Standard Operational Procedure for Vaginal Birth after caesarean section (VBAC)

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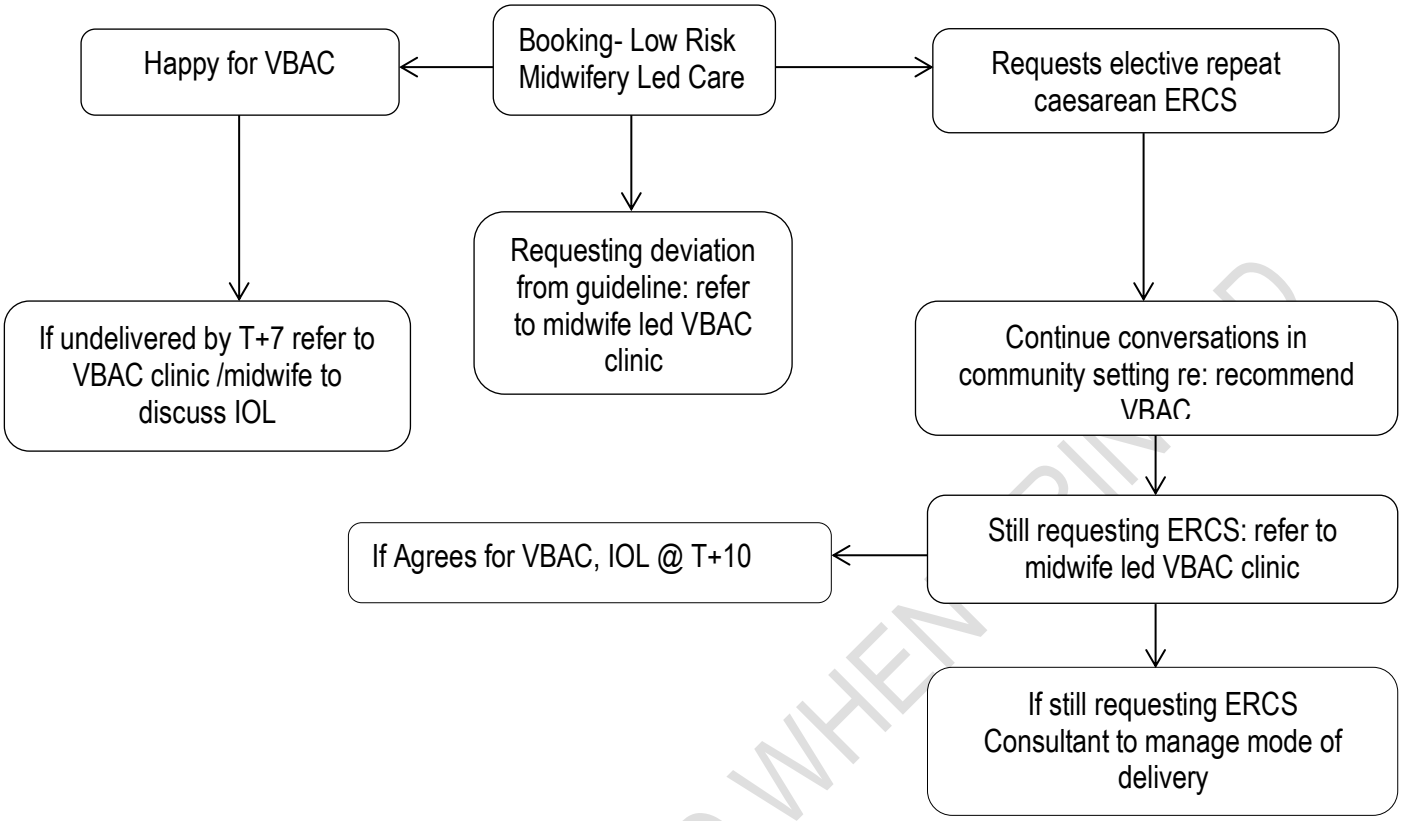
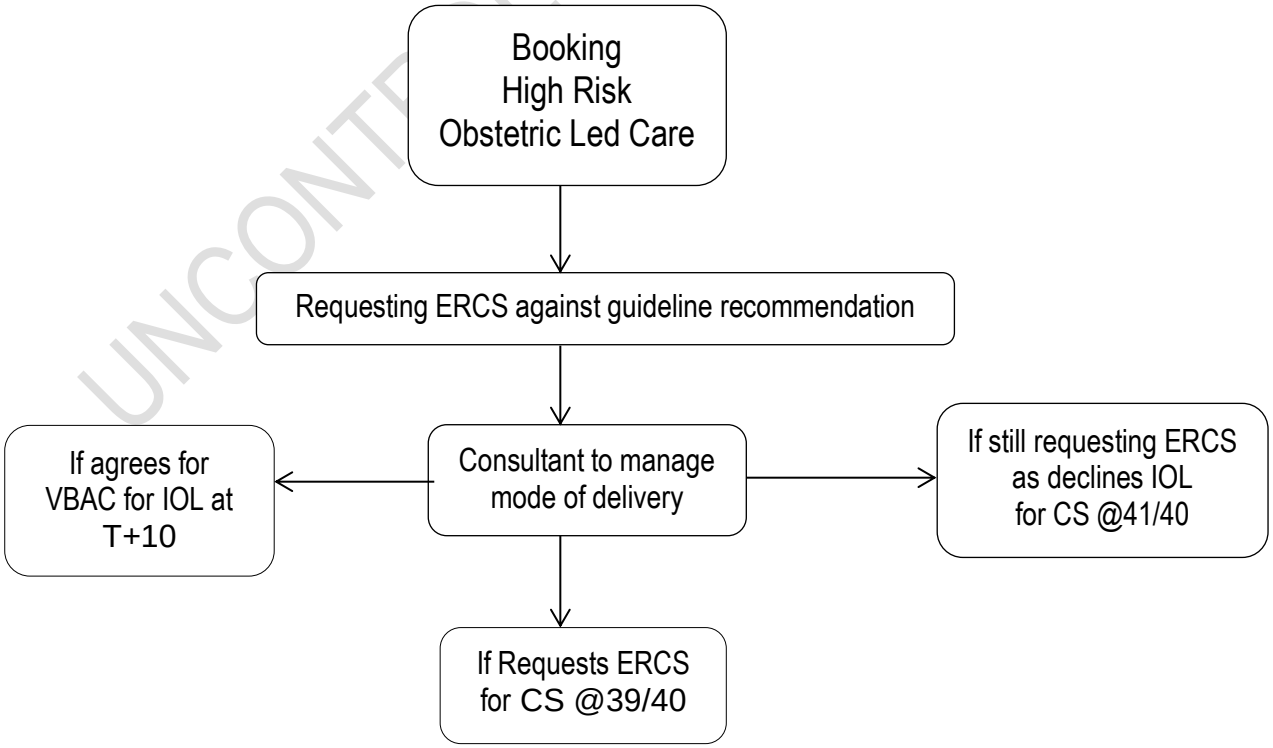
