Family Centered Cesarean Birth

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Objectives
Review History of Abdominal Delivery
Review Statistical Trends
What is Family Centered Cesarean Birth
Why?
How?

Ancient Abdominal Delivery: When?

2000 BC Mesopotamia cuneiform tablet
700 BC Roman Law
600 BC Hindu reference
508 BC Sicily infant survival
200 BC Talmud reference
50 BC Cesar delivered?
1500 AD Mother/baby survival

I have nothing to disclose.
Abdominal Delivery: Why?

700 BC Lex Regia -> 100 BC Lex Cesare
The law forbade burying a dead pregnant woman until her offspring had been excised from her body, so women dying in childbirth were to be cut open, for separate burials. Vain hope of saving the child.

1100 AD: Christian mandate - to save the soul of the child by Baptism and bury separately.

Inheritance law
The historical medical practice of CS virtually always resulted in a dead woman and a dead fetus.

NOT intended to save the life of the mother.

“Cesarean Section”

Latin: ‘Ceadare’ to cut ‘Caesones’ = person born by postmortem operation.

50 BC Lex Regia became Lex Cesare under Cesar.

‘Section’ introduced in 1598 by Jacques Guillimeau in his midwifery text: De l’heureux accouchement des femmes “The Happy Delivery of Women”

Francois Rousset (1530-1603)
Renaissance France
The first author to defy conventional medical wisdom and advise cesarean in the living woman, although almost 100% died.

“Always first ascertain that the child cannot be delivered in a simpler way”
“Verify that the patient is strong and shows no sign of imminent death”
“Use a bold stroke of the scalpel and emulate the decisive blow of the Alexander the Great’s sword as in severing the Gordian knot”
“All involved must pray”

1500s-1600s
Andreas Versalius: 1543
De Corporus Humani Fabrica

1700s Craniotomy less risky to mother than abdominal surgery
OB forceps largely replaced craniotomy, but of limited use.
**HISTORY: 1800s forces of change**

**RELIGIOUS INFLUENCE:**
- France: Roman Catholics pushed for removal of infant for baptism
- British Protestant Obstetricians considered the mother primarily, yet with CS morality at 50%, many women opted for craniotomy

**DEMOGRAPHIC CHANGE:** more women moved to cities, hospitals & CS

**MORE HOSPITALS:** and more abdominal operations, ie ovarian tumors

- Women were afraid CS would kill them; infected cadavers nearby
- Improved anatomical knowledge → but limited by patient’s pain and infection

Mid 1800s: over about 2 decades, the 2 most important advances in surgery

**ANTISEPSIS**

1850 Louis Pasteur: Germ Theory

**Joseph Lister:** antiseptic surgery, carbolic spray

- Concepts spread worldwide slowly

1880s: uterine closure popularized

Increased confidence: DON’T DELAY

**ANESTHESIA**

1846 first use of **ether**, to remove facial tumor

**Clergymen** deplored its use during childbirth as a being counter to the Almighty’s design, “women should sorrow to bring forth children in atonement for Eve’s sin”

**Older physicians** believed pain was a necessary evil, use of pain meds ‘was a needless luxury’

1853 **Queen Victoria** used chloroform for her 8th & 9th

**Use of ether gas was worldwide within 7 months**

1879 **Uganda Successful CS documented:** Mom & baby survived

- Banana wine to sedate 20 yo patient and to clean hands
- midline incision
- cauterise with hot iron
- massage uterus but not sutured
- pinned abdomen with iron needles
- dress wound with root paste
- recovered well

Queen Victoria 1819-1901
9 Deliveries 1841-1857
1928: Alexander Fleming discovers PCN.


Low Cervical CS: so less peritonitis and uterine rupture.

Now that Mom’s outcome had improved, looking to improve fetal status.

1950: Pediatrics advances

Every baby born in a modern hospital anywhere in the world is looked at first through the eyes of Dr. Virginia Apgar.

"women are liberated from the time they leave the womb.”

