McGill Rotation Objectives

Obstetrical Ward (Caseroom)

Medical Expert

1. Be able to diagnose and manage the following antenatal complications
   a. Gestational Hypertension and preeclampsia
   b. Gestational diabetes
   c. Premature rupture of membranes
   d. Antepartum Bleeding (after 20 weeks gestation)
   e. Maternal hypothyroidism
   f. Intrauterine growth retardation

2. Demonstrate the following skills during antenatal visits:
   a. Fundal height measurements,
   b. Leopold manoeuvres,
   c. Fetal Doppler heart monitoring,
   d. Cervical exam

3. Be able to assess and triage risk associated with a trial of labour after Cesarian

4. Be able to assess the factors that will influence the decision to **induce labour**

5. Be able to perform normal risk **labour and vaginal deliveries**
   a. Demonstrate accurate cervical exams to determine the stage of labour
   b. Be able to evaluate for spontaneous rupture of membranes
   c. Fetal surveillance during labour
   d. Be able to diagnose non-cephalic fetal presentation using appropriate techniques

6. Be able to recognize and manage the following complications of labour and delivery
   a. Labour dystocia
   b. Shoulder dystocia
   c. Postpartum hemorrhage
   d. Perineal lacerations
   e. Vacuum assisted delivery
   f. Non-cephalic presentation
   g. Peripartum fever

7. Be able to manage pain in labour

Postnatal and neonatal Care

**The following objectives are relevant to services in which the resident is responsible for newborn assessments*

8. Be able to describe and perform neonatal resuscitation

9. Demonstrate a comprehensive evaluation of a newborn in the first few days of life that will identify complications specific to the newborn period
   a. Hypoglycemia
   b. Hyperbilirubinemia
   c. Neonatal respiratory distress
   d. Congenital anomalies

10. Be able to provide support for breastfeeding, and anticipatory guidance for new mothers

11. Recognize normal neonatal growth and deviations from normal

12. Have an approach to the crying newborn. Recognize the diagnosis of colic, being sure to evaluate for other causes

    a. Recognize the risk factors and signs of infant abuse

Medical Expert/ Clinical judgment

1. Whenever the clinical course of a patient is not going as expected, review provisional diagnosis and management plan, consider alternatives, and change if necessary (e.g. regularly reassess/re-evaluate potentially unstable patients)

Communicator

(*from SOO marking grid; JK Lawrence, Graves, et al 2010)

Listening Skills

1. Use both general and active listening skills to facilitate communication
   - *Allow the time for appropriate silence*
   - *Feed back to the patient what he or she thinks he or she has understood from the patient*
   - *Respond to cues (doesn't carry on questioning without acknowledging when the patient reveals major life or situation changes*
   - *Clarify jargon used by the patient*

Language Skills

Verbal

- Adapt language to be understood by the patient
- Converse at an appropriate level for the patient's age and educational level
- Clarify how the patient would like to be addressed
- Ask open- and closed-ended questions appropriately
- Check back with the patient to ensure understanding (e.g., "Am I understanding you correctly?")
- Facilitate the patients' story (e.g., "Can you clarify that for me?")

Nonverbal

- Be conscious of the impact of one's own body language on communication and adjusts appropriately
- Be observant and responsive to a patient's body language,

Whenever it is recognized that a diagnosis or management plan needs to be modified,

a. Discuss the changes with the woman, her supports and the team

b. Document the changes and the discussion

Professional

1. Completes tasks reliably

2. Is truthful

3. Is on time for clinics, on call shifts, and teaching sessions.

    a. In the event of being late or absent, informs their staff or identified administrator in a timely manner

4. Is aware of own strengths and limitations and seeks help when unsure

5. Is respectful and polite to colleagues, administrative staff, and patients, even in stressful situations

Collaborator

1. When working in a team, acknowledge all team members (including the patient and her supports) and as well as their roles and contributions, and respectfully listen to and respond to others' opinions, especially when they differ from your own.

2. When working in a team, promote collaboration by accepting and giving help where required, contribute where most useful even when not in primary roles, and follow the leadership of others unless it is more appropriate to assume the leadership for a defined period or challenge.

3. When working in teams, respect the professional autonomy of the individual members while promoting collaborative decisions and actions for the benefit of the patient.

4. When a team is working under difficult conditions, try to promote and maintain the effectiveness of the team by remaining calm, helping others in their roles and tasks whenever appropriate, resolving differences actively by considering the best interests of the patient, and by inspiring confidence whenever possible.

