SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

Applies To: All ObGyn
Department: Obstetrics and Gynecology
Revised: April 2019
Effective Date: 12/18/2015

Title: **UNM Gentle Cesarean Delivery: Pilot Guideline**				**Policy**	
Patient Age Group:	(X) N/A	( ) All Ages	( ) Newborns	( ) Pediatric	( ) Adult

BACKGROUND:

- Traditional separation in the initial moments of life in a cesarean delivery can impact maternal-infant bonding and breastfeeding initiation and duration as compared to vaginal delivery
- Early skin-to-skin contact at cesarean delivery improves neonatal thermoregulation
- Early skin-to-skin contact and initiation of latch improves success and duration of breastfeeding in vaginal deliveries
- Many L+D units around the country have safely adopted family-centered practices to improve the experience of women having a cesarean section
- Neonatal and maternal outcomes from family-centered approaches are similar to traditional care
- Limited studies and recommendations support that it is not mandatory to have a pediatrician present at all cesarean deliveries
- The rate of transient tachypnea of the newborn is 3.1% in scheduled repeat cesarean delivery and 1.1% in vaginal delivery

DEFINITION:

Gentle Cesarean delivery is a name for a constellation of interventions designed to promote breastfeeding, mother-infant bonding and to enhance the experience of the woman who desires a more natural de-medicalized birth, one that would more closely approximate that of vaginal delivery. The following components may be considered for and by patients desiring Gentle C/S.

- Ambience changes (dim lighting, music)
- Limitations on the presence of nonessential personnel from the operating room
- Operating room presence of doula or adult family member in addition to partner for support role including helping baby latch on
- View baby being delivered from the abdomen (clear drape)
- View baby immediately after delivery from the abdomen (drop the drape)
- Delayed cord clamping as per routine care (In addition to benefits noted at vaginal delivery this facilitates the mother seeing the baby and allows time for decision if baby can go directly skin to skin or to NICU team)
- Skin-to-skin (after delayed cord clamping)

ELIGIBILITY:

Eligibility criteria specifically for skin-to-skin

Arguably the most logistically complex component of Gentle C/S is skin-to-skin as it necessitates coordination with Pediatrics, Anesthesia, Obstetric surgeons and Nursing. The following are required for skin-to-skin:

- Scheduled repeat cesarean at term (38 0/7 to 41 6/7 weeks ega)
- Scheduled primary cesarean at term (38 0/7 to 416/7)for malpresentation or maternal medical indications not affecting fetal status (i.e. Hx of fourth degree laceration, active genital HSV with intact membranes and not in labor, maternal cardiac or orthopedic conditions)
- Primary or repeat cesarean at term for stage 1 or 2 arrest in labor with no fetal concerns on monitoring and no evidence of chorioamionitis
- Planned scheduled repeat cesarean section, presenting in labor
- Regional anesthesia only (epidural or spinal)

Exclusion criteria*

- Prematurity/postterm (Limited to 38 0/7- to 41 6/7)
- Non-reassuring fetal status
- Non-reassuring maternal status (i.e., suspected abruption, uterine rupture, preeclampsia with severe features/eclampsia, placenta previa)
- General anesthesia
- For BMI> 45, delivering physician should assess body habitus with regard to ability to place and assess infant before offering "gentle C/S"

PROCEDURE:

Procedure for deciding on and implementing components of Gentle C/S

1. Obstetric provider discusses options for components of Gentle C/S
    a. For women who will undergo either scheduled repeat or primary C/S, the discussion regarding options and desires should take place during prenatal care.
    b. For women having a cesarean delivery for failure to progress, the discussion may occur prior to the cesarean; however this discussion is not mandatory.
    c. In both a and b, the discussion should include careful description of precautions for each desired intervention, including possible need to change the plan based on alterations in neonatal or maternal status or nursing availability.
    d. The woman and her obstetric provider check off the components of the Gentle C/S that she is interested in.

2. The woman and physician sign the consent document at the bottom of checklist during prenatal care or at the time of eligible in-labor C/S.

3. Review of patient checklist should occur during the OR huddle for a planned cesarean and, in the event of a decision for Gentle C/S with a women in labor, with an ad hoc meeting of nursing, anesthesia, NICU, OB provider and surgical staff in PACU or L+D prior to going into OR. All team members should contribute to the decision for Gentle C/S components to optimize care for the woman and her baby. If any member of the team feels that requested components of the Gentle Cesarean are not appropriate then these concerns should be addressed prior to starting cesarean When a Gentle Cesarean is planned the scheduling physician should indicate this at the time the surgery is scheduled.

4. Delayed cord clamping: the obstetrical surgeons deliver the baby and hold at maternal abdomen for 60-90 seconds as baby status allows prior to clamping and cutting cord. This practice will also allow the team to dry, stimulate, and observe baby to determine if s/he is appropriate for skin-to-skin with mother.

5. Skin to skin: baby is handed off to the baby nurse or NRP certified provider around the side of the drapes after delayed cord clamping occurs. Requirements for skin-to-skin include:
    a. Meets eligibility requirements above for low risk of needing resuscitation
    b. The operating rooms will routinely be maintained at 70 degrees. The operating room tech is responsible for confirming that each OR in use for obstetrics is at 70 degrees at the start of each shift. Room 14 is the best OR for Gentle Cesareans. After the spinal is placed then temperature will be raised to 72 degrees
    c. Baby Nurse or NRP certified provider receives baby from obstetrical surgical team.
    d. NICU team aware of plan prior to cesarean section.

