

MEDICAL STAFF RULES & REGULATIONS

SUBJECT: Vaginal Birth After Cesarean (VBAC)

RESPONSIBLE PERSONS: Medical Staff, Department of OB/GYN

I. Purpose:

To provide standards for the selection and management of women attempting a trial of labor following a previous cesarean birth.

II. Definitions:

- **Labor:** Regular uterine contractions that cause progressive cervical change.
- **Provider capable of performing a cesarean birth:** An obstetrician, surgeon, or family practitioner who is credentialed to perform a cesarean birth.
- **Admission:** Occurs when labor has been diagnosed, or when decision is made to deliver the patient. Observation to determine if the patient is in labor is not considered admission.
- **Anesthesia Provider:** Refers to an Anesthesiologist or CRNA who is privileged by the hospital.
- **OR Team:** One person competent to scrub for a cesarean birth and one person competent to circulate during a cesarean section. These may be OR technicians, LPN, CNA, or RN. (Also includes the surgeon, anesthesia provider and one person whose sole responsibility is to care for the baby immediately after birth.)
- **Immediately Available:** On-site to respond to STAT.
- **VBAC:** Vaginal birth after cesarean birth
- **ACOG:** American College of Obstetricians and Gynecologists
- **JC:** Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations)
- **NRP:** Neonatal Resuscitation Program

III. Policy:

- A. Patient Selection Criteria – ONLY Patients meeting ALL of the following criteria may be offered the option of VBAC trial**
- a. Patient has only two prior cesarean births with a subsequent vaginal birth.
 - b. A patient with only one prior cesarean birth if she had not had a prior vaginal birth.
 - c. Patient must have a low-vertical or low-transverse uterine scar (without inverted “T” extension) The scar type must be documented in the medical record. **If unknown, the patient is not a candidate for a trial of labor**
 - d. A patient with no history of other uterine surgery such as hysterotomy or myomectomy entering the uterine cavity.
 - e. Confirmed Single Fetus
 - f. Verification of a vertex presentation at onset of labor
 - g. Patient has a clinically adequate pelvis for vaginal delivery.
- B. There must be documentation of comprehensive patient education including provision of the brochure to patient and completion of consent form with signature of patient and physician.**
- a. Documentation by physician indicates information reviewed and questions answered.
 - b. Documentation at time of admission includes determination if patient’s risk level has changed, or patient choice has changed.
- C. Additional Clinical Consideration:**

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- a. Transfer during the active phase of labor increases patient risk as access to timely delivery is not present during transport
- b. Women may present to hospitals that have chosen not to offer VBAC services. Transfer to a hospital providing VBAC services necessitates evaluation of the patient to determine safety and must comply with federal and state law. Hospitals not offering VBAC services should meet the following standards.
 - i. Emergency procedure in place for women with prior cesarean births who present in labor
 - ii. Institution complies with ACOG Guidelines for Prenatal Care and JC Standards for Obstetrical Care
 - iii. Referral and counseling practices established so that women desiring VBAC may be referred to an appropriate center based upon their risk status.
 - iv. Meets NRP Guidelines for infant care.

IV. Prenatal Management Procedure:

- a. Records of prior births must be reviewed by the physician, including type of cesarean birth.
- b. Appropriate patient education will be provided to the patient including:
 - i. VBAC Brochure.
 - ii. Opportunity for patient and significant other/support person to have questions answered.
 - iii. Physician will explain consent form to patient and obtain patient consent for VBAC.
 - iv. Risk level of patient the institution is typically capable of caring for is reviewed with the patient, and anticipated management if risks status changes. The possible referral centers that would be used if higher-level services are needed and transfer is safe should also be reviewed with the patient.
- c. If the primary OB provider cannot perform a cesarean birth, the physician will request a consultation with a provider who is privileged and willing to perform a cesarean birth at the time of admission.

V. Labor Management Procedure: Patients who meet all the selection criteria as outlined in section II who choose a VBAC trial of labor should be managed during Labor as follows:

Upon Admission to The Hospital For VBAC/Trial of Labor

- i. Review with the patient the risks/benefits of proceeding with the VBAC on admission.
- ii. Determine if the patient's risk level has changed, or patient choice has changed. This review will be documented in the medical record.
- iii. If the patient agrees to proceed with the VBAC, the nurse and physician will confirm that a signed VBAC consent form is present in the medical record. If not completed, the physician will complete a VBAC consent form with the patient prior to initiation of a trial of labor.
- iv. An anesthesia bedside evaluation will occur within 2 hours following admission and a note entered in the medical record.
- v. The VBAC clinician checklist will be completed prior to a trial of labor
- vi. The physician will complete and/or update the history and physical
- vii. The physician will complete admission orders to include:
 1. Lab/Blood Bank Preparation
 - a. Patient has been Typed and Screened with blood available on site.
 2. Continuous electronic fetal monitoring.
 - a. All patients attempting VBAC will have continuous electronic fetal monitoring (except for brief periods necessary for the provision of other appropriate medical or nursing care or in cases of fetal demise where only uterine activity monitoring is required).
 - b. The use of internal scalp electrodes and intrauterine pressure catheters is determined by the clinical judgment of the attending physician and labor nurse.

