QUALITY STANDARDS

Vaginal Birth After Caesarean

Care for People Who Have Had a Caesarean Birth and Are Planning Their Next Birth

2024 UPDATE

Provincial Council for Maternal and Child Health
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Ontario Health

Scope of This Quality Standard

The scope of this quality standard extends from postpartum counselling after a Caesarean birth through antenatal and intrapartum care during the next pregnancy and birth. The guidance provided in this quality standard on pregnancy care focuses on people with a previous Caesarean birth who are pregnant with 1 baby that is head-down and at full term (> 37 weeks), who are receiving pregnancy care from any type of clinician. People with more than 1 previous Caesarean birth are included in the scope; however, research evidence is limited for this population. Careful individualized assessment and clinical judgment as part of shared decision-making are essential in this situation.

This standard does not apply to people who have the following contraindications to vaginal birth after Caesarean (VBAC):

- Previous classical or inverted “T” uterine scar
- Previous hysterotomy or myomectomy entering the uterine cavity
- Previous uterine rupture
- Placenta accreta
- Placenta increta
- Placenta percreta
- Placenta previa
- Any other maternal or fetal complication that is a contraindication to vaginal birth

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and care partners know what to ask for in their care
- Help clinicians know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards and their accompanying patient guides are developed by Ontario Health, in collaboration with clinicians, patients, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca.

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care looks like for people who have had a Caesarean birth and are planning their next birth.

Quality Statement 1: Access to Vaginal Birth After Caesarean

People who have had a Caesarean birth before can plan a vaginal birth for their next birth, as long as there is no medical reason not to have one.

Quality Statement 2: Discussion After Caesarean Birth

After a Caesarean birth, people have a discussion with their physician or midwife and receive written information about the reasons for their Caesarean birth and their options for future births.

Quality Statement 3: Shared Decision-Making

Pregnant people who have had a previous Caesarean birth participate in shared decision-making with their physician or midwife. The discussion and planned mode of birth are documented in the perinatal record.

Quality Statement 4: Previous Vaginal Birth

Pregnant people who have had both a previous Caesarean birth and a previous vaginal birth are informed that they have a high likelihood of successful vaginal birth if no contraindication is present.

Quality Statement 5: Operative Reports and Incision Type

Physicians and midwives obtain an operative report from any previous Caesarean births whenever possible. Pregnant people who have had a previous Caesarean birth with an unknown type of uterine incision have an individualized assessment by their physician or midwife to determine the likelihood of a low transverse incision.

Quality Statement 6: Timely Access to Caesarean Birth

Pregnant people planning a vaginal birth after Caesarean are aware of the resources available and not available at their planned place of birth, including physician, midwifery, nursing, anesthesiology, and neonatal care, and the ability to provide timely access to Caesarean birth.

Quality Statement 7: Unplanned Labour

Pregnant people planning an elective repeat Caesarean section should have a documented discussion with their physician or midwife about the feasibility of vaginal birth after Caesarean if they go into unplanned labour. This discussion should take place during antenatal care and again if the person arrives at the hospital in labour.

Quality Statement 8: Induction and Augmentation of Labour

Pregnant people who have had a previous Caesarean birth are offered induction and/or oxytocin augmentation of labour when medically indicated, and are informed by their physician or midwife about the potential benefits and harms associated with the method proposed. Discussion about this should begin in the antenatal period.

Quality Statement 9: Signs and Symptoms of Uterine Rupture

During active labour, pregnant people who have had a previous Caesarean birth are closely monitored for signs or symptoms of uterine rupture.

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2024 Summary of Updates

In 2024, we completed a review of the evidence to capture new or updated clinical practice guidelines and health technology assessments published since the original release of this quality standard in 2018. This update aligns with the most recent clinical evidence, and with current practice in the Ontario landscape. Below is a summary of changes to the overall quality standard:

- Updated the links, secondary references, and data sources where applicable
- Changed the heading *Background* to *Rationale*
- Revised this quality standard and its accompanying resources (e.g., patient guide, placemat, case for improvement slide deck, technical specifications) to align with current Ontario Health design and branding
- Updated the data in the *Why This Quality Standard Is Needed* section, the case for improvement slide deck, and the data tables, using information from the Better Outcomes Registry and Network Ontario
- Updated the terminology to align with Ontario Health preferred terminology:
  - Replaced *health care providers* with *clinicians* or *health care team*
  - Replaced *caregiver* with *care partner*

Below is a summary of changes to specific quality statements:

- Quality statement 1: Modified the description of what supportive care should include
- Quality statement 3:
  - Modified the *Rationale* to include additional considerations during shared decision-making and additional options that should be discussed during antenatal counselling
  - Modified the definition of *shared decision-making* to include equity and person-centred care considerations
  - Updated the definition of *perinatal record* to reflect the latest version of the Ontario Perinatal Record

