Deciding if a VBAC is Right for You

Hospital Policies that Support VBAC, Family-Centered Cesarean, & Informed Choice
Appendix A

Examples of Hospital Policies that Support VBAC, Family-Centered Cesarean, and Informed Choice
I understand:

1. I have had one or more prior Cesarean-section(s) and have refused a repeat c-section to attempt a vaginal delivery. Spectrum Health Gerber Memorial does not offer vaginal deliveries for women who have had previous cesarean sections because it does not have the surgery and anesthesia staff on site at all times.

2. Approximately 60-80% of women who attempt to delivery vaginally after Cesarean Section will deliver vaginally.

3. The benefits of an uncomplicated VBAC include decreased blood loss, decreased post-delivery complications, and a shorter recuperative period.

4. The risk of a uterine rupture during VBAC in someone like me who has had a prior incision in my uterus is approximately 1% or 1 in 100 VBAC deliveries.

5. VBAC poses a higher risk of harm to my baby than to me. In the event of a uterine rupture, the baby may suffer brain damage or death, if not immediately delivered by emergency C-section.

6. If my uterus ruptures during my VBAC, I understand there may not be sufficient time to operate and prevent death or permanent brain injury to my baby.

7. The risk of death or permanent brain damage to the baby when the uterus ruptures is uncertain, but has been reported to be generally less than 1%, or 1 in 100 uterine ruptures.

8. The risks of harm to me if my uterus ruptures include: hysterectomy (loss of the uterus), blood transfusion, infection, injury to internal organs (bowel, bladder, ureter), blood clotting problems, or death (which is rare).

9. My doctor has determined that transfer to a hospital that provides VBAC is not recommended because the risk of transfer outweighs the benefit.

10. During my VBAC, the use of oxytocin (Pitocin), a hormone to make my uterus contract, may be necessary to assist me in my vaginal delivery. This may cause long contractions and increased pain during contractions and increase the possibility of uterine rupture, abnormal position of the baby, and fetal distress, which will increase the need for an emergency Cesarean section.

11. If I choose a VBAC, but require an emergency Cesarean-section during labor, I have a greater risk of problems than if I had an elective repeat Cesarean-section.
By signing below, I confirm I have reviewed this information, have discussed it with my doctor, and have had all my questions answered.

**CONSENT FOR EMERGENCY TREATMENT**

By signing this form, I give my consent to all appropriate treatment in the event of a uterine rupture or other complications including, emergency cesarean section, hysterectomy, blood transfusion for me and/or my baby, and emergency resuscitation.

**REFUSAL OF CESAREAN SECTION**

I understand that by signing this form, I am refusing a repeat Cesarean-section. By signing this form I am choosing to attempt a vaginal birth after cesarean at a small hospital that does not offer this option.

Patient signature: ___________________________ Date: ______________

Witness signature: ___________________________ Date: ______________

Physician signature: ___________________________ Date: ______________
Spectrum Health Gerber Memorial Planned Vaginal Birth After Cesarean Section (VBAC) Education

After having a cesarean section, you must decide between a repeat cesarean section or a vaginal birth after cesarean (VBAC) for the birth of your baby. Research has determined that a VBAC is a reasonable option for many women with success rates of 60-80%. Because both routes of delivery have risks, we want to help you understand the risks and benefits of both options. Additionally, your OB provider will discuss with you any individual factors that may affect your decision.

Spectrum Health Gerber Memorial does not have the resources necessary to offer VBAC deliveries. However, if you choose to attempt a vaginal birth after cesarean section, your OB provider will work with you to plan your delivery at a hospital that offers VBAC as a delivery option.

What are my chances for a successful VBAC?
Your OB provider will help to determine the likelihood that you will have a successful VBAC. Factors include:
- If you ever delivered vaginally from 37 weeks to 41 weeks of pregnancy
- The reason you had a c-section
- The kind of incision you had for your c-section
- The length of your previous labor
- The shape of your pelvis
- The size of your baby
- How far you got in labor last time

What are the benefits of VBAC compared to planned cesarean birth?
- Faster time to heal after birth
- Shorter hospital stay
- Less chance of need for blood transfusion
- Less risk of infection after delivery
- Less risk the baby will have breathing problems
- Quicker return to normal activities, as there is no pain from abdominal surgery
- Greater chance of vaginal birth in later pregnancies
What are the risks of VBAC?

Risks to the mother:
- Tear or opening in the uterus—occurs in 7 to 10 out of 1000 low risk women who try VBAC (0.7% to 1%) If there is a tear in the uterus there are more possible risks:
  - Blood loss and the need to give you blood
  - Need to remove your uterus (hysterectomy). This means you will never be pregnant again.
  - Damage to your urinary bladder
  - Infection
  - Blood clots may develop in your legs
  - Death, which is rare
- Any of the following may increase your risk of tearing your uterus during labor:
  - Labor that does not start on its own (labor induction)
  - Location of uterine scar
  - More than one cesarean section
  - Less than 18 months since your last cesarean delivery
  - Need for medicine during labor to increase your contractions
  - Other unknown risks. These are still being studied.
- If your trial labor does not work your doctor must perform a cesarean section to deliver your baby. The risks of a cesarean delivery are higher when it is done as an emergency. This may double the risk of infection if done after labor.

Risks to the baby:
- Normal risks of a vaginal birth which could include shoulder dystocia and cord compression.
- A tear in the uterus may harm your baby. A tear in the uterus causes brain damage or death to a small percentage of babies (5 to 10 babies out of 10,000 VBAC attempts).

What are the risks of a planned cesarean birth, if that is my choice?
- Tear or opening in the uterus. The chance of this is about 5 in 1000 cesarean sections (0.5%). You will always have a risk for a tear in your uterus. This is because there is a scar on your uterus from the cesarean section you had before. The tears usually occur during labor. Risks to you and the baby are the same as if the uterus tore during VBAC.
- Blood loss with possible need to give you blood
- More scars on your uterus and inside your abdomen
- Infection
- Injury to organs inside your body
- Problems with anesthesia (drugs that make you numb and take away the feeling of pain)
- Blood clots in your legs
- Problems with the placenta (organ that nourishes your baby in your uterus) in later pregnancies
- Death, which is very rare
Why doesn’t Spectrum Health Gerber Memorial offer VBAC?

At Spectrum Health Gerber Memorial we want to make the birth of your baby as safe as possible. The American College of Obstetricians and Gynecologists (ACOG) has recommended that hospitals that offer VBAC have anesthesia staff, a doctor or both, and operating room services immediately available to provide emergency care. Although Spectrum Health Gerber Memorial has a process for assembling needed staff in emergency situations, there are times when certain staff are not on-site at the hospital and must be called in to provide emergency care. This means that it may take longer for staff to arrive than at a hospital that offers VBAC, where these staff are on site and immediately available.

