Mid Essex Hospital Services NHS
NHS Trust

MANAGEMENT OF VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)	CLINICAL GUIDELINES Register no 06030 Status: Public

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Document history

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1.0	Julie Bishop	June 2008
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2.3	Sarah Moon - Clarification to points 6.0 and 7.0	June 2011
3.0	Meredith Deane	June 2012
3.1	Jo Elgar – Additional Appendices B and C	August 2012

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1.0 Purpose of the Guideline

1.1 This guideline refers to the management of women in pregnancy and labour following a previous caesarean section. Providing women with accurate information regarding VBAC is an essential element in reducing caesarean section rates.

1.2 Appropriate care will largely reduce the risk of maternal and neonatal morbidity and mortality. This will include individualised assessment of women with documented plans of care, referral pathways to the obstetric team (when necessary), and timescales for regular review throughout pregnancy and labour.

1.3 The Maternity Unit is committed to promoting normality and supporting women in their choice of place of birth and providing evidence-based information regarding their choice of mode of birth.

2.0 Incidence

2.1 Nationally the vaginal birth after caesarean section (VBAC) success rate is 72-76%

3.0 Equality and Diversity

3.1 The Trust is committed to the provision of a service that is fair accessible and meets the needs of all individuals.

4.0 Vaginal Birth after Caesarean Section (VBAC)

4.1 Plan of care which must include and be documented

- Full risk assessment with timescales for review
- Reason for previous caesarean section
- Discussion on choice of type of birth and evidence-based information
- **Choice of and plan for place of birth** – home, Midwifery-led Unit, Labour Ward
- **Individual management plan including fetal monitoring**, cannula and pain relief options
- Plan if labour commences early and/or before planned caesarean section
- Plan if labour does not commence ie post-dates and Induction of Labour (IOL) management

4.2 **Inclusion Criteria for VBAC** - women with these criteria at booking will automatically opt-in to the low risk care pathway for vaginal birth:

- One previous low transverse caesarean section for non recurrent reason (Refer to point 4.6)
- Women with no other uterine scars or previous rupture
- No medical or obstetric complications

4.3 Patients who fit these criteria (point 4.2) but are undecided or are requesting a caesarean section will be referred to the VBAC clinic and if still undecided will be referred for further counselling and an obstetric consultant appointment.

4.4 It may be reasonable, based on several retrospective studies to offer a VBAC to women who have had two previous caesarean sections who have also had a vaginal birth. Referral should be made to the Obstetric Consultant in the Antenatal Clinic to discuss.

4.5 Women who fit these criteria but have medical complications should be referred to the obstetric team for discussion about mode of birth, VBAC should not be excluded.

4.6 **Non-recurrent Reason for Primary Caesarean Section** as follows:

- Breech, transverse presentations
- Fetal distress
- Failure to progress with malposition
- Multiple birth
- Maternal request
- IUGR/macrosomia
- Placental site insertion (placenta previa)

4.7 These should not preclude women from VBAC or the low risk care pathway

5.0 Contraindications for VBAC

5.1 Contraindications for VBAC are as follows:

- Previous classical or T-shaped incision or extensive transfundal uterine surgery
- Previous uterine rupture
- Chronic medical condition e.g. diabetes
- Inability to perform emergency caesarean delivery because of unavailability of surgeon or anaesthetic staff
- Two or more previous caesarean sections with no vaginal births
- Proven cephalo-pelvic disproportion
- Previous difficult second stage caesarean section following failed operative vaginal birth with extension of the uterine angle, where operative notes at the time indicate planned caesarean section for the next birth
- Malposition or malpresentation diagnosed in labour
- Placenta praevia/accreta
- Previous 3rd/4th degree tear with faecal incontinence

5.2 Women presenting with any of these conditions should be counselled by their Consultant Obstetrician to choose an elective caesarean.

6.0 Factors Associated with Unsuccessful VBAC

6.1 Factors Associated with Unsuccessful VBAC are as follows:

- Induction of Labour
- No previous vaginal birth
- Body Mass Index >35
- Previous Caesarean Section for dystocia
- Birth Weight >4kg
- < 2 years from previous Caesarean Section
- Advanced maternal age

6.2 These factors should not stop women choosing VBAC but should be discussed in the antenatal period.

7.0 Risks and Benefits of VBAC

7.1 Women should be informed of maternal and perinatal risks and benefits of both VBAC and planned Caesarean section to enable them to make a fully-informed decision regarding mode of birth.