Maternal mortality:

We have come far, but progress still needs to be made.

Maternal Mortality Ratio per 100,000 live births

% births attended by skilled staff (2012)

Source: Gapminder Foundation 2015

Source: WHO, UN, World Bank

Trends in Maternal Mortality 2015
Now maternal deaths are regarded as a systems failure. Maternal death reviews are state based, but only 26 states have a well established process in place.

CMQCC.org  CA Maternal Quality Care Collaborative
Modeled on successful U.K. process
TOOLKITS for PIH, Hemorrhage, Reducing Primary CS, Early Elective Delivery
SOON: CV Disease, Maternal VTE

A bipartisan bill in Congress, the Preventing Maternal Deaths Act of 2017, would authorize funding for states to establish review panels or improve their processes.

U.S. neonatal mortality is at lowest point in history.

U.S. Maternal Mortality on the Rise -- Except in CA
Now maternal deaths are regarded as a systems failure
Maternal death reviews are state based, but only 26 states have a well established process in place

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Population access to CS improves maternal and neonatal mortality -- up to a point

SWEET SPOT:
- Netherlands
- Kuwait
- United Arab Emirates

Highest CS:
Brazil 80%
Chile Iran

Quantity of CS
USA 2010:
about 4 million births
32% Cesarean Section
1.2 million CS in US
---> about 137 per hour

How many are scheduled CS?:
Kaiser Permanente SF 25-30%  Z-SFG 42%  OHSU 25-35%
Maternal request =1% perhaps a different subset emotionally
We do A LOT of CS  Let’s look for missed opportunities
At CS, if the baby is VIGOROUS and the mom is alert and coping:

A. We hand baby immediately to mom with the cord still attached
B. We drop the surgical drape so Mom can see baby immediately
C. We use a clear surgical drape so Mom can see baby
D. We keep the drape in place, and she sees baby later

My partner or I had one or more Cesarean Sections:

A. The baby was handed to me with the cord still attached
B. They dropped the surgical drape so I saw the baby immediately
C. They used a clear surgical drape
D. The drape stayed up, I saw baby later

*** WHAT IS A ‘FAMILY CENTERED CESAREAN’? ***
Safety is the number one priority.
PATIENT/FAMILY EXPERIENCE is the second priority.
Preparation and Education of patient and partner.
****Continuous Maternal support ****
Decrease noise in the OR, minimal extraneous OR conversation
View Delivery - elevate Mom’s head, ‘drop the drape’ or clear drape
Early Skin-to-Skin - a free arm, careful placement of EKG, BP cuff, pulse ox
Keep Mom & Baby together - STS, poss breastfeed in OR, move dyad to RR
Honor the Sacred Hour

Thank you to Raylene Phillips MD Pediatrics, Loma Linda University Children’s Hospital

Why “The Sacred Hour?”
- Every culture has ceremonies for special events that are considered “sacred” for that culture.
  - Highly valued as important; deserving great respect
  - Weddings, baptisms, rights of passage
- No one would presume to interrupt a wedding ceremony for routine business.
  - The first hour after birth is one of those sacred times that should be honored, protected and cherished.
Collaboration in Practice
Implementing Team-Based Care

Report of the American College of Obstetricians and Gynecologists
Task Force on Collaborative Practice March 2016

Patient and family advisory councils can help develop policies and approaches that more globally affect all patients and families, creating an environment in which health care providers, patients, and families work together as partners to improve the quality and safety of care.