Why This Quality Standard Is Needed

The primary goals of this quality standard are to improve access to safe vaginal birth after Caesarean (VBAC) and promote informed shared decision-making. Most people who have had a Caesarean birth can have a VBAC, and a large body of evidence suggests that VBAC is safe for most eligible pregnant people.[1-3] However, data from the Better Outcomes Registry and Network show that the rate of planned VBACs has decreased over time in Ontario, from 41.0% in fiscal year (FY) 2014/15 to 39.0% in FY 2022/23, while the rate of planned elective repeat Caesarean births in Ontario for FY 2022/23 was 56.1%.[4] Elective repeat Caesarean births represented 16.2% of Caesarean births in Ontario in FY 2022/23 (data from the Better Outcomes Registry and Network and the Canadian Institute for Health Information), which suggests that increasing Ontario's VBAC rate could also substantially reduce the overall provincial Caesarean birth rate.

People considering planned VBAC need to balance the overall benefits (such as faster recovery time, lower risk of abnormal placentation with future pregnancy, and reduced neonatal respiratory morbidity)[1,3] with the potential harms (such as uterine rupture, which occurs in approximately 1 of 200 planned VBACs, based on the overall rate in Ontario from FYs 2014/15–2022/23 [data from the Better Outcomes Registry and Network]). Overall, the available evidence suggests that both VBAC and elective repeat Caesarean section can be performed safely and, for large populations, any absolute differences in maternal and neonatal outcomes are likely to be small.[1-3,5,6] Informed shared decision-making is therefore especially important so that pregnant people can receive the care that is most consistent with their values and preferences.

There is notable variation in the rates of planned VBAC across regions in Ontario. This variation may be related to differences between hospitals – hospitals with lower birth volumes are more likely to have lower rates of planned VBAC among eligible pregnancies where the pregnant individual's intention was collected (data from the Better Outcomes Registry and Network). In areas that cannot offer timely access to Caesarean birth, choices for planned VBAC may be more limited. Decisions may also be influenced by social, financial, or cultural factors.[7] Birth preferences may develop between pregnancies, and pregnant people may be influenced more by previous birth experience or by information from peers and the internet than by clinicians.[8] Research has also found substantial variation among regions and institutions in the use of shared decision-making between clinicians and patients who are planning their next birth.[8]

This quality standard is designed to help ensure that all people in Ontario who plan a birth after a Caesarean are offered VBAC, as well as hospitals that support and provide VBAC as part of high-quality, evidence-based care.

Measurement to Support Improvement

The Vaginal Birth After Caesarean Quality Standard Advisory Committee identified 6 overarching indicators to monitor the progress being made toward improving care for people having a VBAC in Ontario.

Indicators That Can Be Measured Using Provincial Data

- Percentage of eligible pregnant people who plan a vaginal birth after Caesarean
- Percentage of eligible pregnant people who have a successful vaginal birth after Caesarean
- Percentage of eligible pregnant people who plan an elective repeat Caesarean section

The following are intended as balancing measures to ensure that VBAC continues to be a safe option for people planning a pregnancy after a previous Caesarean section:

- Rate of uterine rupture per 1,000 planned vaginal births after Caesarean
- Percentage of neonates who remained in neonatal intensive care for more than 4 hours among infants born to people who planned vaginal birth after Caesarean and among infants born to people who planned elective repeat Caesarean section
- Rate of neonatal morbidity and mortality among infants born to people who planned vaginal birth after Caesarean and among infants born to people who planned elective repeat Caesarean section

Quality Statement 1: Access to Vaginal Birth After Caesarean

People who have had a Caesarean birth before can plan a vaginal birth for their next birth, as long as there is no medical reason not to have one.

Sources: American Academy of Family Physicians, 2014[2] | Association of Ontario Midwives, 2021[1] | Royal College of Obstetricians and Gynaecologists, 2015[3] | Society of Obstetricians and Gynaecologists of Canada, 2019[6]

Definition

Access: Pregnant people planning a vaginal birth after Caesarean (VBAC) have access to a physician or midwife who is supportive of VBAC. This may include referral to a more comprehensive service that can offer planned VBAC.

Rationale

VBAC is safe and appropriate for most people who have had a previous Caesarean birth.[1-3,6] When no contraindications to VBAC are present, physicians and midwives should offer VBAC as an option and counsel pregnant people and their families to make choices that reflect their values, preferences, and priorities.[2] This kind of supportive care requires the availability of clinicians and facilities that offer and encourage planned VBAC.[2] Local institutional policies, opinion leaders, and audit and feedback are all potentially effective ways of promoting and increasing access to VBAC.[2]

What This Quality Statement Means

For Pregnant People

If you have previously had a Caesarean section, you can plan a vaginal birth in this pregnancy, as long as there is no medical reason not to have one.

