Operative Vaginal Delivery – Full Clinical Guideline

Reference No.: IP/11:23/I2

Contents

1. Introduction

This guideline applies to the indications, approach and post delivery management when undertaking operative vaginal deliveries. It does not define the techniques used in the application of these various tools and is not a substitute for RCOG required training to attain competence.

Three types of Ventouse are in use in the unit, The Kiwi Omnicup, Metal Cups and MityOne vacuum-assisted delivery device. The MityOne device by cooper surgical is a mushroom cup or soft bell cup and the device may vary depending on which hospital you work.

The options available for rotational delivery include Kiellands forceps, manual rotation followed by direct traction forceps or rotational vacuum extraction. Rotational deliveries should be performed by experienced operators, with the choice depending on the expertise of the individual operator.

2. Purpose and Outcomes

The aim of this guideline is to provide up to date information on the principles of the use of the forceps and vacuum extractor for both rotational and non-rotational operative vaginal deliveries.

3. Abbreviations

AC	-	Abdominal Circumference
HC	-	Head Circumference
ITP/ATP	-	Idiopathic / Autoimmune Thrombocytopenia
LSCS	-	Lower Segment Caesarean Section
NYHA	-	New York Heart Association
PR	-	Per Rectum
OSAT	-	Objective Structured Assessment of Technical Skill
VBAC	-	Vaginal Birth After Caesarean

4. Antenatal Communication

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.

5. Definition

Operative vaginal delivery includes all cases where an assisted delivery is required using the handheld Kiwi and MityOne vacuum assisted delivery devices (for both rotational and non-rotational deliveries) and forceps for non-rotational delivery (Wrigley's, Neville Barnes, Haig Ferguson, Simpsons) and rotational deliveries (Keillands).

Advise the woman to have a caesarean birth if vaginal birth is not possible

The delivery should be defined by position and station as below.

Outlet:

Fetal scalp visible without separating the labia
Fetal skull has reached the pelvic floor
Sagittal suture is in the anterio-posterior diameter or right or left occiput anterior or posterior position (rotation does not exceed 45º)
Fetal head is at or on the perineum

Low

Leading point of the skull (not caput) is at station plus 2 cm or more and not on the pelvic floor
Two subdivisions:
- rotation of 45º or less from the occipito-anterior position
- rotation of more than 45º including the occipito-posterior position

Mid

Fetal head is no more than 1/5th palpable per abdomen
Leading point of the skull is above station plus 2 cm but not above the ischial spines
Two subdivisions:
- rotation of 45º or less from the occipito-anterior position
- rotation of more than 45º including the occipito-posterior position

High

Not included in the classification as operative vaginal delivery is not recommended in this situation where the head is 2/5th or more palpable abdominally and the presenting part is above the level of the ischial spines

6. Operator

A Specialty Trainee/ Registrar is able to perform a Ventouse or Forceps delivery once deemed competent by a consultant or senior registrar. Each trainee is responsible for keeping a record of competency assessment (OSAT).

Kielland's forceps should only be performed by a suitably experienced and trained Specialty Trainee/ Registrar or above in the use of this instrument.

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

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

Good standards of hygiene and aseptic techniques are recommended.

7. Indications for Operative Vaginal Delivery

(No indication is absolute and each case should be considered individually)

Indication	Reason
Fetal	Presumed fetal compromise
Maternal	Medical indications to avoid Valsalva Manoeuvres (e.g. cardiac disease NYHA Class III or IV(see below), a hypertensive crises, cerebral vascular disease, uncorrected cerebral vascular malformations, myasthenia gravis, spinal cord injury, the woman requests assistance)

Inadequate Progress in the second stage	**Nulliparous women** **87)** with regional anaesthesia**:** lack of continuing progress for a maximum of three hours (total of active and passive second stage of labour) **however the decision that there is no progress may often be made a lot sooner** - ie if there is no progress at one hour of active pushing this does not mean that a further hour of ineffective pushing should occur before assistance is offered. b) without regional anaesthesia: As above but maximum duration of second stage no greater than two hours **Multiparous women:** lack of continuing progress for two hours (total of active and passive second stage labour) with regional anaesthesia, or a maximum of one hour without regional anaesthesia. ***Care with VBAC***: these patients should be treated with caution and not treated as primiparous women or as multiparous women who have had a previous vaginal birth (see VBAC guideline [V2])