If I can’t deliver by VBAC at Spectrum Health Gerber Memorial, where can I have my baby?

Your OB provider will work with you to arrange for your delivery at a hospital that offers VBAC. Your OB provider can continue to manage your prenatal care and will work together with the doctor who plans to deliver your baby.

By signing this form I agree:
- I read this form or had it explained to me in words I can understand.
- I understand there are risks associated with both planned cesarean section and VBAC.
- I had time to read the patient education material.
- I had time to speak with my OB provider about repeat cesarean section and VBAC. My OB provider answered my questions.
- If I choose to try VBAC for delivery of my baby, I will work with my OB provider to plan my delivery at a hospital that offers VBAC.
- If I choose VBAC, I understand my doctor may still need to deliver my baby by cesarean section.

Patient signature: ____________________________ Date: ______________ Time: ____________
We welcome you to the Gerber Memorial Health Services Family Birth Center. While the safety and well-being of you and your baby are the top priority, we will strive to meet as many of your expectations as possible. We look forward to sharing your upcoming birth with you.

Patient Name_________________________________________________
Date of birth_________________________________________________
OB provider___________________________________________________
Support person’s name_________________________________________
Due Date_____________________________________________________
Expecting: boy   girl   unknown
Doula _______________________________________________________
Baby’s name _________________________________________________
Baby’s doctor________________________________
Did you attend childbirth or refresher classes? Yes  No
Family and friends I would like present during labor and delivery:
(maximum of 4) ______________________________________________

You may choose as many as you like under each category

**During labor I’d like:**
- To stay home as long as possible.
- Lights dimmed.
- Flameless candles.
- Music, will bring my own.
- Music, will use hospital relaxation collection.
- The room as quiet as possible.
- Standing, walking, position changes.
- A birth ball.
- Lying down, mobility not important since I am planning on epidural.
- Bag of waters to break naturally.
- To wear my own clothes.
- To wear hospital gown.
- To be informed of all procedures and discuss options when time allows.
- If labor is not progressing, discuss most natural methods to help.
- Pictures taken by: ___________________________________________
**Monitoring:**
- I prefer minimal monitoring.
- I prefer monitoring that allows me to be mobile.
- I prefer continuous monitoring.

**Hydration:**
- IV on admission in preparation for pain medicine, epidural, and/or antibiotics if Group B Strep is positive.
- IV access site.
- IV only if medically necessary.

**Pain Relief:**
- Aromatherapy - we offer lavender/ clary sage mixed.
- Massage
- Hypnosis techniques
- Breathing techniques
- Relaxation techniques
- Hot or cold packs
- Distraction
- TENS unit
- Sterile water papules
- Acupressure
- Water therapy using whirlpool or shower
- Medicine injection if no IV.
- IV medicine
- Only medicine if I request.
- Would prefer no medicines, I will ask, don’t ask me.
- Would like to avoid epidural.
- Epidural only if IV medicine isn’t effective.
- Epidural

**During pushing I would like:**
- Semi-recline in bed.
- Use a squatting bar on bed.
- Use a birth stool.
- Be side lying.
- Be on hands and knees.
- Deliver in any position I choose.
- Wait to push until I feel the urge.
- Push without a time limit as long as mom and baby are safe.

**At the time of birth I would like:**
- A mirror to watch delivery.
- To touch the baby’s head.
- To reach down and take the baby.
- To let my partner help catch the baby.
OB provider to use oil and/or hot compresses for comfort and to help avoid tearing.
Do not want skin to skin.

**Umbilical Cord:**
- Cut the cord after it stops pulsating and the baby has received all the blood from the placenta.
- Cut the cord as soon as possible for cord blood donation. I will bring the kit.
- Dad will cut the cord.
- Dad does not want to cut the cord, do not ask him.
- I will cut the cord myself.
- _______________ will cut the cord.

**Immediately after birth:**
- I will breastfeed as soon as the baby desires.
- Delay routine hospital procedures until after the baby has breastfed.
- Routine Pitocin to prevent hemorrhage.
- Pitocin only if necessary (required if not breastfeeding).
- I would like to see the placenta.
- Do not show me the placenta.
- I would like to take the placenta home.

**Newborn preferences:**
- I would like all routine medications and immunizations for my baby.
- _______________
- Breastfeeding
- Bottle feeding
- 24 hour rooming in is our practice. If your preference is different, explain.
- If a boy, circumcision.
- I do not want my baby boy circumcised

**If Cesarean becomes necessary - during delivery:**
- I would like music softly playing. My favorite type is _______________
- I plan to take pictures in the operating room.
- I plan to wait on pictures until I am in my room after the surgery.
- I would like to have the surgery explained as it is happening.
- Please do not talk about the surgery, I would rather think about other things.
- I would like the surgical drape lowered so I can see the baby.
- I do not want the surgical drape lowered.
- I would like delayed cord clamping.
- I would like the cord left long so dad can cut the cord.
- Other thoughts: _______________
After the Delivery
I would like the baby brought to me:
☐ Immediately for skin to skin contact
☐ After being cleaned up and wrapped in a blanket

I prefer routine baby procedures:
☐ Delayed until after the surgery so I can have my baby immediately
☐ To be completed before the baby is brought to me
☐ I would like all routine newborn medications and immunizations
☐ Other: ______________________________________________________

If the baby needs medical attention and cannot be with us immediately:
☐ I would like dad/support person to go to the nursery if the baby has to leave the room
☐ Dad/support person will stay with me. Please update us with the baby’s condition

Family and Friends
☐ May come in immediately after my recovery period, approximately 1 hr.
☐ May come in after some time alone with the baby

Preferences for Pain Management
☐ I am interested in the option of an abdominal nerve block (TAP block)
☐ Please give me whatever my anesthesia provider or doctor feels is necessary
☐ I am sensitive to medications and desire the least amount possible
  Medications that have worked well for me in the past:
  ___________________________________________________________
  Medications that have caused problems for me in the past:
  ___________________________________________________________

Time: _____________  Date: _____________  Mother’s signature: ____________________________
Epidural Anesthesia
Gerber Memorial Hospital
Epidural Education Form

Expected Results
A temporary decrease or loss of feeling and or movement to lower part of the body, which may provide relief from pain during a prolonged or difficult labor. This type of anesthesia/analgesia does not alter the mental status as occurs with IV or injection pain medications. Occasionally the anesthesia does not completely take away the pain, or only provides numbness on one side.

