BIRTH PLAN	
My Care Providers	Jen / REDACTED REDACTED. Team of midwives DR D REDACTED or DR W REDACTED or DR C REDACTED? Not sure about DR C REDACTED – will discuss why with Jen this is good to talk about tomorrow. questions like “why/how will these people support me having a vbac?
People in Attendance During my Labour and Birth	PARTNER NAME REDACTED Jen / BACK UP DOULA REDACTED Midwife Undisturbed birth No medical staff or trainees observing my birth for no reason
Birth Room Attitudes	Please don’t offer me drugs – if I need them I will ask Note to self: See book ‘The functions of the orgasms – Michael Odent’ – disconnect from world, no analysing or talking Make plans re SONS NAME REDACTED for pre labour and active labour this is really important. have you had any thoughts on this? Positivity PARTNERS NAME REDACTED to speak to any doctors outside the room yes. also you might word it “If there are any routine conversations please discuss with my husband first outside the room” No consent to talk to me in the shower/bath if I don’t know you I wonder if mentioning being jewish and religious might give power to this statement. i.e. “being religious is it culturally inappropriate and uncomfortable for me to be exposed in front of people i don't know, unnecessarily” - i wonder if if might cause a moment of thought before walking straight in…
Location of Birth	Home – pre labour (are there guidelines that Dr REDACTED has for this or are you ok to stay home as long as you can?) Birth centre
The Environment	At home – prelabour – will do optimal position (eg spinning babies), massage, walking, shopping Dim lights, birth ball (do you have one or should i drop mine to you?), diffuser Music (have you got a speaker or should i bring one?)

Clothing, Eating and Drinking	Keep hydrated – going to toilet at least 2 hrs If pre-labour is long and not hydrated – contractions may fade Go to toilet often as full bladder can stop baby from positioning
Vaginal Examinations	**Jen – help ! Not sure?** **"Vaginal examinations: not just a benign procedure** In order to gain consent for a VE, women need information about the lack of evidence supporting VEs, and about the potential consequences of VEs. I've started a list below and welcome any additions you can think of: ▪ *VEs are invasive and often painful:* There is limited research into women's experiences of VEs (surprise, surprise). Most women report being 'satisfied' with their VE experience, some find it painful, for a few VE is associated with PTSD (Dahlen et al. 2013). I'd be interested in your comments about experiences of VEs. ▪ The findings can be misleading: What the cervix is doing at the moment of a VE does not indicate what the cervix is going to do in the future. Therefore, the findings cannot effectively inform decisions about pain medication or other interventions (although this is often the rationale given for performing them). ▪ The measurements are subjective and inconsistent between practitioners: The accuracy between practitioners is less than 50% (Buchmann & Libhaber 2007). ▪ A VE disregards the woman's knowledge and reinforces the 'external expert': Often the findings do not match the woman's experience and the result can be disempowering, for example in early labour. ▪ A VE can result in accident rupturing of the membranes: It is not uncommon to accidentally break the amniotic sac whilst carrying out a VE – this alters the birth process and increases risk for the baby. ▪ VEs can increase the chance of developing an infection (Dahlen et al. 2013)." lets talk about this! It is a very personal decision. On the one hand there may be obvious physical signs that your labour is progressing so VE might not be appropriate, but if there are concerns it might be helpful as one of many observations to help make decisions. Also you can always change your mind. you may say you are not keen on them and then decide you would like one, or vice versa.
Rupture of Membranes	No consent to do this as a matter of routine (as risks for me would cause stress eg prolapse cord, risk of infection, risk of placenta delivery. ACOG recommends not doing this unless required.)