7.2 **Benefits of VBAC -** these include **reduced risk** of the following:

- Complications of surgery
- Anaesthetic risk
- Infection
- Injury to bowel, bladder
- Deep Vein Thrombosis (DVT)
- Transient Tachypnoea of the newborn (TTN)
- Increased length of hospital stay
- Increased blood loss and consequently blood transfusions
- Wound complications

7.3 Risks associated with VBAC

7.3.1 Uterine Rupture Risk

- It is rare – **risk** is **0.22- 0.74% (2.2-7.4/1000 women)**
- There is virtually no risk of rupture with planned caesarean section
- Augmentation in VBAC labour - **risk** is **0.86% (8.6/1000 women)**
- IOL in VBAC labour – **risk** is **1% (10/1000 women),** this risk increases with the use of prostaglandins

7.3.2 Perinatal Mortality and Morbidity

- The risk of perinatal death in planned VBAC compared to planned caesarean section is 0.3/1000 to 0.13/1000 births. This is the same risk as with a primigravida

- Risk of HIE (Hypoxic Ischaemic Encephalopathy) is **0.8/1000 births**

- VBAC reduces the risk of babies developing respiratory problems
  0.2 – 0.3/1000 births in VBAC
  0.3 – 0.4/1000 births in planned CS

- Intrapartum fetal death is rare – **risk is 1/1000 births**

7.4 Risks of repeat Caesarean Section

7.4.1 A caesarean section following a previous CS may increase the risks of serious complications these could include:

- Placenta accreta/praevia
- Operative injury
- Post-operative ventilation
- ITU admission
- Hysterectomy
- Maternal infection
- Blood transfusion

- Longer hospital stay
- Readmission
- Neonatal morbidity

8.0 Antenatal Management

8.1 Aim

8.1.1 To provide information and counselling to women to enable them to make an informed-choice based on the best available evidence regarding mode of delivery following a previous caesarean section (CS).

8.1.2 The proportion of women who decline Vaginal Birth after Caesarean (VBAC) is a significant determinant of overall rates of CS.

8.2 Promoting Opportunities for VBAC

8.2.1 **Antenatally** (this process begins at the booking appointment)

- Discussion and explanation about previous caesarean section
- Review previous notes if available
- Counselling process begins
- If non-recurrent advise will have VBAC
- Give patient information leaflet for VBAC
- Benefits and risks of VBAC are discussed
- Clinically appropriate informed-choice
- Choices confirmed and documented in early pregnancy
- Referral made to Obstetric Antenatal Clinic/VBAC clinic when necessary

8.2.2 **Labour and Birth**

- Document a Plan of Care
- Manage labour to optimise normality
- Discharge low risk women home when labour not established, after assessment by the Obstetric Registrar/consultant
- Discharge patients home with term PROM, not in labour for 24-36 hours
  (Refer to the guideline entitled ‘Guideline for the term pre-labour rupture of membranes’; register number 08049)
- Continuous 1:1 care in labour
- Identify and manage uterine scar rupture
- Keep interventions to a minimum
- IV access, FBC, Gp need not be undertaken routinely in low risk women
- Offer electronic fetal monitoring (EFM)

Abnormal CTG is the most consistent evidence of uterine rupture, present in 55-87% of cases

- Women should be advised to labour in an obstetric unit with access to blood transfusion and emergency theatres
- Epidural is not contraindicated in VBAC

9.0 Maternal Request Caesarean Sections

9.1 Each woman should be provided with evidence-based information to support her decision-making; she should be advised that maternal request caesarean sections for non-clinical indications will not be supported as a best practice approach to care.

9.2 However, the woman will be referred for counselling if the maternal request is because of fear of childbirth or previous traumatic experience.

9.3 If following counselling and support the issues remain unresolved, then the woman should be referred to a Consultant Obstetrician for a planned caesarean section.