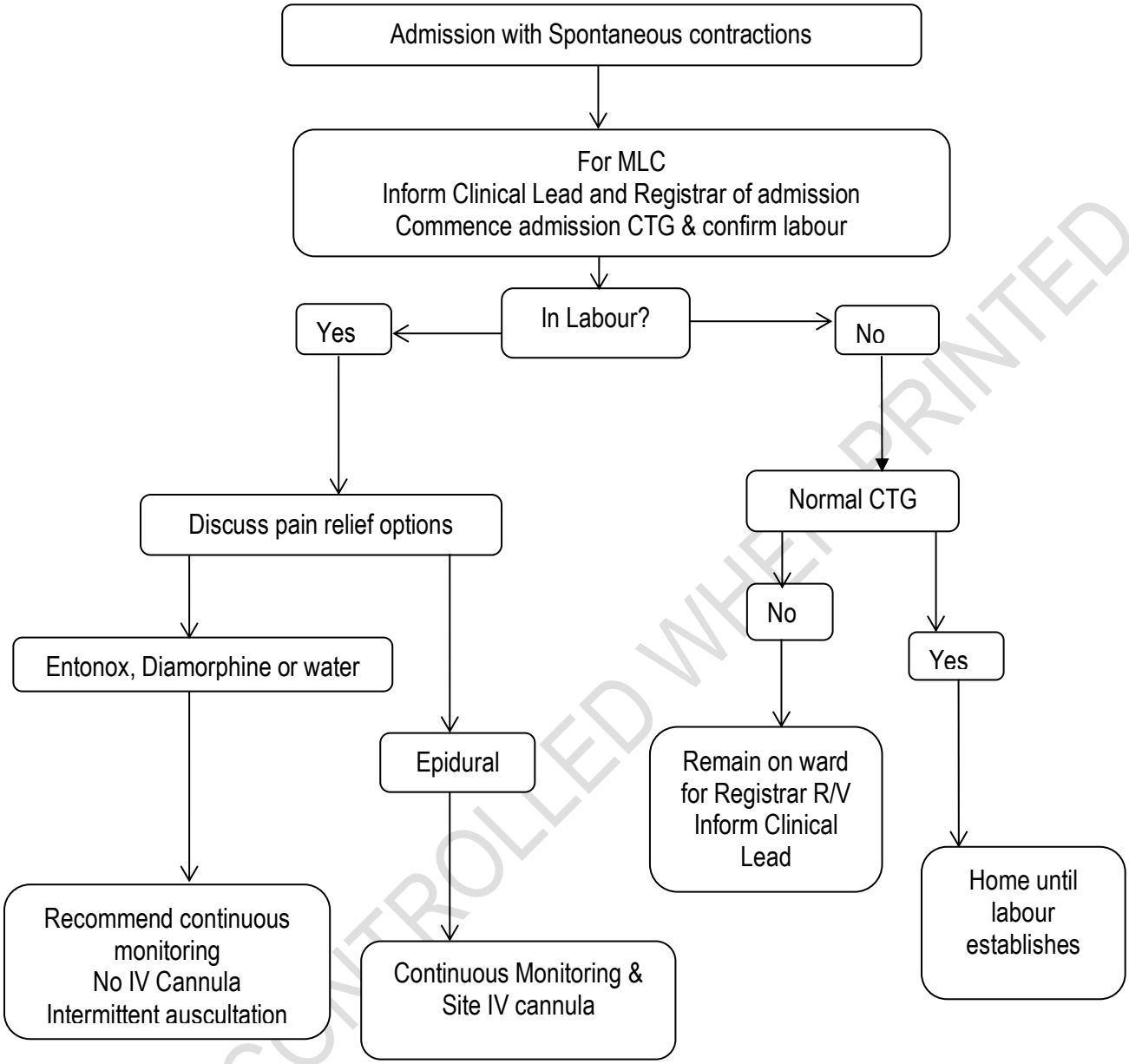
Vaginal Birth after Caesarean Section Care Pathway- Low risk