Technique
Medication is injected through a needle, and a catheter is placed outside the spinal canal in the epidural space.

Risks
Risks for mother:
- **HIGH SPINAL BLOCK:** you could experience shortness of breath, respiratory depression or respiratory/cardiac arrest. You may need an emergency cesarean section and resuscitation.
- **ADVERSE REACTION TO ANESTHETIC AGENT:** May lead to respiratory paralysis, cardiac arrest, brain damage, heart attack, convulsions, stroke or death.

Risks to the baby:
- Reduced blood supply to the placenta may cause fetal distress, brain damage, or death.

Other Considerations:
- Continuous electronic fetal monitoring will be used to check for signs of fetal stress.
- Epidural anesthesia/analgesia may cause slow, less effective labor contractions. Pitocin may have to be added to the IV to stimulate stronger contractions. More epidural medicine may be needed to relieve the pain of stronger Pitocin induced contractions. Pitocin can cause more risk to the baby. Arrested labor may result in cesarean section, which is a major abdominal surgery and poses increased risk for the mother.
- If an epidural is given in early labor, it increases the chance that the baby is in the wrong position as it comes into the pelvis. This may increase the need for a cesarean delivery.
- Epidural anesthesia decreases the mother’s ability to push and increases the need for forceps, vacuum, or cesarean section. Forceps or vacuum assisted deliveries have a greater need for an episiotomy and deep tears into the perineal muscle. This can increase the pain and healing time after giving birth.
- Back strain or injury to the hips and knees may occur due to the inability to feel if the body is in an awkward position.
• The mother cannot respond naturally to labor cues, and may not feel as much control over the birth process.
• You will not be able to walk around, or use the tub, shower, or toilet.
• The epidural may cause the mother’s temperature to rise requiring additional tests for you and the baby to evaluate for possible infections.
• You may need a catheter inserted into your bladder if you are unable to urinate.
• You will be limited to a clear liquid diet only after an epidural because of increased surgical risk if a cesarean is needed.
• You will be monitored often for vital signs after an epidural, so a blood pressure cuff will be placed on your arm, a pulse oximeter will be placed on a finger, and you will receive intravenous fluids.

Postpartum Effects:
• Epidurals may cause severe headaches, migraines, temporary or permanent nerve damage, muscle weakness in legs, numbness or tingling sensation, and long term backache.

Newborn Effects:
• The epidural may decrease the newborn baby’s ability to nurse well for the first 12-72 hours.

All forms of anesthesia or medications have some risk, and rare unexpected complications other than what is listed here may occur.

I understand that it is my choice to choose the type of pain relief method I feel is appropriate for my baby’s birth including an epidural, IV pain medications, or comfort measures as listed on my birth plan.

If I choose an epidural, I understand that every effort will be made to get an epidural administered in a timely manner. I understand an epidural may not be appropriate if the labor is advancing quickly and the procedure cannot be done safely.

If a cesarean delivery becomes necessary, the epidural may be adequate anesthesia for surgery but general anesthesia may be necessary if complete pain relief is not achieved.

I have had the opportunity to ask my OB physician or midwife questions regarding pain relief methods for labor and delivery.

I understand this is NOT A CONSENT FORM FOR THE PROCEDURE OF THE EPIDURAL, but is confirmation that I have been educated on the effects of an epidural which may affect the obstetrical care I receive from my physician or midwife. If I choose to have an epidural during my labor, the anesthesia provider who will be administering the epidural will also inform me of risks associated with the procedure.

Please initial the above statements, and sign below.

Patient signature: __________________________ Date: ________________

OB Provider signature: __________________________ Date: ________________
Spectrum Health Gerber Memorial
Birth Plan For Cesarean Section Delivery

We welcome you to the Gerber Memorial Health Services Family Birth Center. While the safety and well-being of you and your baby are the top priority, we will strive to meet as many of your expectations as possible. We look forward to sharing your upcoming birth with you.

Name_______________________________________________________
OB provider__________________________________________________
Person who will be with me during surgery________________________
Relationship__________________________________________________
Due Date_____________________________________________________
Expecting: boy   girl   unknown
Baby name ___________________________________________________
Baby doctor________________________________
I plan to: Breast Feed    Bottle Feed
Did you attend childbirth or refresher classes? Yes  No

You may choose as many as you like under each category

During the Delivery:

☐ I would like music softly playing. My favorite type is _______________
☐ I plan to take pictures in the operating room.
☐ I plan to wait on pictures until I am in my room after the surgery
☐ I would like to have the surgery explained as it is happening
☐ Please do not talk about the surgery, I would rather think about other things
☐ I would like the surgical drape lowered so I can see the baby
☐ I do not want the surgical drape lowered
☐ I would like delayed cord clamping
☐ I would like the cord left long so dad can cut the cord
☐ Other thoughts: ____________________________________________

After the Delivery
I would like the baby brought to me:
☐ Immediately for skin to skin contact
☐ After being cleaned up and wrapped in a blanket

I prefer routine baby procedures:
☐ Delayed until after the surgery so I can have my baby immediately
☐ To be completed before the baby is brought to me
☐ I would like all routine newborn medications and immunizations
☐ Other: ____________________________________________________
If the baby needs medical attention and cannot be with us immediately:

☐ I would like dad/support person to go to the nursery if the baby has to leave the room
☐ Dad/support person will stay with me. Please update us with the baby’s condition

☐ If your trial labor does not work your doctor must perform a cesarean section to deliver your baby. The risks of a cesarean delivery are higher when it is done as an emergency. This may double the risk of infection if done after labor.

Family and Friends

☐ May come in immediately after my recovery period, approximately 1 hr.
☐ May come in after some time alone with the baby

Preferences for Pain Management

☐ I am interested in the option of an abdominal nerve block (TAP block)
☐ Please give me whatever my anesthesia provider or doctor feels is necessary
☐ I am sensitive to medications and desire the least amount possible

Medications that have worked well for me in the past:

______________________________________________________________________________

Medications that have caused problems for me in the past:

______________________________________________________________________________

Patient signature: ___________________________ Date: _______________ Time: ___________
The following guidelines are intended only as a general educational resource for hospitals and clinicians, and are not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations.

VBAC Guidelines
Revised December 2011

This document represents collaboration among the hospitals in Vermont and New Hampshire. It outlines NNEPQIN’s collective recommendations for VBAC care, based upon thorough and thoughtful review of the literature. It incorporates ACOG guidelines, and presents a regional definition of provider’s “immediate availability” based upon patient risk status. The goal is to maintain the availability of VBAC services throughout the region, while ensuring patient and provider safety. These recommendations apply to VBAC candidates only, and recognize the need to adapt care to the unique circumstances of each case.

