Operative Vaginal Birth

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Authors Name:	Miss Erum Khan, Dr Syeda Tahir		
Authors Job Title:	Consultant Obstetrician, Obs & Gynae Registrar		
Authors Division:	Women and Children's Health		
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Guideline to be followed by (target staff): The scope of this guideline will include indications for operative vaginal delivery, choice of instrument, aspects of safe clinical practice, risk of physical and psychological complications and a review of special circumstances

To be read in conjunction with the following documents:
Bladder Care Guideline

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute

for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

Operative vaginal births (i.e. forceps or ventouse births) account for 10-13% of all births which is equivalent to 400-500 births per year at Milton Keynes University Hospital NHS Foundation Trust. There is potential for clinical risk associated with these births especially because the main reasons for performing instrumental births is to expedite birth in clinical situations where there is risk to the mother or baby.

Documentation is particularly important in these cases so that all the steps in the decision making and procedure are displayed clearly.

Objectives

To provide guidance as to the indications for and the procedure to be followed when performing an operative vaginal birth (forceps and the vacuum extractor) and to provide record keeping standards to aid clear documentation.

Executive Summary

- Operative vaginal birth can be with either ventouse or forceps .
- Operative births are generally performed in the labour ward. However, if the operator has an index of suspicion it might fail then the birth should take place in theatre and classified as a trial of operative vaginal birth.
- Discontinue the procedure if birth has not been achieved after 30 minutes of starting the procedure.
- Adequate documentation entailing reason for the birth, examination findings, steps performed and any difficulties encountered during the birth must be clearly recorded in the maternal records.
- Women should receive a debrief following the procedure.

Scope of document

The scope of this guideline will include indications for operative vaginal birth, choice of instrument, aspects of safe clinical practice, risk of physical and psychological complications and a review of special circumstances

1.0 Roles and Responsibilities:

Doctors – Decision making, intrapartum care.

Midwives – Intrapartum care.

All staff – Communicate clearly with the woman, her family and each other.

2.0 Implementation and dissemination of document

This guideline is available on the Trust intranet and has followed the full guideline review process prior to publication.

3.0 Processes and procedures

Rationale for main recommendations

Preparation for assisted vaginal birth
Can assisted vaginal birth be avoided?

- Encourage women to have continuous support during labour as this can reduce the need for assisted vaginal birth.
- Inform women that epidural analgesia may increase the need for assisted vaginal birth although this is less likely with newer analgesic techniques.
- Inform women that administering epidural analgesia in the latent phase of labour compared to the active phase of labour does not increase the risk of assisted vaginal birth.
- Encourage women not using epidural analgesia to adopt upright or lateral positions in the second stage of labour as this reduces the need for assisted vaginal birth.
- Encourage women using epidural analgesia to adopt lying down lateral positions rather than upright positions in the second stage of labour as this increases the rate of spontaneous vaginal birth.
- Recommend delayed pushing for 1–2 hours in nulliparous women with epidural analgesia as this may reduce the need for rotational and midpelvic assisted vaginal birth.
- Do not routinely discontinue epidural analgesia during pushing as this increases the woman's pain with no evidence of a reduction in the incidence of assist
- There is insufficient evidence to recommend any particular regional analgesia technique in terms of reducing the incidence of assisted vaginal birth.
- There is insufficient evidence to recommend routine oxytocin augmentation for women with epidural analgesia as a strategy to reduce the incidence of assisted vaginal birth.
- There is insufficient evidence to recommend routine prophylactic manual rotation of fetal malposition in the second stage of labour to reduce the risk of assisted vaginal birth.

3.1 How should assisted vaginal birth be defined?

- Use a standard classification system for assisted vaginal birth to promote safe clinical practice, effective communication between health professionals and audit of outcomes.

