**POLICY**

The Obstetrician applies forceps to assist with vaginal delivery, as indicated (2.0).

**Family Practice Physician/ Midwife**
Consult an Obstetrician when forcep use is indicated (2.0).
- Family Practice physicians competent in the use of forceps may apply forceps in an emergent situation when an obstetrician is not available. All forceps applications by family practice will be reviewed by multidisciplinary committee.

Instrument-Assisted delivery occurs in the following rooms:

<table>
<thead>
<tr>
<th>Single Room Maternity Care</th>
<th>Delivery Suite</th>
<th>Operating Room (OR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outlet forceps</td>
<td>Outlet forceps</td>
<td>Trial of forceps</td>
</tr>
<tr>
<td>Low forceps</td>
<td>Low forceps</td>
<td>Rotational forceps</td>
</tr>
<tr>
<td></td>
<td>Mid forceps</td>
<td>Physician Choice</td>
</tr>
<tr>
<td></td>
<td>Rotational forceps, in emergent situations only</td>
<td></td>
</tr>
</tbody>
</table>

**Applicability:** Forceps application for assisted vaginal delivery occurs in the Birthing area of the Acute Perinatal Program.

**PROCEDURE**

**Physician Guidelines**

1.1 **Indications for Forceps Use**
- Evidence of fetal compromise requiring prompt delivery.
- Failure to progress despite adequate uterine activity.
- Maternal fatigue/exhaustion.
- Maternal medical conditions (for example: cerebral vascular disease, cardiac conditions, myasthenia gravis, spinal cord injury).

1.2 **Contraindications for Forceps Use**

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Fetal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical dilatation is incomplete</td>
<td>▪ Clinical evidence of cephalopelvic disproportion (excessive caput, overlapping sutures, inappropriate station)</td>
</tr>
<tr>
<td></td>
<td>▪ Fetal bleeding disorder and/or predisposition to fracture (for example: alloimmune thrombocytopenia, osteogenesis imperfecta)</td>
</tr>
<tr>
<td></td>
<td>▪ Fetal head is higher than 0 station, with the exception of a second twin</td>
</tr>
<tr>
<td></td>
<td>▪ Mentum Posterior</td>
</tr>
</tbody>
</table>

1.3 **Prerequisites for Forceps Use**

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Fetal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvis is adequate for vaginal delivery</td>
<td>Head is fully engaged</td>
</tr>
<tr>
<td>Fully dilated cervix</td>
<td>Exact position and station of fetal head is known</td>
</tr>
<tr>
<td>Membranes are ruptured</td>
<td>Vertex presentation is at 0 station or lower (true station)</td>
</tr>
</tbody>
</table>

1.4 **Physician Assessment and Consent**
Assess fetal presentation, position in the pelvis and confirm full dilatation of the cervix.
- Explain the need for forceps use to the woman and her support person. Identify alternatives, risks, benefits and complications.
- Obtain verbal informed consent from the woman (trial of forceps - obtain written consent). Document in Physician's History and Progress notes.
1.5 Physician Preparation
Anticipate and plan for potential complications (shoulder dystocia, postpartum hemorrhage, or failed forcep delivery).

- When the decision is made to use forceps, the woman does not have any further oral intake (NPO).

Ensure the following preparation is complete:

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Organize</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Current complete blood count (CBC) and group and screen, when indicated</td>
<td>▪ Notify Charge Nurse</td>
</tr>
<tr>
<td>▪ Obtain informed consent</td>
<td>▪ Back - up plan with facilities and personnel available for possible Cesarean section and neonatal resuscitation</td>
</tr>
<tr>
<td>▪ Check an intravenous is established</td>
<td>▪ Consult Pediatrics to be present at delivery</td>
</tr>
<tr>
<td>▪ Specify the forceps required (solid Simpson, Kielland, Tucker-McLean)</td>
<td>▪ Check Anesthesiologist is consulted and available for delivery</td>
</tr>
<tr>
<td>▪ Check the bladder is empty (remove indwelling catheters)</td>
<td></td>
</tr>
</tbody>
</table>

1.6 Physician – Procedure Discontinued
Discontinue procedure when there is failure to deliver the fetus within a reasonable time.

1.7 Physician - Post Procedure Care
- Following forceps assisted delivery, collect cord blood gases.
- Postpartum - consider the following care:
  - Indwelling catheter for 12 hours to prevent urinary retention.
  - Regular analgesia, such as acetaminophen and naproxen administration.
- Prior to the woman’s discharge, review the delivery with her and discuss the impact of the delivery on future pregnancies. Document discussion in the health record.

1.8 Registered Nurse - Preparation and Procedure
Prior to and during the procedure closely monitor fetal health according to Intrapartum Electronic Fetal Monitoring policy.

Add the following equipment to the delivery set-up:

- Goggles (non-sterile)
- In/ out catheter - #12 or 14 French
- Obstetric forceps, as requested
- Sterile drapes
- Sterile gown(s) as needed
- Sterile lubricant
- Stirrups

For trial of forceps:

- Obtain written consent for trial of forceps/ Cesarean section
- Collect stamped OR papers (include OR checklist)
- Transfer woman to OR

When woman is transferred to the Operating Room from:

<table>
<thead>
<tr>
<th>Single Room Maternity Care</th>
<th>Delivery Suite</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Use the delivery cart set-up in the OR area</td>
<td>▪ Bring the delivery cart set-up</td>
</tr>
</tbody>
</table>

Confirm physician’s orders for oxytocin infusion, and retain oxytocin solution on infusion pump (see Labour Induction policy).

Prior to the forceps delivery, assist with the preparation steps outlined in 1.5 and:

1) Position the woman in the lithotomy position wedged to the left.
2) Place legs in stirrups simultaneously.
3) Remove the lower half of the bed and raise bed height.
4) Remove indwelling catheter when present.
5) Clean the woman’s perineum.
6) Prepare for cord blood gas collection.
7) Palpate the uterus for contractions and alert physician.

Document time forceps applied and removed (include rotation of forceps, if used).

1.9 Post Procedure
Collect the cord blood gases and send to the lab.
- Check physician’s orders for analgesia and indwelling catheter.
- Examine the newborn’s face and scalp (Pediatrician)

DOCUMENTATION
- Fetal Heart Tracing and Label
- Interprofessional Progress Notes
- Labour and Birth Summary Record
- Labour Partogram
- Newborn Clinical Path
- Newborn Record, Part 1
- Operating Room paper bundle
- Physician’s History and Progress Notes

REFERENCES


Intrapartum Electronic Fetal Monitoring CF0500

Labour Induction: Administration of Oxytocin: Cervical Ripening: Administration of Cervidil®, Prostaglandin E2 or by Foley Catheter CL0600


Royal College of Obstetricians and Gynaecologists. Operative Vaginal Delivery Guideline No. 26 (2nd ed.)(2005, October). RCOG.