

Audit on Instrumental Deliveries in a Small Isolated Unit

Mrs Kavitha Sivakumar, Mr Suresh Pai

Nobles hospital, Department of Obstetrics and Gynaecology, Isle of Man

Objective

Instrumental deliveries can be associated with increased morbidity to both mother and baby. Incidence can vary between 10-15%. Every unit must have an audit on the instrumental deliveries. A retrospective audit was done to find out the local incidence and complications.

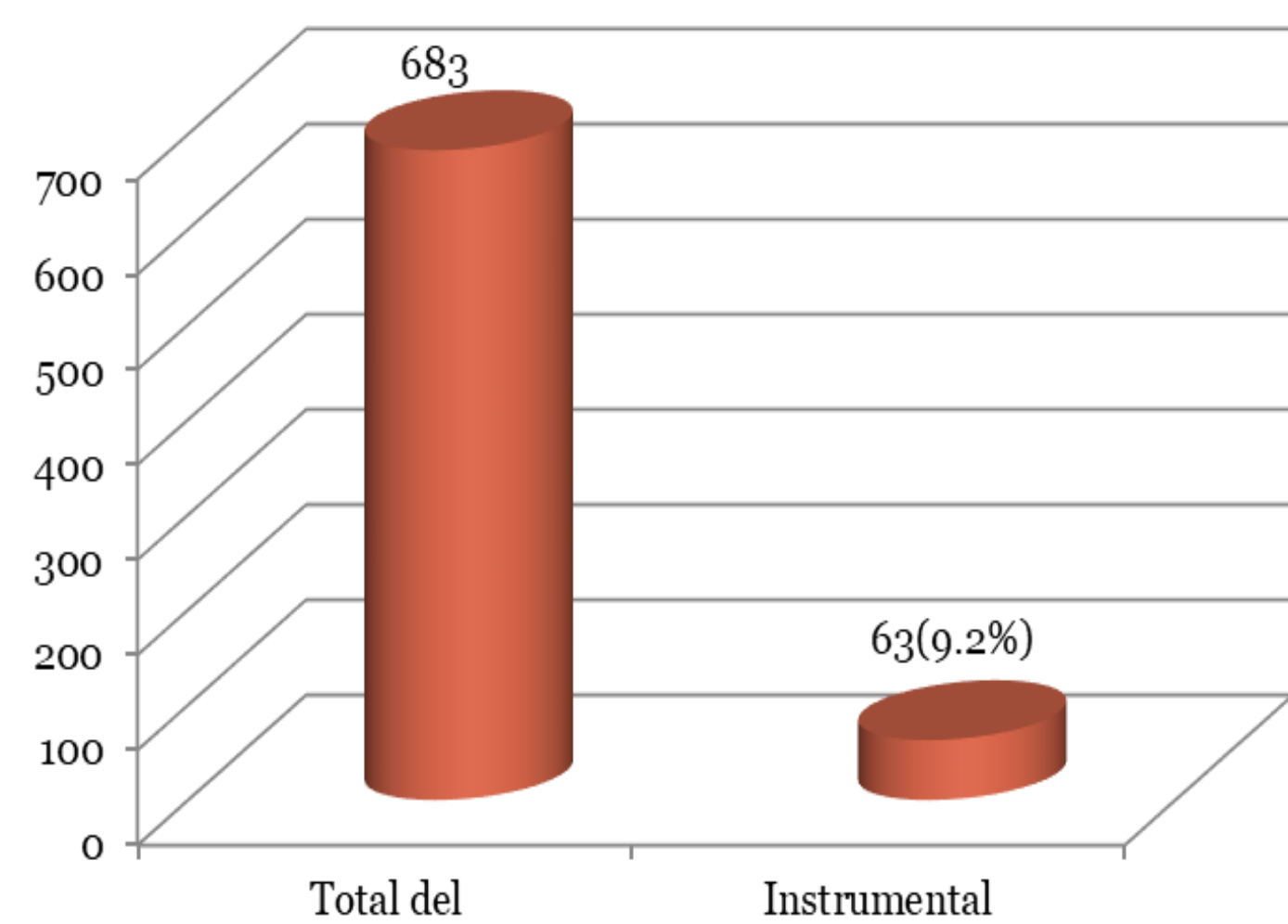
Design

A retrospective audit of instrumental deliveries was performed in comparison with national standards: RCOG guidelines on Assisted Vaginal Birth – Green top guideline No 26 April 2020