Table 1. Classification for assisted vaginal birth

- Outlet

Fetal scalp visible without separating the labia Fetal skull has reached the perineum Rotation does not exceed 45°

- Low

Fetal skull is at station + 2 cm, but not on the perineum Two subdivisions: 1. Non-rotational ≤ 45° 2. Rotational > 45

- ° Mid

Fetal head is no more than one-fifth palpable per abdomen Leading point of the skull is at station 0 or + 1 cm Two subdivisions: 1. Non-rotational ≤ 45° 2. Rotational > 45°

3.2 When should assisted vaginal birth be recommended/contraindicated?

- Operators should be aware that no indication is absolute and that clinical judgment is required in all situations.
- Suspected fetal bleeding disorders or a predisposition to fracture are relative contraindications to assisted vaginal birth.
- Blood borne viral infections in the woman are not an absolute contraindication to assisted vaginal birth
- The use of a vacuum is not contraindicated following a fetal blood sampling procedure or application of a fetal scalp electrode.
- Operators should be aware that there is a higher risk of subgaleal haemorrhage and scalp trauma with vacuum extraction compared with forceps at preterm gestational ages. Vacuum birth should be avoided below 32 weeks of gestation and should be used with caution between 32+0 and 36+0 weeks of gestation.

Indications for assisted vaginal birth

- Fetal

Suspected fetal compromise (cardiotocography pathological, abnormal fetal blood sampling result, thick meconium)

- Maternal

Nulliparous women – lack of continuing progress for 3 hours (total of active and passive second-stage labour) with regional analgesia or 2 hours without regional analgesia Parous women – lack of continuing progress for 2 hours (total of active and passive second-stage labour) with regional

analgesia or 1 hour without regional analgesia Maternal exhaustion or distress Medical indications to avoid Valsalva manoeuvre

- Combined

Fetal and maternal indications for assisted vaginal birth often coexist

3.3 What are the essential conditions for safe assisted vaginal birth?

Safe assisted vaginal birth requires a careful assessment of the clinical situation, clear communication with the woman and healthcare personnel, and expertise in the chosen procedure

3.3a Safety criteria for assisted vaginal birth

Full abdominal and vaginal examination

- Head is ≤ 1/5 palpable per abdomen (in most cases not palpable)
- Cervix is fully dilated and the membranes ruptured
- Station at level of ischial spines or below
- Position of the fetal head has been determined
- Caput and moulding is no more than moderate (or +2)a
- Pelvis is deemed adequate Preparation of mother

3.3b Preparation of mother

- Clear explanation given and informed consent taken and documented in women's case notes
- Trust established and full cooperation sought and agreed with woman
- Appropriate analgesia is in place: for midpelvic or rotational birth, this will usually be a regional block; a pudendal block may be acceptable depending on urgency; and a perineal block may be sufficient for low or outlet birth
- Maternal bladder has been emptied
- Indwelling catheter has been removed or balloon deflated
- Aseptic technique

3.3c Preparation of staff

- Operator has the knowledge, experience and skill necessary
- Adequate facilities are available (equipment, bed, lighting) and access to an operating theatre
- Backup plan: for midpelvic births, theatre facilities should be available to allow a caesarean birth to be performed without delay; a senior obstetrician should be present if an inexperienced obstetrician is conducting the birth
- Anticipation of complications that may arise (e.g. shoulder dystocia, perineal trauma, postpartum haemorrhage)
- Personnel present who are trained in neonatal resuscitation

3.4 Does ultrasound have a role in assessment prior to assisted vaginal birth?

- Ultrasound assessment of the fetal head position prior to assisted vaginal birth is recommended where uncertainty exists following clinical examination.

3.5 What type of consent is required prior to attempting assisted vaginal birth?

- Women should be informed about assisted vaginal birth in the antenatal period, especially during their first pregnancy. If they indicate specific restrictions or preferences then this should be explored with an experienced obstetrician, ideally in advance of labour.
- For birth room procedures verbal consent should be obtained prior to assisted vaginal birth and the discussion should be documented in the notes.
- When midpelvic or rotational birth is indicated, the risks and benefits of assisted vaginal birth should be compared with the risks and benefits of second stage caesarean birth for the given circumstances and skills of the operator. Written consent should be obtained for a trial of assisted vaginal birth in an operating theatre.