5. When working in a team, maintain clear verbal and written communications, closed loop whenever pertinent, and facilitate the participation of all in debriefing sessions.

Advocate

*Adapted from Dr Jean Zigby's Advocacy poster

1. Recognize that you can use your expertise and influence to advance the health and care of your patients. (An example could be to: personally call a consultant or paramediacal staff, engage with an institutional administration)

2. Routinely asks yourself the following questions to determine whether you should make the extra effort on behalf for your patient (ie. "advocate" for them)

    1. *Is this patient particularly vulnerable?*
    2. *Is this patient unlikely to navigate the 'system" effectively?*
    3. *Will this patient's solution need the help of a third party?*

Scholar

1. Use clinical experiences to identify gaps in clinical skills, and close those gaps by appropriate self- or assisted-learning.

2. Formulates clinical questions and search the medical literature in order to answer them

Manager/Leader

1. Looks for opportunities to teach junior learners and peers

2. Prioritizes tasks around patient care effectively

3. After an unexpected or unusual event, debrief effectively with appropriate team members, including the woman and her supports.

Peripartum mental health

1. Enquire about the mental health of all women throughout the peripartum period, assessing to identify discrete signs or symptoms or factors leading to a higher risk (e.g. substance abuse, intimate partner violence, previous mental health disorder, history of sexual abuse), and add an appropriate mood assessment tool (e.g. Edinburgh Postnatal Depression Scale, Generalized Anxiety Disorder scale) when indicated.

2. When concerns are raised about mental health in the peripartum period, actively explore the situation with the woman and her supports, and provide education about normal or common psychological changes in pregnancy, as well as the signs that may be suggestive of a mental health disorder.

3. For women in the peripartum period with an apparent mental health disorder, assess to rule out possible underlying causative or contributing medical conditions (e.g. anemia, thyroid dysfunction).

4. For a woman with a mental health disorder in the peripartum period, determine the risk of harm to self, infant, or others, and when this risk is present ensure urgent management to reduce the risk of harm. Educate the woman and her supports regarding a possible rapid escalation of symptoms, and regarding available resources.

5. For a woman in the peripartum period with a mental health disorder, maintain the therapeutic relationship, provide counselling, refer to the indicated resources and advocate for rapid access when needed. Use medication if indicated, balancing the risk of untreated mental health issues against the risk of medications on the fetus or newborn, and recognizing the benefits of continued breastfeeding if desired.

Gestational diabetes

1. In all pregnant women, identify those who should be screened for gestational diabetes, and interpret the results of the screening tests in the context of the pregnancy (i.e. according to guidelines for gestational diabetes, not regular diabetic guidelines)

2. Given a patient with gestational diabetes, plan for blood glucose control to avoid extremes of hyperglycemia and hypoglycemia, and do not confuse treatment targets and guidelines with those for type 2 diabetes.

3. For a pregnant patient who is receiving specific care for diabetes (gestational or pre-gestational) from other providers, maintain your planned ante-partum care for the patient , and integrate the recommended diabetic care into the overall management plan

4. When caring for a woman with gestational diabetes, closely monitor fetal growth and well-being (e.g. ultrasound, non-stress tests), as well as the maternal status, in order to recognize early indications for induction.

5. When providing intra-partum care to a woman with gestational diabetes,

    a. anticipate potential fetal macrosomia, and if present, anticipate and plan for labour dystocia and shoulder dystocia

b. manage blood sugars actively, using insulin when indicated for optimal care, continuing as necessary into the post-partum.

6. Following the delivery of a woman with gestational diabetes

a. monitor the baby closely for hypoglycaemia, in the immediate post-partum period

b. plan to include screening for diabetes in the postpartum care of the mother.

Antepartum bleeding

1. For a woman presenting with antepartum bleeding, first assess the stability of both the woman and the fetus, as urgent management must begin for unstable cases before the exact cause of the bleeding has been confirmed.

2. If the woman with antepartum bleeding is unstable or if there is suspected fetal compromise, resuscitate immediately and mobilize the necessary resources for urgent delivery, while monitoring the situation and identifying the cause of the bleeding.

3. While managing a woman with antepartum bleeding, assess to diagnose the cause of the bleeding, using methods that minimize risks of harm, to recognize potentially life-threatening causes.