7.1 New York Heart Association Classifications (2009)

Class	Patient Symptoms
Class I (Mild)	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnoea (shortness of breath).
Class II (Mild)	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnoea.
Class III (Moderate)	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnoea.
Class IV (Severe)	Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken,

8. <u>Pre-requisites for Operative Vaginal Delivery</u>

Preparation	Essential Requirements

Assessment- Full abdominal and vaginal Examination	• Head is ≤1/5 palpable per abdomen • Cephalic presentation • Cervix is fully dilated and the membranes ruptured • Exact position of fetal head determined to allow correct choice and placement of instrument • Pelvis deemed clinically adequate • Caput and moulding is no more than moderate (or +2)
Mother	• **Clear explanation and valid verbal consent obtained and documented in notes**, see 7.1 below • Maternal bladder must be emptied (Indwelling catheter should be removed or balloon deflated) • In lithotomy positions with the obstetric wedge in position • Appropriate analgesia is in place, Discuss pain relief options for birth with forceps or ventouse. The option used should be based on the woman's preference and the clinical situation. For mid-cavity rotational deliveries this will usually be under a regional block (Keillands Forceps rotation delivery should be performed under spinal/epidural anesthesia in theatre) A pudendal block may be appropriate, particularly in the context of urgent outlet deliveries. Ensure the level of pain relief is acceptable to the woman before using forceps or ventouse during birth.
Staff	• Aseptic technique • Operator must have the knowledge, experience and skills necessary to use the proposed instruments. ST3 or above with appropriate direct or indirect supervision. More junior trainees must have direct supervision. • Anticipation of complications that may arise (e.g. shoulder dystocia, postpartum haemorrhage) • Personnel present who are trained in neonatal resuscitation • Back-up plan in place in case of failure to deliver • Adequate facilities and back-up personnel are available
Documentation	• Reason for procedure • Time of decision to deliver • Time instrument applied to presenting part and timing of decision to deliver. • Time of when head and body delivered • That verbal/written consent obtained • Full documentation of technique

Location	• Routine assisted deliveries are in the labour ward rooms
Baby	• Paediatrician must be called for deliveries with (or anticipating) fetal distress • Ensure infant resuscitaire available (and checked) in room • Ensure paired cord blood samples are taken from all operative vaginal deliveries.

8.1 Categorisation of instrumental delivery

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

CATEGORY 1: Immediate threat to the life of the women or fetus (as soon as possible or within 30 minutes)

CATEGORY 2: Maternal or fetal compromise that is not immediately life threatening (as soon as possible or within 75 minutes)

The time the decision for instrumental delivery was made should be documented in the patient's healthcare record. The safety of the mother is paramount and this should be prioritised above an exact decision to delivery interval.
The timeframe given in the categorisation of instrumental delivery is the total time within which the baby should be born. This includes the time taken to perform a caesarean section following a failed trial of forceps.

8.2 Consent

For birth room procedures verbal consent should be obtained prior to assisted vaginal birth and the discussion should be documented in the notes.
Each operator must ensure that they have written consent on trust pre-printed instrumental delivery or trial of instrumental delivery consent forms from the patient and document this clearly in the notes, including an explanation of what the procedure will entail, why the procedure is being undertaken and the likelihood of an episiotomy.

Consent needs to be obtained by discussion not only of these risks but additionally the risk of caesarean section in the context of a vaginally deliverable low station fetal head and discussions regarding potential risks of an instrumental delivery need to be discussed within the context of the particular patient undergoing the procedure. In the event of a fetal bradycardia, verbal consent may be taken to avoid delays to delivery.