10.0 Referral to Obstetric Clinic

10.1 If poor obstetric history is identified, women with a previous caesarean section should be referred to the VBAC clinic at 16 weeks, where they will be referred to the Obstetric Consultant at the appropriate gestation i.e: between 24- 36 weeks, according to risk.
These include the following risk factors,

10.2 **Risk Factors:**

- Previous Neonatal Death/Stillbirth
- >3 1st trimester miscarriages
- >2 Caesarean Sections
- >1 mid-trimester or late pregnancy loss
- History of classical CS, inverted T or J incision
- Cervical suture
- Uterine surgery
- Preterm births below 36/40
- Para 4 +
- Antepartum or Postpartum Haemorrhage
- Baby with congenital abnormality
- Previous baby > 4.5kg or < 2.5 kg at term or < 5th centile pre-eclampsia, eclampsia, chronic hypertension
- Pre-existing medical conditions e.g. cardiac, diabetes, epilepsy, blood disorders
- BMI > 35
- Previous CS for dystocia
- Large-for-dates in current pregnancy
- Previous traumatic vaginal birth with significant morbidity
- 2nd stage emergency CS
- Previous baby with pH <7.01
- Previous long Induction of Labour that ended in an Emergency CS

10.2.1 This would apply whether the woman chooses VBAC or not.

10.3 All women will be referred to the Obstetric Clinic at 40 weeks if they have not spontaneously laboured before then, where a stretch and sweep will be offered and discussion regarding mode of induction/delivery will take place.

10.4 If elective caesarean section is booked then the woman should be consented and a pre-operative assessment performed.

11.0 Referral to VBAC Clinic

11.1 All low risk women with a non-recurrent reason for previous caesarean section who have chosen VBAC will opt-in to the low risk care pathway; they do not require referral to the VBAC clinic. The low risk pathway proforma should be completed by the antenatal midwife as soon as possible, or by 25 weeks at the latest; it should be attached to page 22 of the hand-held antenatal notes. (Refer to Appendix B)

11.2 Women who are seen in the obstetric Antenatal clinic may be referred to the midwifery-led VBAC clinic if the patient or her obstetric consultant wishes. Referral to the midwifery-led VBAC clinic can be made by a midwife or obstetrician. Whilst referral before 20 weeks is ideal, patients can be referred and seen in the midwifery-led clinic at any gestation.

11.3 Women who develop risk factors should be referred to the obstetric clinic for their next antenatal appointment.

11.4 Criteria for Referral to Midwifery-led VBAC Clinic

11.4.1 Not all women need to be seen in the VBAC clinic, those who are low risk and decided on VBAC should receive the patient information leaflet and information at booking. The following women should be seen in the VBAC clinic:

- Women requesting VBAC who are high risk- see 10.2
- Women who are undecided about VBAC but meet the criteria for vaginal birth
- Women who require further information about mode of birth/VBAC
- Maternal request for planned caesarean section due to previous traumatic birth experience
- Women choosing VBAC at home or in the Midwifery-led Unit

11.4.2 A discussion should occur about the options of planned VBAC and the alternative of repeat caesarean section.

11.4.3 Women should be referred by the booking midwife before 20 weeks but an appointment can be made at any time in the pregnancy.

11.4.4 The clinic will also provide support, advice and referral for women who have had a previous traumatic birth and/or are tocophobic and are requesting an elective caesarean for this reason.

11.4.5 The following should be discussed:

- The woman's previous birth experience and outcomes
- Identify any risk factors
- Discuss risks and benefits of VBAC and planned caesarean section
- Induction of labour, premature labour, spontaneous rupture of membranes
- Care in labour
- Options for place of birth
- Document all discussions and decisions on the in the handheld records
- During subsequent antenatal appointments revise the handheld records as necessary to ensure an up to date management plan

11.4.6 If there are no identified risk factors and the woman chooses VBAC continue with low risk care pathway and book consultant appointment for 40 weeks to review, perform a stretch and sweep, assess for suitability of ARM and book IOL/CS at 40 weeks and 12-14 days, if not already booked. (Refer to Appendix A)

12.0 Caesarean Section for Non-clinical Indications

12.1 Caesarean section for a previous uncomplicated CS for a non-recurrent reason will not be offered.

12.2 A secondary caesarean section will only be offered if there are medical or obstetric complications in the current pregnancy, all low risk women will follow the low risk pathway for VBAC.

12.3 Maternal request caesarean section will not be offered routinely, only caesarean section for clinical indications will be offered i.e. complex co-morbidities, malpresentation, and placenta praevia

12.4 Women with a previous traumatic birth experience and fear of childbirth who request a CS will be managed according to NICE Guidance:

- Refer to a counsellor specialising in women's mental health (Perinatal mental health expert)
- Refer to the VBAC clinic
- If after counselling and support the woman's issues remain unresolved a CS should be offered
- If the patient's consultant refuses to perform the CS she should be referred to another consultant for a second opinion.