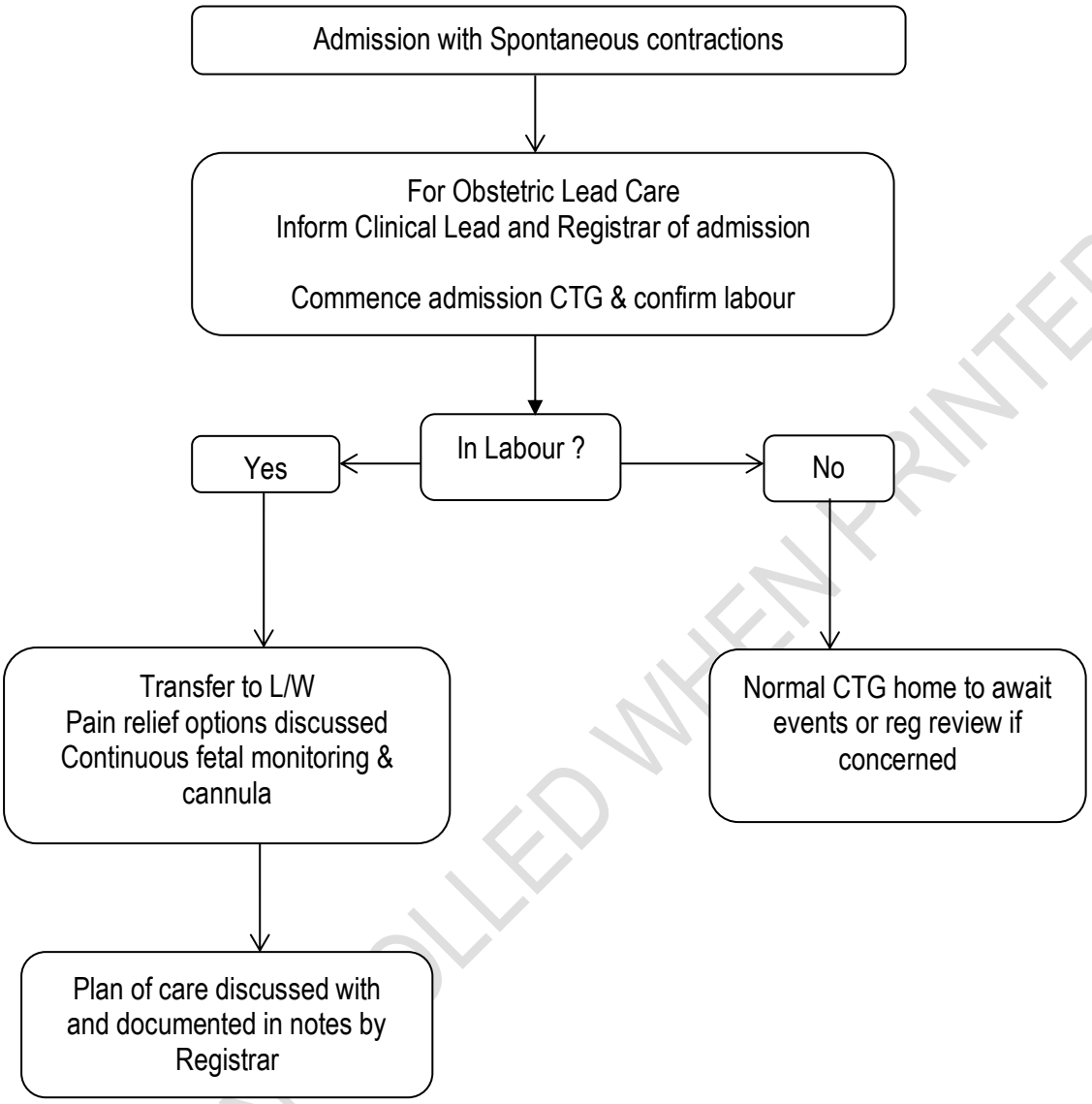
Vaginal Birth after Caesarean Section care pathway- High risk



