Labor and Delivery Policy

Policy Title/Number: Elective Delivery Policy

Manual: Labor and Delivery Clinical Practice Manual

Clinical Policy Manual

Categories:

Contributors:

Review Responsibility: Clinical Policy Committee

Effective Date: March 2007

Last Revised Date:

Team Members Performing:

_____ x RN
_____ LPN
_____ Care Partner/Patient Care Technician
_____ x Other licensed staff (specify): Physician and Certified Nurse Midwife
_____ Other non-licensed staff (specify):

Guidelines Applicable to:

_____ x VUH
_____ VMG*
_____ VCH
_____ PHV

Other (specify):

_____ Exceptions (specify):

*includes satellite sites unless otherwise specified.

Guidelines Applicable to:

_____ All patient care areas
_____ All inpatient areas
_____ Adult areas only
_____ Pediatric areas only
_____ Critical Care/Stepdown areas only

_____ x Selected areas (specify): Labor and Delivery

_____ Exceptions (Specify):

Specific Education Requirements: Yes
Completion of Unit Based Orientation

Physician Order Requirements: Yes
Elective Delivery Policy

I. Outcome Goal: To ensure that elective deliveries occur at 39 week gestation or beyond, unless the delivery is medically indicated.

II. Policy: To outline the procedures to be followed and the information necessary when an elective delivery is planned.

III. Equipment/Supplies: as needed

IV. Protocol: The following steps outline the procedures to be followed when an elective delivery is planned.
   A. Identify the mode of planned delivery – either by Cesarean section or induction of labor
   B. Identify the indication for the elective delivery
   C. Planned deliveries will be in one of the following categories:
      1. Indications not requiring EGA of >= 39 weeks gestation. Indicated deliveries based on provider decisions do not require confirmation of fetal lung maturity. Fetal lung maturity testing may be helpful in decision making for borderline indications. The provider should consider maternal and fetal conditions, gestational age, cervical status and other factors. The following list of indications for delivery is not to be considered either exhaustive or absolute. Indications for delivery may include:
         a. Abruptio placentae
         b. Chorioamnionitis
         c. Fetal demise
         d. Pregnancy Induced Hypertension (PIH), preeclampsia and eclampsia
         e. Premature Rupture of Membranes (PROM)
         f. Post term pregnancy
         g. Prior cesarean sections with vertical incision
         h. Prior classical cesarean section
         i. Maternal medical conditions, including but not limited to:
            Diabetes mellitus
            Maternal HIV disease
            Renal disease
            Chronic pulmonary disease
            Chronic hypertension
            Maternal heart disease
         i. Fetal compromise including but not limited to:
            Intrauterine growth restriction
            Oligohydramnios
            Fetal anomalies requiring early delivery
            Non-reassuring fetal surveillance (NST, OCT, BPP)
2. Indications for delivery that require an EGA of \( \geq 39 \) weeks gestation or confirmation of fetal lung maturation includes the following:
   a. Logistical reasons
   b. Risk of rapid labor
   c. Distance from the hospital
   d. Psychosocial indications

   Fetal lung maturation MUST be confirmed before elective delivery at \(< 39\) weeks gestation (38 6/7 weeks or less) unless fetal lung maturation can be inferred from any of the following criteria listed below:
   a. Fetal heart tones have been documented for 20 weeks by non-electric fetoscope or for 30 weeks by Doppler stethoscope
   b. It has been 36 weeks since a serum or urine human chorionic gonadotropin was found to be positive by a reliable laboratory
   c. Ultrasound measurement of the crown-rump length at 6-11 weeks of gestation supports a gestational age equal to or greater than 39 weeks
   d. Ultrasound measurement at 12-20 weeks supports a clinically determined gestational age of 39 weeks or greater

   If any of these criteria confirms an EGA of \( \geq 39 \) weeks in a patient with normal menstrual cycles (no oral contraceptive pill use immediately prior to conception), it is appropriate to schedule delivery at \( \geq 39 \) weeks of gestation in accordance with menstrual dates. Ultrasonography may be considered confirmatory of menstrual dates if there is a gestational age agreement within 1 week by crown-rump measurements obtained at 6-11 weeks of gestation or within 10 days by an average of multiple measurements obtained between 12-20 weeks of gestation.

   EGA based only on a third trimester ultrasound is not acceptable under ANY circumstance

V. Procedure(s):

   When an elective delivery is planned the following steps will be followed:
   A. The provider will notify the charge nurse in Labor and Delivery. Scheduling of the case will be dependent upon unit census and staffing.
   B. The charge nurse will document the following in the schedule case book:
      1. Patient’s name, medical record number and phone number
      2. Date and time of procedure and time patient is to come in to L&D
      3. Name of the patient’s provider or provider group
      4. EDC and gestational age
      5. Indication for the procedure
      6. The date the procedure was scheduled
      7. Name of the attending provider who approved the scheduling
      8. The signature of the person scheduling the procedure
      9. FLM or documentation of fetal lung maturity when indicated
C. Elective procedures may be cancelled when unit census, patient acuity or staffing requires a reduction in census.
D. When an elective procedure is cancelled, it will be rescheduled as soon conditions that required the cancellation have been resolved.

VI. Nursing Implications:
   Care will be provided according to diagnosis, hospital standards and unit guidelines

VII. Patient/Family Education:
   Will include the plan of care, the type of procedure and the expected length of stay

VIII. Documentation:
   Will be in the Obstetric record by the provider and according to hospital standards

IX. Cross References:
   None

X. References:
   AWHONN Cervical Ripening and Induction and Augmentation of Labor (2nd edition) 2002, Kathleen Rice Simpson, PhD, RNC, FAAN.

XI. Web References:
   None

XI. Contributors:
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XII  **Endorsement:**
*Obstetric Patient Care Committee*
*Women’s Patient Care Center – Leadership/Executive Committee*

Clinical Practice Committee – (month/year approved)

XIII.  **Approval:**

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