For Clinicians

Offer VBAC in a supportive manner to all pregnant people who have had a previous Caesarean birth and who have no contraindication to a vaginal birth.

For Organizations and Health Services Planners

Ensure that clinicians and facilities have systems, processes, and resources in place to offer and support planned VBAC.

Quality Indicator: How to Measure Improvement for This Statement

- Local availability of facilities that have policies supportive of VBAC

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 2: Discussion After Caesarean Birth

After a Caesarean birth, people have a discussion with their physician or midwife and receive written information about the reasons for their Caesarean birth and their options for future births.

Sources: Association of Ontario Midwives, 2021[1] | National Institute for Health and Care Excellence, 2021 (updated 2024)[9] | Society of Obstetricians and Gynaecologists of Canada, 2019[6]

Definitions

Discussion: A conversation between the person who had a Caesarean birth, their family, and a physician or midwife to provide accurate information about the reason for the Caesarean birth, including the clinical situation, recurring and nonrecurring indications for Caesarean birth, and how it might affect options for future births. This conversation should happen before the person is discharged from hospital and should be reviewed at the 6-week postnatal visit. It should take place after each Caesarean birth.

Written information: Written information could be in the form of an operative report, but should be in a format that is easy to read and includes the following:

- Gestational age
- Reason for Caesarean section
- Fetal position and presentation
- Length of labour and dilation before Caesarean section
- Whether labour was induced or augmented
- Type of uterine incision, extension of the incision, and closure
- Any contraindication to future vaginal birth

Rationale

Preferences for future births are usually established between pregnancies.[8] Therefore, vaginal birth after Caesarean should be presented as an option for future births at discharge from hospital and again at the 6-week postnatal visit. It is important to discuss the reasons for the initial Caesarean birth so that the person and their family can use that information for family planning and future births.[8,9] Discussion should also include the association between a delivery interval of less than 18 to

24 months and increased risk of uterine rupture.[1,6] The physician or midwife should ask about the person's emotional state and well-being and encourage them to ask questions.

Information should be provided during the discussion and also in written form so that it can be retained and shared.[9] Written information facilitates communication with care providers from one birth to the next, because the clinical context and factors involved in the previous Caesarean birth are then clear, not only to the physician or midwife but also to the pregnant person and their family. This information can support shared decision-making during the next pregnancy, and this discussion should be repeated for each subsequent Caesarean birth.

What This Quality Statement Means

For Pregnant People

Before you leave the hospital after a Caesarean birth, your physician or midwife should talk with you about why you had a Caesarean birth and what your options are for future births.

They should give you this information in a written report. They should also talk about this at your 6-week follow-up appointment.

For Clinicians

Have a discussion with people who have had a Caesarean birth and provide written information about the reasons for their Caesarean birth and their options for future births.

For Organizations and Health Services Planners

Ensure that systems, resources, and training are available for physicians and midwives to have discussions and provide written information about the reasons for Caesarean births and options for future births.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people who have had a Caesarean birth and who have a discussion with their physician or midwife about the reasons for their Caesarean birth and their options for future births at discharge
- Percentage of people who have had a Caesarean birth and who have a discussion with their physician or midwife about the reasons for their Caesarean birth and their options for future births at the 6-week postnatal visit
- Percentage of people who have had a Caesarean birth and who receive written information after a discussion with their physician or midwife about the reasons for their Caesarean birth and their options for future births at discharge and at the 6-week postnatal visit

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 3: Shared Decision-Making

Pregnant people who have had a previous Caesarean birth participate in shared decision-making with their physician or midwife. The discussion and planned mode of birth are documented in the perinatal record.

Sources: American Academy of Family Physicians, 2014[2] | Association of Ontario Midwives, 2021[1] | Royal College of Obstetricians and Gynaecologists, 2015[3] | Society of Obstetricians and Gynaecologists of Canada, 2019[6] | National Institute for Health and Care Excellence, 2021 (updated 2024)[9]

Definitions

Perinatal record: Standardized documentation of perinatal care. The Ontario Perinatal Record acts as a care map for pregnancy, birth, and the early postpartum period.

