

## Maternity Center Vacuum Delivery Checklist

Checked boxes indicate element was completed.

☐ **Informed consent for vacuum delivery obtained by physician – all elements necessary**

Indications for vacuum discussed. May include:

- Prolonged second stage
- Fetal \_\_\_\_\_
- Maternal \_\_\_\_\_

Alternative strategies considered and discussed. May include:

- Rest or continued pushing
- Augmentation of labor
- Cesarean section

Potential risks of vacuum discussion may include:

- Fetal trauma, temporary and permanent
- Maternal trauma
- Limits on application time and pop-offs

☐ **Fetal parameters assessed by physician and are known by the team before application – all elements necessary**

- Estimated fetal weight \_\_\_\_\_
- Position of the fetal head \_\_\_\_\_
- Station of the fetal head   -3   -2   -1   0   +1   +2   +3

☐ **Cesarean and resuscitation teams activated when necessary – all elements necessary**

- Clinical leader/ Charge RN is aware vacuum delivery is planned.
- Provider credentialed in cesarean delivery is present or activated.
- If fetal compromise is present or develops, NICU team is activated and OR is opened. Anesthesia is notified.

☐ **Recommendations on application time and pop-offs followed – all elements necessary**

(Note: Exceeding these recommendations or using other methods may be necessary for compelling and justifiable reasons.)

Number of pop-offs    1 ☐    2 ☐    3 ☐ (Recommended maximum of 3 pop-offs)

Total minutes of application (maximum recommended time 20 minutes)

Vacuum Start Time: \_\_\_\_\_

Vacuum End Time: \_\_\_\_\_

☐ If recommendations were exceeded, team members reassessed.

OB provider signature: \_\_\_\_\_ Date & Time: \_\_\_\_\_

Labor nurse signature: \_\_\_\_\_ Date & Time: \_\_\_\_\_

Exceptional Beginnings Approved April 8, 2010