Unit Structure:
Each hospital should develop policy and procedure guidelines that reflect the resources and ability of the delivery unit to respond to emergent situations that may develop for patients attempting VBAC. These guidelines should include a description of informed consent, notification, availability of key providers, facilities, and the typical response times for emergency cesarean section.

Each hospital needs to have a system in place for competency review and protocol verification. This can be accomplished in several ways, including but not limited to:
- periodic emergency cesarean drills for staff
- ongoing individual review of emergency cesarean section cases
- regular staff training in the interpretation of fetal heart rate monitoring

These activities will provide ongoing opportunities for quality improvement.
Definitions:

- **Labor**: Regular and painful uterine contractions that cause cervical change.
- **Active Labor**: The cervix is 4-5 cm dilated and there are regular and painful uterine contractions.
- **Adequate Labor**: Contractions every 3 minutes with a 50 torr rise above baseline or contractions every 3 minutes lasting at least 45 seconds that palpate strong.
- **Provider capable of performing a cesarean section**: An obstetrician, surgeon, or family practitioner who is credentialed to perform a cesarean delivery.
- **Admission**: Occurs when labor has been diagnosed, or when decision is made to deliver the patient. Observation to determine if the patient is in labor is not considered admission.
- **Anesthesia**: Refers to a CRNA or anesthesiologist who is privileged by the hospital.
- **OR Team**: One person competent to scrub for a cesarean section and one person competent to circulate during a cesarean section. These may be OR technicians, LNA, CNA, LPN, or RN.

Risk Assessment:

- Each patient should be evaluated for risk factors associated with decreased VBAC success and uterine rupture. (See tables.)
- The association of factors related to an increased risk of uterine rupture has not been able to be translated into the reliable prediction of uterine rupture (1, 2). Patients without risk factors may experience uterine rupture.
- Previous vaginal delivery is associated with higher rates of VBAC success and lower risk of uterine rupture.
- There is limited data on outcomes for women with multiple risk factors present. Some studies suggest that even when multiple risk factors are present, VBAC success rates are often at least 50% or higher (3). All patients should receive counseling about the assumed relative risk for VBAC success and uterine rupture. Management plans for these outcomes should be reviewed with the patient.

The Maternal Fetal Medicine Unit Network recently performed a large multi-center trial evaluating VBAC. Based on the data from this study, a nomogram was created to predict VBAC success. A calculator based on this nomogram can be found at the George Washington University Biostatistics Center web site. It may be useful for individualizing the counseling given to patients about VBAC.

http://www.bsc.gwu.edu/mfmu/vagbirth.html
### Factors Associated With Decreased VBAC Success

<table>
<thead>
<tr>
<th>Factor</th>
<th>References</th>
</tr>
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<tbody>
<tr>
<td>Labor induction</td>
<td>(3, 4)</td>
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<tr>
<td>Labor augmentation</td>
<td>(3, 4)</td>
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<tr>
<td>Short inter-pregnancy interval</td>
<td>(3, 4)</td>
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<tr>
<td>Birth weight &gt;4000 gm</td>
<td>(3, 4)</td>
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<tr>
<td>Gestational age 41 weeks or greater</td>
<td>(3, 4)</td>
</tr>
<tr>
<td>Excess maternal weight gain, variously defined</td>
<td>(3, 4)</td>
</tr>
<tr>
<td>Recurrent indication for initial cesarean delivery</td>
<td>(3, 4)</td>
</tr>
<tr>
<td>Unfavorable cervical status at admission</td>
<td>(3, 4)</td>
</tr>
<tr>
<td>Non-white ethnicity</td>
<td>(3, 4)</td>
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### Factors Associated With Uterine Rupture

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<th>Factor</th>
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<td>Labor induction</td>
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<tr>
<td>Labor augmentation</td>
<td>(8, 9, 10)</td>
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<tr>
<td>Short inter-pregnancy interval</td>
<td>(16, 17, 18)</td>
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### Factors Associated With Decreased VBAC Success

*Data insufficient to demonstrate consistent association.*

<table>
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<tr>
<td>Gestational age 41 weeks or greater</td>
<td>(14, 15)</td>
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<tr>
<td>Birth weight &gt;4000 gm</td>
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<td>Previous single layer closure of the uterus</td>
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<td>Maternal obesity, variously defined</td>
<td>(21)</td>
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<td>Recurrent indication for initial cesarean delivery</td>
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<td>Unfavorable cervical status at admission</td>
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<tr>
<td>Non-white ethnicity</td>
<td>(1)</td>
</tr>
<tr>
<td>3 or more prior cesarean sections</td>
<td>(23, 24)</td>
</tr>
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</table>
Low Risk Patient: Risk for uterine rupture approximately 0.3-0.7%.
- 1 or 2 prior low transverse cesarean section(s)
- Spontaneous onset labor
- No need for augmentation
- No repetitive FHR abnormalities
- Patients with a prior successful VBAC are especially low risk. However, their risk status escalates the same as other low risk patients.

Medium Risk Patient: Risk for uterine rupture is likely greater than 0.7%.
- Induction of labor
- Oxytocin augmentation
- <18 months between prior cesarean section and current delivery.
- 3 or more prior low transverse cesarean sections.

High Risk Patient: Patients who have intra-partum signs or symptoms that may be associated with uterine rupture or failure of vaginal delivery (4).
- Recurrent clinically significant deceleration (variable, late or prolonged fetal heart rate decelerations) not responsive to clinical intervention
- Significant bleeding of uterine origin
- New onset of intense uterine pain
- 2 hours without cervical change in the active phase despite adequate labor

Prenatal Management:
- Records of prior delivery reviewed, including type of uterine incision and method of closure. Evaluate history of previous uterine surgery.
  - VBAC may be attempted in some cases where documentation of the previous uterine scar is not available, as long as there is not a high suspicion of a classical uterine incision. (4) (Level B)
  - Patients with a previous classical uterine incision, previous extensive transfundal surgery or prior uterine rupture are not candidates for VBAC. (4) (Level B)
- Appropriate patient education brochure given to patient and reviewed with patient (NNEPQIN sample available).
- Appropriate VBAC consent reviewed during prenatal care and signed (NNEPQIN sample available). Informed consent should include a discussion of the following.
  - A description of the process of risk assessment.
  - The ability of the institution to care for the patient, based on her risk level.
  - The process of transfer of care, should it become necessary based on risk factors.
  - Institutional management plans for uterine rupture.
- Anesthesia consultation/evaluation per institution guidelines.
- If the primary OB provider cannot perform a cesarean section, consultation with provider privileged to perform a cesarean section.
Basic Intra-partum Care Recommendations for all VBAC Patients:

- Review with the patient the risks/benefits of proceeding with VBAC on admission. Determine if the patient’s risk level has changed, or patient choice has changed. This review should be documented in the medical record.
- Lab/Blood Bank Preparation
  - Type and Screen, or Type and Cross depending on the institution’s blood bank availability in off hours
- Anesthesia personnel notified of admission.
- Pediatric personnel notified of admission.
- OR Team notified of admission and plan in place if cesarean delivery needed.
  - Does not mean an OR is kept open for patients at low risk.
- In Active Labor (4-5 cm dilated).
  - Continuous Electronic Fetal Monitoring.
  - Place 18 gauge IV.
  - Provider on hospital campus who is credentialed to perform a cesarean section.
    - If the primary obstetric provider is not credentialed to perform a cesarean section, the cesarean delivery provider will be consulted.
- All patients attempting VBAC should have their labor progress monitored carefully to ensure adequate progress. Arrest of labor is associated with decreased VBAC success and uterine rupture. Patients with a macrosomic fetus (EFW > 4000 gm), especially those with no previous vaginal birth, are more likely to experience outcomes related to arrest of labor, and require careful monitoring.

Intra-partum Management:

Each hospital should evaluate the resources that they typically have available for the care of laboring women with prior cesarean deliveries. Women should be counseled as to their anticipated risk status and the institutional resources. Cesarean section may be recommended if a woman’s risk status increases and provider services cannot be increased and maintained until delivery.

ACOG states: “Respect for patient autonomy supports the concept that patients should be allowed to accept increased levels of risk, however, patients should be clearly informed of such potential increase in risk and management alternatives...In settings where the staff needed for emergency cesarean section are not immediately available, the process for gathering needed staff when emergencies arise should be clear, and all centers should have a plan for managing uterine rupture.” (4) (Level C)
**Low Risk Patient:**
- No additional interventions other than those listed above.
- Cesarean delivery provider may have other acute patient care responsibilities.

**Medium Risk Patient:**
- Cesarean delivery provider in the hospital during the active phase of labor. Cesarean delivery provider may have other acute patient care responsibilities.
- An open and staffed operating room is available or there is a plan in place if immediate delivery is required. This may be a room where there is adequate lighting, instruments, and general anesthesia can be administered if needed.
- An anesthesia provider is present in the hospital during the active phase of labor.
- Anesthesia staff may have other acute patient care responsibilities.
- There is an established back up protocol for anesthesia services during busy times.

**High Risk Patient:**
- The cesarean delivery provider is present in the hospital and does not have other acute patient care responsibilities
- Anesthesia staff is present and does not have other acute patient care responsibilities.
- An open and staffed operating room is available.

**Caveats:**
- Misoprostil is associated with a high rate of uterine rupture and should not be used when a living fetus is still in-utero (4) (Level A). It may be used after delivery for uterine atony.
- There are limited data regarding the safety of a trial of labor in women with more than 2 prior cesarean sections. The degree of increase in risk of uterine rupture is unclear.
- Single layer closure of the uterus with an interlocking chromic type suture has been reported to be associated with an increased risk of uterine rupture. Operative records should be reviewed for the method of closure.
- Transfer during the active phase of labor typically holds little benefit for the patient as access to timely delivery is not present during transport.
- Attempting VBAC with twin gestation carries a similar risk as for those women with singleton pregnancies. Women without other risk factors, who have twins and are candidates for vaginal delivery, may be considered candidates for attempting VBAC. (4) (Level B)
• Women may present to hospitals that have chosen not to offer VBAC services. Transfer to a hospital providing VBAC services necessitates evaluation of the patient, to determine safety, and must comply with federal and state law. Hospitals not offering VBAC services should meet the following standards:
  • Protocol in place for women with prior cesarean sections who present in labor
  • Institution complies with ACOG Guidelines for Prenatal Care and JACHO Standards for Obstetrical Care.
  • Referral and counseling practices established so that women desiring VBAC may be referred to an appropriate center based upon their risk status.
  • Meets NRP Guidelines for infant care.

Proposed Performance Measure:
The percentage of patients for whom there is documented risk status at the time of admission, and documented change in risk status during labor, should that occur.
### Complication Rates Associated With VBAC and Planned Cesarean Birth
(Includes preterm and term births). (22)

<table>
<thead>
<tr>
<th>Complication</th>
<th>VBAC Attempt</th>
<th>Planned Cesarean Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine Rupture</td>
<td>468/100,000</td>
<td>26/100,000</td>
</tr>
<tr>
<td>Maternal Death</td>
<td>4/100,000</td>
<td>13/100,000</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Maternal Infection</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Infant Infection</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Infant Bag and Mask Ventilation Required</td>
<td>5,400/100,000</td>
<td>2,500/100,000</td>
</tr>
<tr>
<td>Transient Tachypnea of the Newborn (TTN)</td>
<td>3,600/100,000</td>
<td>4,200/100,000</td>
</tr>
<tr>
<td>Infant with Brain Injury</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Infant death in pregnancy or within 7 of birth (Perinatal Death Rate)</td>
<td>130/100,000</td>
<td>50/100,000</td>
</tr>
<tr>
<td>Infant death within 30 days of birth (Neonatal Death Rate)</td>
<td>110/100,000</td>
<td>60/100,000</td>
</tr>
</tbody>
</table>

References:


24. Tasheen F, Griffiths M: Vaginal birth after two caesarean sections (VBAC-2)—a systematic review with meta-analysis of success rate and adverse outcomes of VBAC-2 versus VBAC-1 and repeat (third) caesarean sections. BJOG 2010;117:5-19 (Level II-B)
Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventative Services Task Force

I  Evidence obtained from at least one properly designed randomized controlled trial.
II-1 Evidence obtained from well-designed controlled trials without randomization.
II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

**Level A**—Recommendations are based on good and consistent scientific evidence.
**Level B**—Recommendations are based on limited or inconsistent scientific evidence.
**Level C**—Recommendations are based primarily on consensus and expert opinion.
Patient Education: Birth Choices After a Cesarean Section

(Your Hospital: Insert Name)

This document was created by obstetric doctors, midwives, and nurses from hospitals across Northern New England. It is based upon thorough and thoughtful review of medical studies on vaginal birth after cesarean section (VBAC). It is a collection of everyone’s understanding of these studies. Our goal is to give you a fair review of the risks and benefits of attempting vaginal delivery after a cesarean delivery. We believe vaginal birth after a cesarean section is a good choice for many women.