13.0 Women who Choose VBAC

13.1 Women who choose VBAC should be offered a stretch and sweep 40-41 weeks.

13.2 A caesarean section should be booked for 40 weeks + 12- 14 days.

13.3 If the woman agrees to IOL this should be booked for 40 weeks + 12-14 days.

13.4 An appointment should be made with the Obstetric Team at 40-41 weeks if the woman has not gone into spontaneous labour to discuss IOL and be consented for caesarean section.

13.4 Unless there is another indication, women choosing VBAC do not need to see an anaesthetist.

13.5 They should be given an obstetric anaesthetic assessment (OAA) form to complete which should be filed in the anaesthetic pages of the woman's handheld records.

13.6 If there is another indication, an appointment should be arranged to see the anaesthetist at 32 weeks gestation.

13.7 If prelabour rupture of membranes (PROM) occurs at term the 'Guideline for the term Pre-labour rupture of membranes' should be followed i.e. review at 24 hours and consider for Syntocinon at 48 hours. (Refer to the 'Guideline for the term pre-labour rupture of membranes'; register number 08049)

13.8 If an ARM is possible at term +12-14 this should be performed. (Refer to the 'Guideline for the artificial rupture of the membranes'; register number 07076.

14.0 Choice of Place of Birth with VBAC

14.1 Options for choice of place of birth should be discussed with each woman, while promoting safety it is essential to facilitate choice and offer support for each woman. It may be necessary

to involve a Supervisor of Midwives if a woman chooses a homebirth to ensure support and a Plan of Care is made and communicated to the midwifery team.

14.2 The Head of Midwifery, Community Midwifery Manager and Supervisory Team should be advised of all VBAC women choosing a Homebirth.

14.3 Patients should be advised that the safest place to have a VBAC is on a Maternity Unit where there is easy access to the obstetric and paediatric team, emergency operating theatres and blood transfusion.

14.4 This would ideally be on the Labour Ward but it is possible that a patient having a VBAC could give birth on the midwifery-led unit as an alternative to having a VBAC at home. This would be decided on an individual basis with senior midwifery input into her Plan of Care.

14.5 Women requesting water immersion/ birth would also need a discussion regarding risks and benefits and again, referral to a senior midwife to ensure an individual Plan of Care is documented.

14.6 The risks and benefits associated with each place of birth should be discussed with the woman; these would include potential for transfer to Labour Ward. (Birthplace Study 2011)

15.0 Management of Labour and Birth for Women Suitable for VBAC

15.1 **Management of Spontaneous VBAC Labour** as follows:

- Document a Plan of Care
- Manage labour to optimise normality
- Low risk patients in the latent phase of labour (<4cm dilated) without regular painful contractions may be discharged home following cardiotocograph (CTG) monitoring and review by the Obstetric Registrar/consultant
- Low risk patients with term PROM may be discharged home for 24-36 hours to await labour

16.0 Monitoring the Fetal Heart Rate in VBAC Labour

16.1 **Abnormal CTG is the most consistent evidence of uterine rupture, present in 55-87% of cases**

16.2 Monitoring the fetal heart rate in VBAC Labour as follows:

- Offer electronic fetal monitoring (EFM) once in established labour (>4cm dilated with regular painful contractions)
- If using continuous electronic fetal monitoring (EFM) and there is a poor quality trace, then a fetal scalp electrode (FSE) should be applied where possible
- Document if declined
- Intermittent Auscultation (IA) when performed must be in accordance with EFM Guideline regarding 1st stage (every 15 minutes) and 2nd Stage (every 5 minutes) of labour
- If the patient has chosen intermittent auscultation (IA) for monitoring of the fetal heart, she should be advised of 16.1, and that if there is difficulty in auscultating or an abnormality is detected then the patient would be advised that continuous Cardiotocograph (CTG) is required to adequately monitor fetal wellbeing

17.0 Admission to Labour Ward

17.1 Inform the obstetric registrar/consultant on call of admission.

17.2 The antenatal decision for VBAC should be reviewed by the obstetric registrar/consultant on call with reference to the reasons for the previous caesarean section and with current knowledge of the woman's labour history.