If a woman declines a birth with forceps or ventouse:
• discuss her remaining options (vaginal birth, caesarean birth or reconsidering her decision about forceps or ventouse)
• advise her that her choices may be limited by clinical safety or degree of urgency (for example if a caesarean birth is no longer an option because the baby's head is too low in the pelvis)
• support her decision.

Mediolateral episiotomy should be discussed with the woman as part of the preparation for assisted vaginal birth

<u>Episiotomy</u>
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.

Serious risks

Maternal:

- third and fourth-degree perineal tear, 1–4 in 100 with vacuum-assisted delivery (common) and 8–12 in 100 with forceps delivery (very common)
- extensive or significant vaginal/vulval tear, 1 in 10 with vacuum 1 and in 5 with forceps.

Fetal:

- subgaleal haematoma, 3–6 in 1000 (uncommon)
- intracranial haemorrhage, 5–15 in 10 000 (uncommon)
- facial nerve palsy (rare).

Frequent risks

Maternal:

- Postpartum haemorrhage, 1–4 in 10 (very common)
- Vaginal tear/abrasion/bruising (very common)
- Anal sphincter dysfunction/voiding dysfunction although these may also occur following spontaneous vaginal delivery

Fetal:

- Forceps marks on face (very common)
- Chignon/cup marking on the scalp (practically all cases of vacuum-assisted delivery) (very common)
- Cephalohaematoma 1–12 in 100 (common)
- Facial or scalp lacerations, 1 in 10 (common)
- Neonatal jaundice /hyperbilirubinaemia, 5–15 in 100 (common)
- Retinal haemorrhage 17–38 in 100 (very common).

Other potentially required procedures:

- Episiotomy (5–6 in 10 for vacuum assisted delivery, 10 in 10 for forceps)
- Manoeuvres for shoulder dystocia
- Caesarean section
- Blood transfusion
- Repair of perineal tear
- Manual rotation prior to forceps or vacuum-assisted delivery.

Considerations prior to decision for operative delivery

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 scalptrauma 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.

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.

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

insufficient evidence to recommend the routine use of abdominal or perineal ultrasound for assessment of the station,flexion and descent of the fetal head in the second stage of labour.

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.

Operators should be aware that no indication is absolute and that clinical judgment is required in all situations.

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.

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.

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.

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 recognised manoeuvres. - Please see caesarean section guideline for instruction on disimpaction of the fetal head.

9. Performing Operative Vaginal Delivery in Theatre, when to abandon Operative Vaginal Delivery and Use of Sequential Instruments

Operative vaginal births that are thought to be at a higher risk of failure should be considered a trial and conducted in theatre by an experienced operator where immediate recourse to caesarean section can be undertaken.

Higher rates of failure are associated with:

- maternal body mass index over 30
- estimated fetal weight over 4000 g or clinically big baby
- occipito-posterior position
- mid-pelvic birth or when 1/5th of the head palpable per abdomen
- short maternal stature
- head circumference above the 95th percentile

A trial of instrumental delivery should be performed by a senior registrar year 6 or above, following discussion with the on-call Obstetric Consultant, in theatre (and in cases of a junior registrar with attendance of a senior registrar or Consultant); with anaesthetist and theatre team assembled in case it is necessary to proceed to caesarean section.

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

When mid-pelvic or rotational birth is indicated, the risks and benefits of assisted vaginal delivery should be compared with the risks and benefits of a second stage Caesarean birth for the given circumstances and skills of the operator.

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 against the risk of forceps delivery following failed vacuum extraction.

If there is no descent of the head despite appropriate assessment, correct cup choice and good traction there is NO indication to attempt forceps following failure to deliver with the Ventouse. If however traction is inadequate due to caput, poor maternal assistance or poor vacuum it may be justified to change to forceps. This decision should be made by an experienced operator. The situation may also arise that after good flexion and rotation the cup detaches. A straightforward forceps is appropriate in these circumstances.

10. Ventouse Delivery

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.