Method

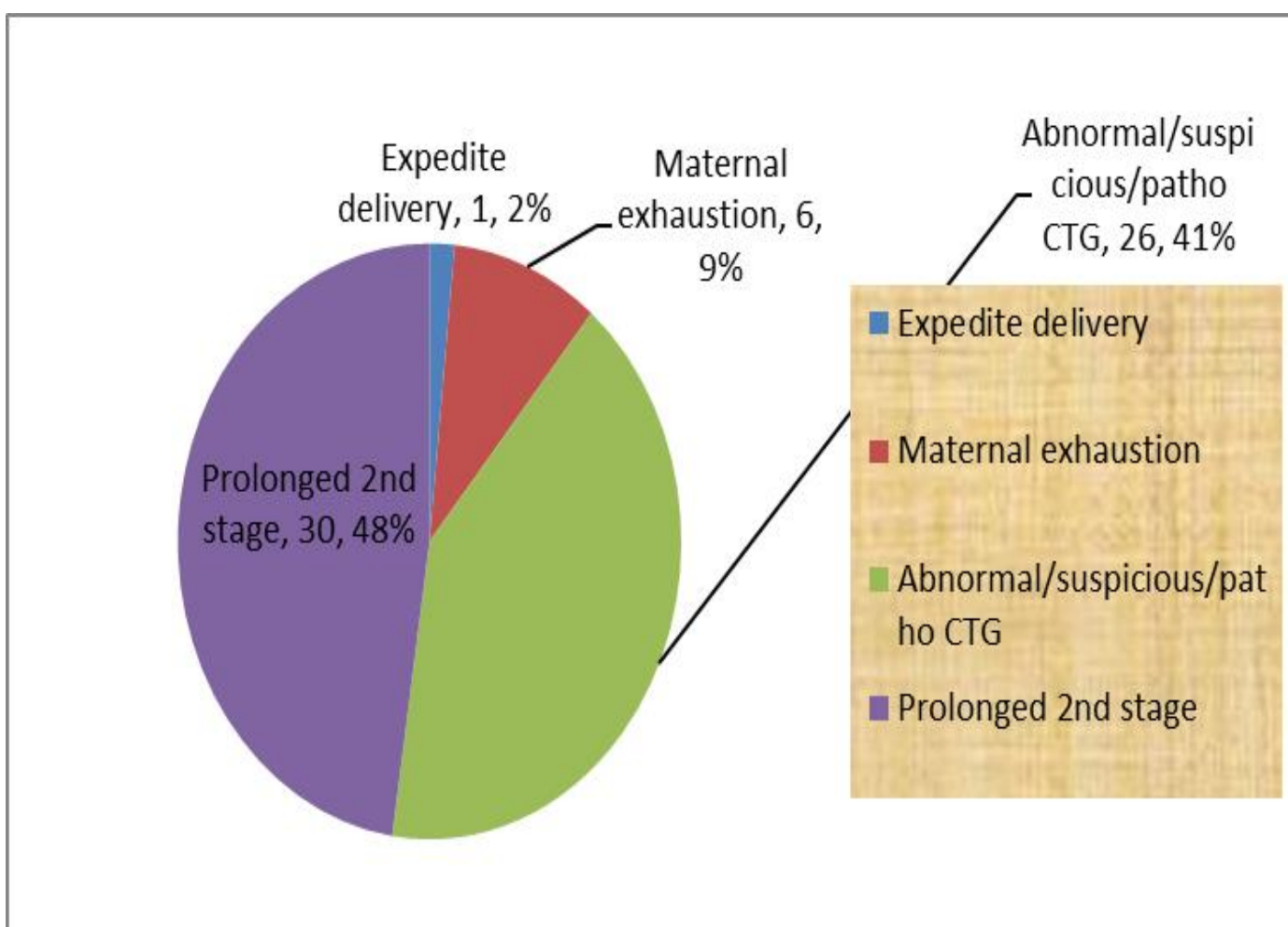
Review of 63 patients (notes) who had Kiwi Ventouse or Forceps assistance during a vaginal delivery from 1 January 2021 to 31 December 2021 was performed. The results were analysed against the national standards and our local unit protocol.