Why address this initiative when ‘outcomes’ are so good?
Listen to Women ! --> lack of choice, illusion of choice, fear, emotional rollercoaster, failure, disappointment not feeling like myself, emotional recovery, picture in my mind, dependency

NEEDED: -> Improve policies to decrease Mother-Infant separation during CS
-> Education for Mother and Partner
-> Decrease fears
-> Help create realistic expectations


RESULTS:
- Birth experiences were rated significantly higher
- No Sign. diff in APGAR or need for NICU admission
- No diff blood loss
- Higher rates of Breastfeeding
- Pts perceived better care from all staff
>95% with prev ‘traditional’ CS prefer this technique
- Less disappointment
- More security
- No mention of infection problems

PHILOSOPHY TALK

• Can we make CS a better experience for the mom baby partner family? DEFINITELY
• Is skin to skin a valuable technique? OBVIOUSLY
• Should we engage with patients about what we are doing, what they want? OF COURSE
• Is increasing patient involvement and satisfaction and teamwork improving quality? ABSOLUTELY
WHY DO SKIN-TO-SKIN IMMEDIATELY AFTER BIRTH?

IT IS EVIDENCE BASED !!

Babies are warmer after birth
Babies are much calmer and cry less
Babies breathe easier, have more normal heart rates
Mothers have higher levels of relaxation hormones
Mothers and babies get to know each other sooner
Mothers and babies are more successful with breastfeeding and breastfeed longer

**JCAHO Perinatal Care Measure 5
EXCLUSIVE BREAST MILK FEEDING**

Skin to skin contact is often interrupted before the first breastfeeding!

Don’t interrupt STS before first breastfeeding!!!

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What is your current opinion?

A. Birth preference documents interrupt my care
B. Birth preference documents help guide education and information sharing

91%
9%

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Please reference:
Protocol
Birth Preferences List
CS Preferences List
WHY BIRTH PREFERENCES LIST?

WHY?
- Everyone loves checklists !!!
- Keeps patient ideas organized
- Excellent discussion tool at visits

Normalize basic requests & Avoid common misunderstandings
- “My baby was given formula, no one asked me”
- “They keep asking me the same things...about bath, HepB, ...”

HOW?
- review with provider at visits, scan to chart , bring to delivery & tape to wall, update white board in DR and in PP room, and then put in basonnece
**Continuous Patient Support**

**Doc ‘A’**: primary surgeon  
Stays with pt and ‘A’ RN  
**Patient Whisperer**  
Announce timing, Alert anesthesia  
Accompany to OR  
Activate Briefing & Timeout in OR  

**Doc ‘B’**:  
goes right to OR  
Briefing board update  
Body tasks: assist ‘B’ RN:  
move pt, ground, foley, etc
Birth Center OR TimeOut EXTRAS
Partner=_________ 2nd=________
Antacids given?
Review Hematocrit
Verify Anesthetic plan
Verify DVT Prophylaxis
Equip: vacuum, special retractor, cell saver, IUD
Mag running for Neuroprotect Y N
Mag running for PreE Y N
Cord gas Y N
Delayed Cord Clamping Y N
Cord blood donation Y N
Skin-to-skin Y N
Send/Keep Placenta?
Specimens for research?

Continuous Patient Support
Why? FEAR

POWER DYNAMICS
– sit if you can

SOUNDS and ODORS

SHAKING

HER SPIRIT

LOOK AT SCREEN for some patient photos and videos
OR set up     Be aware of cords

Please allow partner and 2nd support person in OR
Let's care for the staff
It's HOT in there!

What Mom sees… Just this?

What is she thinking?

“Does my baby look normal?”

“What’s wrong right now?”

“Is it dead?”

“Why is no one telling me or showing me?”
Drop the drape ... and really show baby .... 60sec

Ideally:
face to face

Up and Over
Possible partner cut the cord

Humpty

Ideally:
face to face
Pass thru
Touch and regown with extra half sheet

36&6 wk planned CS
PARTIAL ACCRETA
COOK BALLOON ON MOM ENTIRE FIRST HOUR

MOM HOLD
Three Important TEAM exchanges in the OR:

**Baby out:** OB → ANESTH:
“Baby is vigorous, please drop the drape”  “60sec”

**Baby at warmer:** PEDS → RN:
“Please bring partner to the warmer to see baby”

**Anesth → PEDS:**
“Mom is doing great and is ready for skin-to-skin”
Cut cord long, partner can trim later
Consider gas, donation