10.1 Absolute Contraindications for Delivery with the Ventouse

- Cephalopelvic disproportion
- Inadequately dilated cervix*
- Face, breech or compound presentation
- Gestation less than 32 weeks – vacuum birth should be avoided
- Marked active bleeding from a fetal blood sampling site
- Maternal idiopathic thrombocytopenia (ITP)/ or Fetal Alloimmune Thrombocytopenia (ATP)
- Maternal Haemophilia carrier status and unknown or male fetal sex (unless has had prenatal diagnosis and haemophilia has been excluded in the fetus).
- Von Willebrands Disease

10.2 Relative Contra-indications for Delivery with Ventouse

- Brow presentation
- Marked asynclitism
- Extensive caput
- Extremely deflexed OP position
- Absent contractions or mother unable to push
- Macrosomia or known asymmetry (Abdominal Circumference AC > Head Circumference HC)
- Predisposition to a fetal fracture

The safety of vacuum extraction at between 32 weeks + 0 days and 36 weeks + 0 days of gestation is uncertain and should therefore be used with caution.

10.3 Safety Rules for Delivery with Ventouse / Kiwi / MityOne device

- Do not use any vacuum device you have not been correctly trained to use or do not feel confident using
- Delivery should be completed within 15 minutes of cup application
- There should be evidence of true descent of the head not just elongation of the caput/scalp, with each attempt.
- 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
- The cup should be reapplied no more than twice. After one cup detachment a more experienced operator should be called unless delivery is obviously easily achievable or imminent

- 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 3 pulls to bring the fetal head to the perineum. 3 additional gentle pulls can be used to ease the head out of the perineum.
- If failure with the Ventouse occurs despite good traction a decision to use a second instrument to attempt vaginal delivery should only be made by a senior operator.

10.4 Special Indications for the Ventouse

- Prolapsed cord at full dilatation
- Second twin with acute fetal compromise

11. Forceps Delivery

Forceps may be the first instrument of choice in certain situations: significant caput where there would be loss of suction with a Ventouse, poor maternal effort, under general anaesthetic, operator choice or bradycardia when a quicker delivery with a forceps may be anticipated. Discontinue attempted forceps birth when the forceps blades cannot be easily applied, or the handles do not approximate easily or if there is lack of progressive descent with moderate traction.

11.1 Non-Rotational Forceps

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.
If there is no significant descent after three pulls with Neville Barnes Forceps then the procedure should be abandoned.
The initial assessment of position should be reviewed to ensure original diagnosis of position / station was correct. If original assessment was correct then delivery by LSCS should then be considered. Obstetricians should be aware of the increased risk of fetal head impaction at Caesarean birth following a failed attempt at birth via forceps.
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.

11.2 Rotational Forceps

If rotation cannot be achieved by gentle force or following rotation the fetal head fails to descend the procedure needs to be abandoned and consideration given to delivery by immediate LSCS.

Following a successful rotational delivery with Keillands forceps the vagina needs to be thoroughly inspected for spiral tears in addition to assessment of the perineal tear/episiotomy.

12. Cord bloods

Cord bloods should be taken following all operative vaginal deliveries.

13. Documentation

Documentation within the patient health records is to include the following:

- Why the procedure is indicated
- Record of discussion with the woman of the risks, benefits, and options
- Informed consent has been given
- Head palpable on abdominal examination
- Position and station of the fetal head, amount of moulding and caput present, assessment of maternal pelvis
- Assessment of fetal heart rate and contractions
- Number of attempts and ease of application of vacuum or forceps

- Duration of traction and force used
- Description of maternal and neonatal injuries
- Swab, needle count
- Per rectal examination
- Estimated blood loss
- Cord pH results
- Adverse outcomes e.g. 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.
- Delivery details should be electronically documented on the instrumental delivery proforma.

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.

Adverse outcomes, including unsuccessful 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.
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.

14. Aftercare following Operative Vaginal Delivery

Obstetricians should ensure that the ongoing care of the woman, baby and family is paramount. Obstetricians have a duty of candour; a professional responsibility to be honest with patients when things go wrong.

