Clinical Guideline

LABOUR CARE

SETTING Maternity Services – hospital & community

FOR STAFF Midwives, Obstetricians

PATIENTS Women in labour

GUIDANCE

Communication

All women in labour should be treated with respect and should be in control of and involved in what is happening to them; the way in which care is given is key to this. To facilitate this, healthcare professionals and other caregivers should establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use. This information should be used to support and guide her through her labour.

To establish communication with the woman:

- Introduce yourself and establish her language needs. Explain your role.
- Maintain a calm and confident approach; this demeanour will reassure the woman.
- Knock and wait before entering the woman's room
- Ask permission before all procedures and observations.
- Show the woman and her birthing partner how to summon help. When leaving the room, let her know that you will return.
- Involve the woman in any handover of care to another health professional.

Support in labour

- A woman in established labour should receive supportive one-to-one care
- A woman in established labour should not be left on her own except for short periods or at the woman's request

Documentation of observations

- Observations should be carried out on admission, in established first stage of labour, and second stage of labour as per NICE Intrapartum Guideline (listed below)
- When not in established labour observations are recorded on the blue antenatal pages in the hand held records or the MOEWS chart.
- In established labour observations are recorded on the pink partogram and labour record

For guidance on referral to obstetric care in labour see appendix 1

On admission / first labour contact

1 Listen to the woman's story. Consider her emotional and psychological needs.

2 Review her clinical records – risk assessment (see Appendix 2 and Clinical risk Assessment and Selection of Lead Professional guideline)

3 Assess maternal wellbeing:
   a) Pulse
   b) Blood pressure
   c) Temperature
   d) Urinalysis
   e) Vaginal loss – show, liquor, blood
   f) Contractions – length, strength, frequency
   g) Behaviour

4 Assess fetal wellbeing:
   a) abdominal palpation including symphysis fundal height measurement
   b) fetal movements in the last 24hrs
   c) auscultation of the fetal heart with Pinnard or Doppler for at least one minute after a contraction as per Monitoring the Fetus in Labour guideline. Differentiate between maternal and fetal heart rate at this point.

5 Discuss birth plan including coping strategies for labour and options for pain relief

6 Consider a vaginal examination (VE):
   a) If the woman does not appear to be in established labour, after a period of assessment it may be helpful to offer a VE
   b) If the woman appears to be in established labour, a VE should be offered

Note: Healthcare professionals who conduct VEs should:

- be sure that the VE is really necessary and will add important information to the decision-making process
- be sensitive to the fact that VEs are an invasive procedure and that for many women they can be very distressing
- explain the reason for the examination and what will be involved
- be aware that women may decline a VE – if a woman declines a VE document that a VE has been offered and declined
- ensure informed consent is obtained

- ensure the woman's privacy, dignity and comfort
- explain the findings and their impact sensitively to the woman and her birth companion
- document the findings, discussion and plan

7 Based on the initial assessment the decision should be made as to the appropriate place of birth. If the birth is imminent and the current location is deemed unsuitable, the decision to transfer should be based on whether the current location is preferable to the birth occurring before the transfer is complete.

Latent phase of labour

Definition: A period of time, not necessarily continuous when

- There are painful contractions
- There is some cervical change including cervical effacement and dilatation up to 4cm

1. Women without complications are encouraged to be at home unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed. She should be given clear written and verbal information about when to seek further midwifery input e.g. SRM, bleeding, contractions increasing, reduced fetal movements
2. Discuss strategies for coping with contractions e.g. warm bath, mobilisation, simple analgesia, relaxation and breathing techniques, massage, reassurance, fluid and light diet (provide **'Latent Phase of Labour - Ideas to help you'** patient information leaflet)
3. Do not advise aromatherapy, yoga or acupressure for pain relief. However, if a woman wants to use these techniques , respect her wishes.
4. Provide guidance and support to the woman's birth companion.
5. Should the woman telephone with concerns or for advice, she should be triaged appropriately using the telephone triage documentation. If she would like to be seen she should be invited in to the unit of her planned place of birth.
6. Women who are admitted for the 3rd time in the latent phase of labour should be reviewed by the obstetric team (ST3 or above)

Established first stage of labour

Definition:

- Regular painful contractions
- Progressive cervical dilatation from 4cm

Duration of first stage of labour

Women should be informed that, while the length of established first stage of labour varies between women, first labours last on average 8 hours and are unlikely to last over 18 hours. Second and subsequent labours last on average 5 hours and are unlikely to last over 12 hours.

1 Assume normality unless proven otherwise
2 Ensure privacy and confidentiality
3 Use positive, empowering language
4 Encourage mobilisation and the use of birthing aids such as balls, immersion in water and mats
5 Ensure hydration and encourage nutrition in early labour - Isotonic drinks reduce maternal ketosis without increasing gastric volume
6 Encourage the woman to empty her bladder 2-4 hourly
7 Explain how to summon help, and if leaving her alone inform her when you will return
8 Consider ongoing emotional and psychological wellbeing and changes in behaviour and requirements for pain relief.
9 Assess & document maternal wellbeing (Observations as per NICE intrapartum guideline):
   a) Frequency and strength of contractions half-hourly
   b) Pulse hourly
   c) Blood pressure and temperature* 4-hourly
      *If maternal temperature $\geq$37.5^{o} C at any stage in labour it should be rechecked after an hour
   d) Frequency and volume of emptying the bladder – see bladder care guideline
   e) Abdominal palpation prior to vaginal examination
   f) Vaginal examination offered 4-hourly to assess descent of the presenting part, position of presenting part, and cervical dilatation, or where there is concern about progress or in response to the woman's wishes.
   g) Assessment of vaginal loss hourly and prior to vaginal examination
10 Assess & document fetal wellbeing
   a) Monitoring of the fetal heart as per Monitoring the Fetus in Labour guideline
   b) Vaginal loss – liquor, blood, meconium staining of the liquor.
      - Significant meconium staining is defined as either dark green or black fluid that is thick or tenacious, or any meconium stained fluid containing lumps of meconium thick or fresh
      - If significant meconium is present ensure that the woman is transferred to a consultant led obstetric unit

11 Progress of labour:

Assessment of progress needs to take into consideration all aspects of progress in labour and should include:

a) Cervical dilatation of less than 2 cm in 4 hours for nulliparous women
b) Cervical dilatation of less than 2cm in 4 hours or a slowing in the progress of labour for second or subsequent labours.
c) Overall progress in labour – whether progress is maintained or slows
d) Descent and rotation of the fetal head
e) Changes in the strength, duration and frequency of uterine contractions. In case of uterine Hyperstimulation see Oxytocin use in labour.

If concerns around sepsis, see Pyrexia in Labour on page 8.

Where a diagnosis of delay is made see section below: Management of Delay in Labour

Second stage of labour

1. Assess maternal wellbeing as in first stage of labour (Observations as per NICE intrapartum guideline)
2. Assess fetal wellbeing as in Monitoring the Fetus in Labour guideline
3. Encourage all fours, upright or left lateral positions
4. Ensure adequate hydration
5. Encourage frequent bladder emptying
6. Women should be reassured making noise is normal

Passive second stage of labour

The finding of full dilatation of the cervix prior to or in the absence of involuntary expulsive contractions.

Leave one hour and then:

1 Abdominal palpation
2 Vaginal assessment
3 Assess fullness of the bladder, encourage bladder emptying
4 Assessment of frequency and strength of contractions
5 Consider change of position
6 Offer obstetric referral and transfer to consultant unit if still no urges to push

Active second stage of labour:

- Expulsive contractions with a finding of full dilatation of the cervix or other signs of full dilatation of the cervix
- Active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions.

1 Allow the woman to be guided by her own urge to push
2 Encourage maternal effort as appropriate (including where epidural analgesia in use)
   a) Use positive language
   b) Avoid prolonged Valsalva (breath holding) pushes
3 Encourage the mother to change position to maintain comfort and facilitate pushing. Avoid lithotomy and recumbent positions as this increases fetal distress and the risk of perineal trauma.

First labours:

- A diagnosis of delay in the active second stage should be made when it has lasted 2 hours and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.
- Birth would be expected to take place within 3 hours of the start of the active second stage in most women.

Second and subsequent labours:

- A diagnosis of delay in the active second stage should be made when it has lasted 1 hour and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.
- Birth would be expected to take place within 2 hours of the start of the active second stage in most women.

Where a diagnosis of delay is made see section below: Management of Delay in Labour

Management of Delay in Labour

First stage;