- _Obtain history (e.g. onset, quantity of bleeding, presence of pain, trauma)
- _Determine placental location by ultrasound (previous or current) prior to vaginal exam (do not perform vaginal exam unless placenta previa is ruled out)
- _Assess the uterus (e.g. activity, tone, tenderness) and fetal well-being
- _Use other diagnostic techniques as indicated (e.g. speculum exam)

4. For a woman with antepartum bleeding who is stable with normal fetal surveillance, provide ongoing assessment and management based on the diagnosis and the gestational age (e.g. manage Rh status, administer corticosteroids for fetal lung maturity). Decide whether hospitalization or transfer is indicated and the likely mode of delivery.

5. Following a resolved episode of antepartum bleeding, inform the woman and her supports about the risks of antepartum bleeding in current and in subsequent pregnancies, and about strategies to minimize the risk.

Inducing labour

1. When considering the induction of labour, specifically assess the factors that will influence the decision (e.g. accurate expected date of delivery, indications, contraindications, cervical ripeness, maternal preference) and document the factors clearly to provide justification for decisions.

2. When planning induction of labour

a. Induce labour only when there is a compelling and convincing indication and no contraindication.

b. Prioritize and schedule the induction based on indication and resources.

c. Select the facility with appropriate resources to manage fetal and maternal needs.

3. When considering the induction of labour, obtain and document clear and detailed informed consent for accepting or declining the induction.

4. When inducing labour, use the appropriate method based on obstetrical and medical history, cervical ripeness, patient preference and team considerations

- Methods include cervical ripening (e.g. balloon catheters, prostaglandins) and induction agents (e.g. prostaglandins, oxytocin)
- Assess the effect of the induction on maternal and fetal well-being
- Select women for whom the out-patient management of cervical ripening is appropriate

5. Look for and manage complications of induction (e.g. tachysystole, abnormal fetal surveillance)

6. When your selected method of induction is unsuccessful, modify the management plan accordingly.

Trial of labour after Cesarian

1. In a woman who has had a previous C-section, assess the risks and benefits of a TOLAC and discuss fully with the patient, in order to identify those who are good candidates, those who are not good candidates, or where it would be contraindicated. Document the discussion, including risks and benefits identified.

2. Given a woman who is a candidate for TOLAC, offer TOLAC and help her make an informed decision, by fully discussing the risks and advantages while showing flexibility and understanding of her preferences and concerns.

3. In a woman who has had a previous C-section and who goes into labour or is close to it, be flexible in the management approach and adapt it to the circumstances, while still respecting the plans and preferences of the mother as much as possible (e.g. manage a spontaneous precipitous labour in a woman who had planned a repeat C section, discuss conversion of a planned TOLAC to a C-section when appropriate).

4. Before planning or managing a TOLAC, ensure that the resources necessary for an unexpected immediate operative delivery are available and in place, ensure that the patient and her family are well prepared for the complications that could necessitate this eventuality, and that all discussions and decisions about the TOLAC have been fully documented.

5. Manage a TOLAC for a patient with appropriate maternal and fetal surveillance, close monitoring of the progress of labour, and careful use of induction and utero-tonics if indicated.

6. When managing a TOLAC, carefully assess maternal and fetal well-being and recognize any signs of imminent or actual uterine rupture requiring maternal and fetal resuscitation the urgent conversion to C-section if needed.

Normal Labour and Delivery

1. When a woman presents in labour, assess for risk factors that identify those women for whom

vaginal birth is not appropriate, and establish the preferred expectations for the delivery with the woman and her supports.

2. When a woman presents in labour, diagnose the stage and the phase of labour based on history and abdominal and pelvic exam,

- _to help make a decision to admit or send home that is based on appropriate medical, social and personal factors , and
- _to reduce premature admissions to a labour unit if in the latent phase.

3. Throughout labour

a. Provide support and pain management, using a patient-centred approach and multiple options (e.g. mobility, different positions).

b. Monitor maternal and fetal wellbeing, in order to recognize any changes that would alter the management plan.

c. Follow progress regularly and avoid unnecessary or premature interventions (e.g. using uterotonics when not in active labour, premature diagnosis of dystocia)

4. During the second stage of labour

a. Initiate pushing at the appropriate time.

b. Conduct a controlled delivery in order to minimize trauma.

