Assisted Vaginal Delivery Documentation Sheet

Date: _____ Time: _____

Parity: _____ Gestational Age: _____

BMI: _____

Labour: Spontaneous onset / IOL / Augmented

Name and addressograph

Indications: _____

Location: Room / Theatre

Operator's name: _____ Grade: _____

Senior Obstetrician involved in decision making: Yes / No Name: _____ Grade: _____

Senior Obstetrician present for delivery: Yes / No Name: _____ Grade: _____

Anaesthetist present: Yes / No Name: _____ Grade: _____

Analgesia / Anaesthesia: Epidural top up / Spinal / GA / Pudendal / Local: _____

Examination Findings:

PA: ____ /5 palpable	Cervical dilatation: _____cm
Station:	Fetal position:
Caput: none / + / ++ / +++	Moulding: none / + / ++ / +++
Bladder catheterised: Yes / No	
Perineal warm compress: Yes / No	Perineal support: Yes / No

Type of delivery

Manual rotation: Yes / No

Ventouse: Posterior metal cup / Kiwi / Other _____

Number of pulls: _____ Duration of Cup application: _____mins

Cup detachment: Yes / No; If Yes; number of times: _____

Forceps: Traction / Lift out / Rotational : _____

Number of pulls: _____ Duration of forceps application: _____mins

Second instrument used: Yes / No

If Yes; which instrument: _____Number of pulls: _____

If CS, failure of instrumental to delivery time: _____

Initial decision to delivery time: _____

Any difficulty in delivering shoulders - No / Yes

If yes, please give details _____

✶**If Shoulder Dystocia confirmed please complete PROMPT Shoulder Dystocia proforma**

Time of delivery of baby: _____ **Time of cord clamping:** _____

If cord clamped at < 60 sec, please give indication: _____

Delivery of placenta: CCT / Manual

Perineal tear - 1º / 2º / 3º / 4º Labial tear: Y / N Episiotomy: Y / N

Vaginal Tear: Y / N

Repair:

Vagina _____ Muscle _____

Skin_____

PV: _____ PR: _____

Measured Blood loss: _____ mls.

Diagram

End of procedure swabs needles and instrument check:

Swabs: _____ Needles: _____ Instruments: _____

Signatures 1. _____

2. _____

Baby details at birth:

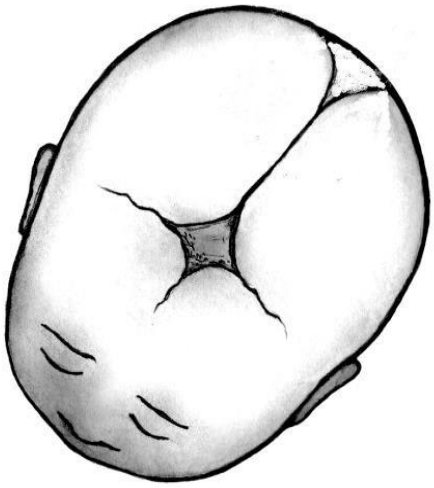
Cord blood: Arterial Venous

pH: _____ _____

BE: _____ _____

Apgars: ___[1]; ___[5]; ___[10]; Birth weight: _____

Admission to NNU: Yes / No



Indicate site of cup application and/or forceps marks etc. on diagram

Scalp abrasion / forceps mark/ facial abrasion / cuts /other :

Please describe:

Additional information:

Vaginal pack: Yes / No

If yes, to be removed after _____ hrs

Indwelling Catheter: Yes / No

If yes, to be removed after _____ hrs

Post- op instructions:

Antibiotics Given: **Cefuroxime 1.5g + Metronidazole 500mg / other:** _____

(To be given within 6 hours of delivery)

Thrombo-prophylaxis: **Post Natal VTE Risk Assessment: 0 / 1 / 2/ 3 / 4**

TEDS / LMWH for 10 days / 6 weeks

If 3rdº / 4thº tear, complete proforma ☐

Email to Suite 17 on SBU.OASIclinic@wales.nhs.uk

Signature:	**Print name:**

Maternity Services

Checklist for Clinical Guidelines being submitted for Approval

Title of Guideline:	Operative Vaginal Delivery
Name(s) of Author:	Labour Ward Forum
Chair of Group or Committee approving submission:	Labour Ward Forum
Brief outline giving reasons for document being submitted for ratification	Update existing policy
Details of persons included in consultation process:	Labour Ward Forum membership
Name of Pharmacist (mandatory if drugs involved):	Anne Willson
Issue / Version No:	6
Please list any policies/guidelines this document will supersede:	Operative Vaginal Delivery, 15th November 2018
Date approved by Group:	25th May 2022
Next Review / Guideline Expiry:	May 2025
Please indicate key words you wish to be linked to document	Instrumental, operative, forceps, ventouse
File Name: Used to locate where file is stores on hard drive	Z:\npt_fs2\Maternity Incidents Stats Etc\Policies\Ratified - Obs