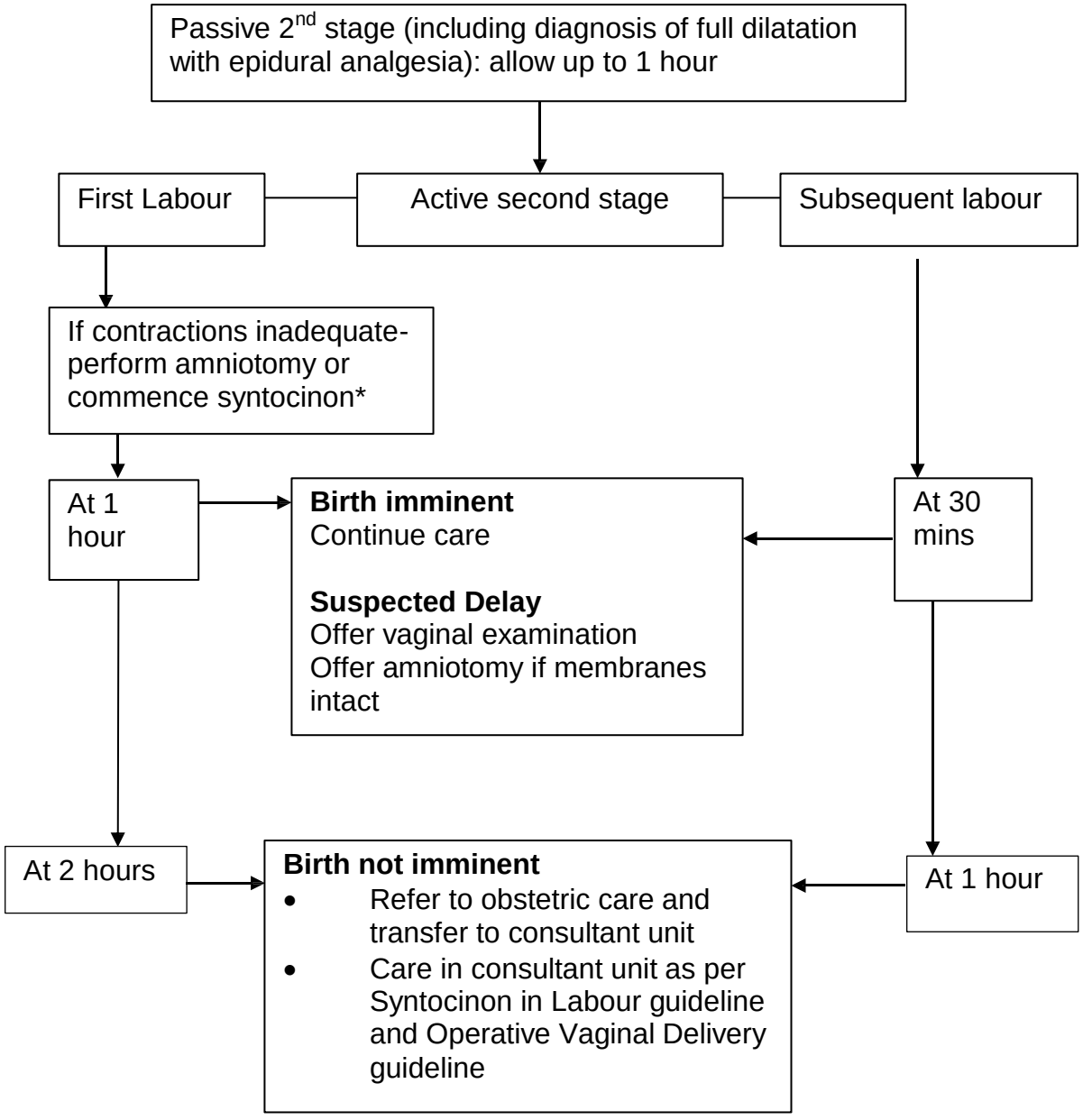
1 Change position – encourage upright position, avoid lithotomy and recumbent positions
2 Ensure good hydration
3 Ensure bladder empty
4 Consider Artificial Rupture of Membranes
5 Consider referral to obstetric care and transfer to consultant unit

6 Care in consultant unit as per Syntocinon in Labour guideline

Second stage;

1. Change position – encourage upright position, avoid lithotomy and recumbent positions
2. Ensure good hydration
3. Ensure bladder empty
4. Support and encouragement

Second stage of labour flowchart:



* See Oxytocin use in labour

Pyrexia in labour

Tympanic temperature of ≥38°C on one occasion or ≥37.5°C on two consecutive occasions at least an hour apart

- Inform obstetric team
- Commence continuous electronic fetal monitoring
- Administer Paracetamol 1gram orally or intravenously
- Recheck temperature in 1 hour

(If at high risk of sepsis such as prolonged rupture of membranes, consider early recourse to antibiotic therapy.)

On rechecking: if temperature still ≥ 38ºC or 37.5°C with other signs of maternal infection (e.g. maternal tachycardia, tachypnoea or fetal tachycardia)

- Perform investigations:
  - Blood cultures
  - Full blood count, CRP
  - Throat swab
  - High vaginal swab
  - Midstream specimen of urine
  - Placental swabs – maternal and fetal surface
- Commence intravenous antibiotics as per antibiotic policy
- Inform Neonatologists of concerns re maternal sepsis at delivery
- See maternity sepsis guideline
- Commence Modified Obstetric Early Warning Score (MOEWS) chart postnatally

Note: Where there is any concern about changes in any maternal observations consider increasing the frequency of the observations and referring for obstetric opinion.

Intrapartum interventions to reduce perineal trauma

- Good communication with the mother to control delivery of the head.
- Do not perform perineal massage or offer lidocaine spray in the second stage of labour
- Warm compress on the perineum during and between the contractions
- NICE intrapartum guideline suggests that there isn't a difference between Hands On or Hands poised approach; however RCOG provide evidence that a Hands on approach to support the perineum and slow delivery of the head may reduce trauma and protect the perineum.

Third Stage of Labour

- Recognise that the time immediately after the birth is when the woman and her birth companion are meeting and getting to know the baby. Ensure that any care or interventions are sensitive to this and minimise separation.

To facilitate informed choice, all women will:

- Have management of the third stage of labour discussed with them in the antenatal period including the risks and benefits of both the active and physiological methods (see appendix 1)
- Receive the UHBristol Patient Information leaflet called 'Third Stage of Labour' in the antenatal period.
- Have their choice for management of the third stage confirmed by the midwife caring for them in labour
- Advise women to have active management because of the lower risk of haemorrhage but support them if they request a physiological management. Document clearly in the notes

Physiological Third Stage

- No routine use of uterotonic
- Do not clamp or divide cord until the cord has stopped pulsating
- Avoid controlled cord traction (CCT)
- Deliver the placenta by maternal effort

60 mins

If:

- Baby requires resuscitation
- Excessive blood loss
- Woman desires to change

Managed Third Stage (see note 1)

- Recommended if
  - woman is at increased risk of haemorrhage e.g. previous haemorrhage
  - has intervention in labour e.g Induction of labour, augmentation, epidural anaesthesia
- Administer uterotonic (Syntocinon 10units IM or Syntometrine 1ml IM) with delivery of anterior shoulder or as soon as possible after the birth
- Delay clamping of the cord for approximately 2 minutes unless baby requires resuscitation
- If the woman requests the cord be clamped after 5 mins, support her in her choice if appropriate
- Wait for the next uterine contraction and signs of placental separation
- Deliver the placenta by controlled cord traction

30 mins

Delay in third stage

If blood loss not excessive:

- Administer a uterotonic if not already administered and consent given
- Empty urinary bladder
- Consider change of maternal position
- Encourage breastfeeding to promote oxytocin production
- **Keep woman informed at all times**
- **Ensure consent & adequate analgesia for any VE**
- Perform CCT with analgesia

Document maternal observations in pink labour notes

- general physical condition, as shown by her colour, respiration and her own report of how she feels
- vaginal blood loss

Frequent Pulse, BP, Resps may also be required if significant bleeding, or resuscitation required

Also document the timing of cord clamping in both methods

Placenta fails to deliver, excessive blood loss or maternal collapse → **Transfer to Obstetric-led care for Manual Removal of Placenta (see Guideline)**

Active Management of the Third Stage in Women at risk of Hypertension or with Maternal Cardiac Disease

- If a blood pressure assessment has not been undertaken during labour avoid Syntometrine for a managed third stage of labour.
- Any woman with antenatal evidence of proteinuric hypertension, pregnancy induced hypertension requiring medication, or who has had a blood pressure ≥ 140/90 mmHg during labour will not receive Syntometrine.
- Syntocinon is used to avoid the transient blood pressure rise associated with use of Syntometrine.
- A plan for the management of women with cardiac disease should have been made in the antenatal period. This should be in the handheld notes and make clear whether an alternative regime of 5 units of Syntocinon in 10ml normal saline over 10 minutes, followed by a Syntocinon infusion of 30 IU in 500ml normal saline over 4 hours, is required.

The Placenta

All placentae that are not required for investigations are placed in a small yellow bag provided in each room and taken to sluice in Central Delivery Suite and placed in the yellow clinical waste bin. The bag must be labelled with the woman's name, date and time (use of a sticker with details on is recommended)

1. Taking a placenta home

Any woman wishing to take a placenta home must be told that it is human tissue and therefore an infection risk if not disposed of in a suitable way. It must be disposed of in a safe manner and she must sign in her buff notes that she understands that she is taking responsibility for its disposal.

Lotus birth, or umbilical nonseverance, is the practice of leaving the umbilical cord attached to both the baby and the placenta following birth, without clamping or severing, and allowing the cord the time to detach from the baby naturally. In this way the baby, cord and placenta are treated as a single unit until detachment occurs, generally two to three days after birth. If a mother chooses lotus birth discuss with a Supervisor of Midwives.

2. Cytogenetics.

In the case of a stillbirth or abortion a small portion of the placenta may be sent for cytogenetics if requested by the obstetrician. The transport medium is found in the freezer on CDS in the treatment room. Consent is required by the mother.

3.Placentae requiring histological examination:

All Placentae should be placed in a bucket of formalin and sent to:

The mortuary if a stillbirth or neonatal death has occurred

The BRI Histopathology department with a placental histopathology request if:

- Suspected chorioamnonitis
- Fetal abnormality
- Intra-uterine growth retardation (<2.5kg)
- Preterm <34 weeks
- Birth asphyxia (Apgar <7/10 at 5 mins or arterial cord pH equal to or less than 7.05
- Unplanned admission to NICU
- Placentae that look abnormal
- Placental abruption
- Vasa praevia
- All multiple pregnancies. The cords must be clearly marked.

It is essential that they are transported in the transport box to comply with health and safety regulations

This is not an exhaustive list and a clinician (midwife, neonatologist or obstetrician may request placental histology on a case by case basis)

A placental swab from the fetal surface is sent to Microbiology when there is:

- maternal pyrexia
- offensive liquor

Please ensure the name of the consultant is written on the request form it to ensure the report is processed accurately

Appendix 1

When discussing the risks and benefits of the two methods of managing the third stage, the midwife should explain the following:

Active Management;

- Shortens the third stage compared to the physiological method
- Is associated with nausea and vomiting in about 100:1000 women
- Is associated with an approx. risk of 13:1000 of haemorrhage of more than 1 litre.
- Is associated with and approx. risk of 14:1000 of a blood transfusion

Physiological Management;

- Is associated with nausea in about 50:1000 women
- Is associated with an approx. risk of 29:1000 of a haemorrhage of more than 1 litre
- Is associated with an approx. risk of 40:1000 of a blood transfusion

Appendix 2

The following risks and benefits should be assessed when considering transfer from midwife led care to obstetric care. If transferring from a setting outside the consultant unit the likelihood of birth taking place during the transfer should be taken into account.

- Indications for electronic fetal monitoring (EFM) including abnormalities of the fetal heart rate (FHR) on intermittent auscultation
- Delay in the first or second stages of labour
- Significant meconium-stained liquor
- Maternal request for epidural pain relief
- Obstetric emergency – antepartum haemorrhage, cord presentation/prolapse, postpartum haemorrhage, maternal collapse or a need for advanced neonatal resuscitation
- Retained placenta
- Maternal pyrexia in labour - see page 7 of this guideline
- Malpresentation or breech presentation diagnosed for the first time at the onset of labour, taking into account imminence of birth
- Either raised diastolic blood pressure (over 90 mmHg) or raised systolic blood pressure (over 140 mmHg) on two consecutive readings taken 30 minutes apart
- Uncertainty about the presence of a fetal heartbeat
- Third- or fourth-degree tear or other complicated perineal trauma requiring suturing.