3.6 Performing assisted vaginal birth

3.6 a. Who should perform assisted vaginal birth?

- Assisted vaginal birth should be performed by, or in the presence of, an operator who has the knowledge, skills and experience necessary to assess the woman, complete the procedure and manage any complications that arise.
- Advise obstetric trainees to achieve expertise in spontaneous vaginal birth prior to commencing training in assisted vaginal birth.
- Ensure obstetric trainees receive appropriate training in vacuum and forceps birth, including theoretical knowledge, simulation training and clinical training under direct supervision.
- Competency should be demonstrated before conducting unsupervised births.

Complex assisted vaginal births should only be performed by experienced operators or under the direct supervision of an experienced operator.

3.6 b. Who should supervise assisted vaginal birth?

An experienced operator, competent at midpelvic births, should be present from the outset to supervise all attempts at rotational or midpelvic assisted vaginal birth.

3.7 Where should assisted vaginal birth take place?

- Non-rotational low-pelvic and lift out assisted vaginal births have a low probability of failure and most procedures can be conducted safely in a birth room.

- Assisted vaginal births that have a higher risk of failure should be considered a trial and be attempted in a place where immediate recourse to caesarean birth can be undertaken.

3.8 Higher rates of failure are associated with:

- Maternal BMI greater than 30
- Short maternal stature
- Estimated fetal weight of greater than 4 kg or a clinically big baby
- Head circumference above the 95th percentile
- Occipito–posterior position
- Midpelvic birth or when one-fifth of the head is palpable per abdomen.

3.9 What instruments should be used for assisted vaginal birth?

- The operator should choose the instrument most appropriate to the clinical circumstances and their level of skill.
- Operators should be aware that forceps and vacuum extraction are associated with different benefits and risks; failure to complete the birth with a single instrument is more likely with vacuum extraction, but maternal perineal trauma is more likely with forceps.
- Operators should be aware that soft cup vacuum extractors have a higher rate of failure but a lower incidence of neonatal scalp trauma.
- Rotational births should be performed by experienced operators; the choice of instrument depending on the clinical circumstances and expertise of the individual. The options include Kielland's rotational forceps, manual rotation followed by direct traction forceps or vacuum, and rotational vacuum extraction.

3.10 VACCUM EXTRACTION AS COMPARED WITH FORCEPS ASSISTED BIRTH

More likely to fail at achieving vaginal birth
More likely to be associated with cephalhaematoma
More likely to be associated with retinal haemorrhage
More likely to be associated with maternal worries about baby
Less likely to be associated with significant maternal perineal and vaginal trauma
No more likely to be associated with birth by caesarean birth
No more likely to be associated with low 5 min Apgar scores
No more likely to be associated with the need for phototherapy

3.10a Risk-based information can be summarised as follows:

Maternal outcomes:

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

3.10b Perinatal outcomes:

- Cephalhaematoma; predominantly vacuum, 1–12%.
- Facial or scalp lacerations; vacuum and forceps, 10%.
- Retinal haemorrhage; more common with vacuum than forceps, variable 17–38%.
- Jaundice or hyperbilirubinaemia; vacuum and forceps, 5–15%.
- Subgaleal haemorrhage; predominantly vacuum, 3 to 6 in 1000.
- Intracranial haemorrhage; vacuum and forceps, 5 to 15 in 10 000.
- Cervical spine injury; mainly Kiellands rotational forceps, rare.
- Skull fracture; mainly forceps, rare.
- Facial nerve palsy; mainly forceps, rare.
- Fetal death; very rare. The 'Odon' device is a new low-cost instrume

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

- Discontinue vacuum-assisted birth where there is no evidence of progressive descent with moderate traction during each pull of a correctly applied instrument by an experienced operator.
- Complete vacuum-assisted birth in the majority of cases with a maximum of three pulls to bring the fetal head on to the perineum. Three additional gentle pulls can be used to ease the head out of the perineum.