Vaginal birth after Caesarean Section (VBAC) labour Care pathway-Low Risk



Vaginal birth after Caesarean Section (VBAC) labour Care pathway-High Risk



1. Purpose/Background:

Pregnant women with a previous section may be managed by either planned vaginal birth after caesarean section (VBAC) or elective repeat caesarean section (ERCS). Having considered the risks and the benefits of VBAC and ERCS, the senior clinicians at St Mary's strongly recommend VBAC for woman who have had a single prior lower segment caesarean section and who have no other risk factors; maximising quality of care and a way of reducing the CS rate in line with national guidance. A careful discussion of the risks and benefits of all methods of delivery should be discussed. This process of discussion may take several weeks or months and involve more than one clinician. It is essential that the strong recommendation for VBAC is done at booking and future antenatal appointments were deemed appropriate.

2. Scope:

This document is for use by all healthcare professionals caring for pregnant women. It applies to all women cared for by St Mary's Maternity Services.

To provide, information to the carer of women, undergoing vaginal birth after previous caesarean section.

3. Responsibilities

It is the responsibility of all Midwifery Nursing and medical staff to:

- Access read understand and apply this guidance
- Attend any mandatory training pertaining to the guidance

It is the responsibility of the department to:

- Ensure the guideline is reviewed as required in line with trust and national recommendations
- Ensure the guideline is accessible to all relevant staff

4. Procedure:

Women who have previously delivered by caesarean section should be identified by the community midwife at the booking appointment and given the **new VBAC**

antenatal notes. These notes provide sections to document antenatal care, as well as information regarding the risks and benefits of VBAC and ERCS.

This Standard operating practice should be used in conjunction with the new 'VBAC ANTENATAL CARE RECORD'

Women with one previous uncomplicated transverse lower segment caesarean for a non- recurring factor (e.g. breech; placenta praevia; suspected fetal compromise) who in this pregnancy have no other risk factors do not need to be referred for obstetric-led care as a matter of course. (See Midwifery led VBAC care pathway.

High risk women should always be booked under Consultant Led Care.

4.1 12 week scan appointment

- Following confirmation of viability and gestation, the woman will either be booked for Midwifery Led Care pathway or Consultant led care.
- Previous delivery notes should be checked to specifically check which type of uterine incision was used at the previous caesarean section and what the indication was. If there is any doubt about the incision or it has not been recorded or delivery was in another hospital, it should not be assumed that the previous incision was lower segment transverse. In these cases, the woman should be referred to the consultant antenatal clinic.
- If any contraindication to VBAC is identified from the proforma, the woman should be referred to the consultant antenatal clinic.
- If any complications arise during pregnancy the woman will be referred to a CLC clinic.
- If the (low risk) woman requests a repeat caesarean section, she should continue with Community Midwifery care. A Consultant appointment at 39 weeks will be arranged to enable a LSCS to be booked for 41 weeks.

4.2 Midwifery led care for women who request a VBAC

Women who request a VBAC can have MLC if they fulfil the following criteria:

- No more than 1 previous caesarean section

- Documented evidence that the previous caesarean section was through a lower segment transverse incision
- No contraindication to VBAC identified on the 'pregnancy after caesarean section pathway' form
- Categorised as low risk on the antenatal risk assessment
- Women must agree to be on the midwifery led care pathway

Contraindications to VBAC

- Previous ruptured uterus
- Classical caesarean scar
- Absolute contraindications to vaginal birth
- Placenta previa
- Two or more previous LSCS

This list is not exhaustive and a review of the previous LSCS delivery records and current pregnancy is recommended to identify contraindications to VBAC (RCOG 2015)

4.3 VBAC and post dates.

If undelivered by T+7 women are to be offered a sweep and balloon induction should be booked at T+10. If the woman declines induction, immediate referral to VBAC midwifes to discuss ERCS.

4.4 Place of labour

Women with a history of caesarean section should be advised against a home birth. If the woman is requesting a home birth she should be referred to the consultant obstetrician clinic or VBAC midwife for ongoing discussions and debriefing.

4.5 Care in Labour

- **IV access and bloods**

  There is no indication for IV access if the woman remains low risk on admission to Labour ward (NICE 2019)

- **Fetal Monitoring**

Continuous CTG monitoring is usually advised for women in labour who have had previous caesarean section, because of increased risk of serious medical problems for the baby (NICE 2019) However it is uncertain that whether continuous CTG monitoring in these circumstances allows risk to be identified sooner than if intermittent auscultation is used.