17.3 If the patient has remained undecided about VBAC during the antenatal period and presents in labour the obstetric registrar should assess labour progress and plan ongoing management, patient should be offered VBAC if there are no contraindications

17.4 One to one midwifery care must be provided.

17.5 **In Labour:**

- Once in established labour VE 4 hourly unless slow progress
- The obstetric registrar should be informed if there is slow progress
- Slow progress in the presence of strong contractions is an indication of dystocia and the likelihood for a repeat caesarean section
- Identify signs and symptoms of uterine scar rupture; pain, bleeding, fetal heart rate abnormalities
- Monitor and record maternal and fetal observations to ensure wellbeing
- Commence partogram when in established labour
- 1 hourly pulse and blood pressure and 15 minutes Fetal Heart Rate (FHR) assessment (in 1st stage) and 5 minute FHR assessment (in 2nd stage)– continuous monitoring is recommended
- Keep interventions to a minimum
- Intravenous (IV) access, FBC+Gp need not be taken routinely in low risk women
- If cannulating insert a grey cannula (16G) and take blood for group and save (Gp + S) , full blood count (FBC) and clotting screen
- Mobilise and keep nutrition light with adequate fluid intake, once in established labour restrict intake to water, fruit squash or isotonic non-carbonated
  (Refer to entitled 'Guidelines for nutrition in labour and antacid prophylaxis for the pregnant woman at term'; register number 04253)
- Give Ranitidine 150 mg orally, 6 hourly during labour.
- If slow progress is diagnosed syntocinon may be used – this is a **Obstetric Consultant decision,** following full assessment of the woman and fetus
- Ensure adequate analgesia, epidural is not contraindicated
- If epidural requested or required an indwelling urinary catheter will be required to prevent over distension of the bladder
  (Refer to the 'Guideline for the management of normal labour and prolonged labour in low risk patients; register number 09079; and 'Guideline for the completion of the partogram in pregnancy; register number 09046

18.0 Management of Slow Progress

18.1 When there is evidence of **secondary arrest** i.e. when there is normal progress of labour until cervical dilatation reaches 6-9cm, followed by cervical dilatation less than 0.5cm/hour accompanied by contractions decreasing in strength and frequency, **oxytocin should not** be used because of the significant risk of uterine rupture/dehiscence.

18.2 Syntocinon may be used for slow progress following ARM, this is a consultant decision

19.0 Second Stage Management

19.1 Management of 2nd Stage

- 30 minutes for passive descent after diagnosis of full dilatation
- 30 minutes of Active Pushing after this
- Inform Obstetric Registrar/Consultant on call if no progress
- Obstetric Registrar/Consultant on call to assess need for operative vaginal delivery in theatre or room
- Maximum 1 hour Active Pushing

19.2 If epidural is in situ allow 60 minutes for passive descent, otherwise follow the same pathway of care.

20.0 Operative Vaginal Delivery

20.1 If an operative vaginal delivery is indicated and the presenting part is at or above the spines or with more than 1/5th of the head palpable inform the obstetric registrar or consultant on call and arrange trial of operative vaginal delivery in theatre.

20.2 Descent of the head should occur with each pull, absence of descent with traction on a correctly positioned instrument should be regarded as a reason to abandon the procedure in favour of caesarean section.

21.0 VBAC Induction of Labour (IOL) and Augmentation

21.1 VBAC Induction of Labour (IOL) and Augmentation as follows:

- Review at 40 weeks in Obstetric Clinic if undelivered
- IOL is an Obstetric Registrar/Consultant decision
- Full documentation in notes including a plan of care
- Perform on Antenatal Ward or Labour Ward
- Book for 40 weeks and 12-14 days
- Offer perform membrane sweep at 40 weeks – **reduces need for IOL**
- If a patient declines or is unsuitable for IOL then a planned caesarean section should be booked for 40 weeks +12-14 days – unless there is a clinical indication to book it earlier
- Admit to Antenatal Ward and perform artificial rupture of membranes (ARM)
- If ARM is not possible – plan for elective caesarean section
- The use of prostaglandins and syntocinon for IOL is an Obstetric Registrar/ consultant decision based on the individual woman
- Only administer syntocinon following vaginal examination (VE) and assessment by Registrar
- 2 hourly vaginal examinations should be performed while syntocinon is administered

21.1.1 **Risk of uterine rupture increases by 2-3 times with IOL and use of prostaglandins**

21.1.2 **There is a 1.5 fold increased risk of Caesarean Section for VBAC with IOL or augmented labours compared with VBAC who labour spontaneously**

21.2 Proactive management and assessment of labour is essential to monitor progress and fetal and maternal wellbeing.

21.3 Refer early to Obstetric registrar/Consultant if abnormalities are detected and ensure a multidisciplinary approach to the care of these patients.