Incidence 2021: 9.2% - ventouse or forceps deliveries

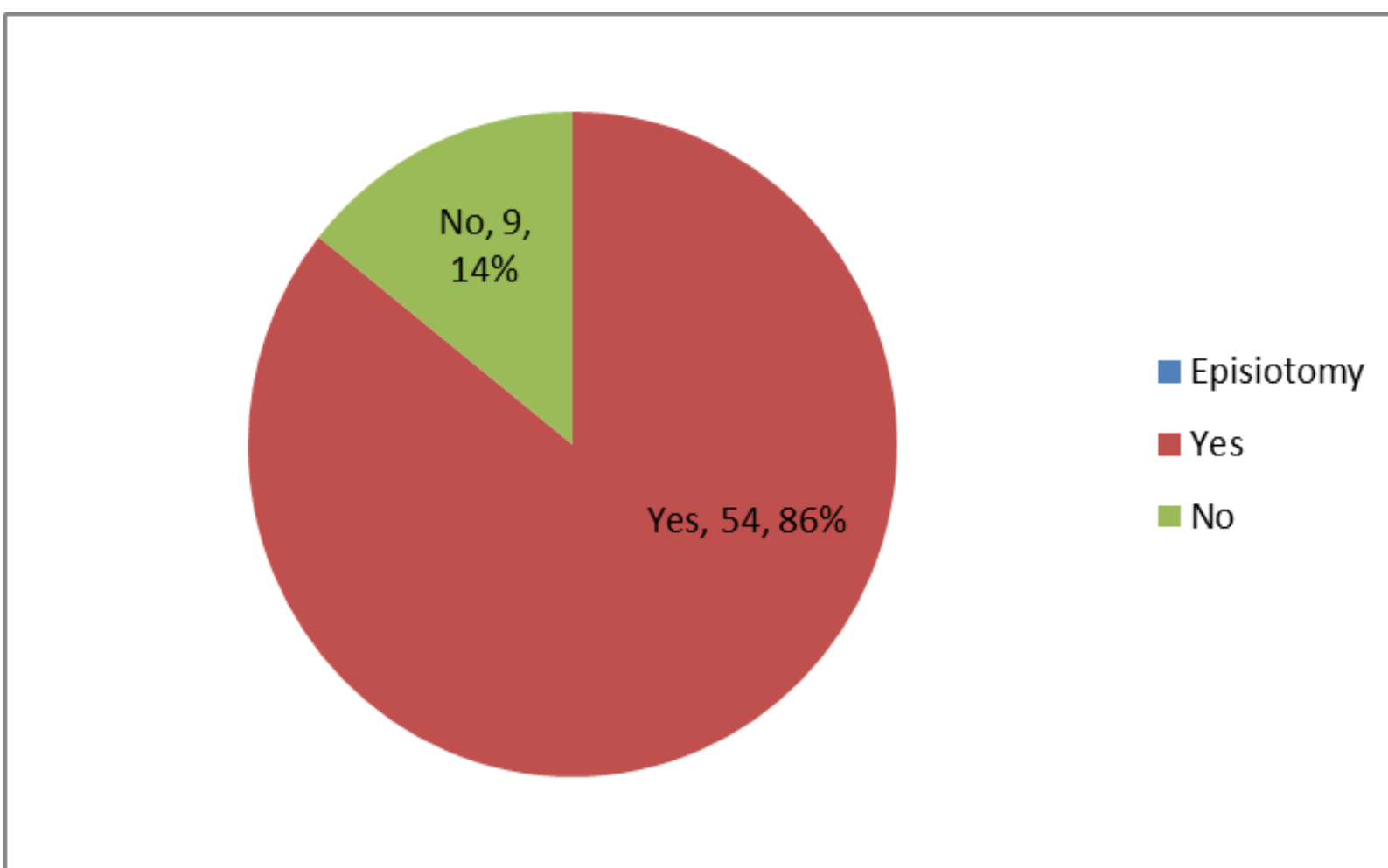


Indication

58% were maternal exhaustion or prolonged second stage.



14% had no episiotomies- all were ventouse deliveries



Results

The incidence of instrumental delivery was 9.2% (63) (Total number of deliveries over 1 year were 683) with 100% documentation of consent for all patients delivered either in labour room or theatre.

59%(37) of the women had forceps delivery out of which 11% had sequential an initial attempt with ventouse.

58%(36) of the instrumental delivery were for either maternal exhaustion or prolonged second stage, 41%(26) were for abnormal CTG, 1 had expedited delivery.

70% of delivery were in labour ward, 30% of them followed trial of instrumental in the theatre.