Your Hospital wants to give you the best care possible. Taking part in choices about your delivery is an important part of this care. Because you had a cesarean birth before, you come to this delivery experience with further choices to make. We will give you information so that you can make choices that are best for you and your family. The goal is a healthy mother and baby, whether the birth is vaginal or cesarean.

What are the benefits of VBAC compared to a planned cesarean birth?

• Faster time to heal after birth
• Shorter hospital stay
• Less risk of infection after delivery
• No chance of problems caused by surgery (infection, injury to bowel or urinary tract, or blood loss)
• Less risk that the baby will have breathing problems
• Quicker return to normal activities because there is no pain from surgery.
• Greater chance of having a vaginal birth in later pregnancies
• Less risk of problems with how the placenta attaches in future pregnancies.
Can all women with previous cesarean birth attempt VBAC?

Some women should not try VBAC. If the cesarean scar is in the upper part of the uterus, where contractions occur, the risk of the uterus tearing (also called uterine rupture) is high. These women should have repeat cesarean births and avoid labor. Women with a scar in the lower part of the uterus have a lower risk of the uterus tearing and VBAC is considered safe. The type of scar you have in your skin may not be the same type of scar you have in your uterus. Your doctor or midwife will review the records of your previous birth to find the location of your uterine scar. If you have had three or more cesarean births and no vaginal births, the risk of the uterus tearing during labor may increase and VBAC may not be recommended. Your doctor or midwife will review these risks with you.

What are the risks of VBAC?

- A tear or opening in the uterus (womb) occurs in 5 to 10 women out of every 1,000 low risk women who try VBAC (0.5% to 1.0%).
- Risks to the mother if there is a tear in the uterus include:
  - Blood loss that may need transfusion
  - Damage to the uterus that may need hysterectomy (removal of the uterus)
  - Damage to the bladder
  - Infection
  - Blood clots
  - Death, which is very rare.
- Risks to the baby if there is a tear of the uterus are brain damage and death. Not all tears in the uterus harm the baby. About 7% of the time the baby is harmed when the uterus tears. In other words, 5 to 10 babies out of every 10,000 VBAC tries will suffer brain damage or death (0.05% to 0.1%) due to uterine rupture.
- The normal risks of having a vaginal birth are also present for VBAC.
- The risk of your uterus tearing during labor is increased with any of the following:
  - Labor that is induced (does not start on its own)
  - More than 1 cesarean section
  - Less than 18 months since your last cesarean delivery
  - Need for medicine during labor to increase contractions
- If a vaginal birth cannot occur, then a cesarean birth must be done. Overall, 70-80% of attempted VBAC are successful. A cesarean section after attempting vaginal delivery has the same types of risks as a planned cesarean delivery. However, the risk of infection, transfusion, blood clots and needing hysterectomy is increased.
How can I reduce risks to my baby and me?

- Regular prenatal care is very important in reducing all risks in pregnancy.
- Having labor occur naturally, rather than using medications to start labor, brings down the risk of a tear in the uterus. Your doctor or midwife will talk to you about this, taking into account your own situation.
- Having at least 18 months time between the date of your last cesarean birth and the due date of this pregnancy helps insure the strength of the uterus during this pregnancy.

What are the risks of a planned cesarean birth, if that is my choice?

- The risk that the uterus will tear before a planned cesarean birth is very low. Because you have a scar on your uterus from your prior cesarean birth, you will always be at risk for having a tear in your uterus. The tears usually occur during labor. The risks to the baby and you are the same as if the uterus tore during a VBAC.
- Blood loss
- More scars developing on the uterus
- Infection
- Scarring inside the abdomen
- Injury to organs inside the body
- Problems with anesthesia
- Blood clots
- Risk in later pregnancies of problems with the placenta
- Death, which is very rare

If I choose a repeat cesarean birth, what can I expect in my recovery?

Each woman has her own special experience with cesarean delivery and recovery. Many women talk about their recovery from their second cesarean as easier than their recovery from their first cesarean. This may be due to knowing what to expect in a second cesarean and feeling less tired because you did not have labor. Still, recovering from any type of childbirth takes time.

Overall, how do the risks of VBAC compare to repeat cesarean birth without labor?

- The risk of the uterus tearing during a low risk VBAC is 5 in 1,000 (0.5%). Because you have a scar on your uterus from your prior cesarean birth, you will always be at risk for having a tear in your uterus. The tears usually occur during labor. The risk that the uterus will tear before a planned cesarean birth is very low. The risks to the baby and you are the same as if the uterus tore during a VBAC.
- Overall, the risk of blood transfusion, hysterectomy, blood clots and infection are increased in women who attempt vaginal delivery. These increased risks are from the women who are not successful in vaginal delivery.
• The risk of your baby dying or being seriously injured during VBAC is the same as during a first labor. There is a higher risk of the baby dying or being injured with VBAC compared to a planned repeat cesarean birth. The overall risk with VBAC is about 11 out of 10,000 (0.1%) and with a planned repeat cesarean birth 6 out of 10,000 (0.06%).

Complication Rates Associated With VBAC and Planned Cesarean Birth (Includes Preterm and Term Births).

<table>
<thead>
<tr>
<th>Complication</th>
<th>VBAC Attempt</th>
<th>Planned Cesarean Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine Rupture</td>
<td>468/100,000 (0.5%)</td>
<td>26/100,000 (0.026%)</td>
</tr>
<tr>
<td>Maternal Death</td>
<td>4/100,000 (.004%)</td>
<td>13/100,000 (0.013%)</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Maternal Infection</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Infant Infection</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Infant breathing problems requiring immediate interventions</td>
<td>5,400/100,000 (5.4%)</td>
<td>2,500/100,000 (2.5%)</td>
</tr>
<tr>
<td>Infant breathing problems which last 6-48 hours</td>
<td>3,600/100,000 (3.6%)</td>
<td>4,200/100,000 (4.2%)</td>
</tr>
<tr>
<td>Infant with Brain Injury</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Fetal/Infant Death during pregnancy or the first 7 days after birth</td>
<td>130/100,000 (0.13%)</td>
<td>50/100,000 (0.05%)</td>
</tr>
<tr>
<td>Infant death within 30 days of birth</td>
<td>110/100,000 (0.11%)</td>
<td>60/100,000 (0.06%)</td>
</tr>
</tbody>
</table>

What is the chance that trying a VBAC will result in a vaginal birth?