Appendix 3

High risk labour:

Risk factors (not exhaustive)

Antenatal:

- Previous caesarean section or other uterine scar, previous retained placenta, breech presentation, multiple pregnancy, pre-eclampsia, diabetes mellitus, morbid obesity - B.M.I. > 35 (primigravida),.B.M.I..39.9 (mutigravida if no co-morbidities) IUGR / poor fetal biophysical profile, APH

Intrapartum:

- APH / abruption, Fetal distress / fetal scalp blood sampling, slow labour progress (use discretion), pre-eclampsia identified during labour

Actions

- Take FBC, Group & Save
- Nil by mouth / isotonic sports drinks
- Ranitidine 6 hourly - oral or intravenous

Monitoring

Process	Tool	Responsibility of:	Frequency of review	Responsibility for: (plus timescales)			
				Review of audit results & recommendations	Development of action plan	Monitoring of action plan and implementation	Making improvement lessons to be shared
Documentation of the maternal observations carried out during established first stage of labour as described in the guideline	Clinical Audit	CDS working party	Ongoing audit	Six monthly at Women's Clinical Audit Meeting	CDS Working Party within 3 months of the Clinical Audit Meeting	CDS Working Party as a minimum 6 monthly	Refer to CDS Working Party Monitoring Form

Version 4.3

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Consultation:
[redacted], Consultant Obstetrician
CDS working party
Normal Birth Working Group

Ratified by: CDS Working Party

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Review date: March 2019

References
National Institute of Health & Clinical Excellence (December 2014) Intrapartum Care: care of healthy women and their babies during childbirth. RCOG (2015) The Management of Third and Fourth Tears. www.rcog.org.uk

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RELATED DOCUMENTS

Syntocinon in labour guideline http://nww.avon.nhs.uk/dms/download.aspx?did=10474
Operative Vaginal Delivery guideline http://nww.avon.nhs.uk/dms/download.aspx?did=1766
Sepsis in pregnancy and the puerperium guideline http://nww.avon.nhs.uk/dms/download.aspx?did=13812
Third stage of labour (pt info) nww.avon.nhs.uk/dms/download.aspx?did=9644
Manual Removal of Placenta http://nww.avon.nhs.uk/dms/download.aspx?did=15184
Fetal Monitoring in Labour http://nww.avon.nhs.uk/dms/download.aspx?did=1783
Clinical Risk Assessment and Selection of Lead Professional http://nww.avon.nhs.uk/dms/download.aspx?did=11238

SAFETY NA

QUERIES Practice Development Midwife, [redacted] or the coordinating midwife on CDS [redacted]. A supervisor of midwives can be contacted 24/7 via the hospital switchboard.

Clinical Guideline

CAESAREAN SECTION

SETTING Maternity Services, St Michael's Hospital

FOR STAFF Medical, nursing and midwifery staff

PATIENTS Patients undergoing caesarean section procedure

GUIDANCE

This is a practical guide to elective and emergency Caesarean section (CS). Antenatal provision of information and Vaginal Birth after Caesarean is not covered in this guideline.

Women requesting CS without obstetric indication

For pathway see appendix 1

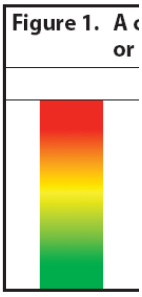
Consent for CS

Written consent should be obtained even in emergencies. Risks of caesarean section should be explained as per the RCOG Consent Advice No 7; discussion should include risks to the mother and the fetus, as well as implications for future pregnancies and birth after CS. Fetal risks include cuts to the skin (approximately 2 in 100 cases) and respiratory morbidity (particularly for Elective CS).
For Elective CS use the UHBristol Caesarean Specific Consent form –v2 (Appendix 2).
However, it is recognized that in severe emergencies (Category 1 CS only) verbal consent is appropriate. The decision and the reasons for verbal consent must be documented.
A competent pregnant woman is entitled to refuse the offer of treatment such as CS, even when the treatment would clearly benefit her or her baby's health. Such a refusal and the relevant risks associated with it must be clearly documented in the notes.
A consultant obstetrician or ST6/7 should be involved in the decision for CS unless doing so would be life threatening to the mother of fetus.
The person making the decision for CS must clearly document the indications

- In the maternal hand held record
- On the operation note (Medway delivery record)

Urgency Categorisation

The urgency of CS should be documented using the following scheme in order to aid clear communication between healthcare professionals about the urgency.



Category 1: Immediate threat to the life of the woman or fetus

- Includes CS for acute severe bradycardia, cord prolapse, uterine rupture, fetal blood sampling pH less than 7.2.
- Deliver as quickly as possible taking into account rapid delivery may be harmful incertain circumstances.
- Decision to delivery audit standard = within 30 minutes

Category 2: Maternal or fetal compromise which is not immediately life-threatening

- There is 'urgency' to deliver the baby in order to prevent further deterioration of either the mother or baby's condition.
- Deliver as quickly as possible, in most situations within 75 minutes, taking into account rapid delivery may be harmful in certain circumstances.
- Decision to delivery audit standard = within 30 and 75 minutes

Category 3: No maternal or fetal compromise but needs early delivery

- Includes CS carried out where there is no maternal or fetal compromise but early delivery is necessary e.g. breech with ruptured membranes
- Includes LSCS at < 37 weeks gestation for maternal or fetal reasons
- Decision to delivery standard = within 24 hours

Category 4: Elective CS

- Includes all CS carried out at a planned time to suit the mother and maternity team

Emergency Caesarean (Category 1, 2 & 3)

Emergency CS for maternal or fetal compromise should be undertaken within the time frames relevant to the category of urgency. However, it must be taken into account that emergency situations have the potential to cause psychological trauma to the mother.

Fetal distress:

Start Intra-Uterine Resuscitation

- Stop syntocinon
- Turn mother to left lateral
- Administer terbutaline 250 mcg SC
- Start / Increase IV fluids
- Administer facial 02

The **time of decision** (surgeon decides and woman consents in writing) and **reasons for any delay** in undertaking category 1 or 2 CS **must** be documented in both

- the partogram
- the operative note (Medway delivery record)

Pre-operative requirements

- Inform coordinating midwife who will liaise with the Anaesthetist and Theatre coordinator (**use 2222 call for category 1 CS)**
- Ensure woman is wearing an appropriate identification bracelet and check with the woman that the details on it are correct
- Obtain informed consent
- Site cannula if IV access not already established

- Send bloods for FBC and G&S if not already done
- Administer Ranitidine 150 mg orally or 50mg IV (prescription required)
- Put on anti-embolic stockings
- Mother to remove jewellery and underwear
- Put theatre gown on mother if time
- Transfer to theatre as quickly as possible
- Maintain left lateral position until anaesthesia is initiated **(cat 1 and 2 only)**
- Continue Fetal Monitoring until surgeon ready to commence **(cat 1 and 2 only)**
- Insert indwelling urinary catheter once anaesthesia effective
- Shave pubic area if time
- Call neonatologist

The surgeon should assist in the transfer to theatre unless there is an urgent need for them elsewhere.

- On arrival into theatre there must be clear communication of the patient's name, reason for caesarean section and urgency category.
- The urgency category may change once the patient is in theatre i.e. following recovery of a fetal bradycardia, and in this instance clear communication is required within the team.
- The operating surgeon must be ready for knife-to-skin as soon as adequate anaesthesia is achieved, particularly for category 1 CS.
- The surgeon should communicate with the neonatologist if there any additional concerns i.e. possible fetal sepsis or hypovolaemia
- It is the responsibility of the attending neonatologist to determine whether senior support is required.

Elective Caesarean (Category 4)

The risk of respiratory morbidity is increased in babies born by CS before labour, but this risk decreases significantly after 39 weeks.

- Planned CS should not routinely be carried out before **39** weeks.
- The reason should be clearly documented if a planned CS is performed before 39 weeks.
- If CS for Breech presentation with no other obstetric indication inform the woman that a scan will be performed on the morning of admission and if no longer breech a caesarean will not be required.

There is evidence that antenatal steroids can reduce the need for NICU admissions if an elective CS has to be performed before 39 weeks. This should be discussed on an individual patient basis.

Maternal Haemoglobin should be optimised antenatally to aim for a HB ≥110g/l at the time of elective section, if Haemoglobin <110 g/l at 36 weeks consider need for intravenous iron.

Booking elective CS in clinic

1. Written consent should be obtained by the obstetrician booking the CS (use the procedure specific consent form - appendix 2)
2. The CS date should be booked in the Caesarean Section diary by calling ANC on ext 25299/ 25297

3. Give the patient's name, hospital number, EDD, gestation on the date of Caesarean (in weeks and days), indication and the named Consultant Obstetrician. Highlight any potential intraoperative risks.
4. Ensure the woman's correct telephone number is recorded in the diary
5. Give the woman the UHBristol Caesarean Section – Enhanced Recovery information leaflet and explain that the woman will be contacted on the evening before the planned CS to confirm the time of admission on the day of the procedure
6. Explain that occasionally the CS date may be changed if there is a need to re-prioritise cases due to clinical workload or complex cases
7. Arrange pre-op clerking appointment within 7 days of the agreed CS date
8. Provide anti-embolic stockings with instructions

The following may be done at the time of booking the CS or at a pre-op clerking appointment:

9. Arrange an anaesthetic review (bleep 2923)
10. A Group and Save (G&S) and a full blood count (FBC) should be taken within 7 days of the agreed CS date.
11. Prescribe and supply antacid/ anti-emetic regimen (premeds) and pre-op drinks. Women should be given instruction on the timing of their medications according to the time of admission on the day of the CS.

    Early admission
    - Take ranitidine at 10 pm
    - Come in at 8am
        - No food from 2am
        - Clear fluids until 6am
        - Take medication/ pre-op drinks at 6am

    Late admission
    - Take ranitidine at 10 pm
    - Come in at 10am
        - No food from 5am
        - Clear fluids until 9am
        - Take medication/ pre-op drinks at 9am
12. Provide Chlorhexidine skin wash and advise the woman to shower using this on the morning of the CS.