21.4 The Obstetric Registrar/Consultant referral and input into management and assessment of these patients is vital
(Refer to the 'Guidelines for Induction Augmentation of Labour with Syntocinon'; register number 04270).

21.5 The risks and benefits of induction/augmentation should be clearly explained to the patient and documented in her hand held records.

21.6 ARM can be performed in the antenatal inpatient ward with transfer to labour after 2 hours if contractions have not commenced or labour establishes.

22.0 VBAC Augmentation with Syntocinon

22.1 The risks and benefits of augmentation with syntocinon should be clearly explained to the patient prior to administration, and documented in the handheld records.

22.2 The Obstetric Registrar/ Consultant on call and the Labour Ward Co-ordinator should be involved in formulating a plan of care in collaboration with the patient.

22.3 This should specify the amount and rate of syntocinon to be administered (as directed by the Obstetric Registrar/ Consultant on call) and clear instructions for the timing of vaginal examinations to assess progress, maximum 2 hourly while in progress
(Refer to the guideline for 'Induction and augmentation of labour with syntocinon'; register number 04270)

22.4 Vaginal examinations and abdominal palpation to assess progress in labour should be carried out by an obstetric registrar or consultant 2 **hours** after syntocinon has been commenced.

22.5 If the cervix has failed to dilate 2 cm during that time the consultant should be informed and the patients should be advised to have a caesarean section.

22.6 The fetal heart rate (FHR) must be continuously monitored (CTG) and any abnormal features should be reviewed immediately by the obstetric registrar/ consultant and the syntocinon infusion stopped. If the CTG does not return to normal immediately then the woman should be offered a caesarean section.
(Refer to guideline for 'Guideline for fetal heart rate monitoring in pregnancy and labour'; register number 04265)

23.0 VBAC and Pre-labour Rupture of Membranes at Term (PROM)

23.1 Women should be reviewed by the Obstetric Registrar/ Consultant on call in order to exclude any contraindications/risks.

23.2 In the absence of other risk factors the patient may be managed conservatively for the first 24 -36 hours after membrane rupture has been confirmed.

23.3 Investigations and assessment should not differ from patients without a uterine scar.

23.4 If after 24 -36 hours there are no signs of labour commencing, further management should be discussed with the Obstetric Registrar/ consultant on call.

23.5 If the patient declines conservative management a plan of care should be formulated with the Obstetric Registrar/consultant on call reflecting the patient's preferences.

23.6 Options include either an elective caesarean section or induction of labour using an oxytocin infusion.

23.7 The oxytocin (syntocinon) infusion should only be commenced if the cervix is favourable i.e. a Bishop score of 5 or more.

23.8 The duration of oxytocin administration should be limited.

23.9 If after 4 hours of an oxytocin infusion, there is no evidence of cervical dilatation or other signs of progress in labour such as cervical effacement and descent of the fetal head then the woman should be delivered by caesarean section.

23.10 The use of prostaglandin ripening agents should be discussed with the obstetric consultant.

24.0 Signs of Uterine Rupture or Dehiscence

24.1 Risk of Uterine Rupture

24.1.1 It is rare:

- **Risk is 2.2-7.4/1000 patient in labour following 1 previous caesarean section**
- **Risk is 8.6/1000 in augmented VBAC**
- **Risk is 10/1000 in IOL VBAC labour, increases with prostaglandin use**

24.2 Signs and Symptoms:

- Loss of presenting part on vaginal examination
- Fetal distress
- Cessation of uterine contractions
- **Failure to progress – especially secondary arrest of labour**
- Maternal tachycardia and hypotension
- Abdominal pain – constant
- Scar tenderness particularly breakthrough pain when epidural anaesthetic is in use
- PV bleeding
- Blood stained urine
- Maternal collapse

25.0 Care on Co-located Midwifery-led Unit including Waterbirth

25.1 Some women may choose to labour and give birth on the Midwifery-led Unit.

25.2 An individualised Plan of Care should be documented in the handheld notes antenatally after discussion about the risks and benefits in the VBAC clinic and with a Senior Midwife.