- 60%-80% of women who try a VBAC have a vaginal birth. There is no perfect way to say who will deliver vaginally. A number of factors increase the chance of success. However, even if none of these factors are present, the chance of vaginal delivery is at least 50%. Factors that predict success are:
  - Cesarean birth for a reason that is not likely to happen again (i.e. breech presentation)
  - Having a vaginal birth in the past
  - Labor that occurs naturally
  - The length of the pregnancy is less than 40 weeks
  - A cervix that is at least 2 cm dilated and very thin when admitted to the hospital

How do women make a choice about a VBAC?

- Having a vaginal birth is very important to some women. For many women, the benefits of trying a vaginal birth outweigh the risks. Women who deliver vaginally have less postpartum discomfort, shorter hospital stays, and describe a feeling of wellness sooner than women recovering from cesarean section.
- Other women choose cesarean birth because they do not want to go through labor. They may be more concerned about the risk of the uterus tearing and the risks of vaginal delivery than the risks of cesarean birth.
- There may be added benefits and risks, some of them emotional, with either choice. We want you to discuss these with your provider and family.
- Future Child Bearing: If a woman is very certain in her desire to have no more children, then the VBAC benefit of less uterine scarring and a better place for the placenta to attach is not present and a repeat cesarean section may be best. However, if there is even a small chance of another pregnancy, a low risk VBAC may be the better choice.
- The purpose of this pamphlet is to help you make the choice that is best for YOU.

If I select VBAC, what can I expect during prenatal care and at the hospital?

- You will be asked to sign a consent form showing that you understand the risks and benefits of your choice. The form will ask you to give your choice.
- Your doctor or midwife will talk with you when to call or come in for labor.
- You may meet with an anesthesiologist before your labor.
- Constant fetal heart rate and contraction monitoring during active labor (when your cervix is 4-5 cm dilated).
• You will have an IV so that fluids and medications may be given to you if needed.
• Blood samples will be taken.
• You options for pain medication during labor are not affected by your prior cesarean section.
• A doctor able to perform a cesarean birth will be on the hospital grounds during the active phase of labor.

What is my hospital’s experience with VBAC?

[Your Hospital] has been performing VBAC for (Insert # of yrs) years. In Northern New England, 60-80% of women who try VBAC have a vaginal birth. [Your hospital] has anesthesia staff, a doctor for the baby and operating room services available 24 hours per day. Your risk of a tear in the uterus and how far along you are in labor determine if all these people are present in the hospital. In cases of tear in the uterus, injury to the baby may occur. The risk of injury to the baby increases with the time it takes to deliver the baby and the damage to the placenta. We have specific plans to respond once a problem is detected. However, there is risk associated with every pregnancy. Risk can never be completely removed. We share the same goal as you: a healthy baby delivered to a healthy mom. We will make every effort to ensure this.

You also have the choice of having your birth at a hospital where anesthesia, operating room staff and doctors for the baby are always present in the hospital. This may lower the risk to the baby if there is a tear in the uterus, but not in all cases. However, delivery at another hospital may mean travel during labor and having your baby away from your local community and support system. You may want to talk to your doctor or midwife about the risks and benefits of planning to deliver at such a hospital. Changing care from one hospital to another during labor may be of little benefit and may increase the risk of harm to you and your baby.

What if I change my mind?

If during the VBAC process you have questions about continuing, we encourage you to talk with your doctor or midwife. You may change your mind about VBAC. However, if delivery is about to happen, a cesarean section may not be possible.

Am I comfortable with making the decision?

Each woman’s decision is personal. Your doctor or midwife is your best source of information. She or he will guide you and your family in deciding how you have your baby. The overall goal is a healthy mother and baby, whether the delivery is by vaginal or cesarean birth.
Spectrum Health Gerber Memorial
Refusal of Repeat Cesarean Section Form

I understand:

1. I have had one or more prior Cesarean-section(s) and have refused a repeat c-section to attempt a vaginal delivery. Spectrum Health Gerber Memorial does not offer vaginal deliveries for women who have had previous cesarean sections because it does not have the surgery and anesthesia staff on site at all times.

2. Approximately 60-80% of women who attempt to delivery vaginally after Cesarean Section will deliver vaginally.

3. The benefits of an uncomplicated VBAC include decreased blood loss, decreased post-delivery complications, and a shorter recuperative period.

4. The risk of a uterine rupture during VBAC in someone like me who has had a prior incision in my uterus is approximately 1% or 1 in 100 VBAC deliveries.

5. VBAC poses a higher risk of harm to my baby than to me. In the event of a uterine rupture, the baby may suffer brain damage or death, if not immediately delivered by emergency C-section.

6. If my uterus ruptures during my VBAC, I understand there may not be sufficient time to operate and prevent death or permanent brain injury to my baby.

7. The risk of death or permanent brain damage to the baby when the uterus ruptures is uncertain, but has been reported to be generally less than 1%, or 1 in 100 uterine ruptures.

8. The risks of harm to me if my uterus ruptures include: hysterectomy (loss of the uterus), blood transfusion, infection, injury to internal organs (bowel, bladder, ureter), blood clotting problems, or death (which is rare).

9. My doctor has determined that transfer to a hospital that provides VBAC is not recommended because the risk of transfer outweighs the benefit.

10. During my VBAC, the use of oxytocin (Pitocin), a hormone to make my uterus contract, may be necessary to assist me in my vaginal delivery. This may cause long contractions and increased pain during contractions and increase the possibility of uterine rupture, abnormal position of the baby, and fetal distress, which will increase the need for an emergency Cesarean section.

11. If I choose a VBAC, but require an emergency Cesarean-section during labor, I have a greater risk of problems than if I had an elective repeat Cesarean-section.

Patient Initials to Confirm Understanding
By signing below, I confirm I have reviewed this information, have discussed it with my doctor, and have had all my questions answered.

**CONSENT FOR EMERGENCY TREATMENT**

By signing this form, I give my consent to all appropriate treatment in the event of a uterine rupture or other complications including, emergency cesarean section, hysterectomy, blood transfusion for me and/or my baby, and emergency resuscitation.

**REFUSAL OF CESAREAN SECTION**

I understand that by signing this form, I am refusing a repeat Cesarean-section. By signing this form I am choosing to attempt a vaginal birth after cesarean at a small hospital that does not offer this option.

Patient signature: ___________________________  Date: ____________

Witness signature: ___________________________  Date: ____________

Physician signature: ___________________________  Date: ____________
Protocol For
Trial Of Labor After
Cesarean Section (TOLAC)
Against Medical Advice

This protocol is applicable to the following sites:

Applicability Limited to: N/A
Reference #: 0
Version#: 1
Effective Date: February 26, 2014
Functional Area: { Functional Areas > Values (by comma) }

1. Purpose
This Hospital does not possess the required staff or facilities to provide VBAC deliveries. Women who desire VBAC should be instructed to present to a hospital with staff and facilities to provide VBAC in accordance with ACOG guidelines. The purpose of this policy is to address those instances in which a woman presents to the Hospital in active labor with viable fetus with history of a previous cesarean section and refuses a repeat cesarean section delivery and the risk of transfer to a facility that provides VBAC deliveries outweighs the benefit of transfer.