Prize-winning photo by Christian Berthelot

Three Important TEAM exchanges in the OR:

Baby out: OB → ANESTH:
“Baby is vigorous, please drop the drape”

Baby at warmer: PEDS → RN:
“Please bring partner to the warmer to see baby”

Anesth → PEDS:
“Mom is doing great and is ready for skin-to-skin”

In the OR, if mom is ready and baby had a normal brief exam:

A. We bring baby back to mom bundled in a blanket
B. We bring baby back to mom for skin-to-skin time
Three Important TEAM exchanges in the OR:

Baby out: OB → ANESTH:
“Baby is vigorous, please drop the drape”

Baby at warmer: PEDS → RN:
“Please bring partner to the warmer to see baby”

Anesth → PEDS:
“Mom is doing great and is ready for skin-to skin”

VIDEO receive baby 48 sec
DURING SKIN-to-SKIN:

Observe dyad → WHO?

Keep baby nares visible

‘Slow slide’

May need repositioning
Uninterrupted Skin-to-Skin Contact Immediately after Birth
(for the stable baby and mother)
- Is endorsed by multiple organizations
- Is safer for both baby and mother
- Has multiple short- and long-term beneficial effects
  - Physiologic stability
  - Structural and functional brain development
  - Psychological and emotional wellbeing

Anesthesiologists
- Mothers’ vital signs are usually more stable
  - Temperature
  - Blood pressure
  - Oxygen saturations
- Mothers requires less medication
  - Focused on baby – not surgery
  - Reduced pain and anxiety

"Thank you for bringing the baby to mother so soon after birth. It makes my job so much easier." Anesthesiologist

Breastfeeding after Cesarean Delivery
A Systematic Review & Meta-analysis of World Literature
- Cesarean delivery is associated with lower rates of breastfeeding initiation.
- However, those who successfully initiate breastfeeding after cesarean delivery are as likely to practice exclusive breastfeeding at 6 months as mothers who give birth via vaginal delivery.

Effects of only 15 minutes of Skin-To-Skin Contact in the OR
San Francisco General Hospital: Intervention to provide 15 minutes of STS in the OR

Figure 2. Comparison of Skin-to-Skin Contact Rates After Cesarean Birth

The rate of skin-to-skin contact within 1.5 hours increased from 20% to 68%
Optimizing Support for Breastfeeding as Part of Obstetric Practice

Cesarean birth is associated with lower breastfeeding rates, and women who undergo cesarean delivery may need extra support to establish and sustain breastfeeding. Skin-to-skin contact is feasible in the operating room and is associated with reduced need for formula supplementation.

**Education of Staff**

"Skin to Skin in the First Hour After Birth: Practical Advice for Staff After Vaginal and Cesarean Birth"

Kajsa Brimdyr, PhD, CLC
Healthy Children Project
327 Quaker Meeting House Rd
East Sandwich, MA 02537
Phone: (508) 888 8044
www.healthychildren.cc

**Educating Parents**

- **DVD**
  - "The Magical Hour: Holding Your Baby Skin to Skin in the First Hour after Birth"
  - Birthing and Breastfeeding classes
  - During early inductions & after epidurals
  - Before scheduled cesarean deliveries

- **Handout**
  - "A Baby’s 9 Instinctive Stages"

$5 poster

google: The Magical Hour
Make your own CS photo book
ERAS  Enhanced Recovery after Surgery

ACOG  Committee on Gynecologic Practice:
→ New Committee Opinion COMING :

Perioperative Pathways / Enhanced Recovery after Surgery
POSTPARTUM DEBRIEF

TO DO : review delivery and hospital care, review prenatal care, LISTEN
DO depression screen and offer resources to ALL women
ASK : How can we improve care FOR YOU?

Postpartum debrief ‘just another new mother?’