- If there is minimal descent with the first two pulls of a vacuum, the operator should consider whether the application is suboptimal, the fetal position has been incorrectly diagnosed or there is cephalopelvic disproportion. Less experienced operators should stop and seek a second opinion. Experienced operators should re-evaluate the clinical findings and either change approach or discontinue the procedure.

- Discontinue vacuum-assisted birth if there have been two 'pop-offs' of the instrument. Less experienced operators should seek senior support after one 'pop-off' to ensure the woman has the best chance of a successful assisted vaginal birth.

- The rapid negative pressure application for vacuum-assisted birth is recommended as it reduces the duration of the procedure with no difference in maternal and neonatal outcomes.

- The use of sequential instruments is associated with an increased risk of trauma to the infant. However, the operator needs to balance the risks of a caesarean birth following failed vacuum extraction with the risks of forceps birth following failed vacuum extraction.

- Obstetricians should be aware of the increased neonatal morbidity following failed vacuum-assisted birth and/or sequential use of instruments, and should inform the neonatologist when this occurs to ensure appropriate care of the baby.

- Obstetricians should be aware of the increased risk of obstetric anal sphincter injury (OASI) following sequential use of instruments.

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

- Discontinue attempted forceps birth where the forceps cannot be applied easily, the handles do not approximate easily or if there is a lack of progressive descent with moderate traction.

- Discontinue rotational forceps birth if rotation is not easily achieved with gentle pressure.

- Discontinue attempted forceps birth if birth is not imminent following three pulls of a correctly applied instrument by an experienced operator.

- If there is minimal descent with the first one or two pulls of the forceps, the operator should consider whether the application is suboptimal, the position has been incorrectly diagnosed or there is cephalopelvic disproportion. Less experienced operators should stop and seek a second opinion. Experienced operators should re-evaluate the clinical findings and either change approach or discontinue the procedure.

- Obstetricians should be aware of the potential neonatal morbidity following a failed attempt at forceps birth and should inform the neonatologist when this occurs to ensure appropriate management of the baby.

- Obstetricians should be aware of the increased risk of fetal head impaction at caesarean birth following a failed attempt at birth via forceps and should be prepared to disimpact the fetal head using recognized manoeuvres..

3.13 What is the role of episiotomy in preventing maternal pelvic floor morbidity at assisted vaginal birth?

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

3.14 When should assisted vaginal birth be recommended/contraindicated?

- Operators should be aware that no indication is absolute and that clinical judgment is required in all situations.
- Suspected fetal bleeding disorders or a predisposition to fracture are relative contraindications to assisted vaginal birth.
- Blood borne viral infections in the mother are not an absolute contraindication to assisted vaginal birth.
- Vacuum extraction is not contraindicated following a fetal blood sampling procedure or application of a fetal scalp electrode.
- Operators should be aware that there is a higher risk of subgaleal haemorrhage and scalp trauma with vacuum extraction compared with forceps at preterm gestational ages.
- Vacuum birth should be avoided below 32 weeks of gestation and should be used with caution between 32+0 and 36+0 weeks of gestation.

3.15 Consent

Safe operative vaginal birth requires a careful assessment of the clinical situation, clear communication with the mother and healthcare personnel and expertise in the chosen procedure.

- Informed consent from women in labour
- For births in the room, verbal consent should be obtained and documented.

  Any preferences or objections to any instrument written in the woman's birth plan should be discussed and taken into consideration.