Elective CS in Women with Diabetes

- Delivery recommended by 38 weeks in women with Type 1 and Type 2 Diabetes
- Steroids should be considered if CS undertaken before 38 weeks with Supplementary insulin cover to optimise maternal glycaemic control; see guideline Supplementary IV Insulin Following Betamethasone
- Women with diabetes should not receive pre-op drinks
- When CS prioritised should be first on the operating list
- If requires insulin in pregnancy will need sliding scale insulin perioperatively; see guideline Diabetes in pregnancy Intrapartum Care

Practicalities of the Elective CS List

Elective CS lists are held daily on normal working days.
During the CDS handover the obstetrician responsible for running the CS list will be identified; this may be the Consultant, ST 6-7 or ST3-5 dependent on the complexity of the cases and the workload on CDS.
An extra obstetric SHO is allocated to help run this list, and is identified on the SHO rota.
If there is no dedicated 'Section SHO' then the SHO or consultant for CDS will assist.

Theatre briefs take place at 8.30 (Mon-Thurs) and 9.00 am (Fri) to allow for patient review and pre-op checks between 8.00am to 8.30am.
The CS list will start promptly after the theatre brief.
The SHO should remain in theatre after the brief to complete the sign-in for the first patient.

The theatre brief should:

- Include the theatre practitioner, anaesthetic assistant, operating surgeon, anaesthetist and midwife/ nurse caring for the women
- Determine list order
- Share information about potential anaesthetic or surgical problems

Emergency obstetric cases take priority over elective CS cases.
The reasons for any significant delay in elective CS must be recorded on a clinical incident form and Medway.

Preoperative Checks

- Ensure woman is wearing an appropriate identification bracelet and check with the woman that the details on it are correct
- Check FBC results and that the G&S is in date
- Check e-match status. In high-risk women (placenta praevia, coagulation disorders etc.) liaise with the consultant obstetrician and anaesthetist to decide whether to cross-match blood/ use intra-operative cell salvage
- Confirm the gestational age according to the dating scan
- Check presentation by ultrasound before CS for Breech presentation
- Note position of placenta on past ultrasound reports
- Verify consent on admission to CDS
- Sign the admission VTE risk assessment on the drug chart
- Once the patient is in theatre the surgeon undertaking the procedure verifies:
    - the identity of the patient
    - the procedure to be carried out
    - consent
- The patient's name and the procedure to be undertaken is written on the board in theatre

All CS

Women's preferences for the birth, such as lowering the screen to see baby born, choice of music should be accommodated where possible. Only one partner/relative/friend is allowed in theatre for CS under regional anaesthesia unless exceptional circumstances in which case gain prior agreement with senior surgeon, anaesthetist, and CDS co-ordinator.
If under General Anaesthetic birth supporters are not allowed.

WHO Surgical Checklist will be undertaken at every CS, however in the event of a category 1 CS the full check may be delayed until the situation allows a time out.

Neonatology attendance is required for all CS except elective (category 4) operations unless there is evidence of fetal abnormality or fetal problems are anticipated.

Antibiotic Prophylaxis will be administered at all CS. Antibiotics will be administered before knife to skin. Antibiotics effective against endometritis, urinary tract and wound infections, which occur in about 8% of women who have had a CS, should be used (refer to antibiotic policy).

Delayed Cord Clamping consider delayed cord clamping for at least 1 minute unless immediate neonatal resuscitation is required or there is significant maternal blood loss.

Cord Gases Paired cord blood samples should be taken and analysed after *all* CS. Results must be documented as per **Monitoring the Fetus in Labour** guideline.

Uterotonic agents

- **Carbetocin 100 micrograms** by *slow* intravenous injection should be given once the baby is born to encourage contraction of the uterus and to decrease blood loss
- **Syntocinon 5 – 10 units** may be recommended for women with significant cardiac disease (see Individualised maternal medicine care plans for recommended management)
- **If further uterotonics are required** use oxytocin infusion, syntometrine (unless contraindicated) and prostaglandins (misoprostol/ carboprost) as in guideline Management of Obstetric Haemorrhage.

Thromboprophylaxis

- VTE Risk Assessment will be completed in line with the local guideline **Thromboprophylaxis During Pregnancy, Labour & Postnatal Period**
- All women undergoing CS require anti-embolic stockings unless specifically contraindicated
- Where appropriate prescribe Low Molecular Weight Heparin (Clexane)

Post CS information letter (appendix 3)

- Women delivering by their 1st or 2nd CS should have a 'Post Caesarean Information Letter' completed by the surgeon when the operation notes are written
- If the women is deemed not suitable for VBAC in a future pregnancy this letter will not be completed and this will be indicated on the operation notes

Anaesthetic Care (see obstetric anaesthesia guideline)

The obstetrician informs the anaesthetist of the urgency category and indication
Women having a CS should be given information on different types of post-CS analgesia so that analgesia best suited to their needs can be offered.
Women are encouraged to have CS under regional anaesthesia rather than GA because it is safer and results in less maternal and neonatal morbidity. This includes women who have a diagnosis of placenta praevia.
General anaesthesia for emergency CS should include preoxygenation, cricoid pressure and rapid sequence induction to reduce the risk of aspiration.
The surgeon must be ready for immediate knife-to-skin.
The operating table for CS should have a lateral tilt of 15 degrees.

Surgical Technique

If problems are encountered timely senior support (ST6/7 or consultant) must be requested.

The surgeon should use the technique he/she is most familiar with and taking into account the good practice points from the NICE guidance, these include:

- Follow *infection control* precautions. Wear double gloves for Serology positive women.
- Use a *Joel Cohen* technique if possible (appendix 4)
- *Blunt* rather than sharp extension of the uterine incision results in less blood loss and lower PPH incidence
- Repair the uterus in two layers
- Do not *routinely* exteriorize the uterus
- If possible use controlled cord traction and *not* manual removal of the

placenta to reduce the risk of endometritis
- Do not routinely close the visceral or the parietal peritoneum
- In the event that a midline abdominal wall incision is used, the abdominal wall should be closed by a mass closure technique using slowly absorbable sutures (PDS or equivalent)
- Routine closure of the fat layer does not reduce the incidence of wound infection, however the fat layer should be closed where there is >2cm subcutaneous fat

Post-Operative Care
Care will be administered as detailed in **Recovery after Obstetric Operative Intervention** guideline
Early eating and drinking: Women who are recovering well after CS and who do not have complications can eat and drink when they feel hungry or thirsty.
Urinary catheter removal: Removal of the urinary bladder catheter should be carried out once a woman is mobile after a regional anaesthetic and not sooner than 12 hours after the last epidural 'top up' dose or spinal.

Post CS discussion
The obstetrician undertaking the post-operative review on day 1 or 2 will:

- Ensure mother understands the indication for CS
- Discuss implications for future pregnancies before discharge
- Give the post CS information letter to the woman and discuss as appropriate
- Tick the box on the P/N review sticker to indicate that the letter has been given and discussed

The process for continuous audit, multidisciplinary review of audit results and subsequent monitoring of action plans.

Process	Tool	Responsibility of:	Frequency of review	Responsibility for: (plus timescales)			
				Review of results	Development of action plan and recommendations	Monitoring of action plan and implementation	Making improvement lessons to be shared
Documentation of • Classification of Urgency of CS • Timing of all grade 1 CS • Reason for performing a grade 1 CS	Continuous Clinical Audit	Multi-professional group reporting to CDS Working party (CDSWP)	Continuous Audit- reviewed monthly at CDSWP	Monthly at CDSWP Presented quarterly to Women's Services Clinical Audit Meeting	Multi-professional group undertakes recommendations and action planning	Review and monitoring monthly at CDSWP	See CDSWP monitoring proforma for dissemination of learning

The above table outlines the minimum requirements to be audited; additional audits will be commissioned in response to deficiencies identified within the service through morbidity and mortality reviews/benchmark data provided by CHKS or in response to national initiatives e.g. NICE, RCOG guidelines, CNST standards
Version 5.2
Reviewed and Updated September 2015

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Consultation
CDS Working Party, Antenatal Working party, Supervisors of Midwives

Ratified by
CDS Working Party October 2015

Date: Oct 15
Review Due: Oct 18

RELATED DOCUMENTS

Thromboprophylaxis During Pregnancy, Labour & Postnatal Period
Recovery after Obstetric Operative Intervention
Monitoring the Fetus in Labour
Obstetric Anaesthesia guideline
Obs & Gynae Antibiotic Guideline
Anaemia Antenatal & Postnatal
Supplementary IV Insulin Following Betamethasone
Diabetes in pregnancy Intrapartum Care

REFERENCES

- NICE guideline CG132 Caesarean Section November 2011
- NHS Litigation Authority – Clinical Negligence Scheme or Trusts (2001). Maternity – Clinical Risk Management Standards
- RCOG Good Practice No 11. Classification of urgency of caesarean section – A continuum of risk London 2010
- RCOG Consent advice No.7 Caesarean Section London October 2009
- Lucas DN, Yentis SM, Kinsella SM, Holdcroft A, May AE, Wee M and Robinson PN (2000).
  Urgency of caesarean section-a new classification. Journal of the Royal Society of Medicine, 93, 346-350
- RCOG - Clinical Effectiveness Support Unit (2001). The Use of Electronic Fetal Monitoring: The use and interpretation of cardiotocography in intrapartum fetal surveillance. Evidence-based Clinical Guideline Number 8. London: RCOG Press
- Thomas J, Paranjothy S. RCOG - Clinical Effectiveneness Support Unit (2001). The national sentinel caesarean section audit report. London: RCOG Press
- Thomas J, Paranjothy S, James D (2004). National cross sectional survey to determine whether the decision to delivery interval is critical in emergency caesarean section. BMJ;328:665-7
- Tuffnell DJ Wilkinson K, Beresford N (2001). Interval between decision and delivery by caesarean section – are current standards achievable? Observational case series. BMJ;322:1330-3
- CEMACH – Why Mothers Die 2000-2002. RCOG press London.
- RCOG (2004). Obtaining Valid Consent. Clinical Governance Advice No. 6. London: RCOG Press
- Mathai M, Hofmeyr GJ. Abdominal surgical incisions for caesarean section. Cochrane Database of Systematic Reviews 2007, Issue 1.