25.3 The following should be discussed:

- Intermittent auscultation
- Risks of uterine rupture and water birth
- Difficulty in removal from pool if complications arise
- Need for transfer to Labour Ward
- Pain relief options
- Chances of successful VBAC

25.4 A referral may need to be made to the woman's Consultant Obstetrician for further discussion.

26.0 Staffing and Training

26.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training; this will include the recognition and management of uterine rupture, scar dehiscence and fetal heart abnormalities

26.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in accordance with their code of conduct and local requirements for safe practice.

27.0 Infection Prevention

27.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

27.2 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using High Impact Intervention guidelines to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

27.3 All staff should ensure that they follow Trust guidelines on infection control, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. vaginal examinations and conducting deliveries.

28.0 Audit and Monitoring

28.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy, the Maternity annual audit work plan and the NHSLA/CNST requirements. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

28.2 As a minimum the following specific requirements will be monitored:

- Documented antenatal discussion on the mode of delivery
- Documented plan for the place of labour
- Documented individual management plan for labour
- Documented plan for labour should this commence early
- Documented plan for labour should this not commence as planned, that has been discussed with the consultant obstetrician
- Documented plan for the monitoring of the fetal heart in labour
- Process for audit, multidisciplinary review of audit results and subsequent monitoring of action plans

28.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 28.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

28.4 The findings of the audit will be reported to and approved by the Maternity Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to

address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

28.5 The audit report will be reported to the monthly Maternity Directorate Governance Meeting (MDGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

28.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

28.7 Key findings and learning points will be disseminated to relevant staff.

29.0 Guideline Management

29.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

29.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

29.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

29.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

30.0 Communication

30.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarize themselves with and practice accordingly.

30.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

30.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

30.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

31.0 References

British Medical Journal (2011) Birth place study: BMJ 2011; 343: 10.1136/bmj.d7400 Published 24 November.

www.bmj.com/content/343/bmj.d7400

National Institute for Clinical Excellence (2011) Clinical Guideline No 132 Caesarean Section. NICE: London.

Clinical Negligence Scheme for Trusts (2012/2013) CNST Maternity Standards Version 2012/2013. DNV:NHSLA.

Kings Fund (2008) Safe births everybody's business.

National Institute for Clinical Excellence (2008) Clinical Guideline Caesarean Section. NICE: London.

Royal College of Obstetricians and Gynaecologists (2007) Birth after previous caesarean birth Green-top guideline no 45 February; RCOG: London.

National Service Framework (2007) Every Child Matters; NSF: London

Department of Health (2007) Maternity Matters; DoH April.

Safer Childbirth (2007) Minimum standards for the organisation and Delivery of Care in Labour RCM/ RCOG October.

Department of Health (2006) Modernising Maternity Care; Do H August

Hamid, R et al: management of scarred uterus in subsequent pregnancies: Current obstetrics and gynaecology (2006) 16, 168-173.

National Institute for Clinical Excellence (2004) Caesarean Section Guideline 13; NICE: London, April

Surname: First Name Hospital No: NHS No:

High Risk VBAC Proforma Checklist

Please Complete as follows:

Attended VBAC Clinic	Yes / No (please circle)
Non recurrent VBAC – low risk pathway	Yes / No
VBAC Patient Information leaflet discussed and given	Yes / No
High risk pathway	Yes / No
Attended Obstetric Consultant appointment Appointment Date:	Yes / No

Date:

Signature: Designation:

Print Name:

SECTION 1: to be completed at VBAC appointment

Surname:		**NHS Number:**	
First name:		**Date of Birth:**	
Hospital Number:		**EDD by USS:**	
Consultant:		**Named Midwife:**	