Shared decision-making: A collaborative process that allows people and their clinicians to make decisions together. Using an approach that is sensitive to people's preferences and aligns with their needs, the health care team should:

- Invite the person to participate (as well as their family and care partners, if the person consents)[10]
- Consider factors that may affect a person's involvement or ability to communicate (e.g., the language in which care is delivered, health literacy, or cultural or religious beliefs)[11]
- Present options[10]
- Provide evidence-based information about the benefits and harms of each option, as well as care during labour and discussion of potential interventions[10]
- Help people evaluate the options based on their values and preferences[10]
- Facilitate deliberation and decision-making[10]
- Help implement decisions[10]
- Provide decision-making aids or other tools[10]

Rationale

Eligible pregnant people who have had a previous Caesarean birth should receive counselling on both planned vaginal birth after Caesarean (VBAC) and elective repeat Caesarean section.[1,2,6] The choice of

mode of birth requires shared decision-making and considers the person's values and preferences, the outcomes of the previous Caesarean birth and previous operative report, the person's risk profile and risk tolerance, and clinical factors relevant to the current pregnancy. This process also includes the person's partner or family, if desired.

Physicians and midwives should inform pregnant people who have had a previous Caesarean birth that VBAC is safe for most people, but not without risk.[1-3,6] Antenatal counselling should include information about preparedness during labour (e.g., options for pain management, electronic fetal monitoring, IV access, and immediate access to Caesarean section) and unbiased information about the benefits and potential harms of VBAC versus elective repeat Caesarean section, including:

- Expected postpregnancy function, pain, and recovery time
- Potential complications
- Potential maternal and neonatal morbidity and mortality
- Implications for future pregnancies

The risk of uterine rupture during labour after previous Caesarean is estimated to be 1 in 200.[1-3,6] Uterine rupture requires an emergency Caesarean section, and it increases the risk of maternal bleeding and the need for a hysterectomy.[6] Uterine rupture may result in maternal or perinatal death if a Caesarean section is not performed quickly enough.[6] The use of a decision aid is recommended to facilitate best practices in shared decision-making, informed consent, and documentation.[3] Decision aids present risk information in a balanced and comprehensive manner, to help the person clarify their preferences, which supports informed decision-making.

Physicians and midwives should document antenatal counselling on VBAC, the person's decision about their planned mode of birth, and a plan for mode of birth if spontaneous labour occurs before the scheduled delivery date when elective repeat Caesarean section is chosen.[1,3,6]

What This Quality Statement Means

For Pregnant People

When you are choosing how you want to give birth, you and your physician or midwife should work together to make decisions. Conversations should include what is important to you about your birth experience, and the benefits and possible harms of both vaginal birth after Caesarean and a planned repeat Caesarean section.

For Clinicians

Provide antenatal counselling that supports shared decision-making for the planned mode of birth and offer VBAC when appropriate. Document the discussion and the planned mode of birth in the perinatal record. Consider using a decision aid, such as My Next Birth, developed by Perinatal Services BC.

For Organizations and Health Services Planners

Ensure that systems are in place so that physicians and midwives have the skills to support shared decision-making (including the use of decision aids, such as My Next Birth) and document the discussion and planned mode of birth in the perinatal record.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of pregnant people who have had a previous Caesarean birth and who have a documented discussion with their physician or midwife about their values and preferences, the benefits and potential harms of planned VBAC, and the benefits and potential harms of elective repeat Caesarean section
- Percentage of pregnant people who have had a previous Caesarean birth and whose planned mode of birth is documented in their clinical chart

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 4: Previous Vaginal Birth

Pregnant people who have had both a previous Caesarean birth and a previous vaginal birth are informed that they have a high likelihood of successful vaginal birth if no contraindication is present.

Sources: American Academy of Family Physicians, 2014[2] | Association of Ontario Midwives, 2021[1] | Royal College of Obstetricians and Gynaecologists, 2015[3] | Society of Obstetricians and Gynaecologists of Canada, 2019[6] | National Institute for Health and Care Excellence, 2021 (updated 2024)[9]

Rationale

The strongest predictor of successful vaginal birth after Caesarean (VBAC) is a previous vaginal birth; in this scenario, the VBAC success rate is high – approximately 85% to 90%.[3] Previous vaginal birth is also independently associated with a reduced risk of uterine rupture.[1,3] Physicians and midwives should inform pregnant people who have had a previous Caesarean birth and a previous vaginal birth or VBAC that they have a high likelihood of VBAC success for the current pregnancy. Physicians and midwives should encourage planned VBAC if no contraindication is present because of the faster recovery time, lower risk of abnormal placentation with future pregnancies, and lower risk of harm from uterine rupture.[1-3,6]

What This Quality Statement Means

For Pregnant People

If you have had a vaginal birth before, you are very likely to have a successful vaginal birth after Caesarean, as long as there are no medical reasons to avoid one in this pregnancy.

For Clinicians

Inform pregnant people who have had both Caesarean and vaginal births, and who have no contraindications to vaginal birth in their current pregnancy, that they have a high likelihood of successful VBAC.

