check even when the perineum appears intact, and this should be documented in the case notes.

2.10 Paired cord blood samples

Paired cord blood samples should be obtained and recorded after all attempts at assisted vaginal birth [1].

2.11 Trauma assessment and repair

The perineum and lower vagina should be assessed for trauma and sutured in accordance with the “Perineal or Genital Trauma following Childbirth – Identification and Repair” guideline. All items used during invasive procedures must be accounted for [1].

- The swab and needle count is the responsibility of the operator
- All swabs must be counted aloud by the operator and the assistant (MCA, Midwife or Doctor) immediately prior to the procedure and this should be documented on the white board within the room by the assistant.
- Any swabs inserted into the vagina during the procedure must be:
    - Recorded on the whiteboard as individual items and not as part of the swab count
    - Secured to the sterile drapes with a theatre clip
- If at any time, there is a change of operator the swab count must be confirmed prior to that person leaving the room and a handover performed using SBAR
- Following the procedure, **before leaving** the room, all swabs must be counted aloud again by the operator and the assistant, and this should be documented in the health records by both members of staff
- The swab count **must** be correct before leaving the room.
- Where a vaginal pack is intentionally left in situ the “Bakri Intrauterine Balloon and Vaginal Pack In situ Form” must be completed and attached to the front of the hospital notes. The in situ sticker must also be placed on every history page within the notes and on each page of the HDU chart. This is the responsibility of the operator who leaves the pack in.The pack must be removed prior to transfer to the postnatal ward
- Any unaccounted items must be documented on the white board in red and until proven otherwise it should be assumed that the item is in the wound. All swab bags and rubbish bags should be checked. If the item is still unaccounted for, the midwifery coordinator must be informed, and actions taken as per UHL “Management of Surgical Swabs, Instruments, Needles and Accountable items “Policy.

2.12 VTE Risk assessment

Following an assisted vaginal birth, patients should be assessed for risk factors for thromboembolism [1].

- A VTE risk assessment should be performed after an instrumental delivery, a midcavity or rotational assisted delivery scores 1 point on the UHL VTE risk assessment tool.

2.13 Analgesia

Appropriate analgesia should be offered following operative vaginal delivery [1].

- Analgesia should be prescribed on a regular basis and should include Paracetamol and a NSAID (Diclofenac or similar) unless there are contraindications.

2.14 Bladder care post procedure

The timing and volume of the first void urine should be documented. Post void residual should be measured if urinary retention is suspected **[1,6].**

- Patients who have had a spinal or epidural top up for a trial of an instrumental delivery should be offered an indwelling catheter for the first 12-24 hours to avoid asymptomatic urinary retention (see Bladder Care Guideline)

2.15 Debriefing

There is no evidence to support routine debriefing following an assisted vaginal birth, but the birthing woman or person should be made aware of the indication for the operative delivery and management of any complications prior to discharge [1].

- It is important that a discussion takes place following delivery with the patient to inform them of the indication for the operative delivery and any management of any complications prior to discharge.
- Individualise care for all who have sustained a third- or fourth-degree perineal tear, or who have ongoing pelvic floor morbidity
- The future plan of care should be reviewed carefully with anyone who has experienced a third- or fourth-degree tear, as they may be at increased risk of further anorectal damage with a subsequent birth.
- Women and people should be counselled regarding the risk of recurrence and implications for future childbirth

2.16 Documentation

Any assisted vaginal birth must be adequately documented in the patient's health care record. This includes abandoned/failed operative vaginal delivery [1, 8].

As a minimum, a timed, dated and signed entry of the following should be made (on the appropriate page in the health record and the E3 print out for operative delivery should be completed):

- Details of surgeon
- Details of supervisor where appropriate
- Informed consent
- Indication for operative delivery
- Time of decision and time of delivery
- Clinical assessment of patient
- Type of analgesia
- Description of the procedure, including bladder care measures, the type of instrument used, more than one instrument used plus indication for dual instrumentation, Number of contractions / durations of instrument application until delivery.
- Where procedure abandoned, including reason
- Perineal trauma/episiotomy including suturing (the perineal repair page must be completed)
- Estimated blood loss
- Cord gases

PLEASE NOTE THAT DETAILS OF ATTEMPTED INSTRUMENTAL DELIVERY MUST BE DOCUMENTED ON THE APPROPRIATE PAGE EVEN WHEN YOU PROCEED TO CAESAREAN SECTION AFTER FAILED ATTEMPT AT INSTRUMENTAL DELIVERY.