5. Immediately following vaginal birth,

a. Care for the well newborn with skin to skin care, assessment, delayed cord clamping, and early initiation of breast feeding

b. Assess the need for resuscitation of the newborn and manage appropriately

c. Assess uterine tone and bleeding, and administer prophylactic oxytocin in the third stage.

d. Deliver the placenta in an acceptable manner.

e. Assess for perineal trauma.

6. Following a vaginal delivery

a. Debrief with the team, including the woman and her supports and document appropriately.

b. Reassess the mother and baby, and review ongoing management plans before leaving the birthing unit.

Preterm labour

1. When assessing a pregnant woman who is not in labour, look for risk factors for premature labour, and manage the treatable factors to reduce risk whenever possible.

2. When caring for a pregnant woman who is not in labour, educate her and her supports about signs and symptoms of preterm labour and how to seek help.

3. For a woman presenting in suspected preterm labour, confirm the presence or absence of labour, using appropriate techniques (e.g. assessment of contractions, speculum exam, fetal fibronectin, cervical assessment).

4. For a woman in preterm labour, manage according to the gestational age and fetal surveillance to minimize neonatal morbidity and mortality, by

- _Mobilizing the team to ensure availability of resources, including early consultation, that may be needed for the mother and the infant,
- _Administering appropriate medications (e.g. antenatal corticosteroids, tocolytics, antibiotics, Magnesium sulphate)
- _Arranging for transfer if necessary, at the appropriate time.

5. Following the birth of a preterm infant, particularly the ones who require intensive care, provide support and advocacy for the woman and family, in the context of an ongoing therapeutic relationship.

Pain in labour

1. Prior to labour discuss pain and pain relief with women, correcting misconceptions and providing education.

2. For a woman in labour use a patient-centered approach to clarify her pain experience, her emotional state, as well as her expectations and preferences for pain management.

3. When managing pain for a woman in labour, optimize the use and effectiveness of support and other non-pharmacological measures (e.g. hydrotherapy, TENS, ambulation).

4. When providing pharmacological pain relief in labour, use an appropriate method (e.g. opiates, nitrous oxide, epidural anesthesia), taking into account the woman's choices, the stage of labour, and possible side-effects (e.g. fetal surveillance changes, newborn respiratory depression, labour prolongation).

5. Look for and manage side-effects of pain management (e.g. maternal fever, fetal surveillance changes).

6. When pain in labour is unusual or unresponsive to typically effective management, assess to rule out unusual or pathological causes (e.g. uterine rupture, pulmonary embolus, history of sexual abuse) that would require other interventions or approaches.

Noncephalic presentation

1. For any woman in the third trimester or in labour, determine the exact fetal presentation using appropriate techniques (e.g. Leopold's maneuvers, vaginal exam if not contraindicated, ultrasound).

2. When a non-cephalic presentation has been identified pre-labour, discuss, with the mother and her

supports, alternative plans or possibilities for delivery (e.g external version, trial of labour, planned C section) according to the presentation. Inform women of possible complications (e.g. cord prolapse) and appropriate actions.

3. When a non-cephalic presentation is identified in labour, discuss the delivery options with the mother, while seeking second opinion and team support as necessary, and while initiating preparations for a possible Caesarian section.

4. When facilitating an unavoidable breech delivery, optimize the process by avoiding traction and by ensuring head flexion through delivery.

5. After a vaginal breech delivery anticipate that the newborn is more likely to require resuscitation.

Pre-labour rupture of membranes

1. In all pregnant patients, even pre-term, presenting with vaginal fluid loss, look for and diagnose pre-labour rupture of membranes using history, abdominal exam to verify presentation, speculum exam (avoid doing vaginal examination unless indicated for management),and fluid inspection and analysis (e.g. nitrazine, fern test).

2. In a pregnant patient with signs and symptoms suggestive of PROM but negative confirmatory tests, do not exclude the possibility of PROM, and plan appropriate fetal/maternal surveillance for signs of fever and/or infection.

3. For all patients with PROM, rule out contraindications to vaginal delivery, and, if there are no contraindications, offer induction of labour through an informed discussion within the context of risk factors (e.g. GBS status), patient preference and system demands (e.g. staffing availability).

4. In a patient with PROM in whom labour has not been induced,

- _monitor for signs of infection (e.g. fever, fetal tachycardia, odour) even for those patients on prophylactic antibiotics

- _treat suspected or confirmed chorio-amnionitis aggressively and early (e.g. IV antibiotics), and do not rely on the previous prophylactic treatment.