For Organizations and Health Services Planners

Ensure that processes and systems are in place to inform people who have had both Caesarean and vaginal births, and who have no contraindications to vaginal birth in their current pregnancy, that they have a high likelihood of successful VBAC.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of pregnant people who have had a previous Caesarean birth and a previous vaginal birth, and who are planning a VBAC for their current pregnancy

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 5: Operative Reports and Incision Type

Physicians and midwives obtain an operative report from any previous Caesarean births whenever possible. Pregnant people who have had a previous Caesarean birth with an unknown type of uterine incision have an individualized assessment by their physician or midwife to determine the likelihood of a low transverse incision.

Sources: Association of Ontario Midwives, 2021[1] | Royal College of Obstetricians and Gynaecologists, 2015[3] | Society of Obstetricians and Gynaecologists of Canada, 2019[6]

Definitions

Uterine incision: The type of cut made to the uterus during Caesarean birth. This may be different than the incision made in the skin. Low transverse, a horizontal incision in the lower uterus, is the most common type used in Canada and has a lower risk of uterine rupture than other types of incisions.[1-3,6]

Individualized assessment: Assessment that includes the circumstances of the previous Caesarean birth, the person's values and preferences, the person's risk profile, and clinical factors relevant to the current pregnancy and fetal health during labour.

Rationale

Physicians and midwives should make every effort to obtain the operative report from the previous Caesarean section to develop an appropriate plan of care for people considering a vaginal birth after Caesarean (VBAC).[1] Physicians and midwives should review the operative report and note the type of uterine incision used, as well as any extensions of the incision, to determine the feasibility of VBAC.[6] A previous classical or inverted "T" uterine scar, a previous myomectomy entering the uterine cavity, or a previous uterine rupture are contraindications to labour after Caesarean.[6]

When the operative report is unavailable, physicians and midwives should discuss and explore specific details of previous Caesarean births to determine the likelihood of a low transverse uterine incision.[6] Considerations should include the reason for the previous Caesarean, gestational age at the time of the previous Caesarean, and any other relevant clinical details. Any other previous relevant gynecologic history – including other uterine surgeries or interventions – should be considered and documented. If the likelihood of a low transverse incision is high, labour after Caesarean can be

offered with informed consent and a discussion of possible increased risks of harm due to uterine rupture.[6] Inability to obtain the previous operative reports should be documented.[1]

What This Quality Statement Means

For Pregnant People

Your physician or midwife should read the report from your previous Caesarean birth. If they don't know the type of scar on your uterus from your previous Caesarean birth, they should help determine whether a vaginal birth after Caesarean is right for you.

For Clinicians

Obtain operative reports from previous Caesarean births whenever possible to develop an appropriate plan of care. Inability to obtain the operative record should be documented, and VBAC may still be offered with shared decision-making. Document the discussion and planned mode of birth. When the incision type used in the previous Caesarean birth is unknown, assess the person's preference and the clinical circumstances surrounding the previous Caesarean birth to determine whether VBAC is feasible.

For Organizations and Health Services Planners

Ensure that physicians and midwives and facilities have the necessary resources, systems, and processes in place to obtain and send operative reports from previous Caesarean births in a timely way whenever possible. When the incision type used in the previous Caesarean birth is unknown, ensure that physicians and midwives are equipped with the knowledge and skills to assess the clinical circumstances surrounding previous Caesarean birth and determine whether VBAC is feasible.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of pregnant people who have had a previous Caesarean birth whose physician or midwife makes a documented attempt to obtain the operative report from the previous Caesarean birth
- Percentage of pregnant people who have had a previous Caesarean birth with an unknown type of uterine incision and have a documented individualized assessment to determine whether VBAC is feasible

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 6: Timely Access to Caesarean Birth

> Pregnant people planning a vaginal birth after Caesarean are aware of the resources available and not available at their planned place of birth, including physician, midwifery, nursing, anesthesiology, and neonatal care, and the ability to provide timely access to Caesarean birth.
>
> Sources: American Academy of Family Physicians, 2014[2] | Association of Ontario Midwives, 2021[1] | Royal College of Obstetricians and Gynaecologists, 2015[3] | Society of Obstetricians and Gynaecologists of Canada, 2019[6] | National Institute for Health and Care Excellence, 2021 (updated 2024)[9]

Definition

Timely access: When there is an indication for Caesarean section, it should occur promptly, as delay in surgery could result in serious maternal and/or neonatal harm.