14.1 Antibiotics

A single prophylactic IV stat dose of antibiotics as per Obstetric Infections guideline should be recommended following assisted vaginal birth within 6 hours after cord clamping as it significantly reduces confirmed or suspected maternal infection compared to placebo. A dose of antibiotics are required for all instrumental deliveries in the room or in theatre.
Please see the Obstetric Antibiotic Guideline

14.2 Assessment of Thromboembolism Risk

In addition to individual risk factors that patients may have for thromboembolic disease, prolonged labour and immobility are independent risk factors for thrombosis therefore each patient needs to be individually assessed regarding the risk/benefit from thromboprophylaxis post delivery.(see Thromboprophylaxis guideline –T8 Appendix D)

14.3 Regular Analgesia

Paracetamol and ibuprofen should be considered in the absence of contraindications.

14.4 Bladder Care (*to be read in conjunction with Bladder Care guideline - B4*)

If following operative delivery under regional anaesthesia, this remains effective or there is vaginal trauma it is recommended to insertan indwelling catheter. In the absence of any urinary tract injury or other complications the urinary catheter can be removed 12-18 hours post operative delivery.

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. Following catheter removal, vigilance is important to ensure the absence of voiding difficulties. Strict input/output fluid balance charts should be maintained. A post void residual should be measured if urinary retention is suspected. **Offer women physiotherapy-directed strategies to reduce the risk of urinary incontinence at 3 months.**

14.5 Discussion following Operative Delivery

It is both good medical practice and essential that the woman is seen by the operator or a member of the consultant team prior to discharge home, allowing time to answer any questions and giving the woman an extra opportunity to understand the rationale for the assisted delivery.

In uncomplicated instrumental deliveries of low risk women, a midwifery led discharge may be suitable provided it is clearly documented within the delivery documentation.

Inform women that there is a high probability of a spontaneous vaginal birth in subsequent labours following assisted vaginal birth.

15. Birth Trauma to Baby

Document description of injury in the baby notes and explain to parents. Review by Advanced Neonatal Nurse Practitioner (ANNP) / Paediatrician.
Consider medical photographs with consent of parents and store in health records. Complete a neonatal body mapping form – see Appendix A - available on NETi (Trust intranet site)
Adverse outcomes, including unsuccessful forceps or vacuum delivery, should trigger an incident report as part of the risk management process.

16. Monitoring Compliance and Effectiveness

Health records of women who have delivered following an operative vaginal delivery will be audited as agreed within the BU audit forward programme.
Any issues highlighted will be addressed to the Maternity Development Committee who will be responsible for implementing and monitoring of action plans.

17. Auditable standards

- Proportion of assisted vaginal births; the UK average is between 10-15%.
- Proportion of unsuccessful assisted vaginal births.
- Proportion of sequential instrument use
- Case note review to audit appropriate care of women with failed assisted vaginal birth or sequential instrument use for:
  - When to use sequential instrument and when to discontinue
  - Use of ultrasound scan to confirm fetal position.
- Proportion of 3rd and 4th degree perineal tears (1-4% for vacuum and 8-12%for forceps)
- Proportion of neonatal morbidity
- Proportion of documentation of written or verbal consent (100%)
- Completion of documentation (100%)
- Proportion of women after assisted vaginal delivery birth receiving a postnatal review explaining the birth and discussing birth options in future pregnancy (100%)

18. References

Royal College of Obstetricians & Gynaecologists (RCOG) Green Top Guideline No.26 Assisted Vaginal Birth, April 2020

National Institute for Health and Care Excellence (NICE) Clinical Guideline 190: Intrapartum care for healthy women and babies, July 2017.