Risks of Caesarean section discussed:			
Increased risk of infection		Increased risk of placenta praevia	
Increased risk of Thrombosis		Increased risk of placenta accreta	
Increased risk of haemorrhage		Pain and sub fertility due to scar tissue	
Increased risk of blood transfusion		Damage to bladder/bowel	
Baby 1:4 chance of RDS/TTN Possible nick to baby's head		Risk of scar rupture without labour 1 to 12 : 10,000 births	
Risks of VBAC discussed:		**Benefits of VBAC discussed:**	
Risk of scar rupture with labour<0.5% 22 to 74 : 10,000 births		70% to 80% National success rate	
Increased risk of repeat C/Section		Quicker recovery e.g. drive a car, less pain, etc	
		Reduced risk of infection and all other problems associated with C/Section	

History of previous LSCS:	
Reason for LSCS	
Emergency or elective?	
Was an epidural anaesthesia sited and at what stage of labour?	
How many cms dilated at time of c/section?	
Debriefed by surgeon following c/section?	
Any other maternal or fetal risks	
Referral to Consultant	

Plan of care for labour discussed:	
Stay at home until labour established	
Continuous fetal monitoring (CTG) : FHR most common indication of scar dehiscence	
IV cannula and bloods	

6 hourly ranitidine; fluids only	
Close monitoring of progress in labour: 1cm in 1 to 2 hours of active labour.	
All analgesia available; pool not recommended due to continuous fetal monitoring	
Plan of care if in premature labour:	
Proceed to VBAC if no contraindications	
Plan of care if Spontaneous rupture of membranes and no labour:	
Conservative management if no contraindications. If no contractions after 24hrs - full discussion with obstetric team. Syntocinon augmention or LSCS after 48hours	
Plan of care if not in labour by 40 weeks:	
No prostin induction – can go to term +12 -14 days	
Stretch and sweep at term and T+7	
Consultant Appointment:- **Either** ARM and syntocinon if favourable and no contraindications **or** date for ELCS	

Preferred mode of delivery before VBAC discussion		
Preferred mode of delivery following VBAC discussion		
Place of Delivery		
VBAC class offered	Yes / No	Accepted Declined Undecided
Signature of Lead midwife for VBAC		
Date		

SECTION 2: To be completed by the Obstetric Consultant

Seen by Consultant for VBAC review (pre-term)?	**Yes** **At /40**	**No**
Care plan documented in antenatal notes?	**Yes**	**No**
Intended delivery following Obstetric consultation		

Seen by Consultant at 40 weeks?	**Yes**	**No**
Care plan documented in antenatal notes (post term)?	**Yes**	**No**

Please secure this proforma on page 22 of the patient's Antenatal Care Records

Name: Hospital No: NHS No:

Booking VBAC Proforma Checklist

Please Complete as follows:

Either:

Non recurrent VBAC – low risk pathway	Yes / No (please circle)
VBAC Patient Information leaflet discussed and given	Yes / No
Low risk pathway proforma completed	Yes / No

Or:

High risk pathway or requiring further discussion (Refer to VBAC clinic)	Yes / No

Date:

Signature: Designation:

Print Name:

Please attach to page 22 of Patient's hand held records.

VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC) Low Risk Pathway Proforma
To be completed by 25 weeks and attached to page 22 of hand held antenatal records.

Surname:		**NHS Number**	
First name:		**Date of Birth**	
Hospital Number:		**EDD by USS**	
Consultant		**Named Midwife**	

Risks of VBAC discussed:		**Benefits of VBAC discussed:**	
See Patient Information Leaflet (PIL)			
History of previous LSCS			
Reason for LSCS Include whether emergency or elective			
Any other maternal or fetal risks			
Referral to Consultant made			

Plan of care for labour discussed:	**Tick box**
Stay at home until labour established	
Continuous fetal monitoring (CTG) recommended : FHR most common indication of scar dehiscence	
IV cannula and bloods if necessary	
6 hourly ranitidine; fluids only	
Close monitoring of progress in labour: 1cm in 1 to 2 hours of active labour.	
All analgesia available; pool not recommended as currently unable to moniter fetal heart rate continuously	
Plan of care if in premature labour before 37 wks: Proceed to VBAC if no contraindications	
Plan of care if Spontaneous rupture of membranes and no labour:	
Conservative management if no contraindications. If no contractions after 24 to 36hrs - full discussion with obstetric team. Syntocinon augmention or LSCS after 48hrs.	
Plan of care if not in labour by 40 weeks:- as per PIL– appt. and discussion with consultant needed	

Place of Delivery		
VBAC class offered	**Yes** **No**	**Accepted** **Declined** **Undecided**
Signature of midwife		
Date		