- Adverse events, including failed forceps or vacuum extraction, Adverse outcomes, including unsuccessful assisted vaginal birth, major obstetric haemorrhage, OASI, shoulder dystocia, birth trauma, term baby admitted to the neonatal unit, low Apgar score less than 7 at 5 minutes and cord arterial pH less than 7.1 should trigger an incident report as part of effective risk management processes.

2.17 Antibiotic prophylaxis

A dose of prophylactic antibiotics should be given to all patients who have had an instrumental delivery [1, 9]

- Refer to the Antimicrobial Summary UHL Womens Guideline

2.18 Duty of candour:

- Obstetricians have a duty of candour; a professional responsibility to be honest with patients when things go wrong.

- Duty of candour sticker and letter should be placed in the notes, and a copy of letter should be given to the patient in case of any complications

2.19 Reducing psychological morbidity for the woman or person

•Shared decision making, good communication, and positive continuous support during labour and birth have the potential to reduce psychological morbidity following birth.

• Review before hospital discharge to discuss with the woman or person the indication for assisted vaginal birth, management of any complications and advice for future births. Best practice is where the review is conducted by the obstetrician who performed the procedure.

• Offer advice and support to women or person who have had a traumatic birth and wish to talk about their experience. The effect on the birth partner should also be considered.

Offer women and people with persistent post-traumatic stress disorder (PTSD) symptoms at 1 month referral to skilled professionals as per the NICE guidance on PTSD.

3. Education and Training:

All obstetric trainees should have an opportunity to attend the RCOG Operative Birth Simulation Training (ROBuST) day, and a Workshop on Perineal Repair.

Maternity care Assistants/Maternity Support Workers will complete the Maternity Care Assistant/Support worker Core Competency Package which includes safe practice in assisting with swab, instrument, needle and sundries count as outlined in the UHL policy Surgical Swabs Instruments Needles and Accountable - Management UHL Policy

Midwives will attend a Perineal Repair workshop during their Preceptorship time which will include safe practice in assisting with swab, instrument, needle and sundries count as outlined in the UHL policy Surgical Swabs Instruments Needles and Accountable - Management UHL Policy.

4. Supporting References:

1) RCOG Green-Top Guideline No 26 ‘Assisted Vaginal Birth’, April 2020
2) Burlington DB. Food and Drug Administration Public Health Advisory: Need for CAUTION when using vacuum assisted delivery devices. Center for Devices and Radiological

3) Johnstone TA. Minimising risk: obstetric skills training. Clin Risk 2003;9:99–102.
4) Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Guidelines for Use of Rotational Forceps. College Statement No. C-Obs 13. Melbourne: RANZCOG; 2004 [www.ranzcog.edu.au/publications/ statements/Cobs13.pdf].
5) Gardella C, Taylor M, Benedetti T, Hitti J, Critchlow C. The effect of sequential use of vacuum and forceps for assisted vaginal delivery on neonatal and maternal outcomes. Am J Obstet Gynecol 2001;185:896–902.
6) Carley ME, Carley JM, Vasdev G, Lesnick TG, Webb MJ, Ramin KD, et al. Factors that ar associated with clinicallyovert postpartum urinary retention after vaginal delivery. Am J Obstet Gynecol 2002;187:430–3.
7) Committee on Practice Bulletins – Obstetrics. ACOG Practice Bulletin No. 154: Operative Vaginal Delivery. Obstet Gynecol 2015;126:e56-65
8) Royal College of Obstetricians and Gynaecologists. Operative Vaginal Delivery. Consent Advice No. 11. London: RCOG; 2010
9) Liabsuetrakul T, Choobun T, Peeyananjarassri K, Islam QM. Antibiotic prophylaxis for operative vaginal delivery. Cochrane Database Syst Rev 2017;8:CD004455
10) https://www.rcog.org.uk/media/rntlozz3/oasi-care-bundle-guide-final-_-050118.pdf

5. Key Words:

Operative vaginal delivery, forceps, ventouse

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

EDI Statement

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

CONTACT AND REVIEW DETAILS	
Original author: A Akkad, Consultant Obstetrician **Guideline Lead (Name and Title)** Dr.Farah Shakeel Consultant Updated by: Dr.Maria Akmal and Dr.Farah Shakeel.	**Executive Lead;** Medical Director
Details of Changes made during review: **October 2024** **Title of document changed from 'operative vaginal delivery' to 'assisted vaginal birth'** **Complete guideline update and review**	