Rationale

In an emergency, the risk to the person and the newborn is increased if a Caesarean birth is delayed.[3,6] Therefore, the physician or midwife should advise that the safest place for a vaginal birth after Caesarean (VBAC) is in hospital, where there is access to continuous fetal monitoring and timely access to Caesarean birth. Physicians and midwives must be aware of the availability of physician, midwifery, nursing, anesthesiology, and pediatric staff for people in labour in their hospital.[6] This information should be shared with people planning a VBAC as part of shared decision-making (Quality Statement 3).[1] Hospitals should have written policies and protocols to promote and ensure access to VBAC that include how physicians are notified or consulted to provide timely Caesarean birth if needed.[2,6] Maternal factors that may increase the potential risk of uterine rupture should be discussed and considered when planning birth location, and referral to a more comprehensive service that includes supports for planned VBAC may be appropriate.

What This Quality Statement Means

For Pregnant People

If you choose to have a vaginal birth after Caesarean, your physician or midwife should tell you about the expertise available and not available where you plan to give birth, and what would happen if you needed an unplanned Caesarean birth.

For Clinicians

Inform pregnant people planning a VBAC about the physician, midwifery, nursing, anesthesiology, and neonatal resources available and not available at their planned place of birth in case they need an unplanned Caesarean birth. If an out-of-hospital birth is planned, inform people about plans for transport and timely transfer to hospital.

For Organizations and Health Services Planners

Ensure that physicians and midwives and other relevant staff in the health service have the knowledge to inform pregnant people planning a VBAC about the resources available and not available at their planned place of birth. Practice should be supported by a written policy, protocol, or guideline.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of pregnant people planning a VBAC who have a documented discussion about the resources available and not available at their planned place of birth, including obstetric, nursing, anesthesiology, neonatal care, and the ability to provide timely access to Caesarean birth

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 7: Unplanned Labour

> Pregnant people planning an elective repeat Caesarean section should have a documented discussion with their physician or midwife about the feasibility of vaginal birth after Caesarean if they go into unplanned labour. This discussion should take place during antenatal care and again if the person arrives at the hospital in labour.
>
> Sources: American Academy of Family Physicians, 2014[2] | Royal College of Obstetricians and Gynaecologists, 2015[3]

Definition

Unplanned labour: When labour begins spontaneously, before the scheduled elective repeat Caesarean section.

Rationale

During antenatal care, physicians and midwives should discuss the possibility of unplanned labour occurring before the scheduled delivery date with people who are planning an elective repeat Caesarean section. Any preferences for attempting a vaginal birth after Caesarean (VBAC) in this situation should be documented in the person's perinatal record.

People planning an elective repeat Caesarean section who experience unplanned labour should engage in shared decision-making with their physician or midwife about the feasibility of VBAC when they arrive at the hospital in labour.[2,3] People's preferences, clinical factors that may increase the risk of uterine rupture, and the clinical judgment of the physician or midwife should be considered when determining the mode of birth.[2] Obstetrical care providers and pregnant people should continue to engage in shared decision-making during unplanned labour after previous Caesarean if there are any changes in maternal or fetal health status that may affect the risks associated with labour and the likelihood of vaginal birth.[2]

What This Quality Statement Means

For Pregnant People

If you plan to have another Caesarean birth but you go into labour before your scheduled Caesarean, it may still be possible to have a vaginal birth. Talk to your physician or midwife about your options if you go into labour early.

For Clinicians

Engage people who plan an elective repeat Caesarean section in shared decision-making about the feasibility of VBAC if they go into unplanned labour.

For Organizations and Health Services Planners

Ensure systems, processes, and resources are available for physicians, midwives, and facilities to engage people in shared decision-making about the feasibility of VBAC if they go into unplanned labour.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of pregnant people planning an elective repeat Caesarean section who have a documented discussion that includes shared decision-making with their physician or midwife during antenatal care about the feasibility of VBAC in the event of unplanned labour
- Percentage of pregnant people planning an elective repeat Caesarean section who experience unplanned labour and have a documented discussion that includes shared decision-making with their physician or midwife about the feasibility of VBAC

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 8: Induction and Augmentation of Labour

Pregnant people who have had a previous Caesarean birth are offered induction and/or oxytocin augmentation of labour when medically indicated, and are informed by their physician or midwife about the potential benefits and harms associated with the method proposed. Discussion about this should begin in the antenatal period.

Sources: American Academy of Family Physicians, 2014[2] | Association of Ontario Midwives, 2021[1] | Royal College of Obstetricians and Gynaecologists, 2015[3] | Society of Obstetricians and Gynaecologists of Canada, 2019[6] | National Institute for Health and Care Excellence, 2021 (updated 2024)[9]

Definitions

Induction of labour: Starting contractions in a pregnant person who is not in labour to help achieve a vaginal birth within 24 to 48 hours.[12]

Augmentation of labour: Stimulating the uterus to increase the frequency, duration, and intensity of contractions after spontaneous labour has started.[13]

Rationale

Evidence suggests that compared with spontaneous labour, induction or augmentation of labour after a previous Caesarean delivery increases the risk of uterine rupture by 2 to 3 times, and increases the risk of Caesarean birth by 1.5 times.[3] However, because the absolute risk of uterine rupture is low, induction and augmentation of labour can be offered when the indication is appropriate and after counselling on potential benefits and harms.[6] Physicians and midwives should talk with their patient or client about the decision to induce or augment labour, the proposed method to be used, time intervals for serial vaginal examination, and criteria for labour progress that would lead to discontinuing labour and proceeding to a Caesarean birth.[3]

If oxytocin augmentation is used, clinicians should pay very close attention to labour progress and uterine activity. The use of oxytocin requires one-to-one nursing or midwifery care and continuous electronic fetal monitoring during active labour.