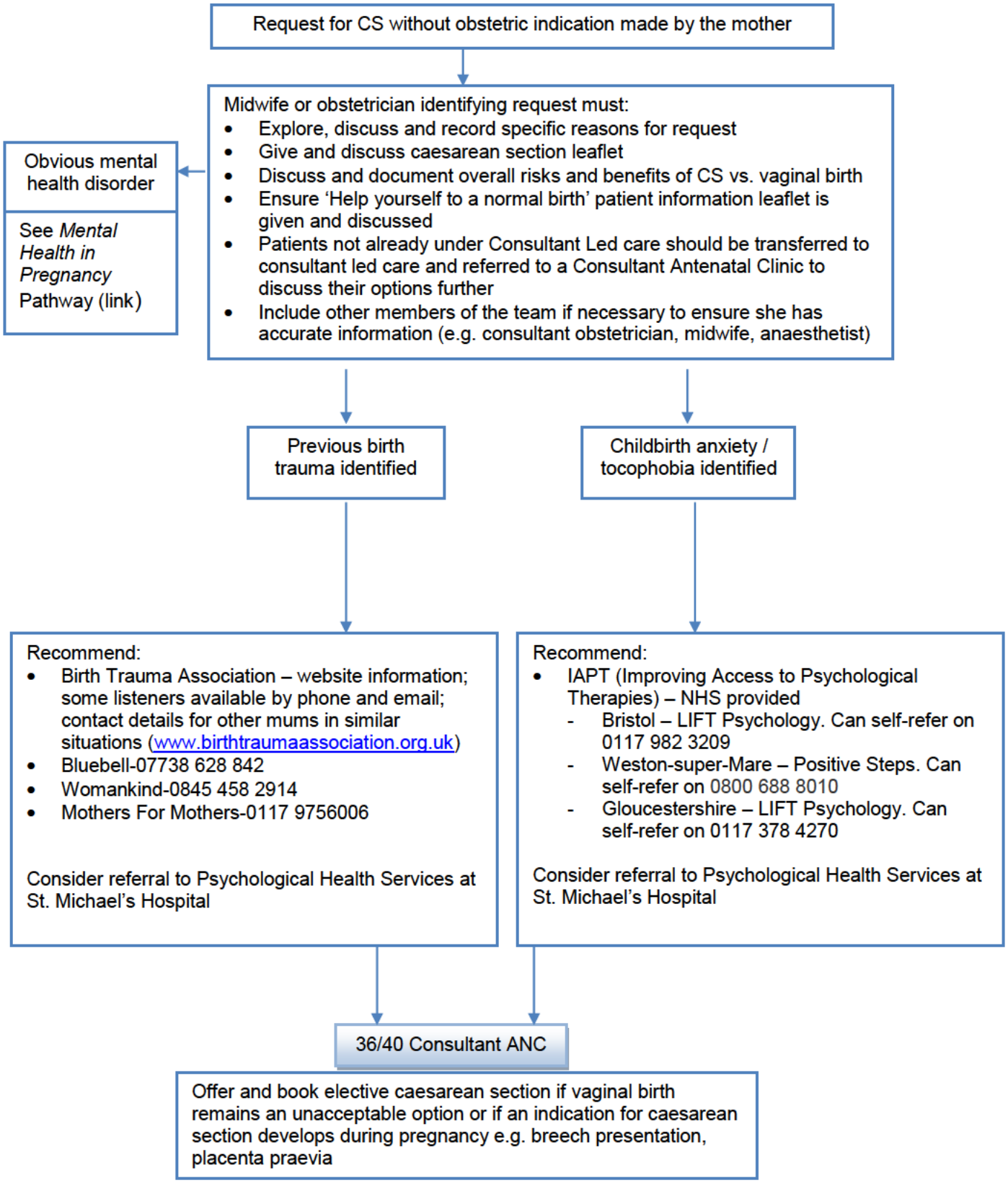
SAFETY

There are no unusual or unexpected safety concerns to staff or patient.

QUERIES

Contact [redacted]

Appendix 1 **Pathway for women requesting CS without obstetric indication**



Appendix 2

Consent Form 1

Hospital no: _____

NHS no: _____

Surname _____

Forename _____

Gender _____ D.o.B. ___/___/_____

Name of proposed procedure or course of treatment

Caesarean section

An operation to deliver your baby/ babies through a cut in the tummy, this can be a planned procedure for example if the baby is breech or you have had a previous caesarean section; or an emergency caesarean if there are complications of labour or concerns about the wellbeing of you or your baby.

Statement of health professional *(to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)*

I have explained the procedure to the patient. In particular, I have explained:

The intended benefits*: Safe delivery of baby/babies in a situation where the risks of vaginal delivery are more than those of a caesarean section operation*

Serious or frequently occurring risks

Frequent risks:

- *Common: persistent wound and abdominal discomfort, repeat caesarean section in subsequent pregnancies, readmission to hospital, minor cuts to the baby's skin*
- *Uncommon: haemorrhage (bleeding), infection, breathing difficulties in baby*

Uncommon but Serious risks:

- *Emergency hysterectomy (removal of the womb) , 7-8 women in every 1000 (uncommon)*
- *Need for further surgery at a later date, 5 women in every 1000 (uncommon)*
- *Admission to intensive care unit, 9 women in every 1000 (uncommon)*
- *Increased risk of a tear in the womb in future pregnancies, 2-7 women in every 1000 (uncommon)*
- *Developing a blood clot in the veins of the leg or lung, 4-16 women in every 10 000 (rare)*
- *Stillbirth in future pregnancies, 1-4 women in every 1000 (uncommon)*
- *In a future pregnancy, the placenta covers the entrance to the womb (placenta praevia), 4-8 women in every 1000 (uncommon)*
- *Injury to the urinary system, 1 woman in every 1000 (rare)*
- *Injury to the bowel, 1 woman in every 1000 (rare)*
- *Death, approximately 1 woman in every 12 000 (very rare)*

Any extra procedures which may become necessary during the procedure

☐ blood transfusion

☐ other procedures*: hysterectomy(removal of the womb), repair to damaged organs*

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- The following leaflet/tape has been provided: _____
- This procedure will involve: ☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

Doctor's Signature ……..….. Date ……

Name (PRINT) …… Job title ……..

Contact details (if patient wishes to discuss options later) ……..……

Top copy accepted by patient: yes/no (please ring)

Statement of interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way which I believe he/she can understand.

Signature…….. Date……

Name (PRINT)……..

Appendix 3

University Hospitals Bristol NHS
NHS Foundation Trust
St Michaels's Hospital
Southwell Street
Bristol
BS2 8EG
Tel: 0117 3425201

Name:

Address:

Hospital ID:

Dear

About your caesarean section

Congratulations on the birth of your baby on:

Your baby was born by caesarean section because:

After giving birth by caesarean most women are able to give birth vaginally in future pregnancies. If you have another pregnancy you will be seen by an obstetrician as well as your midwife and they will discuss your birth options with you. Most women (around 3 out of every 4) who plan a VBAC (Vaginal Birth after Caesarean) go on to give birth to their next baby vaginally and unless your obstetrician or midwife advises otherwise, we recommend that you plan for a VBAC with any future baby.

If you would like to discuss anything arising from this letter or need any further information clarified, please contact your community midwife in the first instance.

You can get further information from

- www.caesarean.org.uk
- www.Nct.org.uk or 0300 330 0700
- www.powertopush.ca
- National Institute of Clinical Excellence at www.nice.org.uk/guidance?action=download&o=29336
- Association for Improvements in the Maternity Services: www.aims.org.uk or on 0300 365 0663. They also publish a booklet called 'Birth after Caesarean'

Signed: Print Name:

Job Title: Date:

Appendix 4

Technique of Abdominal Incision for Caesarean Section

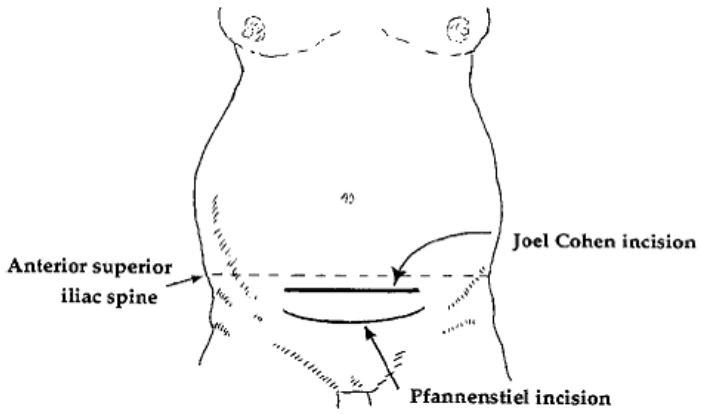
Pfannenstiel Incision

The traditional lower abdominal incision for caesarean delivery is the incision described in 1900 by Pfannenstiel. Classically, this incision is located two fingers-breadth above the pubic symphysis. Here the skin may be entered via a low transverse incision that curves gently upward, placed in a natural fold of skin (the 'smile' incision). After the skin is entered, the incision is rapidly carried through subcutaneous tissue to the fascia, which is then nicked on either side of the midline. The subcutaneous tissue is incised sharply with a scalpel. Once the fascia is exposed, it is incised transversely with heavy curved Mayo scissors. In the standard technique, the upper and then the lower fascial edges are next grasped with a heavy toothed clamp, such as a Kocher, and elevated. Under continuous tension, the fascia is then separated from the underlying muscles by blunt and sharp dissection. Once the upper and lower fascia have been dissected free, and any perforating vessel sutured or electrocoagulated, the underlying rectus abdominus muscles are separated with finger dissection. If the muscles are adherent, sharp dissection is necessary to separate them. The peritoneum is then opened sharply in the midline. The initial entry is then widened sharply with fine scissors exposing intraperitoneal contents.

Joel-Cohen Technique

Joel-Cohen (Joel-Cohen 1977) described a transverse skin incision, which was subsequently adapted for caesarean sections. This modified incision is placed about 3 cm below the line joining the anterior superior iliac spines. This incision is higher than the traditional Pfannenstiel incision. Sharp dissection is minimised. After the skin is cut, the subcutaneous tissue and the anterior rectus sheath are opened a few centimetres only in the midline. The rectus sheath incision may be extended laterally by blunt finger dissection (Wallin 1999) or by pushing laterally with slightly opened scissor tips, deep to the subcutaneous tissues (Holmgren 1999).The rectus muscles are separated by finger traction. If exceptional speed is required in the transverse entry, the fascia may be incised in the midline and both the fascia and subcutaneous tissue are rapidly divided by blunt finger dissection (Joel-Cohen 1977).