My Contraction Management	**Methods for early labour** • Take a soothing shower or a relaxing bath. • cup of herbal tea • Do some yoga • Watch a movie • Music • Practice breathing techniques **For the Surge Breathing,** imagine that you are filling an inner balloon as you slowly draw the breath up (inhaling gently through your nose) as long as you can go and then breathe out (again through your nose) directing the energy of the breath down. You can imagine that the balloon is either gently deflating, or drifting away into the sky. Another great visualisation that can be used in conjunction with this breath and your surges, is to imagine yourself being lifted up over a gentle wave, reaching the peak, and then gently coming down the other side. (have you been able to practice any of this in pregnancy?) • Massage of lower back • Sacrum squeeze Place your hands on the lower back and feel for the tailbone. This triangular space is the sacrum. If you feel around you will notice a soft hollow space that surrounds the sacrum (back dimples). Place your hands on the hips as if you are holding a fish bowl and bring your thumbs to this empty space around the triangular bone. Press the hips together and push down with your thumbs with intensity. Keep pressing without release until the contraction is done • *Use a birth ball for comfort* • *Changing positions as need be to keep labour going* Mind the bump techniques and assistance from my wonderful doula! Massage – Yoni Water – shower and bath Remind me/encourage me to change positions TENS? (yes! I have 2 tens machines that are available to be used. i will drop one to you at the end of pregnancy or in early labour) Want to try manage without gas/air Note to self: finishing reading Birth Skills and Gentle Birth

Fetal Monitoring	Doppler intermittent monitoring only (as no synto and no epidural)
Positions and Equipment to help my Labour	Birth Ball Shower Bath Squatting (not for delivery) All fours Walking and rocking

Pushing my Baby Out	Jen, your thoughts on the below:? This is all great. good to mention in your antenatal appointment with MIDWIFE REDACTED, and this is how i generally see her practice. The only time this may change is if there was an epidural or concerns. HOWEVER even in these scenarios i don't believe having a lot pf people yelling push push will necessarily get you to work harder so I will be mindful of this and aim to keep the space calm and focused if need be. we can chat further if you like :) "Spontaneous pushing before full dilatation is a normal and physiologically helpful when: 1. *Baby's head descends into the vagina before the cervix has dilated*. In this case the additional downward pushing pressure assists the baby to move beyond the cervix. 2. *Baby is in an OP position and the hard prominent occiput (back of head) presses on the rectum.* In an OA position this part of the head is against the symphysis pubis and the baby has to descend deeper before pressure on the rectum occurs from the front of the head. In the case of an OP position, pushing can assist rotation into an OA position. Yet to find any evidence that pushing on an unopened cervix will cause damage. I have been told many times that it will, but have never actually seen it happen. Borrelli et al. (2013) found no cervical lacerations, 3rd degree tears, postpartum haemorrhages in the women with an EPU. A recent review of the available research (Tsao 2015) concluded: *"Pushing with the early urge before full dilation did not seem to increase the risk of cervical edema or any other adverse maternal or neonatal outcomes."* I have encountered swollen (oedematous) cervixes – mostly in women with epidurals who are unable to move about. But, this occurs without any pushing. I can understand how directed, strong pushing could bruise a cervix. But I don't see how a woman could damage herself by following her urges. In many ways the argument regarding pushing, or not, is pointless because once the Ferguson reflex takes over it is beyond anyone's control. You either let it happen, or start commanding the women to do something she is unable to do ie. stop pushing. When left to get on with their birth, occasionally women will complain of pain associated with a cervical lip being 'nipped' between the baby's head and their symphysis pubis during a pushing contraction. In this case the woman can be assisted to get into a position that will take the pressure off the cervical lip (eg. backward leaning). When undisturbed women will usually do this instinctively. At a recent waterbirth a mother (first baby) who had been spontaneously pushing for a while on all fours floated onto her back. A little while later she asked me to feel where the baby was (for her not me) – baby was not far away with a fat squishy anterior lip in front of the head. The mother also had a feel, then carried on pushing as before. Her daughter was born around 30 mins later Ignore pushing and don't say the words 'push' or 'pushing' during a birth. Asking questions or giving directions interferes with the woman's instincts. Do not tell the woman to stop pushing. If she is spontaneously pushing (and you have not coached her) she will be unable to stop. It is like telling someone not to blink. Pushing will help not hinder

Positions during pushing	• "Lateral and hands-knees positions reduce the chance of tearing, and supine, squatting or lithotomy positions increase the chance of tearing" • "A slow birth of the baby's head reduces the chance of tearing. It allows the tissues to gently stretch over time as the baby moves forward with each contraction and retracts afterwards – 2 steps forward and 1 step back…. extremely small study of 4 women birthing without instructions (imagine that!) found that they altered their own breathing and stopped pushing as the baby's head crowned " • "**Coached pushing increases the chance of perineal tearing**, and this may be because it interferes with the instinctive response during crowning. The intense sensations experienced during crowning usually result in the woman 'holding back' while the uterus continues to push the baby out slowly and gently." • Hands on during birthing – ie holding perineal/holding/ pulling baby = likely to tear. **Hands off approach (default) unless needed. GREAT!**
Talking to me and 'directing' my pushing	Jen – advice? (i think you covered this above)
Epidural	No Note to self: A Cochrane review found that: *"Women who used epidurals were more likely to have a longer delivery (second stage of labour), needed their labour contractions stimulated with oxytocin, experienced very low blood pressure, were unable to move for a period of time after the birth (motor blockage), had problems passing urine (fluid retention) and suffered fever and association between epidural analgesia and instrumental birth."* The review also found an increased risk of instrumental delivery, and c-section for fetal distress with an epidural.