5. Given a patient with preterm PROM

- _initiate treatment as per local protocol (e.g. admission, steroids, IV antibiotics and monitoring).

- _plan appropriate definitive treatment depending on gestational age and the capacity of the facility and team, and considering the indications for consultation or for transfer to another care facility.

6. Assess the baby born after pre-labour rupture of membranes for signs of sepsis, and initiate treatment promptly if sepsis is suspected.

Labour dystocia

1. When a patient presents with possible labour, diagnose or rule out active labour, based on history, and on abdominal and pelvic examination (i.e. avoid premature admissions to labour and delivery).

2. For a patient in labour, assess and document progress of labour by following cervical dilation and fetal descent.

3. Make a diagnosis of labour dystocia based on lack of progress in cervical dilation and fetal descent, and in the context of maternal and environmental factors; avoid making the diagnosis too early or too late.

4. When labour dystocia is suspected or diagnosed, first consider and use non-pharmacological methods to treat (e.g. ambulation, continuous support, amniotomy).

5. When labour dystocia is suspected or diagnosed, systematically look for and identify possible contributing factors (i.e. uterine contractility, fetal size and presentation, pelvic architecture, maternal pain and psychogenic state) in order to optimize management.

6. For a patient with labour dystocia that has not responded to appropriate non-pharmacological intervention, use an appropriate utero-tonic medication, while maintaining careful surveillance of maternal and fetal well-being.

7. For a patient with labour dystocia, look for and recognize the fetal and maternal indications for operative delivery.

Fetal health surveillance during labour (monitoring, etc.)

1. When a patient requires care that is beyond your personal or facility limits, advocate firmly to obtain this care in a timely fashion from an appropriate resource

2. Whenever the clinical course of a patient is not going as expected, review provisional diagnosis and management plan, consider alternatives, and change if necessary (e.g. regularly reassess/re-evaluate potentially unstable patients)

3. Whenever it is recognized that a diagnosis or management plan needs to be modified, a. When uncertain seek additional information or help without delay

b. Discuss the changes with the woman, her supports and the team

c. Document the changes and the discussion

4. Use clinical experiences to identify gaps in clinical skills, and close those gaps by appropriate self- or

assisted-learning.
5. After an unexpected or unusual event, debrief effectively with appropriate team members, including the woman and her supports.

Gestational hypertension/ preeclampsia

1. At the beginning of all pregnancies, identify and assess the risk factors for gestational hypertension/preeclampsia and consider initiating preventive treatment for those at high risk.

2. Consider the diagnosis of preeclampsia at prenatal visits, even if the blood pressure is not obviously elevated, and especially when the patient has new poorly defined constitutional symptoms.

3. When preeclampsia is suspected, look for confirmatory evidence (symptoms, signs, basic investigations), to establish or rule out the diagnosis. Classify according to current nomenclature and re-assess regularly for progression of disorder.

4. For gestational hypertension or non-severe preeclampsia, follow closely and manage according to maternal and fetal well-being and gestational age.

5. For a woman with a diagnosis of pre-eclampsia with adverse conditions or severe preeclampsia manage actively by

- Initiating MgSO4 in a timely fashion and other medications as appropriate (e.g. anti-hypertensives)
- assessing the need for prompt delivery, and arranging for delivery and/or consultation when indicated

6. For any woman with gestational hypertension or pre-eclampsia who has delivered, continue management and monitor for progression or complications throughout the post-partum period.

Postpartum hemorrhage

1. For all pregnant women, identify risk factors for PPH (e.g. grand multiparous, prolonged labour, anticoagulants) and prepare accordingly.
2. Manage the third stage of labour with prophylactic utero-tonics, consideration of controlled cord traction and assessment of uterine tone after placental delivery.
3. Following all births, closely monitor for the ongoing blood-loss (both visible and occult) in order to accurately estimate the total blood loss. and to promptly recognize and diagnose a PPH.
4. When a diagnosis of PPH is made, a. Distinguish stable from unstable patients, and adjust management accordingly
5. Activate the team to provide extra support early.
6. Look for correctible etiologies, in order to treat specifically:
    a. poor uterine tone (uterotonics)
    b. retained products of conception (remove)
    c. trauma (repair)
    d. distended bladder (urinary catheter)

e. coagulation deficit (correct)

d. monitor closely to anticipate and recognize the need for further intervention

5. For a PPH that has stabilized, continue to monitor over an extended period until recurrence is unlikely.
6. For a patient who has had a PPH, provide counselling for next pregnancy

Shoulder dystocia

1. For all deliveries, assess the risk factors for shoulder dystocia, develop a plan of management according to the risks, and adjust the preparations according to the evolving risks.