Written consent should be obtained for trial or operative vaginal birth in theatre. The following factors should be present before undertaking an operative vaginal birth in theatre:

- Vertex presentation
- Full dilatation
- Ruptured membranes
- The fetal head is less than 1/5th palpable per abdomen
- The position / station of the head has been clearly defined
- Adequate uterine contractions - consider Oxytocin infusion
- Empty bladder
- The woman has an adequate analgesia i.e. Spinal or Epidural anaesthesia
- There is no known cephalo-pelvic disproportion

3.16 The probability of a successful birth with the ventouse is reduced when

- There is lack of maternal effort
- There is a malposition
- Where there is significant caput
- Inadequate contractions

3.17 Indications for operative vaginal birth

Indications for assisted vaginal birth

Fetal

- Suspected fetal compromise (cardiotocography pathological, abnormal fetal blood sampling result, thick meconium)
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Maternal

- Nulliparous women – lack of continuing progress for 3 hours (total of active and passive second-stage labour) with regional analgesia or 2 hours without regional analgesia Parous women – lack of continuing progress for 2 hours (total of active and passive second-stage labour) with regional analgesia or 1 hour without regional analgesia
- Maternal exhaustion or distress Medical indications to avoid Valsalva manoeuvre

Combined

Fetal and maternal indications for assisted vaginal birth often coexist

3.18 Contraindications to forceps birth

- Incomplete cervical dilatation
- No more than one fifth of the head palpable per abdomen
- Excessive traction required
- If position of fetal head is not clearly defined.

3.19 Analgesia

- If the mother already has an epidural in situ this can be used to provide adequate analgesia for instrumental birth.
- If an epidural is not in situ, perineal infiltration with local anaesthetic may be all that is required in straightforward ventouse extractions
- Pudendal block is useful additional analgesia for non-rotational forceps deliveries
- Epidural or spinal analgesia is used for trial of vaginal birth in theatre
- Epidural or spinal for rotational forceps (manual rotation is preferred to rotational forceps)

3.20 Preparation for Operative Vaginal birth

- Explain indications and obtain a consent
- Document the discussion
- Put the woman into lithotomy position
- Should be aware of the peculiarities of different vacuum devices or forceps.
- Should also be aware of the manufacturer's recommendations for ventouse

3.21 ABCDEFGHIJ of Ventouse birth

A. **A**sk for help. **A**ddress patient. **A**ssess need for **A**naesthesia to ensure adequate analgesia or regional anaesthesia

B. **B**ladder empty. Make sure the bladder is not full as this may lead to dystocia and also may lead to bladder injury with an instrumental birth. If needed perform a straight catheterisation; Remove Foley's catheter if it is in situ.

C. **C**ervix fully dilated or a thin anterior rim (can be pushed away) with vertex in the pelvic floor if imminent birth indicated.

D. **D**etermine position. Think of dystocia and review HELPERR pneumonic

E. **E**quipment ready- Ventouse cup. Check the equipment for leaks by applying the cup to the palm of a gloved hand.

F. Apply the cup over the saggital suture, as far posterior as possible, even touching the overlying **f**ontanelle. Raise the vacuum to 0.2 kg/cm2, then run a finger round the cup to ensure that no maternal soft tissue has been trapped. The vacuum can then be increased to

0.8 kg/cm2 and maintained at this level. When using the metal cup only 2-3 minutes is required to produce a "chignon"

G. **G**entle traction is applied in the axis of the pelvic curve during contractions. Simultaneously encouraging maternal expulsive effort

H. **H**alt traction when the contraction is over. **H**alt the procedure if you have disengagement of the cup three times or no progress in three consecutive pulls

I. Evaluate for **i**ncision. Episiotomy may not be necessary.

J. The Ventouse is removed once the **j**aw is retractable

The decision to birth interval depends on the urgency of the clinical situation, however all instrumental births should be conducted within 30 minutes of the decision.