The use of Syntocinon	No Syntocin Note to self: An Australian study (Dekker et al. 2010) found that the risk of uterine rupture during VBAC was 0.15% in spontaneous labour, 1.91% in augmented labour and 0.88% in labour induced using prostin and oxytocin. Fitzpatrick et al. (2012) also found an increase in rupture with induction and augmentation. In contrast a US study (Ouzouian et al. 2011) found no different in rupture rates between spontaneous and induced labours – but found a significantly greater vaginal birth rate following spontaneous labour. Another study (Harper et al. 2011) found an increased chance of rupture during induction when the woman has an 'unfavourable' cervix. **Delivering the placenta after the birth – synto? To discuss risks/advantages with Midwife. How long to wait ? If excess bleeding ?** **This will probably be recommended as "standard" however if everything has been calm and spontaneous until this point physiological third stage might be appropriate. have a chat about it with MIDWIFE (and DR B) if you decide to do this we will also support it by not interrupting this time with your baby and just sitting back and let you fall in love with your baby and PARTNER REDACTED which increases your oxytocin production (essential for contractions). You will probably be told if the placenta isn't out by a certain time they might offer you syntocinon at that point.**
My baby Immediately Following Birth	Delayed cord clamping (i.e until stops pulsating), skin to skin and breastfeeding Baby not to be wiped clean immediately (straight on your chest, or you can pick up your baby. beautiful!)
Episiotomy	Think suture is more trauma? If not bleeding and well aligned, no need if 1st or 2nd degree. Only if medically necessary. Totally reasonable. only if needing to birth baby immediately due to concerns.

Strep B swab?	Jen thoughts? Is this routine here? In UK it is not. Not sure as inaccurate (and evidence – see Sarah Buckley suggests that it isn't worth screening everyone at 26 weeks) as can change and I am also SUSPECTED as allergic to penicillin. Will discuss with obstetrician. http://www.aims.org.uk/Journal/Vol15No4/WarOnGroupBStrep.htm Option - they can test at birth and check baby after birth? Maybe I should confirm whether I am allergic to penicillin Here screening is at 36 weeks. This is a link to the hospital policy. Other things to consider with gbs is if you are positive do you get the antibiotics or decline? if you opt for antibiotics for you to be "covered" you need to have had them for 4 hours before birth. (so if the plan is to come in and birth you might miss them.) If you are positive and don't get covered with antibiotics you will be recommended to stay for 48 hours to monitor the baby. http://www.seslhd.health.nsw.gov.au/rhw/manuals/documents/Antenatal_Pregnancy%20Care/groupbproph.pdf
Stretch and sweep	I will not consider this until at least 41/42 weeks - pros and cons Jen? Will consider balloon catheter at this point as well Note to self: Cochrane review on this concluded that: *'Routine use of sweeping of membranes from 38 weeks of pregnancy onwards does not seem to produce clinically important benefits. When used as a means for induction of labour, the reduction in the use of more formal methods of induction needs to be balanced against women's discomfort and other adverse effects.* *POST NOTE: we actually discussed this at length over the phone and the woman decided to decline stretch and sweeps*
Baby Injections: Vitamin K, Hepatitis, Others	Vit K after birth - OK Hepatitis – isn't this given after several weeks? Which Hep vaccine is this? Note not standard in UK
Feeding my baby	Breastfeeding

Separation of my baby from me	
My Flexibility	
If I need an instrumental or assisted birth	Am OK with instrumental birth if medically required
If I need a Caesarean birth	lets talk about this

Dr B to sign off:

- No cannula
- No CFM (only doppler) because no synto/epidural
- Birth centre rooms
- Back up Obstetrician to be confirmed by Dr B