MOST IMPORTANT: --> communication and compassion, listening
--> evaluate from the woman’s perspective
A woman’s perception of the delivery may differ from the actual outcome
Her perception determines whether the birth was traumatic or gratifying
First time mother’s experience is especially important
Anxiety and satisfaction are inversely related
Anxiety and recovery are inversely related

IT WAS REALLY GOOD

I feel so much , so much better
PAIN GOES AWAY
Everything goes away
JUST WANT TO HOLD THE BABY
That’s all , yeah

Thank you so much for the great care , being so supportive during a scary time ! I loved
your stories , hearing about your daughters & listening to停牌 sex.
Thanks for being an awesome doc !
Waves often come in sets of THREE
Evidence Based Modern Surgical Techniques and Safety
ERAS ‘before and after’ surgical prep and recovery optimization
FCCB addresses HER SPIRIT and baby bonding

Missed Opportunities??
Scheduled Cesarean Birth Preferences

NAME _______________________ Partner_________________ and __________________

IMPORTANT INFO about us (ie medical history, previous birth, feelings, culture, breast feeding choice, fears):

We are trying to make a cesarean delivery as special and intimate as possible. We hope for skin-to-skin contact, and to respect the sacred hour. We understand that our primary goal is the safety of both mother and baby, and that our preferences may not always be realized.

Before the operating room:

- Please introduce yourself to us so that we are familiar with you.
- Please explain procedures and medications.
- We may want to take photos and video, but understand that the staff must be comfortable with this.
- We aim for immediate and extended skin-to-skin contact.
- I would like to wear a soft stretchy band from the hospital (belly band) instead of bra - to help support baby on my chest for skin-to-skin in the OR.
- I would like to bring a second support person into the OR, especially if my baby and partner go to the nursery
- I understand that sometimes general anesthesia is necessary. If it is, I would like my partner to be as close as possible, and to have skin to skin contact with our baby as soon as possible.

In the operating room:

- We understand there will be a “Time Out” before the surgery to review important issues about our care.
- Please keep all other talk to a minimum, and use quiet voices whenever possible.
- Please allow us to play music for comfort.
- Please place monitors as discreetly and safely as possible, and please do not strap my arms down.
- Please allow my partner or a staff member to be at my side at all times for my comfort and reassurance.
- Please raise the head of the OR bed at birth time, if possible. I would like to push to assist with the delivery.
- If my baby is vigorous, please drop the drape so I can see my baby right away for about 30 seconds or more of cord pulsing. I understand my baby will be handed to the pediatrician next.
- Please reassure me and my partner about baby status if we cannot see and hear our baby.
- My partner would like to come to the baby bed as soon as possible, and to trim the umbilical cord.
- When my baby is stable, please bring her back for skin-to-skin time. I hope to have my arms free to hold her.
- If I do not feel well, please allow my partner to hold my baby.
- I understand my baby may cry, rest, look around, and breastfeed during these first 30 minutes or so in the OR.
- Please defer ID bands and baby weight until we leave the operating room, and all meds until later.
- Please allow our baby to stay with us and not go to the nursery, unless special nursery care is necessary.
- If our baby needs to go to the nursery for medical reasons, please allow my partner to accompany, and bring our second support person into the OR to comfort Mom.
TIPS about the operating room for my partner, from the hospital staff:

- Emotional support for Mom is a priority in this unfamiliar environment.
- Remember that the OR is a busy place and we are working for your safety.
- Please try to not interrupt staff doing their jobs, unless necessary. Staff will be talking and explaining things.
- Move slowly and carefully in the OR, as there are cords and many items in the OR.
- Let us know right away if you feel weak or faint.
- For Mom’s comfort: sitting with, touching and talking to Mom, reassurances, and keeping her from focusing on OR noises and activity are very important. Small talk with her is great.
- You may take photos and video at the birth. We may ask you to stop filming if it is distracting to the staff. If the baby comes back to Mom for skin-to-skin, please put your phone away so that you have both hands to help.