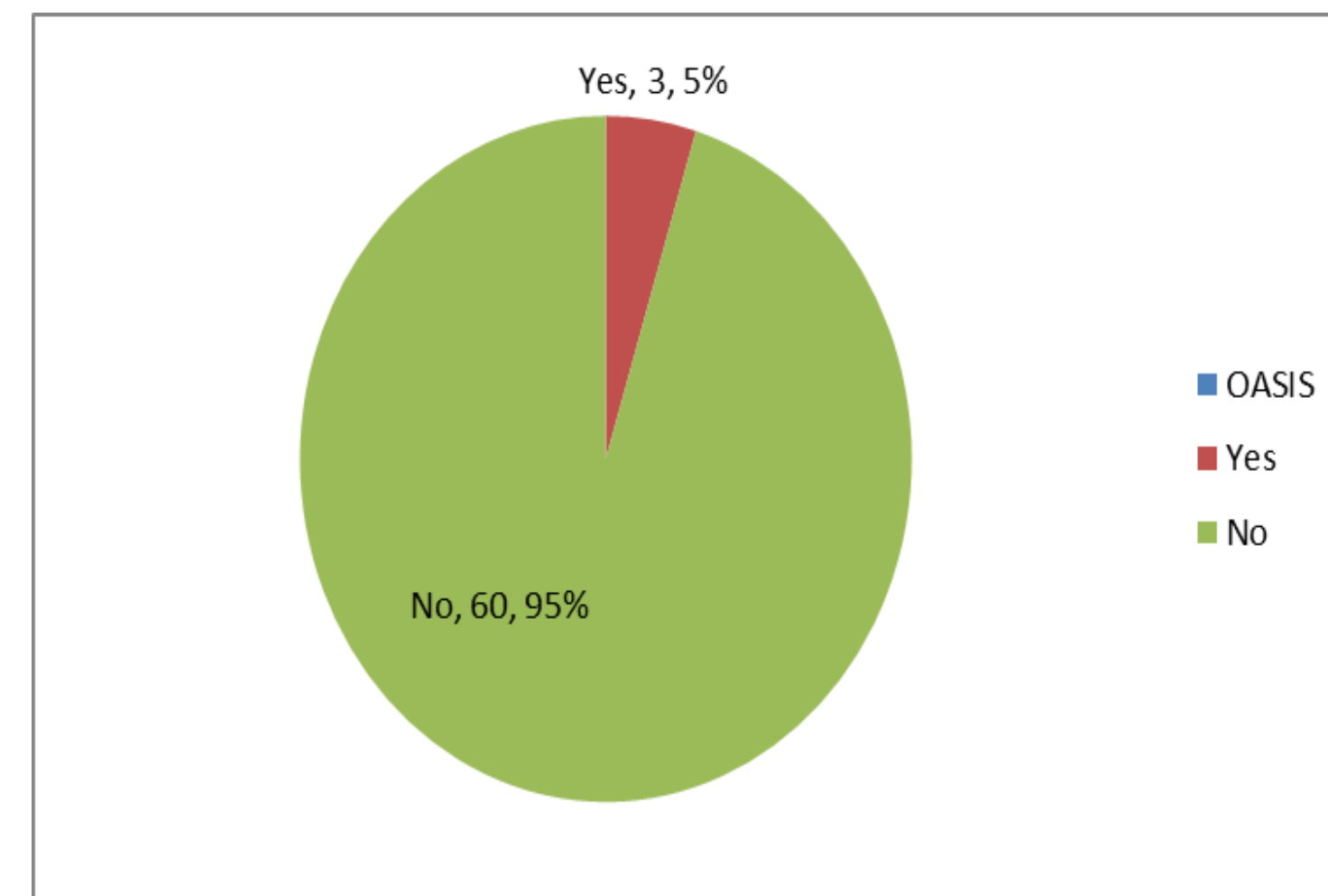
14% of the procedures did not have episiotomies- all of them were ventouse deliveries

None of the instrumentals exceeded the recommended maximum number of pulls. 37% of patients did not receive prophylactic antibiotics.