In people who have had a previous Caesarean birth, pregnancy that continues beyond 40 weeks is not a contraindication for labour.[6] Induction of labour should be considered only after 41 weeks, unless

there are other medical indications for it.[12] Mechanical methods of induction such as amniotomy or Foley catheter cervical ripening are preferred, because they are associated with a smaller increased risk of uterine rupture.[1,3,6] Misoprostol or prostaglandins should not be used during labour after Caesarean birth because of their association with a high risk of uterine rupture.[2]

What This Quality Statement Means

For Pregnant People

You may be offered drugs or other methods to speed up your labour if you need it. Be sure to talk with your physician or midwife about the benefits and potential harms of what they recommend.

For Clinicians

Offer induction and/or oxytocin augmentation of labour when medically indicated, and discuss the benefits and potential harms associated with the method proposed, including increased risk of uterine rupture. Do not use misoprostol to induce labour after Caesarean.

For Organizations and Health Services Planners

Ensure that physicians and midwives have the resources, knowledge, and skills to offer and monitor induction and/or oxytocin augmentation when medically indicated, and to discuss the benefits and potential harms associated with the method proposed.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of pregnant people who attempt a vaginal birth after Caesarean and present with documented clinical indications for labour induction who receive labour induction
- Percentage of pregnant people who attempt a vaginal birth after Caesarean and present with documented clinical indications for labour augmentation who receive labour augmentation

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 9: Signs and Symptoms of Uterine Rupture

During active labour, pregnant people who have had a previous Caesarean birth are closely monitored for signs or symptoms of uterine rupture.

Sources: Association of Ontario Midwives, 2021[1] | Royal College of Obstetricians and Gynaecologists, 2015[3] | Society of Obstetricians and Gynaecologists of Canada, 2019[6] | Vaginal Birth After Caesarean Advisory Committee consensus | National Institute for Health and Care Excellence, 2021 (updated 2024)[9]

Definition

Uterine rupture: A tear in the uterine scar during labour or birth. This is an urgent situation that requires emergency Caesarean section or hysterectomy as soon as possible.[6]

Rationale

People who labour after a previous Caesarean have a higher risk of uterine rupture than those who choose an elective repeat Caesarean section. Labour progress should be assessed regularly, and people should be monitored closely for signs or symptoms of uterine rupture and receive immediate medical attention if there are any concerns.[1,3,6]

Signs or symptoms of uterine rupture may be sudden in onset and include[1]:

- Atypical and abnormal fetal heart tracings, including a changing baseline heart rate and/or variability (e.g., fetal bradycardia in the first or second stage of labour)
- Maternal hypotension
- Maternal tachycardia
- Hematuria and/or excessive vaginal bleeding
- Maternal restlessness
- Loss of fetal presenting part in the pelvis

Continuous electronic fetal monitoring beginning at the onset of active labour and continuing for the duration of labour in people who have had a previous Caesarean birth can identify atypical and abnormal fetal heart rate in a timely manner, including fetal bradycardia—the most consistent/common predictive sign of uterine rupture.[3,6,14] Clinicians should recognize and respond to atypical and abnormal fetal heart tracings.

Any unusual pain or increased requirement for pain relief in people who receive epidural analgesia should command immediate medical attention, because this may be indicative of a pending uterine rupture.[1,3]

What This Quality Statement Means

For Pregnant People

While you are in labour, your clinicians should watch you closely for signs and symptoms of a tear in your uterus.

For Clinicians

Monitor people who have had a previous Caesarean birth closely for signs or symptoms of uterine rupture during active labour.

For Organizations and Health Services Planners

Ensure that processes and resources are in place to support monitoring of people who have had a previous Caesarean birth closely for signs or symptoms of uterine rupture during active labour.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of pregnant people who attempt a vaginal birth after Caesarean who are monitored closely for signs and symptoms of uterine rupture through continuous electronic fetal monitoring
- Rate of uterine rupture in pregnant people who plan a vaginal birth after Caesarean

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Appendix 1: About This Quality Standard

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For Pregnant People

This quality standard consists of quality statements. These describe what high-quality care looks like for people who have had a Caesarean birth and are planning their next birth.