At the delivery:

- I DO / DO NOT want to see my baby immediately as she emerges. Please raise the head of the bed if possible.
- My partner __________________________ would like to announce the sex of the baby.
- We DO/ DO NOT want to donate our cord blood.
- We DO/ DO NOT want you to show us our placenta and allow us to take pictures.
- We DO / DO NOT want to take our placenta home.
- I understand that my baby may be placed in a bassinet while moving us back to our room.
  I would like to hold her on my chest if possible during this move.

AFTER THE BIRTH
I request that any accepted procedure be delayed for the first hour after birth AND after breastfeeding both sides
Please give any injections while baby is on the nipple, for baby’s comfort.
  - Erythromycin eye ointment Yes No (consent to be signed)
  - Vitamin K injection Yes No (consent to be signed)
  - Hepatitis B vaccine Yes No (consent to be signed)
  - Weigh and measure the baby and place ID bands after the first hour if possible

POSTPARTUM
  - I plan to breastfeed. Please do not offer a pacifier or formula.
  - Baby bath: Please DO NOT bathe our baby. Please DO help us bathe our baby on the second day of life.
  - We DO NOT want a circumcision.
  - We DO want a circumcision and we request EMLA cream 60 min prior to the procedure, a penile block 10 minutes prior to the procedure, and for my partner to be present to support baby with pacifier and sugar water.
  - I would like to see a lactation consultant.
  - We will prioritize keeping our baby naked and diapered on Mom’s skin to promote breastfeeding.
  - Please support us to manage our visitors so we can rest, breastfeed on demand, and continue skin to skin contact.
  - Please discuss the option of going home after 2 nights with us, but we understand it may be 3 nights.
  - We want to follow the “Enhanced Recovery after Surgery” concepts for pain control, diet, activity, and wound care.

DISCHARGE PLANNING
Mom and baby first appointment is scheduled for ______________________________
Baby’s 2 week pediatric appointment is scheduled for ______________________________
Mom’s Postpartum appointments:
  - possible early postpartum appointment for blood pressure check or other issue
  - 3-6 week appointment (may include IUD or birth control implant)

IMPORTANT CONTACT INFORMATION
LACTATION support: _____/_____-_______ BABY question: _____/_____-_______ MOM question: _____/_____-_______
We appreciate any information regarding: Maternal support groups, classes, anxiety/depression resources
We appreciate any advice regarding my plans for: baby care, self-care, transitioning home
**Family Centered Cesarean Section**

<table>
<thead>
<tr>
<th>Mother may have 1-2 support people in the OR (ie partner &amp; grandma/doula)</th>
<th>RN</th>
<th>OB</th>
<th>Ped</th>
<th>Anes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Mother may choose music to be played in the OR</th>
<th>X</th>
<th></th>
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<table>
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<tr>
<th>Double drape (with clear window) used</th>
<th>X</th>
<th></th>
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<tr>
<th>Anesthesia places ECG leads away from mother’s chest, and IV &amp; BP cuff on non-dominant arm</th>
<th></th>
<th>X</th>
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</table>

<table>
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<tr>
<th>Keep mother's chest warm in anticipation of skin-to-skin with instant hot pack, or Forced Air Warming Unit or warm blanket</th>
<th>X</th>
<th>X</th>
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</thead>
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<table>
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<tr>
<th>Elevate head of bed, to facilitate viewing the birth &amp; more comfortable skin-to-skin</th>
<th>X</th>
<th>X</th>
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<tr>
<th>After delivery of the head, OB delivers body slowly</th>
<th>X</th>
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<table>
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<tr>
<th>After delivery of the head, if vigorous baby, drape is dropped if parents desire to see the birth</th>
<th>X</th>
<th>X</th>
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<tr>
<th>Consider delayed cord clamping for 30 or more seconds, while baby in face down drainage position - seeing Mom</th>
<th>X</th>
<th>X</th>
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<tr>
<th>Pediatricians receive the baby as usual; 1minAPGAR on warmer; goal to be back to mom by 5 minutes for skin-to-skin; baby positioned transverse with nares visible</th>
<th>X</th>
<th>X</th>
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<table>
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<tr>
<th>At end of surgery, while drapes are removed &amp; mother is cleaned Partner may help with weighing baby and observe other routine care</th>
<th>X</th>
<th></th>
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<tr>
<th>Once mother is on the recovery bed, baby placed skin-to-skin again and the dyad are transported together to recovery</th>
<th>X</th>
<th>X</th>
<th>X</th>
</tr>
</thead>
</table>