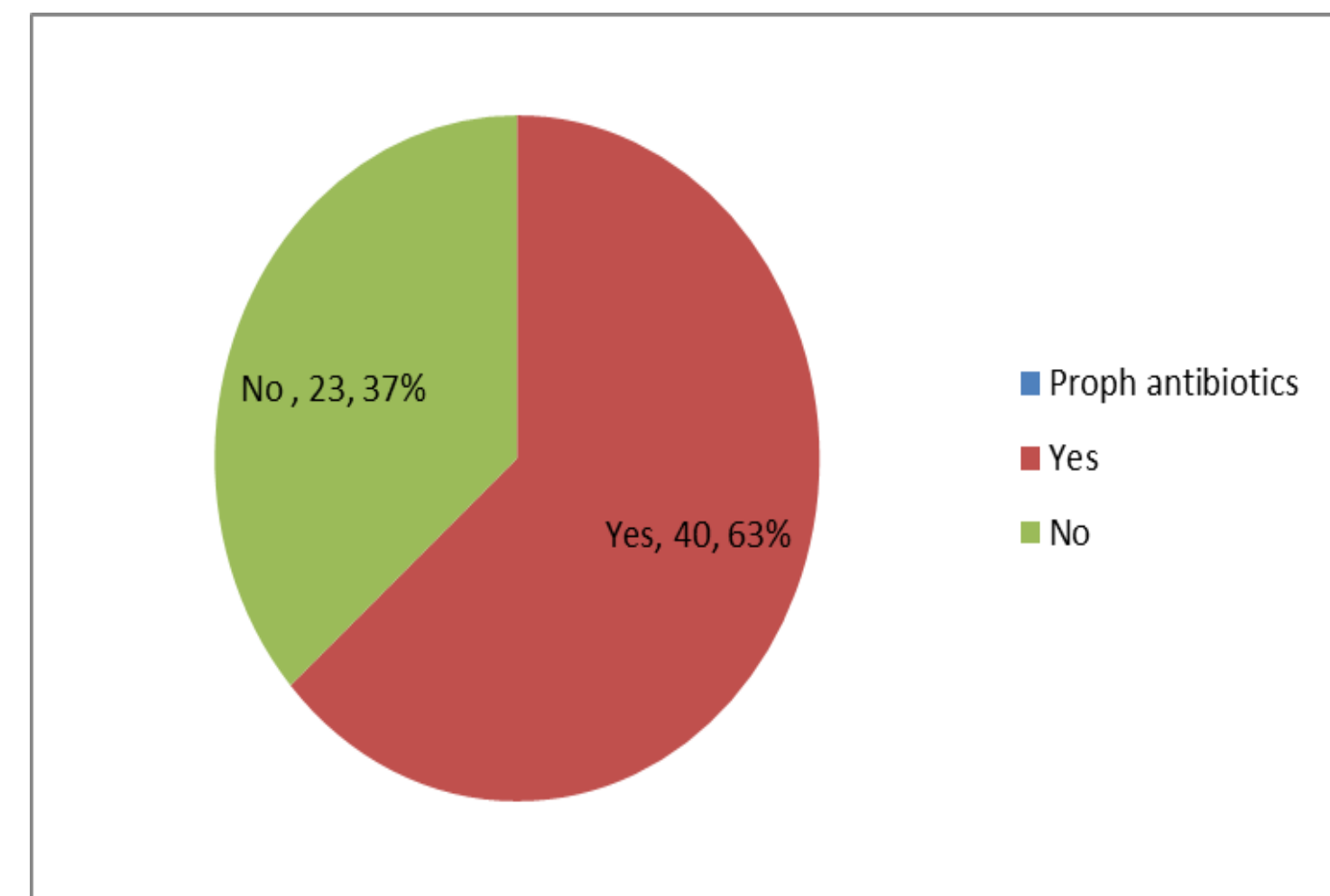
All the procedures were documented either in the computer notes or in the notes. But 43% were not documented in the computer notes. Only 33% had debrief (doctor or midwife) as per the documentation of which 42% are doctors.

27% of the procedures had PPH. 6% of them had major PPH with a blood loss of over 1 L, Four procedures were followed by shoulder dystocia, 5% of them sustained anal sphincter injuries. One after ventouse and forceps, third one following sequential instrumental delivery.