The Joel-Cohen incision has several advantages compared to the Pfannenstiel incision. These include less fever, less pain (and therefore less analgesic requirements), less blood loss, shorter duration of surgery and shorter hospital stay.



Clinical Guideline

FEMALE GENITAL MUTILATION (FGM)

SETTING Hospital and Community Maternity settings

FOR STAFF Obstetric and Midwifery staff working with pregnant women

PATIENTS All pregnant women at all stages of pregnancy

Background

The term “Female Genital Mutilation” (FGM) comprises of all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non medical reasons (WHO 2008).

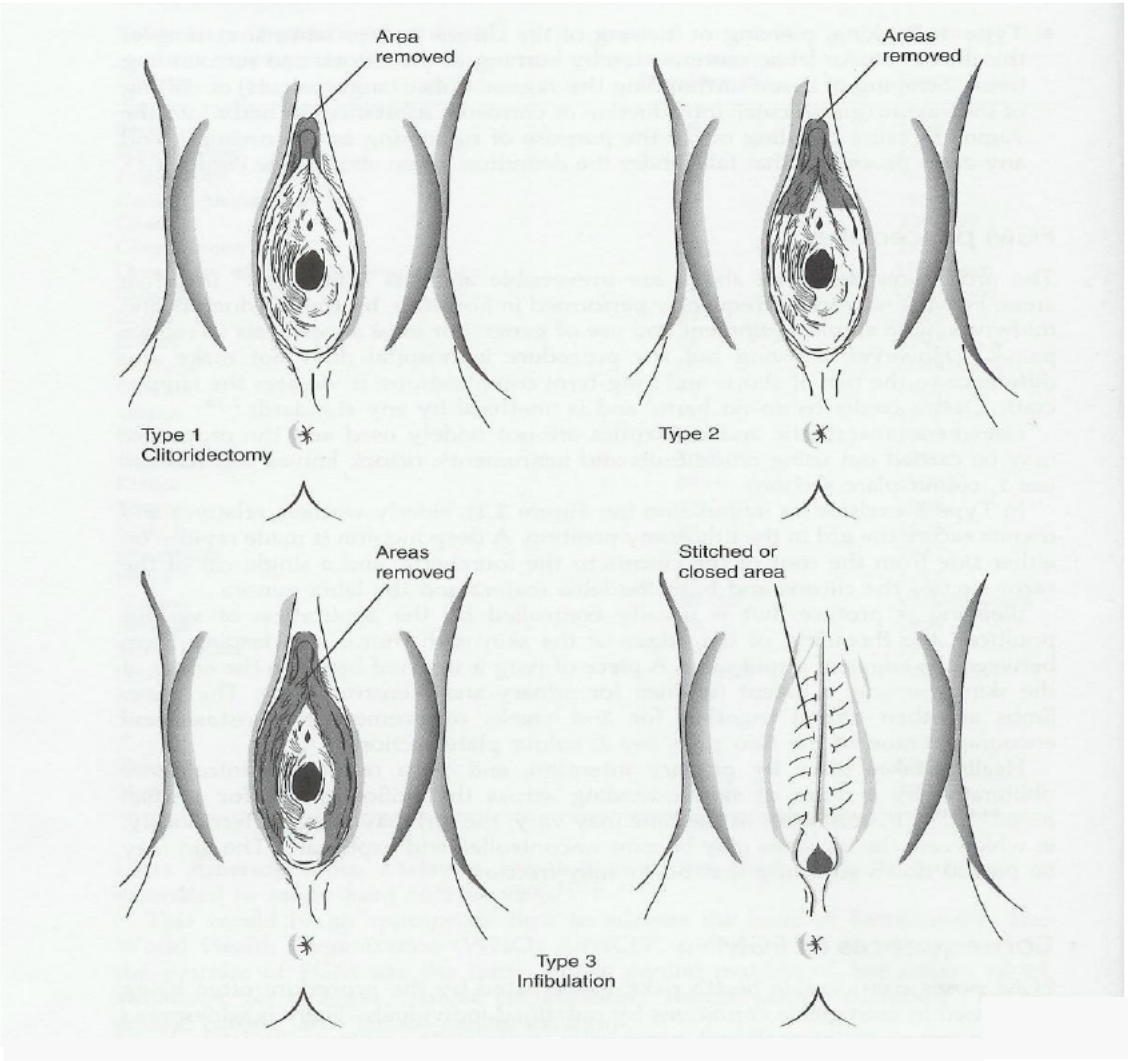
FGM is common in various forms in 28 African countries, Asia and in the Middle East (WHO 2010). The highest prevalence is from the Horn of Africa & includes Somalia, Egypt, Mali & Guinea (Momoh 2005). Increasing global mobility has resulted in rising awareness of the procedures presenting in industrialised countries, where it is found among immigrant communities (RCOG 2003).

While it is not known when or where the practice of FGM originates, a variety of reasons have been given including custom and tradition, protection of virginity and promiscuity, enhanced fertility, hygiene, aesthetic reasons and religious demand. Neither the Bible nor the Koran endorse the practice.

FGM is an illegal practice (FGM Act 2003), some women who have arrived in Britain as refugees or migrants from other countries may have been subjected to the procedure in one form or another.

Referral to the Children and Young People Service (CYPS) is required to ensure central information is held regarding the discussions with the family around the UK law and illegal nature of FGM at all times. CYPS will retain this information confidentially on their IT system and if health, schools or the police require information they will approach CYPS as the central point to ensure the family were given information that it is an illegal practice. This confidential sharing of information is to identify and safeguard both babies and other female children in the family who may be at risk of FGM.

Types of FGM



WHO (1996), classifies 4 types of Female Genital Mutilation (FGM).

1. Removal of the hood of the clitoris – known as **Sunna**

2. Removal of the clitoris together with partial or total excision of the labia minora

3. Removal of the clitoris & labia minora with stitching/narrowing of the vaginal opening – known as **infibulation**

4. Unclassified. This includes:

- Pricking, piercing or incision of the clitoris and/or labia
- Stretching of the clitoris and/or labia
- Cauterization by burning off the clitoris and surrounding tissue
- Scraping (angurya cuts) or cutting (gishri cuts) of the vagina or surrounding tissue
- Introduction of corrosive substances or herbs into the vagina
- Any other procedure that falls under the definition of female genital mutilation given above.

FGM Types 1 and 2 account for 80% of all cases of genital mutilation (WHO 1996).

15% of women who have undergone genital mutilation have been infibulated – Type 3 (WHO 1996, FGCENP 2003).

Justification given for FGM

Reasons given by communities for practicing FGM include:

- Custom & tradition
- Family honour
- Hygiene & cleanliness
- Preservation of virginity / chastity
- Social acceptance especially for marriage
- The mistaken belief that it is a religious requirement
- A sense of belonging to the group & conversely the fear of social exclusion

It is important to acknowledge that FGM is the accepted norm for those who practise it. The woman will know the procedures that will be necessary and the cultural taboos that apply during labour and birth, and it is vital that she is actively involved in decisions about her care. Her family may be also be closely involved in decision-making. The women must be treated with kindness and sympathy and in a non-judgemental way. Female staff should be available, as this is generally the women's preference. Trust guidelines should be followed if an interpreter is required.

Best Practice Points

1. FGM encompasses all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs. FGM is classified into four types with Type 3 (Infibulation) being the most extensive.

2. FGM is illegal (FGM Act 2003) and is a violation of human rights.

3. FGM is practiced in 28 countries in Africa, in Asia and the Middle East. FGM is also found in countries where these populations have migrated.

4. University Hospital's Bristol Trust's guideline for use of interpreters should be followed. If an interpreter is required it must not be someone from the local community or a partner/ husband/family member.

5. All women must be asked at booking in a sensitive manner if they have been "cut", "circumcised" or "sunna". If the woman moves into your area from another area you should be prepared to discuss FGM if you cannot clearly identify if this has already been discussed.

6. Women who have undergone FGM should be identified by the community midwife during the ante-natal period and referred to the antenatal consultant clinic for further assessment as necessary. Good documentation to ensure information is shared with the Consultant re the referral is of paramount importance.

7. Child protection must be considered and communicated to relevant health professionals and social care. For any woman who answers yes to FGM having been performed a referral to Social Care CYPS must be made clearly stating that this is the reason for the referral and you are sharing the information. The form should also clearly document any advice you give and or leaflets about the law and FGM being illegal in the UK. This is the responsibility of the healthcare professional identifying FGM has been carried out initially. In the majority of cases this will be the community midwifery team. The generic CYPS referral form should be used.

8. To reduce the risk of complications in labour and at birth, antenatal reversal (deinfibulation) of FGM is recommended when appropriate. It should be discussed as early as possible and appropriate referrals made. The Consultant will review the anatomy and if she or he considers vaginal assessments and or catheterisation may be problematic a reversal may be considered, after discussion with the woman.

9. Women should be counselled and advised that reinfibulation is not available and against the law in the UK.

10. If reversal of FGM has not been performed in the antenatal period, it is important to encourage women to attend place of birth in early labour.

11. After reversal of FGM or birth, it may be necessary to consider counselling and/or follow up as anatomy and physiology have altered

12. All discussions with the women and their families must be documented in their maternity records.

Management

Antenatal care

Women with FGM should be identified at initial health needs assessment. Questions such as, 'Have you been cut?' or, 'Were you closed as a child?' will be understood and will not cause offence. If women are uncertain the midwife may conduct a sensitive assessment of the genitalia to ascertain if FGM has taken place if they feel confident to.

Women should also be asked if they have encountered any problems with dyspareunia, menstruation or micturition. The term mutilation may cause offence and should be avoided (Momoh 2005).

Pregnant women who have undergone FGM type 3 or 4, or when the midwife is uncertain, should be referred to a consultant antenatal clinic for assessment and discussion. A written plan should be made for birth by the obstetric team.

Concerns of risk of FGM to female children of the family should be communicated to CYPS and relevant healthcare professionals, GP, health visitor, this list is not exhaustive.