**Contraindications**

- Prematurity
- Emergency cesarean (although if baby vigorous, team may adapt some features)
- Anticipated resuscitation (ex: fetal anomalies, anticipate low Apgar score)

Of course, aspects of this protocol may be inappropriate in some situations, and clinical judgment should always take precedence
- with vasa previa, slow delivery of body inadvisable
- weigh immediately if infant appears >4000g or <2300 g or if mother requests
- always defer to parents’ preferences regarding viewing the birth, or initiating skin-to-skin in the OR
- elevating the head of the bed may impact surgical visualization in an obese patient
- transport with baby on mom’s chest not appropriate if she is not alert, comfortable, or strong enough to hold infant
- insufficient nursing staff to remain with baby in OR
Birth Preferences

Name__________________________ Partner_________________ other support people__________________________________

IMPORTANT INFO about us (ie medical history, previous birth, feelings, culture, breast feeding choice, fears):

INTRODUCTION
We look forward to a wonderful, loving birth. We realize that flexibility and a willingness to accept change is important as labor is often unpredictable. If intervention seems advised, we would like to be informed and to have the opportunity to discuss the options with each other, our doctors, and our labor team before making any decisions.

We prefer to use the decision making aid “BRAIN”- What are the BENEFITS? What are the RISKS? What are the ALTERNATIVES? What does my INTUITION tell me? Do we need to do this NOW?

We will bring our labor support reference materials with us.

FIRST STAGE LABOR I request:
- To be mobile as much as possible, as I will focus on breathing and moving to help cope with labor
- Intermittent monitoring if possible, or wireless telemetry if continuous monitoring is necessary
- Minimal vaginal exams
- Encouragement to use non-pharmacological pain management: walking, movement, acupressure, breathing, visualization/relaxation, use of tub or shower (please show us where these are on admission)
  - Please DO/DO NOT offer me pain medication.
- To avoid a saline lock unless it is necessary. Please offer ice chips and juice.
- A quiet room with low or natural lights, and please keep staff conversation at a low level
- To play our own music and use aromatherapy

SECOND STAGE LABOR I request:
- To determine my own positions for pushing, but I welcome suggestions!
- To allow time to push instinctively, waiting for my own urge to push
- Access to use a mirror
- Help to support a slow crown along with perineal support, warm compresses, mineral oil, verbal guidance
- A quiet room at birth time, so our baby hears only our voices
- Help with a “hands-on delivery” so that I can help deliver my own baby or my partner can help deliver my baby
- Our baby be placed on my chest immediately at birth and to allow us to announce the sex of our baby
- That our baby be dried and/or stimulated on my chest if possible, and to avoid routine bulb suctioning of our baby
- Delayed cord clamping, and to feel the pulsing cord.
- For my partner to be offered the opportunity to cut the cord
- We ARE/ARE NOT donating cord blood
- To experience the sacred hour and delay: ID bands, weight and other procedure until after the first hour and initial breastfeeding
- Low lights in the delivery room, so the baby can open his or her eyes easily
- No baby hat
- PREFER or DEFER post-delivery Pitocin, uterine massage, and cord traction. Please discuss concerns with us.
- Please wait at least 10 minutes to address perineal tears. I would appreciate under-the-knee leg supports
- I DO/DO NOT want to see the placenta and take photos
- I DO/DO NOT want to take the placenta home (We will remove the placenta from the hospital within 2 hours of delivery)

AFTER THE BIRTH
I request that any accepted procedure be delayed for the first hour after birth AND after breastfeeding