2. Anticipate and remain vigilant for the signs of impending shoulder dystocia with any delivery, and, when appropriate, prepare the woman and the team for the possibility of shoulder dystocia.

3. Recognize shoulder dystocia promptly when it occurs, communicate its presence clearly to the team, including the woman, and, working as a team, use appropriate manoeuvres to resolve it.

4. After the shoulder dystocia is resolved,

- Examine the mother and the newborn for signs of trauma.
- Debrief with the team, including the woman and her supports.
- Document the manoeuvres used and the timing of events (including head to shoulder time).

5. Managing shoulder dystocia

1. When a shoulder dystocia occurs, inform the team (including the woman) and institute without delay an accepted algorithm to resolve the dystocia.

2. Avoid actions that may increase the shoulder impaction (e.g. pressure on the fundus, maternal pushing when the shoulder remains impacted) or that may injure the baby (e.g. traction on the head, pivoting the head to rotate the shoulders). Identify one member of the team to coach the woman to push only when instructed.

3. Resolve the shoulder dystocia using a systematic approach that includes:

- External manoeuvres: hyperflexion of the hips (McRoberts), suprapubic pressure on the anterior shoulder, all fours position
- Internal manoeuvres: shoulder rotations (Rubin, Woods), delivery of posterior arm,
- Episiotomy may be considered at any point.

4. Complete one manoeuver before encouraging more maternal pushing, then, if it does not work, move rapidly to the next manoeuver before the next pushing effort.

5. If initial manoeuvres are unsuccessful call for additional assistance, consider changing maternal position, and repeat the above manoeuvres.

Perineal lacerations

1. After every delivery, assess for the presence, the location and the degree of perineal laceration, and distinguish between those that need repair and those that do not, including a rectal exam when appropriate.

2. When a perineal laceration occurs, ensure appropriate conditions (e.g. assistance, lighting, retraction, hemostasis, analgesia) are present for assessment and repair of perineal trauma.

3. Identify those injuries (e.g. third and fourth degree or other complicated lacerations) that may need consultation for further management.

4. Repair lacerations using techniques that will reduce the risk of complications (e.g. bleeding, infection, incontinence, pain).

5. Laceration repair procedures

    1. At all deliveries, ensure optimal conditions (e.g. lighting, analgesia, position, assistance availability of equipment) for a careful examination and repair of vaginal/perineal trauma, assessing its extent, and identifying trauma requiring repair.

    2. Identify complicated perineal trauma (e.g. 3rd or 4th degree tears, complex vaginal tears) and consider the need for assistance or consultation for the repair.

    3. Repair a second degree perineal laceration using a systematic approach that includes

        • _identification of key anatomic structures - apex of laceration, hymenal ring, perineal muscles, intact anal sphincter.

        • _securing the apex and aligning the hymen and the perineal body, then suturing the vaginal mucosa from apex to hymen

        • _suturing the perineal muscles

        • _suturing the skin or planning to let heal by secondary intention

    4. Following the repair of perineal laceration, re-examine for completeness of repair and hemostasis. This may include a rectal examination.

Vacuum assisted delivery

1. For a woman in labour, look for signs that she may need an assisted delivery (e.g, labour dystocia, atypical or abnormal fetal surveillance, maternal fatigue) and, when these signs are present, start the appropriate preparations, including a back-up plan with additional help as necessary.

2. When assisted delivery is contemplated, assess for contraindications (e.g. any presentation other than cephalic, cervix not fully dilated, unengaged head, <34 wks) and, when present, make appropriate alternative plans for delivery.

3. When an assisted delivery is indicated, discuss the options with the woman, obtain informed consent,

and prepare the team.

4. When performing an assisted delivery, use a standardized approach (e.g. the A to J mnemonic from ALARM)

5. When an assisted delivery is not progressing as expected, do not persist with excessive efforts, but abandon the procedure and initiate the alternative back-up delivery plan.

6. Following an assisted delivery, examine the woman and the newborn for signs of trauma (e.g. maternal trauma, subgaleal bleeding) or need for further care.