Intrapartum care

Obstetric complications

These may occur as a result of scarring. In addition, the mechanical barrier posed by infibulation in Type 3 can lead to prolonged or obstructed labour. Women who have undergone Type 4 mutilation may have such severe scarring that vaginal stenosis results.
Women with FGM should be reviewed early in labour where possible by the Obstetric Registrar.

When a woman is admitted to the labour ward with FGM :-

1. Review the plan for labour in the women's notes. If there is no plan the woman should be reviewed by the obstetric team and a plan made

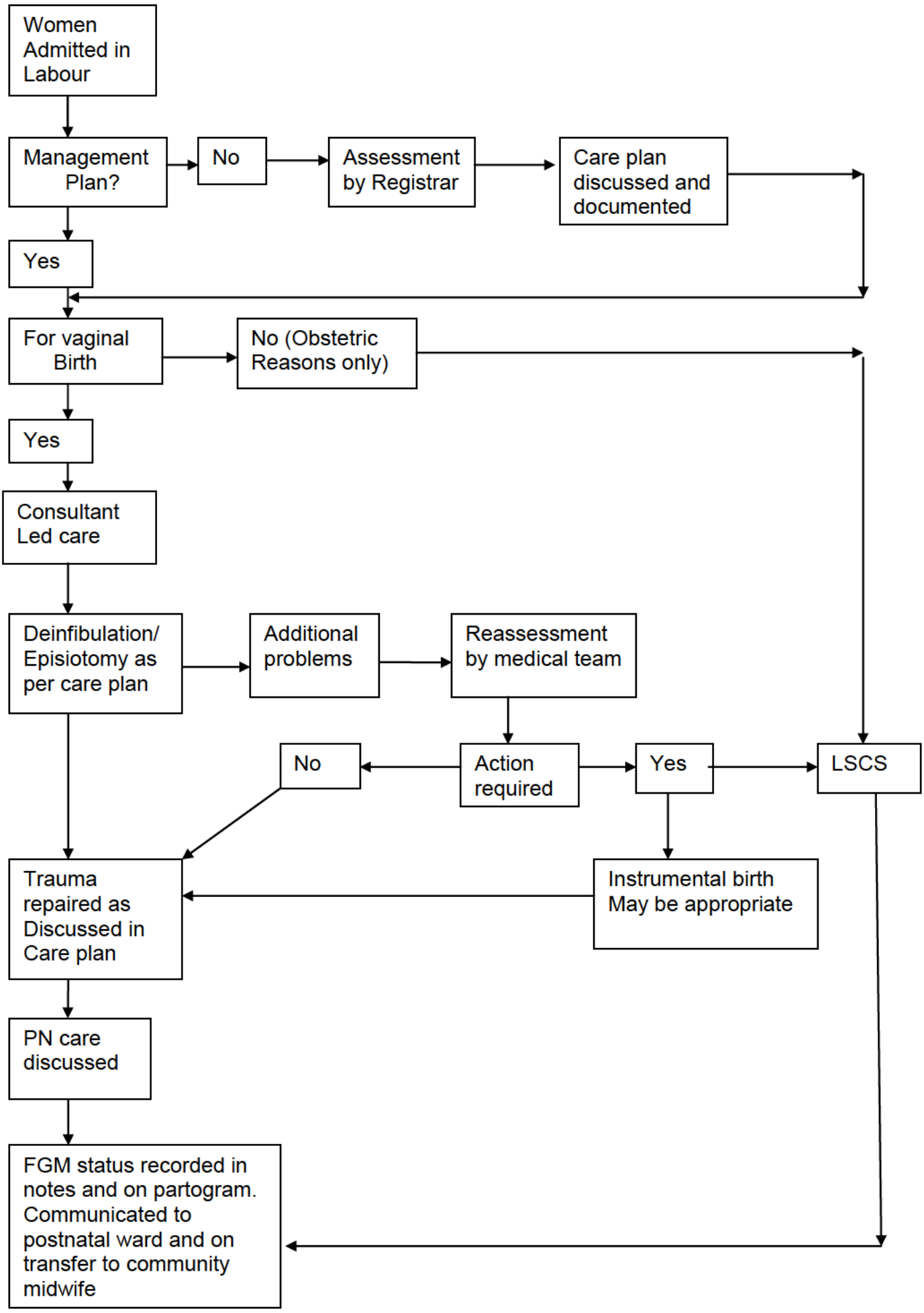
2. Discuss with the woman her care plan options and potential problems.

3. If FGM is identified as Type 3 consider the following management options:

- If de-infibulation has not been performed antenatally, it may need to take place during labour.
- Posterior medio-lateral episiotomy may also be necessary if scar tissue does not stretch adequately when the head is delivered.
- Epidural analgesia may be offered to facilitate vaginal examination and deinfibulation/episiotomy if necessary
- Vaginal examination may be difficult or impossible, even with epidural. Per rectum examination may be used to assess the cervix, but specific consent must be obtained first.
- Bladder catheterisation may be difficult or impossible. Regular emptying of the bladder should be encouraged.
- Application of fetal scalp electrode may not be possible.
- There may be further genital tract trauma during delivery

4. Re-suturing to restore infibulation is illegal in the UK (HMSO 2003).

It is important to document any of the above management decisions in the woman's notes, explaining clearly reasons why decisions have been made. See Intrapartum Care Algorithm below.


Women Admitted in Labour
Management Plan?
No
Assessment by Registrar
Care plan discussed and documented
Yes
For vaginal Birth
No (Obstetric Reasons only)
Yes
Consultant Led care
Deinfibulation/ Episiotomy as per care plan
Additional problems
Reassessment by medical team
No
Action required
Yes
LSCS
Trauma repaired as Discussed in Care plan
Instrumental birth May be appropriate
PN care discussed
FGM status recorded in notes and on partogram. Communicated to postnatal ward and on transfer to community midwife

Postpartum care

- The woman may find the rate of lochia loss unfamiliar or frightening, and will need reassurance and explanation.
- She may find the rate of urination noisy and alarming
- Post-delivery urinary retention may occur because of painful voiding
- A vulvo-vaginal haematoma may develop
- Child health records must be updated to state that mother has had FGM. Any female children of this mother evidence would suggest are considered at higher risk of FGM. Sharing of information is vital to assist with safeguarding these children if applicable. The Personal Child Health Record (PCHR) OR "Red book" must also show clear documentation at transfer of care from hospital to community and midwife to health visitor.

References

Albert.J (2009):A ray of light in FGM darkness. Midwives August/September 2009

DOH 2006: Working together to safeguard children 2006. London

Edozien L 2004 *The labour ward handbook* The Royal society of Medicine Press Limited, London, p109

FGCENP (Female Genital Cutting Education and Networking Project) 2003. Available online at http://www.fgmnetwork.org/intro/fgmintro.html

HMSO Her Majesty's Stationery Office) 2003 *Female Genital Mutilation Act 2003.* Available online at http://www.opsi.gov.uk/ACTS/acts2003/20030031.htm

HMSO; The Childrens Act 1989 & 2004. London

Lee.B (2007): FGM: an outmoded practice? Midwives Feb 2007

Lhbsu. L (2009): Female Genital Mutilation. Midwives Dec 2009

Momoh C 2005 *Female genital circumcision also known as female circumcision. Information for health professionals* 2nd Edn., Guy's & St Thomas' Hospital Trust, London

RCM (Royal College of Midwives) 1998 *Position paper no.21: female genital Mutilation (female circumcision)* RCM, London [online] Available online at http://www.rcm.org.uk

RCN (Royal College of Nursing) 2006 *Female Genital Mutilation. An RCN educational resource for nursing and midwifery staff.* Available online at http://www.rcn.org.uk/publications/pdf/female_genital_mutilation.pdf

Thanks to North Bristol for sharing their policy for FGM with UHB.
RCOG (Royal College of Obstetricians and Gynaecologists) 2003 *Statement no. 3: Female genital mutilation* RCOG, London [online] Available on http://www.rcog.uk

RCOG 2009: Greentop guidelines No.53 FGM and its management.

London

WHO (World Health Organisation) 1996 *Female genital mutilation: report of a WHO technical working group1995* [online] WHO, Geneva Available on http://www.fgmnetwork.org/eradication/state/who.html

WHO (World Health Organisation) 2010; FGM Fact sheet. Accessed on line 26/08/10

Useful web addresses

www.swcp.org.uk
www.who.int
www.amnesty.org
www.equalitynow.org
www.fgmnationalgroup.org
www.fgmnetwork.org
www.forwarduk.org.uk
www.rcm.org.uk

DVD

FGM Resource & Training- FGM National Clinical Group

Discussed and ratified at Ante-Natal Working Party November 2012
Written November and finalised December 2012
Review November 2015

RELATED DOCUMENTS

http://www.rcn.org.uk/publications/pdf/female_genital_mutilation.pdf
http://www.opsi.gov.uk/ACTS/acts2003/20030031.htm
DOH 2006: Working together to safeguard children 2006. London

SAFETY

QUERIES [redacted]

Clinical Guideline

REPAIR OF PERINEAL TRAUMA

SETTING Maternity

FOR STAFF Obstetric and midwifery staff

PATIENTS Patients who have delivered and require perineal suturing

GUIDANCE

Classification is as follows:

First degree Involving perineal skin and/or vaginal mucosa only
Second degree Involving perineal muscles and not involving the anal sphincter.
Third degree Involving perineal muscles and the anal sphincter complex (External Anal sphincter and Internal Anal Sphincter):

- **3a:** less than 50% of EAS thickness torn
- **3b:** more than 50% of EAS thickness torn
- **3c:** IAS torn

Fourth-degree Involving perineal muscle and both the anal sphincter complex and anal epithelium

a) Assessment of perineal trauma.

• Discuss with the woman the need and process of the assessment in order to obtain informed consent. Verbal consent is appropriate for assessment.

• Offer inhalational analgesia (unless working epidural/spinal)

• Ensure good lighting

• Ensure the position of the woman enables the practitioner to clearly visualise any perineal trauma, whilst being aware of the comfort and dignity of the woman.

• Perform the initial examination gently and with sensitivity in the immediate period following birth (during which time skin to skin contact with the baby should not be interrupted unless requested by the mother).