3.22 ABCDEFGHIJ for forceps birth

A. **A**sk for help, **A**ddress patient, and is **A**nalgesia adequate?
B. **B**ladder empty? Make sure the bladder is not full as this may lead to dystocia and also may lead to bladder injury with an instrumental birth. If needed perform a straight catheterisation.
C. **C**ervix must be completely dilated.
D. **D**etermine position of fetal head. Think of shoulder dystocia and review **HELPERR** pneumonic
E. **E**quipment ready (suction, cord clamp, instruments etc.).
F. Apply **F**orceps. Many obstetricians will coat the blades with obstetric cream for ease of application.
G. **G**entle traction
H. **H**andle elevated to follow the "J" shaped pelvic curve.
I. Evaluate for **I**ncision, or episiotomy, when the perineum distends
J. Remove forceps when the **J**aw is reachable

Note: Clinicians to have awareness of the OASI Care Bundle and complete OASI audit form following birth.

Check forceps applied correctly

i. Posterior fontanelle should be midway between shanks and 1cm above plane of shanks.

ii. Fenestration in forceps' blades admits no more than 1 fingertip.

iii. Lambdoidal sutures should be above and equidistant from upper surface of each blade.

The decision to birth interval depends on the urgency of the clinical situation, however all instrumental births should be conducted within 30 minutes of the decision.

3.23 Should prophylactic antibiotics be given?

- A single prophylactic dose of intravenous amoxicillin and clavulanic acid should be recommended following assisted vaginal birth as it significantly reduces confirmed or suspected maternal infection compared to placebo
- Good standards of hygiene and aseptic techniques are recommended

3.24 Should thromboprophylaxis be given?

- Reassess women after assisted vaginal birth for venous thromboembolism risk and the need for thromboprophylaxis.

3.25 What analgesia should be given after birth?

- In the absence of contraindications, women should be offered regular nonsteroidal antiinflammatory drugs (NSAIDs) and paracetamol routinely

3.26 Sequential use of instruments

- The use of sequential instruments is associated with an increased risk of trauma to the infant; however, the operator must balance the risks of a caesarean section following failed vacuum extraction with the risks of forceps birth following failed vacuum extraction.
- Obstetricians should be aware of increased neonatal morbidity with sequential use of instruments and should inform the neonatologist when this occurs to ensure appropriate management of the baby.
- The sequential use of instruments should not be attempted by an inexperienced operator without direct supervision and should be avoided if possible.

3.27 Care following operative vaginal birth

- Explanation of events and debrief for staff if necessary.
- Explain the procedure to the patient and debrief.
- Explain the importance of good perineal hygiene
- Bladder care - see Bladder care guideline.
- Women should be offered physiotherapy-directed strategies to prevent urinary incontinence.
- Analgesia as required
- Women should be reassessed after an operative vaginal birth for risk factors for venous thromboembolism and, if appropriate, thromboprophylaxis should be prescribed.
- Prior to discharge, patient needs to be reviewed by the Obstetrician

3.28 What precautions should be taken for care of the bladder after birth?

- Women should be educated about the risk of urinary retention so that they are aware of the importance of bladder emptying in the postpartum period.
- The timing and volume of the first void urine should be monitored and documented.
- A post void residual should be measured if urinary retention is suspected.
- Recommend that women who have received regional analgesia for a trial of assisted vaginal birth in theatre have an indwelling catheter in situ after the birth to prevent covert urinary retention. This should be removed according to the local protocol.
- Offer women physiotherapy-directed strategies to reduce the risk of urinary incontinence at 3 months.
- Women who have had regional analgesia for a trial of assisted vaginal birth should be offered an indwelling catheter for 6–12 hours after birth (in keeping with the local protocol) to prevent asymptomatic bladder overfilling, followed by fluid balance charts to ensure good voiding volumes.