2. Definitions
Labor: Regular uterine contractions that cause progressive cervical change.
Hospital: Immediately Available: Present on hospital campus
TOLAC: Trial Of Labor After Cesarean
VBAC: Vaginal Birth After Cesarean
NRP: Neonatal Resuscitation Program
ACOG: American College of Obstetricians and Gynecologists
AIC: Anesthesia In-Charge

3. Responsibilities
Regular uterine contractions that cause progressive cervical change. OB Provider, OB Registered Nurse (RN), Nursing Administrative Supervisor (NAS), OB Clinical Manager, Certified Registered Nurse Anesthetist (CANA), Anesthesia In Charge (AIC), Surgery Staff and Pediatrician.
4. **Protocol**
   
   A. A pregnant woman, greater than 20 weeks, presenting to the Hospital, will be assessed for labor by a qualified medical provider per EMTALA policy (RM16ADM)-Emergency Medical Condition Treatment/Transfer Policy (Emergency Medical Treatment and Active Labor Act EMTALA).
   
   B. For patients in active labor, the OB provider will determine the plan of care. If the laboring patient has had a previous cesarean section and refuses a repeat c-section delivery, the patient will be informed of the risks of refusing a repeat cesarean section and attempting TOLAC at this hospital, including the lack of Immediately Available obstetrics, pediatrics, anesthesia, and surgical staff.
   
   C. If the patient continues to refuse a repeat C-section, the OB provider will review the Refusal of Repeat Cesarean Section Form with the patient and obtain the patient’s signature evidencing the patient’s informed refusal of c-section and decision to proceed with TOLAC against medical advice.
   
   D. **IN THE EVENT THE PATIENT REFUSES C-SECTION AND PROCEEDS WITH TOLAC; THE ATTENDING OB PHYSICIAN WILL REMAIN ONSITE UNTIL THE PATIENT HAS DELIVERED.**
   
   E. Intrapartum trial of labor management will be provided by the nursing staff and OB providers according to standard practice for obstetrical patients, with the following exception:

   *Cytotec* (misoprostol) is not to be used in women with a previous cesarean. It may be used after the birth for uterine atony.

5. **Documentation (as a result of using the protocol)**
   
   A. Documentation of patient’s counseling of the risks of a TOLAC.
   
   B. Refusal of Repeat Cesarean Section Form.

6. **Revisions**

   This Hospital reserves the right to alter, amend, modify or eliminate this protocol at any time without prior written notice and in compliance with Administrative Policy: Policy and Procedure Structure, Standards and Management.

7. **References**

   
   
   
   D. National Institutes of Health Consensus Development Conference


8. Protocol Development and Approval

Document Owner: ________________________________

Writer(s) (formerly Author): ________________________________

Reviewer(s): ________________________________

Approver: ________________________________

9. Keywords

No set
Brookings Health System
South Dakota

Procedure for our cesarean section patients are as follows:

- We have an RN go to the OR with the patient. Her only job is to care for infant in the delivery room, recovery room, and transfer to the floor.
- This nurse assists with skin-to-skin as soon as mother and baby are stable after delivery. Most babies go directly to mother after a two minute assessment on warmer.
- Baby stays skin-to-skin as mother travels to recovery room. More often than not, even though skin-to-skin we do not see baby initiate breastfeeding until mother is in recovery room.
- The PAR nurse takes care of mother in recovery room while the OB nurse takes care of baby, assists with skin-to-skin, and gives any breastfeeding assistance as needed.
- After mother is stable and ready to be transferred to the postpartum unit, the PAR nurse and OB nurse accompany mother and baby to room per cart.
- Mother is transferred to the postpartum bed while holding baby. We have one staff member watching baby to ensure a safe transfer.
- This procedure of keeping baby and mother together in OR, PAR, and transfer to postpartum floor has made our patients very satisfied. Patients that have had a prior c/s without this process are so grateful for the change in policy.
- If the patient has a volunteer doula, the doula is welcome to come to OR with the patient. The doula continues to be a necessary support in the delivery process even if cesarean section is done.

Mother-Baby Contact in the Immediate Postpartum Period (Step 4)

1. Mother and newborn couples, unless infant or mother is unstable, and regardless of feeding preference, will be:
   a. Offered skin-to-skin (STS) contact immediately after birth for at least an hour.
      i. Definition of skin-to-skin contact or skin-to-skin care refers to contact between the newborn infant and its mother (although in the case of incapacitation of the mother, another adult such as the baby’s father or grandparent may hold the baby skin-to-skin). Baby should be placed naked against mother’s naked ventral surface. The baby may wear a diaper and/or hat, but no other clothing should be between the mother’s and baby’s bodies.
      ii. Documentation of STS contact will be placed in infant’s EMR.
      iii. All mothers of cesarean section delivery should be given their infant to hold STS as soon as the mother is safely able to hold and respond to her baby.
b. Routine newborn procedures are postponed until after the first feed during the initial period of STS contact, and should be conducted, when feasible, at the mother’s bedside.

c. Routine assessments are performed while infant STS contact with mother.

d. Implementation of newborn procedures

1. Infant dried and placed skin-to-skin prone on mother’s chest
2. Infant covered with warm, dry blanket
3. May suction if necessary while in STS
4. Assess and assign APGARS
5. Replace damp blankets as needed
6. STS contact begins immediately after birth and continues for at least 1 hour.
7. Newborn Vitamin K and prophylactic eye antibiotic to prevent ophthalmia neonatorum may be delayed for the first hour of birth to allow uninterrupted mother-infant contact and breastfeeding. (ABM Clinical Protocol #5, pg 130)

e. Delivery and/or nursery nurse will offer assistance to assess baby’s readiness for feeding within one hour of birth.

f. STS contact will continue, uninterrupted, until baby completes the first feeding.

g. If STS contact is interrupted for clinical reasons, it should be resumed as soon as mother and infant are able.

2. Mothers whose babies are being cared for in the nursery due to acute care needs:

a. Acutely ill infants being cared for in the nursery will be placed STS with their mother when clinically stable.

b. Mothers will be encouraged to remain with their baby as much as feasible.

c. Frequent STS contact will be encouraged.

d. Mothers will be educated and assisted with breastfeeding when infant is clinically stable to nurse.