Systematic assessment of genital trauma should include:
Assessment of the extent of perineal trauma to include:

- the apex / apices of the injury
- the injury to the perineal muscle
- the injury to the perineal skin
- an assessment of bleeding
- a rectal examination to assess whether there has been any damage to the external or internal anal sphincter if there is any suspicion that the perineal muscles are damaged
- Provide explanation of findings and advise to the women on recommended management if genital trauma is identified (see non suturing of the perineum section)

Request further assessment from a more experienced midwife or obstetrician if uncertainty exists as to the nature or extent of perineal trauma, this may require transfer to CDS St Michael's Hospital.

b) Non suturing of the perineum

- Non-suturing is only suitable for first degree perineal and labial tears where alignment is good and there is no bleeding.
- Advise women to gently part their labia whilst washing to ensure healing occurs without bilateral fusion if suturing is not undertaken.
- Substantial labial tears (bilateral & unilateral) should be sutured in order to obtain haemostasis and appropriate cosmetic appearance.
- If after perineal assessment suturing is advised but declined by the woman a full discussion of risks associated with this decision will be undertaken and documented in the notes.

c) Methods and materials used in repair of episiotomies, first, and second degree tears and labial tears

Who can perform the repair

- A midwife or an obstetrician who has been deemed competent in accordance with the standards set in the training needs analysis document.

Consent

- Obtain verbal consent and document in the suturing workflow in Medway. Written consent should be obtained for all repairs undertaken in operating theatre.

- If a woman declines suturing advise the woman that in the case of second degree trauma the muscle should be sutured in order to improve healing and reduce the long term complications due to potential shortening of perineal body. This discussion should then be documented in hand held notes

Methods

- Undertake as soon as possible to minimise the risk of infection and blood loss. (ideally within 1 hour but a minimum standard of 2 hours)

- Undertake with tested effective analgesia in place using infiltration with up to 20 ml of 1% lidocaine or equivalent, or topping up the epidural (spinal anaesthesia may be necessary). If the woman reports inadequate pain relief at any point this should immediately be addressed.

- Use a continuous non-locked suturing technique for the vaginal wall and muscle layer.

- Use a continuous subcuticular technique to repair the skin. If the skin is opposed after suturing of the muscle in second degree trauma, there is no need to suture it.

The following basic principles should be observed when performing perineal repairs:

• Use aseptic techniques.

• Check equipment, swabs and needles are counted before and after the procedure. (See local operating procedure for swabs, needles and instruments)

• Good lighting is essential.

• Assist the woman to adopt a position that allows adequate visual assessment of the degree of trauma and for repair. Only maintain this position for as long as necessary for systematic assessment and repair

• Difficult trauma should be repaired by an obstetrician in theatre under regional or general anaesthesia. An indwelling catheter should be inserted for 24 hours to prevent urinary retention. (See local guidance on Postnatal Bladder Care at http://nww.avon.nhs.uk/dms/download.aspx?did=7253)

•If a delay is anticipated in transferring to theatre for the repair, an indwelling catheter should be inserted in the room when awaiting the repair.

• Good anatomical alignment of the wound should be achieved, and consideration given to the cosmetic results.

• Do a rectal examination after completing the repair to ensure that suture material has not been accidentally inserted through the rectal mucosa or any trauma to the anal sphincter has been overlooked.

• Information should be given to the woman regarding the extent of the trauma, pain relief, diet, hygiene and the importance of pelvic-floor exercises using relevant, current patient information leaflets. (After the birth of your baby, Care of your stitches, Repair of 3rd or 4th degree tear)

Materials used
An absorbable synthetic suture material should be used to suture the perineum (2/0 Velosorb Fast and 3/0 Velosorb Fast for labial tears)

Anterior episiotomies (sometimes necessary in women with female genital mutilation) require suturing, leaving the circumcision 'reversed' or 'opened' with 3/0 Velosorb Fast

Pain relief
Diclofenac (100mg suppository) should be offered routinely following perineal repair of first- and second-degree trauma, unless contraindicated.

Prescribe regular analgesia (Paracetamol 1g 4-6 hrly (max 4g 24 hours) and Ibuprofen 600mg 8 hrly (max 1800mg in 24 hours and at least 10-12 hours post diclofenac suppository) before transfer from the Delivery Suite, unless contraindicated.

Standards for record keeping (episiotomies, first, and second degree tears and labial tears)
Document the extent of the trauma, the method of repair and the materials used using either the proforma in the intrapartum notes, the instrumental delivery proforma or using Medway. Documentation of the advice given after suturing is recorded in the notes

d) Management of 3rd and 4th degree tears (OASIS)

Repair

- Carry out repair in theatre to obtain optimum conditions. (Theatre one)
- Regional or general anaesthesia is used. Anaesthesia will allow the woman to be pain-free and the anal sphincter to relax, which is essential to retrieve the retracted torn ends of the anal sphincter. This also allows the ends of the sphincter to be brought together without any tension.
- Have an assistant and/ or a theatre practitioner to aid visualisation.

Who should perform the repair?

- The repair should be conducted by an ST3 or above who has been deemed competent in performing the repair independently (OSATS or CME).
- If the mother has sustained a third degree tear in her previous pregnancies, the repair needs to be directly supervised by an ST6 (a senior registrar) or above.

Technique
Figure of eight sutures should be avoided during repair of OASIS because they are haemostatic in nature and may cause tissue ischaemia

External anal sphincter repair (EAS)
For repair of a full thickness external anal sphincter tear, either an overlapping or end to end (approximation) method can be used. For partial thickness (all 3a and some 3b) tears and end to end technique should be used. The burying of surgical knots should be beneath the superficial perineal muscle to prevent knot migration to the skin.

Internal sphincter repair (IAS)
Where the torn IAS can be identified, it is advisable to repair this separately with interrupted sutures or mattress sutures without any attempt to overlap the (IAS) The torn anal mucosa should be repaired with sutures either using continuous or interrupted technique.
Materials:

Repair of EAS
Use Polydioxanone, (Maxon) 2-0 as retains tensile strength and may be associated with less infection and better long-term function of the anal sphincter complex.

Repair of IAS:
The use of fine sutures, such as 3-0 Maxon or 2-0 Velosorb(not fast) will cause less irritation and discomfort.
Warn women of the possibility of knot migration if long-acting or non-absorbable materials are used.

Antibiotics

Post operatively Augmentin (Co amoxyclav) 625mg for 5 days. If allergic, follow trust policy on antibiotic prescription for an appropriate antibiotic.

Laxatives
Post-operative laxatives (evidence of reducing incidence of wound dehiscence) Lactulose (10-

20mls BD) for 7 days after the repair (the effectiveness should be monitored as appropriate)

Pain relief
Diclofenac (100mg suppository) unless contraindicated.

Prescribe regular analgesia:
First line Paracetamol 1g 4-6 hrly max 4g in 24 hours
Second line Ibuprofen 600mg 8 hrly (max 1800mg in 24 hours and ensure at least 10-12 hours post diclofenac) and

See postnatal pain relief guideline if further pain relief is required

Bladder care
Insert an indwelling catheter for 12 hours at the start of the procedure.

Supporting information
Women should be given information regarding the extent of trauma and the repair carried out. Information should also be given regarding perineal hygiene, pelvic floor exercises and follow arrangements. The information leaflet for third and fourth degree perineal tears should be given to the women. Documentation of the advice given after suturing is recorded in the notes

Standards for record keeping (3rd and 4th degree tears)
Document the extent of the trauma, the method of repair and the materials used in the work stream for 'perineal repair' in the Medway maternity database or the third degree tear delivery proforma. Complete an incident report.

Follow up care

- Initial physiotherapy and advice whilst in hospital and an outpatient physiotherapy appointment made by the woman for 6weeks
- Obstetric review before discharge
- Outpatient appointment made for around 3 months in the OASIS clinic when advice on the choice of mode of delivery for future pregnancies will be discussed. An appointment will be generated directly from information retrieved from Medway
- Women will be offered endoanal ultrasonography at follow up and referred to colorectal surgeon if required
- Women will be advised to consult their general practitioner if they develop anal incontinence at any time as symptoms may appear after a long interval.

Process for monitoring the rate and cause of returns of women with problems relating to all types of perineal repair

A clinical incident form will be completed for all women re-admitted with problem related to all types of perineal repair. A review of the rate and causes of re- admissions will be presented yearly to the maternal morbidity meeting with selected case note review.

Yearly OASIS audit

Expectations for staff training
All relevant staff will be trained in Perineal suturing as identified within the Training Needs Analysis.

Monitoring process:
- See table below

References:

National Institute for Health and Clinical Excellence. (2015). *Intrapartum care: Care of healthy women and their babies during childbirth*. London: NICE. Available at: www.nice.org.uk
Royal College of Obstetricians and Gynaecologists. (2015). *The Management of Third- And Fourth-Degree Perineal Tears*. London: RCOG. Available at: www.rcog.org.uk
Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards for Maternity Care: Report of a Working Party*. London: RCOG Press. Available at: www.rcog.org.uk

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Version 2
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Version 3
Updated by [redacted] and [redacted]

Minor amendments: June 2012, [redacted]
Version 3
Update March 2016 – [redacted]

Consultation Process
CDS Working Party
CDS band 7 midwives

Ratification
Central Delivery Suite Working Party March 2016

Date March 2016

Review March 2018

RELATED DOCUMENTS	Standard operative policy for midwives and doctors when suturing Antibiotic policy Postnatal pain relief
SAFETY	There are no unusual or unexpected safety concerns (to staff or patient),
QUERIES	Contact [redacted] Practice Development Midwives [redacted], or senior obstetrician or the coordinating midwife on CDS [redacted].

Monitoring process : perineal suturing

Process	Tool	Responsibility of:	Frequency of review	Responsibility for: (plus timescales)			
				Review of results	Development of action plan and recommendations	Monitoring of action plan and implementation	Making improvement lessons to be shared
Cases with recurring themes, or those which present potential significant learning will be reviewed at the maternal morbidity meetings	Case Note review	Maternal Morbidity	Two yearly	Maternal Morbidity	Maternal Morbidity	MCCWP or Education and training WP (where appropriate)	Through MCCWP or Education and training WP as outlined below
An audit of all cases of 3rd and 4th degree tears and 1% of all women who have delivered • Who can perform the procedure • Documentation of consent for all types of perineal repairs • Management of 3rd and 4th degree tears • Standard of record keeping for all types of perineal repairs • Documentation of information given regarding support following the repair.	Data collection from Medway maternity computer system and case note review	CDSWP	Annual	Presented to Women's Services Clinical Audit Meeting	By CDSWP in the month following the audit meeting	Review by CDSWP @ 6 months	See monitoring statement for dissemination of learning