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- c. Labor progress will be closely monitored so that arrest disorders can be detected in timely fashion.
 3. Large bore IV (18 gauge or larger) to be started and maintained throughout labor and delivery
 4. If the primary obstetric provider is not credentialed to perform a cesarean birth, notify the consulted cesarean birth provider of the VBAC patient admission. **The physician who is credentialed to do a cesarean birth must be immediately available on-site if the attending is not credentialed to do surgery.**
 5. **In the event an In-house Obstetrician will be involved in the care or management of the VBAC patient they will:**
 - a. **Perform a bedside consultation**
 - b. **The in-house Obstetrician will communicate to the Nurse regarding their role in the care of the patient.**
 6. Notify the anesthesia provider of VBAC patient admission. The anesthesia provider must be on-site and immediately available during trial of labor.
 7. Notify the surgical team of admission and confirm plan is in place for cesarean birth
 - a. A surgical team including circulating nurse and scrub nurse or tech and anesthesiologist (or anesthesiologist authorized to initiate and monitor operative anesthesia) must also be immediately available and on-site from the time of patient's admission.
 - b. Assure operating room is immediately available
 - i.
 8. Notify pediatric/neonatal providers of VBAC patient admission
 9. Notify neonatal resuscitation team of VBAC patient admission
 - a. An infant resuscitation team comprised of NRP certified members with a designated team leader must be on-site and immediately available at bedside upon notification by the labor and delivery unit.
 - viii. **Note: Should any of the required individuals be called to other surgeries, cesarean births or become otherwise unavailable, back-up staff and physicians must be immediately available and identified.**
 - ix. Analgesia and anesthesia shall be mutually determined by the patient, attending physician and the anesthesia provider.
 - x. Birth may occur in an LDR suite/room unless maternal fetal condition warrants transfer to the cesarean birth suite or operating room.
 - xi. Medication Considerations:
 1. Use of oxytocin will be at the discretion of the physician and according to established Trinity Health protocol using the lowest dose possible to achieve labor progress.
 2. Prostaglandin agents are not to be used in patients attempting VBAC. They may be used after birth for uterine atony.
 - xii. Institution meets the following standards for care:
 1. NRP Guidelines for Neonatal and Pediatric Care
 2. AAP/ACOG Guidelines for Prenatal Care
 3. Joint Commission standards for Obstetrical Care
- VI. Documentation Requirements:**
- a. The Attending Physician will document in the medical record that he/she has obtained the informed consent including that risks and benefits are discussed and all patient's questions are answered and patient agrees to trial of labor.
 - b. The standard VBAC consent form for a trial of labor must be signed by the patient on admission before attempting a VBAC. The nurse will verify that the executed VBAC consent is in the medical record at admission.
 - c. If the consent has been signed more than 30 days prior to admission for the VBAC, the patient's desire to proceed must be assessed and the consent form re-validated by patient and physician signatures and date.

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- d. The attending physician will complete and sign the appropriate orders during the patient's hospitalization.
- e. The VBAC checklist will be completed and placed in the medical record prior to a trial of labor

VII. References:

- A. American Academy of Pediatrics & American College of Obstetricians and Gynecologists. (2007). *Guidelines for Perinatal Care* (6th ed.). Elk Grove Village, IL: Author.
- B. American College of Obstetricians and Gynecologists (1999). *Induction of labor*. (Practice Bulletin #10). Washington, DC: Author.
- C. American College of Obstetricians and Gynecologists. (1999). *Induction of labor with misoprostol*. (Committee Opinion #228). Washington, DC: Author.
- D. American College of Obstetricians and Gynecologists (2004). *Vaginal birth after previous cesarean delivery*. (Practice Bulletin #54). Washington, DC: Author.
- E. American College of Obstetricians and Gynecologists. (2006). *Induction of labor for vaginal birth after cesarean delivery*. (Committee Opinion #342). Washington DC: Author.
- F. Simpson, K.R. (2008) *Cervical ripening and induction and augmentation of labor*. (AWHONN Practice Monograph). Washington, D.C., Association of Women's Health Obstetric and Neonatal Nursing

DEVELOPED BY:

ORIGINAL DATE:

REVIEWED:

This policy has been taken from Trinity Vaginal Birth after Previous Cesarean Birth issued 5/18/2009

REVIEWED BY:

Medical Executive Committee 8/09

APPROVAL FOR IMPLEMENTATION BY: Mount Carmel St. Ann's Board of Trustees 10/09