3.29 How can psychological morbidity be reduced for the woman?

- Shared decision making, good communication, and positive continuous support during labour and birth have the potential to reduce psychological morbidity following birth.
- Review women before hospital discharge to discuss the indication for assisted vaginal birth, management of any complications and advice for future births. Best practice is where the woman is reviewed by the obstetrician who performed the procedure.
- Offer advice and support to women who have had a traumatic birth and wish to talk about their experience. The effect on the birth partner should also be considered.
- Do not offer single session, high-intensity psychological interventions with an explicit focus on 'reliving' the trauma.
- Offer women with persistent post-traumatic stress disorder (PTSD) symptoms at 1 month referral to skilled professionals as per the NICE guidance on PTSD.

3.30 What information should women be given for future births?

- Inform women that there is a high probability of a spontaneous vaginal birth in subsequent labours following assisted vaginal birth.
- Individualise care for women who have sustained a third- or fourth-degree perineal tear, or who have ongoing pelvic floor morbidity

3.31 What type of documentation should be completed for assisted vaginal birth?

- Documentation for assisted vaginal birth should include detailed information on the assessment, decision making and conduct of the procedure, a plan for postnatal care and sufficient information for counselling in relation to subsequent pregnancies. Use of a standardised proforma is recommended.
- Paired cord blood samples should be processed and recorded following all attempts at assisted vaginal birth.
- Adverse outcomes, including failed assisted vaginal birth, major obstetric haemorrhage, OASI, shoulder dystocia and significant neonatal complications should trigger an incident report as part of effective risk management processes.

3.32 How should serious adverse events be dealt with?

- Obstetricians should ensure that the ongoing care of the woman, baby and family are paramount.
- Obstetricians have a duty of candour; a professional responsibility to be honest with patients when things go wrong.
- Obstetricians should contribute to adverse event reporting, confidential enquiries, and take part in regular reviews and audits. They should respond constructively to outcomes of reviews, taking necessary steps to address any problems and carry out further retraining where needed.
- Maternity units should provide a safe and supportive framework to support women, their families and staff when serious adverse events occur.

4.0 Statement of evidence/references

References:

Royal College of Obstetricians and Gynaecologists. (2011). Greentop Guideline Number 26. Operative Vaginal Delivery. London: RCOG.

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
2	December 2006	Dennis Danso	Revised guideline – new template required
	May 2010	Miss Pandit	Review date extended
	October 2010	Miss Thampi	Review date extended
3	September 2010	Premila Thampi	Updated guideline
4	January 2015	Olaniyi Agboola	Reviewed and updated
5	January 2017	Miss Thampi	Reviewed and updated
5.1	November 2018	Erum Khan & Lydia Stratton-Fry	Updated guideline to reflect use of vacuum extractors in section 4.5. Approved at CIG on 05/12/2018
6	October 2020	Erum Khan & Syeda Tahir	ROCG updated – Green top guideline

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Syeda Tahir	Women and Children's			ROCG updated 2020 (version 6)	Yes
Matrons			June 2017		Yes
Head of Midwifery			June 2017		Yes
Consultants			June 2017		Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
a) Rate of operative vaginal birth b) Rate of failed operative vaginal birth c) Rate of sequential instrument use d) Rate of third and fourth degree perineal tears e) Rate of neonatal morbidity e.g. admission to SCBU, Apgar score of less than 7 at	a-e) Statistics f) Clinical Audit	Risk midwife or delegated individual	Quarterly-Maternity CSU, Monthly – Maternity CIG	Maternity CIG

5 minutes, cord arterial pH of less than 7.1 f) Standard of documentation				

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and Children	Department	Maternity
Person completing the EqIA	Syeda Tahir	Contact No.	
Others involved:	Erum Khan	Date of assessment:	12/2020
Existing policy/service	yes	New policy/service	

Will patients, carers, the public or staff be affected by the policy/service?	no
If staff, how many/which groups will be affected?	

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Emails
How are the changes/amendments to the policies/services communicated?
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed

Review date of EqIA	12/2023		