Baby Nurse Role: The skin to skin portion of the Gentle Cesarean requires a registered nurse or NRP certified provider dedicated to the care of the baby. They will be present in the operating room prior to the initiation of the cesarean delivery. The Baby Nurse will continue to care for the infant through a minimum of two q 15 minute vital sign assessments.

NICU role: 2 team members will come to the cesarean section, one fully scrubbed to receive baby from the Baby Nurse or NR certified provider who is gowned and gloved, if baby shows immediate signs of requiring resuscitation. The 2 NICU team members remain at the warmer until the decision has been made for the Baby Nurse or NRP certified provider to initiate skin to skin. The NICU team is present similar to their role with term NSVDs with meconium where the baby is handed to mother or NICU team based on rapid initial assessment. The Baby Nurse or NRP certified provider may bring the baby from skin to skin to the warmer and call the NICU team back at her discretion.

Approved UNM Labor and Delivery Patient Safety Committee 10-28-2015 (revised April 2019)

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4) Ozlu F, Yapicioglu H, Ulu B, et al. Do all deliveries with elective caesarean section need paediatrician attendance? *J Matern Fet Neonat Med.* 2012; 25: 2766-2768.
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6) Gordon A, McKechnie EJ, Jeffery H. Pediatric presence at cesarean section: justified or not? *Am J Obstet Gynecol.* 2005; 193 (3): 599-605.
7) Smith J, Plaat F, and Fisk NM. The natural cesarean: a woman-centered technique. *Brit J Obstet Gynecol.* 2008; 115:1037-1042.

DOCUMENT APPROVAL & TRACKING

Prepared by: Gillian Burkhardt MD

Approved by: L&D Steering Committee

Approval: _____ _____

Chair, Department of Obstetrics and Gynecology — Date

SOP # / Version #	Effective Date	Supersedes	Review Date	Summary of Change(s)

Information about the Gentle Cesarean Delivery:

For many reasons, some women in the United States deliver their baby by cesarean section. When births are low risk, studies show that we can make cesarean sections healthier for both moms and babies by doing some of these things:

- Mother and baby can bond better if the baby is placed on the mother, skin to skin, right away after birth. If the baby gets to be on the mother's or partner's chest skin to skin within 2-3 minutes, breastfeeding can be easier.
- Improved latch and more successful breastfeeding have been demonstrated for skin to skin in vaginal deliveries and benefit is anticipated but not proven for skin to skin in cesarean deliveries
- Baby's temperature and sugar are regulated more easily
- Better family satisfaction with the birth experience

Potential concerns include:

- Short delay in completing cesarean during period of delayed cord clamping
- May be harder for neonatal provider to assess infant on maternal chest, with low lighting, or if drapes in the way
- Mother or family may experience unanticipated stress due to seeing surgery and blood through clear drapes. This to be discussed with your provider carefully

In order to ensure a safe experience for everyone involved, the Gentle cesarean section cannot be offered for all situations involving a cesarean birth.

There are certain instances in which a family-centered cesarean section cannot be offered due to safety of mother and baby, which include:

- birth before 39 weeks
- concerns about baby's heart rate monitoring,
- concerns about illnesses in mother which can include significant obesity
- need for general anesthesia

You may plan a "Gentle Cesarean", however concerns for your health or your baby's health may require a change to a more traditional cesarean including handing your baby directly to the pediatric team and possibly transferring your baby to one of our nurseries during your cesarean delivery.

Gentle Cesarean Delivery Checklist:

For Physician: Indication for Cesarean

- ☐ Scheduled repeat cesarean at 39 0/7 to 40 6/7 weeks
- ☐ Scheduled primary cesarean for malpresentation or other acceptable maternal indications at 39 0/7 to 40 6/7 weeks
- ☐ Primary cesarean during labor for failure of labor to progress in the first stage with no diagnosis of chorioamnionitis. At 39 0/7 to 40 6/7 weeks

For Patient: The following are components of the Gentle C/S. Please discuss with your doctor and check all that you would like to have pending review in your individual case for safety and feasibility.

- ☐ Dim lighting in operating room
- ☐ Music in operating room
- ☐ Decreased number of nonessential personnel in operating room as safe and appropriate
- ☐ Doula or additional adult family member in operating room during delivery. All family/support people may be asked to leave at short notice in case of an emergency.
- ☐ See delivery as baby comes though the cut in your abdomen (clear drape). You will see blood and fluid on the surgical field.
- ☐ See baby immediately after delivery (drop the drape). You will see blood and fluid on the surgical field.
- ☐ Delayed cord clamping for 60-90 seconds if baby is vigorous as per current routine practice (with drape down to allow you to see infant, cord clamped by doctors to maintain sterile field)
- ☐ Baby skin-to-skin if baby is vigorous (after delayed cord clamping, a nurse will bring the baby around the drape and help hold baby on your chest
- ☐ Support person cuts cord second time in PACU with plastic clamp closer to infant

While we would like to offer this service to all families delivering by cesarean section, it is not always possible to accommodate all or any component due to safety concerns in your individual case. **I understand that the plan for my surgery may change at any time due to concerns from my medical team about my health, the health of my baby, or the safety of other patients cared for by the medical staff.**

Patient (please print)	Patient Signature	Date
Provider (please print)	Provider Signature	Date
Witness (please print)	Witness Signature	Date