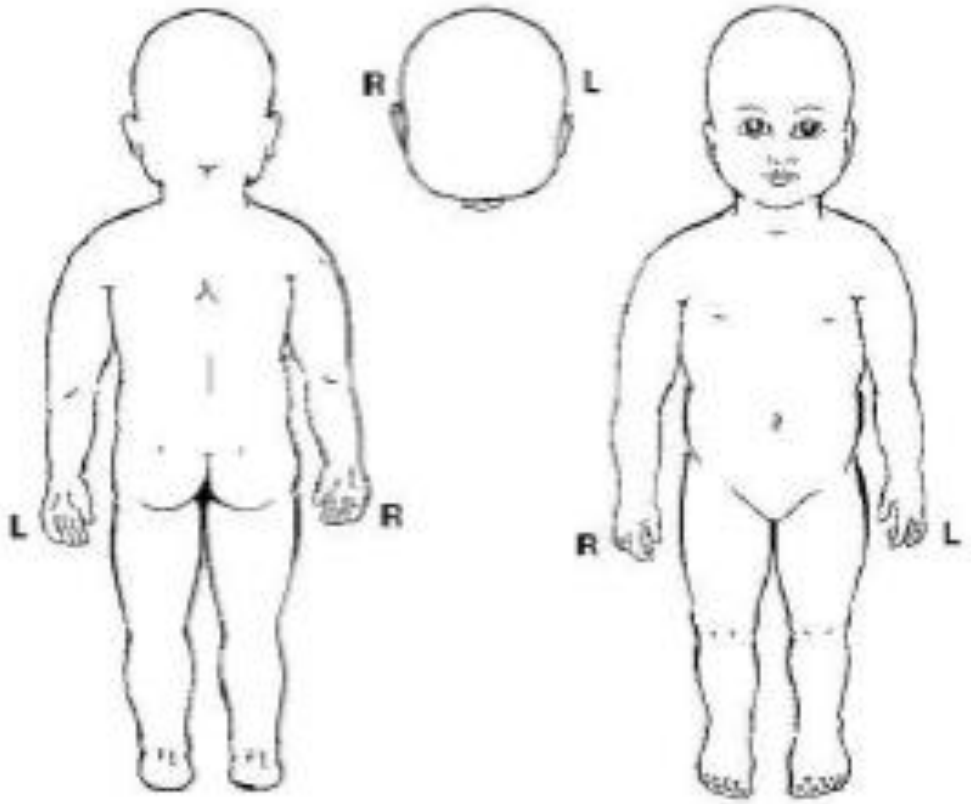
Royal College of Obstetricians & Gynaecologists (RCOG) Green Top Guideline No.26 Operative Vaginal Delivery, January 2011

Royal College of Obstetricians & Gynaecologists (RCOG) Consent advice 10 Operative vaginal Delivery, July 2010

Neonatal Body Mapping

Affix patient label here	Date: Time: Ward: Signature: Print name: *(Staff member completing)*

Please record the approximate **shape, size and location** of wounds / marks / areas of discolouration on the chart below. Please also consider referral to Clinical Photography if appropriate.



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Version / Amendment	Version	Date	Author	Reason
	1	Oct 2009	Mr. Tamizian – O&G Consultant, Maternity Development Committee	Merger of guidelines IP/06:04/I2 & IP/06:04/I3 into one
	2	Nov 2010	Mr. O Tamizian – O&G Consultant S. Derbyshire - MW	Review
	3	April 2014	Mr. O Tamizian – O&G Consultant Dr A Phillips - StR	Review
	4	Oct 2017	Mr. O Tamizian – O&G Consultant	Review
UHDB	5 (UHDB W1)	May 2020	Miss A Tirlapur - Consultant Obstetrician	Review and merge with QHB. Added ABX prophylaxis
	2	Aug 2023	Miss A Tirlapur - O&G Consultant	Review
	2.1	May 2024	Miss S Chaudhry - Consultant Obstetrician	Changes to bring inline with NICE guidance on Care of Women in Labour
Intended Recipients: All Maternity Staff				
Training and Dissemination: Cascaded through lead midwives/doctors; Published on Intranet, NHS mail circulation list. Articles in Business Unit newsletter				
To be read in conjunction with: Bladder Care guideline (B4); Perineal Repair after Vaginal Delivery (P2); Thromboprophylaxis During Pregnancy, Labour and After Vaginal Delivery (T8)				
Consultation with:	Miss M Thangavelu – Consultant at QHB			
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