  - **Continuous monitoring should be offered to all VBAC women.**
    It is recommended to offer continuous CTG monitoring to women in labour with a previous caesarean section if using oxytocin, for a delay in labour, or if performing amniotomy. (NICE 2019)
  - **Women choosing not to have continuous monitoring**
    This should be reviewed on a case to case basis and discussed with the clinical lead midwife and registrar, if no previous birth plan is evident. For A low risk VBAC women, an Admission CTG should be performed following conformation of established labour along with contractions. Following a normal CTG the women can chose to have intermittent auscultation or remain on a continuous CTG.

- **Analgesia in labour**

All of the usual options are available for women having a VBAC. Low risk VBAC women can opt to go into the birthing pool following a reassuring admission ctg and confirmation of established labour.

- **Syntocinon For Delay in Labour**

There is evidence that augmentation of labour with oxytocin and regional analgesia both reduced the chance of another caesarean section for women in labour who have had a caesarean section in the past. The likelihood of an instrumental vaginal birth is increased with both. This should be explained to the women so they that they can make a fully informed decision. (NICE 2019)

The final decision to start Syntocinon must be made by the consultant on call. The midwife should not commence Syntocinon unless she is happy that the case has been discussed with a Consultant. A management plan clearly documenting the intervals for serial vaginal examination and the selected parameters of

progress that would necessitate discontinuing VBAC labour should be clearly written in the notes prior to commencing Syntocinon.

In the second stage of labour after 1hr of pushing, if delivery is not imminent then there should be a medical review and a clearly documented plan for the second stage

4.6 Scar Rupture

Early diagnosis of uterine scar rupture followed by expeditious laparotomy and resuscitation is essential to reduce the associated morbidity and mortality in the mother and infant. There is no single clinical feature that is indicative of uterine rupture but the presence of any of the following peripartum should raise the concern of the possibility of this event:

- Abnormal CTG or unusual change in FH during Auscultation
- Severe abdominal pain, especially if persisting between contractions
- Chest pain or shoulder tip pain, sudden onset of shortness of breath
- Acute onset scar tenderness
- Abnormal vaginal bleeding or haematuria
- Cessation of previously efficient uterine activity
- Maternal tachycardia, hypotension or shock
- Loss of station of the presenting part

5 Implementation/training/awareness

- VBAC workshops for all midwifes will be incorporated into mandatory study days to ensure best practice and guideline is being followed
- VBAC V's ERCS workshops for woman during the antenatal period
- To follow the new Midwifery Led Pathway, in line with SHIP and the Wessex care pathways
- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
Women assigned to the correct pathway (low/High Risk)	VBAC Notes	2 yearly	10 sets	Audit Midwife	LW Meeting

7. **Related Documents:**

Guidelines:

- Induction of labour
- Caesarean section

Patient Information:

- Induction of Labour with cervical balloon
- Planned Caesarean section

8. References:

National Institute for Health and Care Excellence (NICE).,2019. *Intrapartum Care for women with existing medical conditions or obstetric complications and their babies:* NICE Guideline

Royal College of Obstetrics and Gynaecology (RCOG).,2015 *Birth After Previous Caesarean Birth:* Green top Guideline, No:45

9 DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
Sept 2006	1.0	Sept 2009	Sept 2006		New document
July 2009	2.0	July 2011	July 2009		Reviewed Document
Oct 2009	3.0	Oct 2011	Oct 2009		Maternity CSG
August 2011	4.0	August 2014	August 2011		Maternity CSG
2nd January 2012	4.0	August 2014	2nd January 2012		Slight amendments made to fit into template
23rd April 2012	5.0	23rd April 2015	23rd April 2012		Amendments made to monitoring box to reflect CNST recommendations. Approved at Maternity CSG
1st August 2012	5.0	23rd April 2015	1st August 2012		Changes to proforma
May 2016	6.0	03/05/2019	03/05/2016	Clinical Director of SWCH	Approved at Maternity CSG
July 2019	SOP 1			MCEG	Converted to SOP. New Pathways
April 2021	SOP V2	April 2024	13th April 2021	MCSG	Minor wording changes section 4.5.Ratified