**OASIS -5%
1-ventouse and 1-forceps
3- sequential**

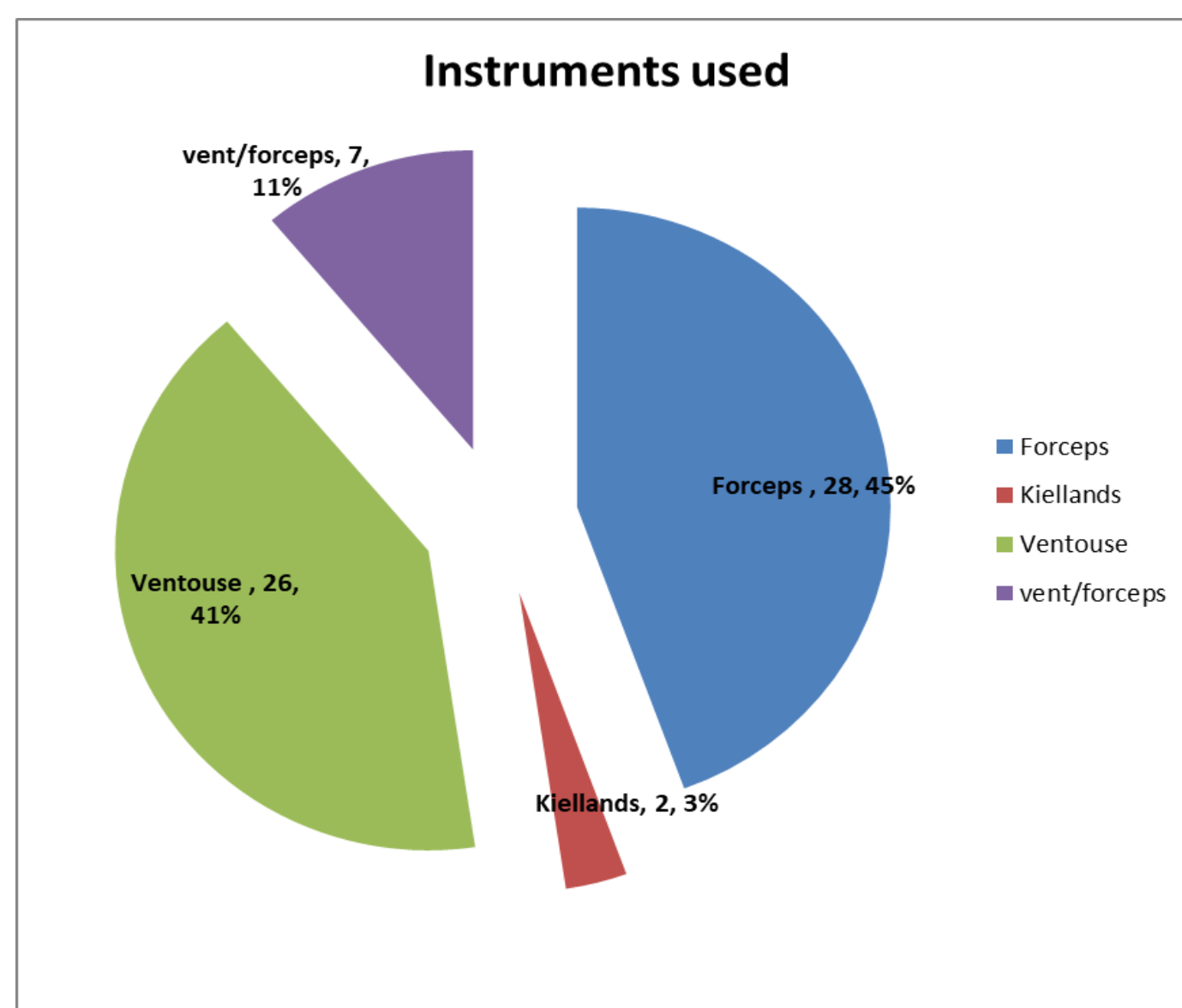


**Prophylactic antibiotics
37% did not receive**



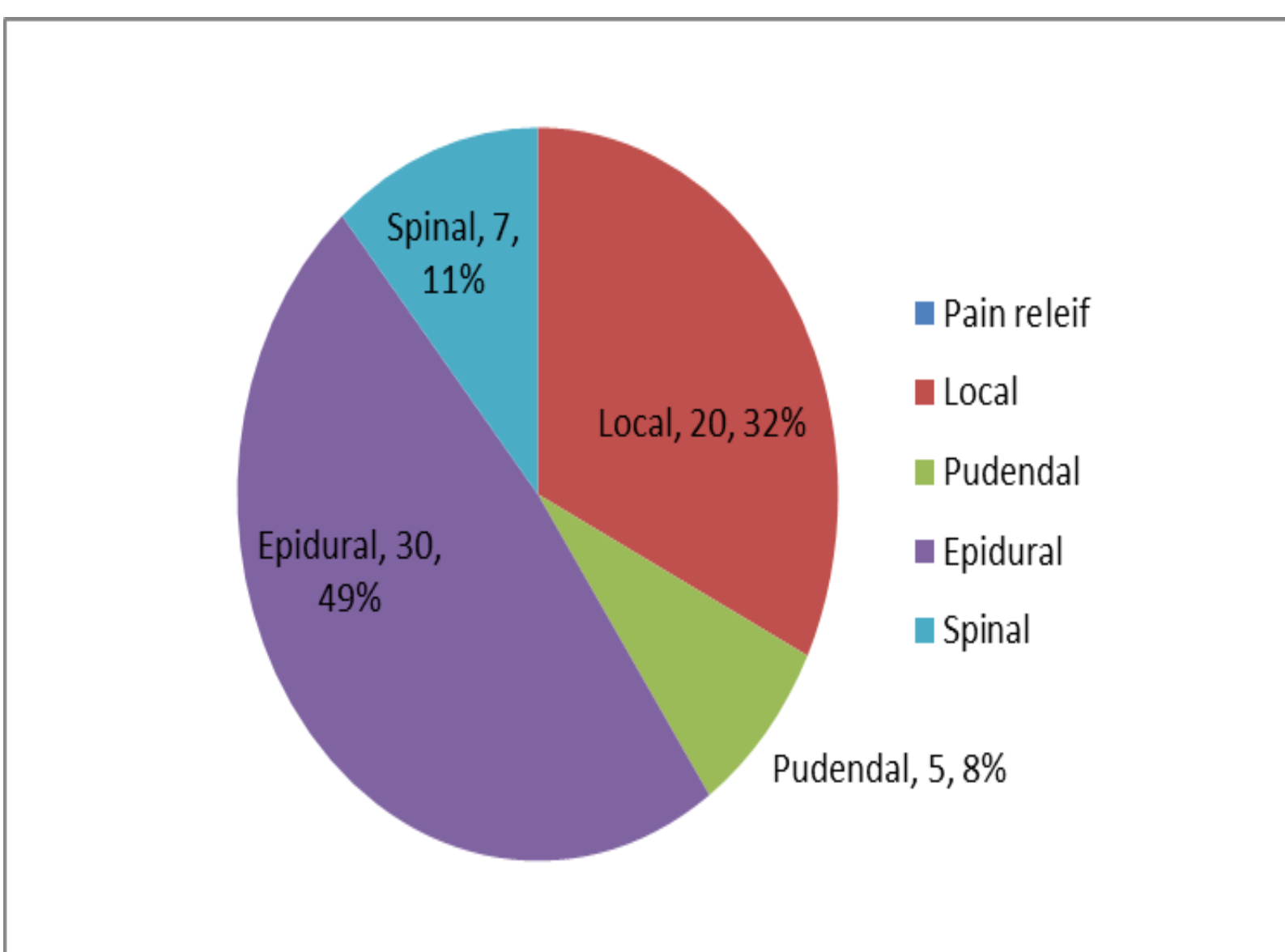
Instruments

59% - forceps delivery out of which 11% - sequential



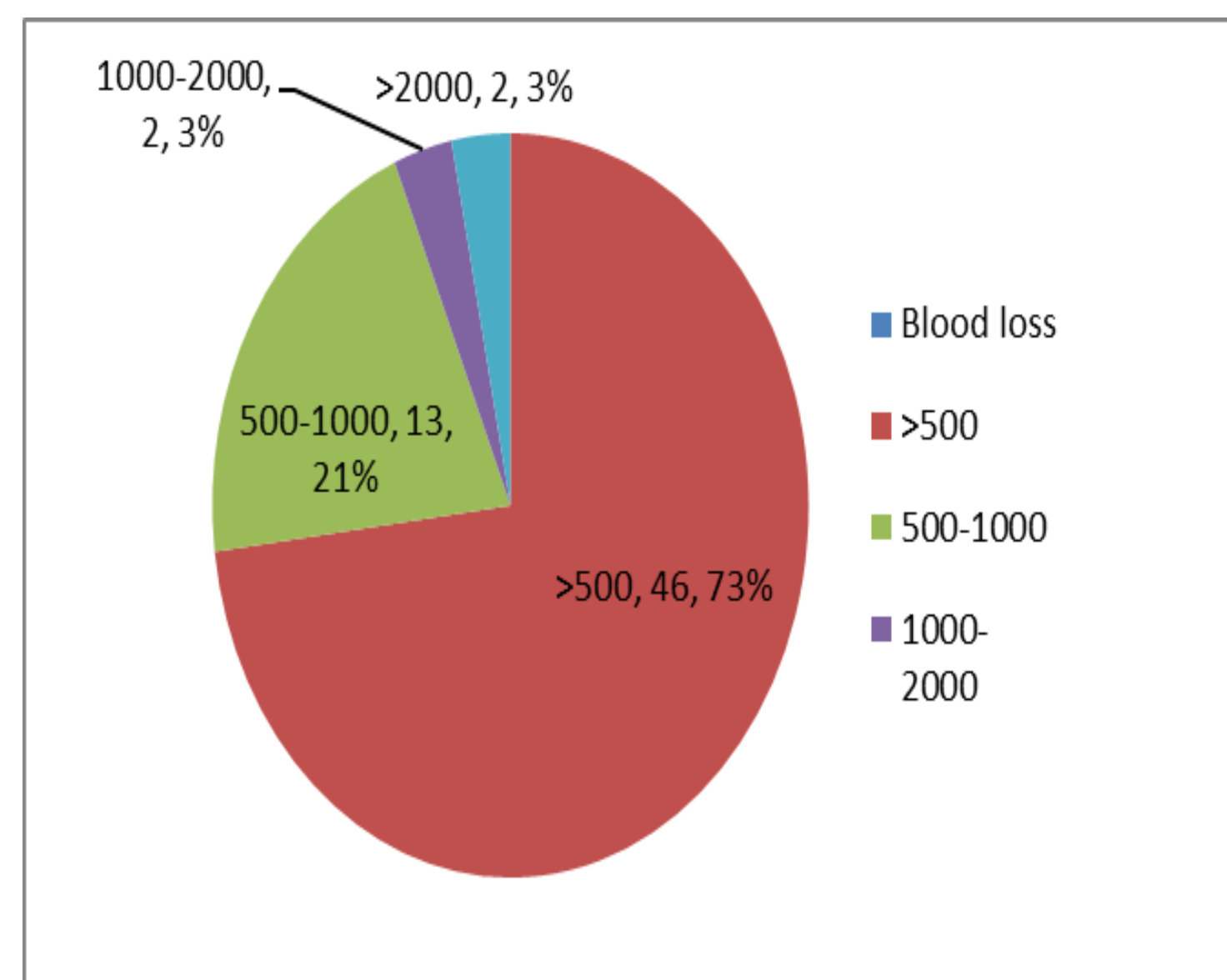
Pain relief

59% had epidural or spinal

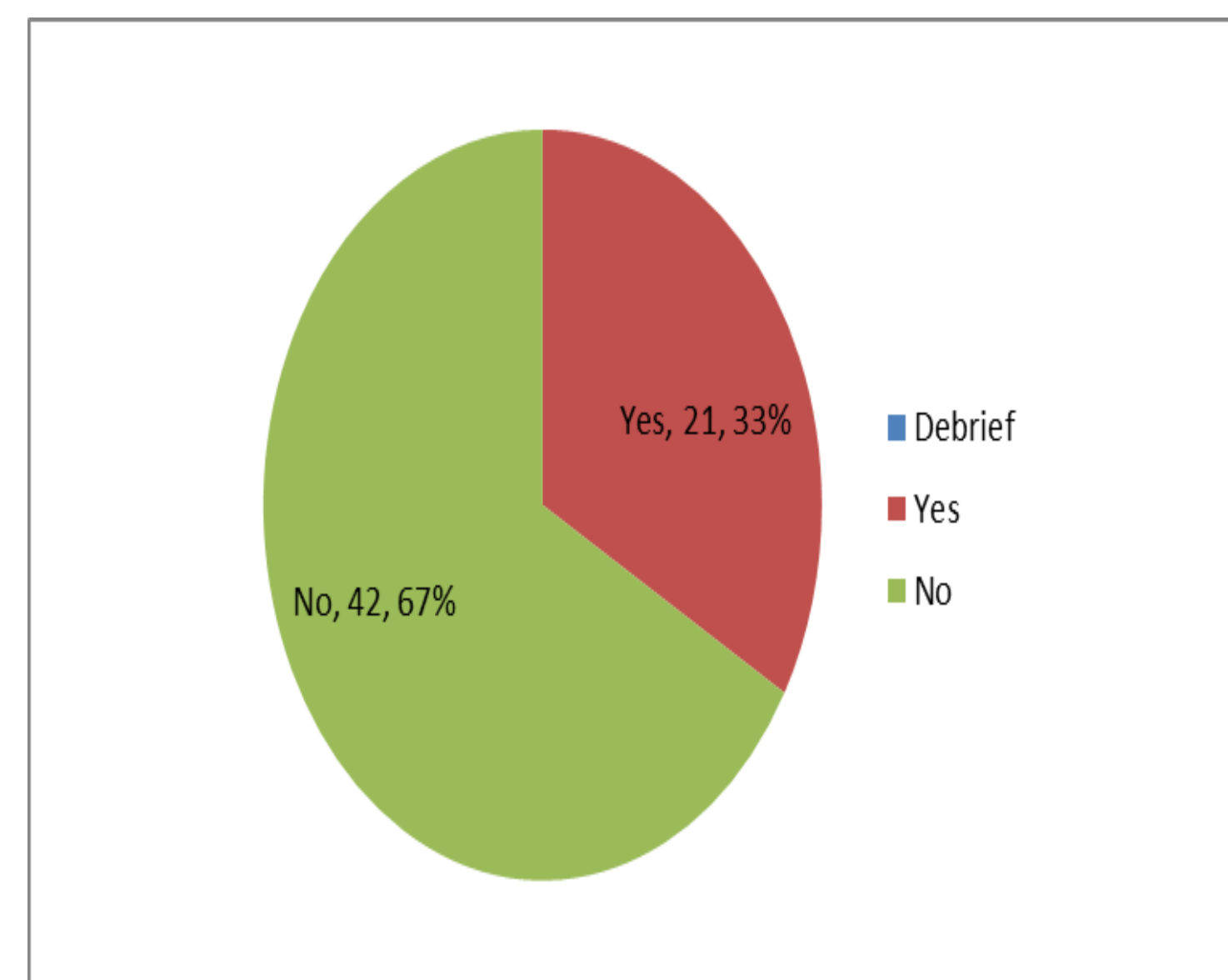


Blood loss

27% had PPH, 6% major PPH (blood loss of >1 L)



**Only 33% had debrief.
14/21 who had documented debrief were by the doctors**



Conclusions

- Incidence of instrumental delivery were well within national standard.
- We were good in taking consent for the procedure and documentation, however our computer documentation needs improving. All Doctors and midwives need to be educated and reminded on importance of documentation
- Around one third of women did not receive Prophylactic antibiotics which was highlighted
- Our maternal complication rates following the instrumental deliveries were within national standards.
- Debriefing is important. It has been agreed that all instrumental delivery patients must be reviewed by doctors before discharge.