7. At the appropriate time following an assisted delivery, debrief with the woman (and her supports), and with the team. Document thoroughly.

8. Vacuum assisted delivery technique:

1. When considering a vacuum assisted delivery, assess the cervix and the station and position of the head to ensure that the procedure would be safe and likely to succeed.

2. Optimize the chances of success by ensuring adequate analgesia, emptying the bladder,, and by engaging the mother and her supports in the procedure. Check that the equipment is working.

3. Apply the vacuum cup, ensuring the position is correct and there is no entrapment of maternal tissue.

4. Apply traction coordinating the pulls with maternal pushing, pulling firmly but not excessively without pivoting.

5. When applying traction to a vacuum cup, assess the descent on each pull. Reassess the plan if there are indications that the procedure will not succeed:

- no progress after two pulls with a properly positioned cup and good traction,
- three pop offs without obvious cause,
- delivery not imminent after four contractions,
- delivery not imminent after 20 minutes of vacuum application.

Peripartum fever

1. When a labouring or postpartum woman has a fever, determine whether the cause is an infection (e.g. chorioamnionitis, endometritis) or not (e.g. epidural, work of labour), and re-evaluate the diagnosis regularly as approach may differ.

2. When a labouring or postpartum woman has a suspected infection,

- Consider the possible impacts of the infection on the woman and on the fetus/neonate.

- Initiate appropriate maternal and fetal surveillance or assessment of the newborn.

3. When an intrauterine infection is suspected, treat empirically and aggressively (e.g. early I.V. antibiotics, fluids) based on the likely cause, even for those who have received GBS antibiotic prophylaxis, and formulate a plan for delivery.

4. For all postpartum women, identify those at higher risk of infection (e.g. long labour, C-Section), recognize early signs and, if not present, advise the woman regarding symptoms

Breastfeeding

1. Enquire about newborn feeding plans at a prenatal visit. Promote exclusive breastfeeding, help establish reasonable expectations, and provide adequate information to develop a plan for feeding that respects the mother's preferences and choice.

2. For a mother who is not breastfeeding her newborn, provide support for her decision, and provide information and counsel for feeding with human milk substitute.

3. Examine women for breast anatomy that may affect breastfeeding (e.g. inverted nipples), and suggest interventions and resources that may be helpful.

4. For all deliveries, including C-section, facilitate skin-to skin contact as soon as possible and assist in obtaining comfortable and effective early latch.

5. For all mothers who are breastfeeding, especially in the immediate newborn period, encourage early access to suitable professional support if any concerns or difficulties with breastfeeding arise.

6. When breastfeeding appears to be challenging, first assess the latch and determine whether it is effective, and then assess for other barriers to successful breastfeeding in women and their newborns (e.g. lack of support, postpartum depression, breast pain, tongue tie, prematurity).

7. Facilitate the continuation of breastfeeding when conditions arise, such as:

- The mother has a breast infection (e.g. mastitis, abscess, candidiasis) or a nipple lesion (e.g. fissure, dermatitis),.

    - The mother requires medications or investigations

    - The infant is hospitalized

8. Use population and condition specific growth curves to monitor infant growth.

9. Educate the mothers of exclusively breastfed babies about normal weight gain, stool and voiding patterns and how to assess the adequacy of feeding.

10. Support breast feeding for the first two years of life and beyond.

First week of life

1. For a newly delivered baby who does not require resuscitation but appears unwell, assess for etiology (e.g. hypoglycemia, maternal drug effect, sepsis) and arrange for diagnostic tests and ongoing care.

2. Look for and identify newborns who appear well but may be at a higher risk of complications (e.g. hypoglycemia, sepsis, hyperbilirubinemia, drug withdrawal, social stressors), in order to plan management.

3. For all newborns perform a thorough physical examination to detect congenital abnormalities (e.g.

palate, pulses, heart sounds, hips, testes, anus).

4. Prior to discharge ensure the following:

- Adequate feeding plan has been established,

- Newborn screening (e.g. bilirubin, metabolic, hearing test) has been completed or arranged

- Family education regarding care of the newborn (e.g. car seat, infant sleeping) respecting cultural differences.

- Plan a follow-up visit with a health care professional within a few days of birth, especially for firstborns, families with psychosocial stressors, or if there were any perinatal issues.

5. When the parents (or other caregivers, including health care professionals) of a newborn express concern that the baby is unwell, listen carefully,