Please give any injections while baby is on the nipple, for baby’s comfort.

  o Erythromycin eye ointment Yes No (consent to be signed)
  o Vitamin K injection Yes No (consent to be signed)
  o Hepatitis B vaccine Yes No (consent to be signed)

  o Weigh and measure the baby and place ID bands after the first hour if possible
IF CESAREAN BECOMES NECESSARY, we hope for a Family Centered Cesarean Birth, but are aware of ‘safety first’
- To have a staff member or partner at Mom’s side at all times to comfort her.
- To have my partner and birth assistant both in the operating room with me.
- Quiet or low voices from the staff in the operating room.
- Monitors to be placed away from the front of the chest, and to have my arms unstrapped.
- Please raise the head of the OR bed at birth time, if possible. I would like to push to assist with the delivery.
- **If my baby is vigorous, please drop the drape** so I can see my baby right away for 30 or more seconds of cord pulsing.
- Please reassure me and my partner about baby status if we cannot see and hear our baby.
- My partner would like to come to the baby bed as soon as possible, and to trim the umbilical cord.
- When my baby is stable, please bring her back for skin-to-skin time. I hope to have my arms free to hold her.
- If I don't feel well, please allow my partner to hold my baby.
- I understand my baby may cry, rest, look around, and breastfeed during these first 30 minutes or so in the OR.
- Please defer ID bands and baby weight until we leave the operating room, and all meds until later.
- Please allow our baby to stay with us and not go to the nursery, unless special nursery care is needed.
- Allow my second support person into the OR, especially if my baby and partner go to the nursery.
- I understand that sometimes general anesthesia is necessary. If it is, I would like my partner to be as close as possible, and have skin to skin contact with our baby as soon as possible.

**TIPS about the operating room for your partner, from the hospital staff:**
- Remember that the OR is a busy place and we are working for your safety.
- Please try to not interrupt staff doing their jobs, unless necessary. Staff will be talking and explaining things.
- Move slowly and carefully, as there are cords and many items in the OR.
  - Let us know right away if you feel weak or faint.
  - For MOM’s comfort: sitting with, touching and talking to Mom, reassurances, and keeping her from focusing on OR noises and activity is very important. Small talk with her is great.
  - You may take photos and video at the birth. We may ask you to stop filming if it is distracting to the staff. If the baby comes back to MOM for skin-to-skin, please put your phone away so that you have both hands to help.

**POSTPARTUM**
- I plan to breastfeed. Please do not offer a pacifier or formula.
- Baby bath: Please DO NOT bathe our baby. Please DO help us bathe our baby on the second day of life.
- We DO NOT want a circumcision.
- We DO want a circumcision and we request EMLA cream 60 min prior to the procedure, a penile block 10 minutes prior to the procedure, and for my partner to be present to support baby with pacifier and sugar water.
- I request to see a lactation consultant.
- We will prioritize keeping our baby naked and diapered on Mom’s skin to promote breastfeeding.
- Please support us to manage our visitors so we can rest, breastfeed on demand and continue skin to skin contact.
- We understand we may go home after 1-2 nights after a vaginal delivery.
- If cesarean, we hope to follow the ‘Early Recovery after Surgery’ concepts for pain control, diet, activity, and wound care. Please discuss with us the option of going home after 2 nights, but understand it may be 3 nights.

**DISCHARGE PLANNING**
Mom and baby first appointment is scheduled for _______________________________

Baby’s 2 week pediatric appointment is scheduled for _______________________________

Mom’s Postpartum appointments:
- possible early postpartum appointment for blood pressure check or other issue
- 3-6 week appointment (may include IUD or birth control implant)

**IMPORTANT CONTACT INFORMATION**
LACTATION support: ____/____-______ BABY question: ____/____-______ MOM question: ____/____-______

We appreciate any information regarding: Maternal support groups, classes, anxiety/depression resources
We appreciate any advice regarding my plans for: baby care, self-care, transitioning home