Within each quality statement, we have included information on what these statements mean for you as a patient.

In addition, you may want to download this accompanying patient guide on VBAC to help you and your family have informed conversations with your clinicians. Inside, you will find information and questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people who have had a Caesarean birth and are planning their next birth. They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality, evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions, available in the technical specifications. Measurement is key to quality improvement. Collecting and using data when implementing a quality standard can help you assess the quality of care you are delivering and identify gaps in care and areas for improvement.

There are also a number of resources online to help you, including:

- Our patient guide on VBAC, which you can share with patients and families to help them have conversations with you and their other clinicians. Please make the patient guide available where you provide care
- Our measurement resources, including the technical specifications for the indicators in this quality standard, the “case for improvement” slide deck to help you to share why this standard

was created and the data behind it, and our measurement guide containing supplementary information to support the data collection and measurement process

- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of care across Ontario. This is a place where clinicians can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the quality standard, which included extensive consultation with clinicians and lived experience advisors and a careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

Appendix 2: Glossary

Term	Definition
Care partner	An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person who has had a Caesarean birth and is planning their next birth. Other terms commonly used to describe this role include “caregiver,” “informal caregiver,” “family caregiver,” “carer,” and “primary caregiver.”
Clinicians	Regulated professionals who provide care to patients or clients. Examples are midwives, nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, social workers, and speech-language pathologists.
Culturally appropriate care[15]	Care that incorporates cultural or faith traditions, values, and beliefs; is delivered in the person’s preferred language; adapts culture-specific advice; and incorporates the person’s wishes to involve family or community members.
Family	The people closest to a person in terms of knowledge, care, and affection; this may include biological family or family of origin, family through marriage, or family of choice and friends. The person defines their family and who will be involved in their care.
Health care team	Clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, child life specialists, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.

Appendix 3: Values and Guiding Principles

Values That Are the Foundation of This Quality Standard

This quality standard was created, and should be implemented, according to the Patient, Family and Caregiver Declaration of Values for Ontario. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients, and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

A quality health system is one that provides good access, experience, and outcomes for all people in Ontario, no matter where they live, what they have, or who they are.

Guiding Principles

In addition to the above values, this quality standard is guided by the principles outlined below.

Acknowledging the Impact of Colonization

Clinicians should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities, as well as recognizing their strength and resilience. This quality standard uses existing clinical practice guideline sources that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

French Language Services

In Ontario, the *French Language Services Act* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 26 designated areas and at government head offices.[16]

Social Determinants of Health

Homelessness and poverty are 2 examples of economic and social conditions that influence people's health, known as the social determinants of health. Other social determinants of health include employment status and working conditions, race and ethnicity, food security and nutrition, gender, housing, immigration status, social exclusion, and residing in a rural or urban area. Social determinants of health can have strong effects on individual and population health; they play an important role in understanding the root causes of poorer health. People with a mental illness or addiction often live under very stressful social and economic conditions that worsen their mental health,[17] including social stigma, discrimination, and a lack of access to education, employment, income, and housing.[18]

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma, the impact that traumatic experiences can have on human beings, and the potential to traumatize or retraumatize patients when providing them with care.[19,20] A trauma-informed approach does not necessarily involve addressing the trauma directly. Rather, it involves acknowledging that a person may have experienced a previous traumatic event that may contribute to their current health concerns, and taking steps to reduce opportunities for traumatization (e.g., using active strategies around consent, attending to individual patient needs, recognizing the inherent power imbalance in clinician–patient relationships, and facilitating greater patient agency and choice in all interactions).[21,22] A trauma-informed approach emphasizes the creation of an environment in which a person can feel comfortable disclosing trauma, and it involves understanding, respecting, and responding to the effects of trauma.[20-22]

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References

(1) Association of Ontario Midwives, Gure F, MacDonald T, Minichiello A. Clinical practice guideline no. 14: management of vaginal birth after previous low-segment Caesarean section [Internet]. Toronto (ON): The Organization; 2021 [cited 2024 Apr]. Available from: https://www.ontariomidwives.ca/sites/default/files/2021-06/CPG-Vaginal-birth-after-caesaean-section-2021-PUB.pdf

(2) American Academy of Family Physicians. Clinical practice guideline: planning for labor and vaginal birth after Cesarean [Internet]. Leawood (KS): The Academy; 2014 [cited 2016 Jun]. Available from: http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/AAFP%20PVBAC%20guideline.pdf

(3) Royal College of Obstetricians and Gynaecologists. Birth after previous Caesarean birth green-top guideline no. 45 [Internet]. London (UK): The organization; 2015 [cited 2016 Jun]. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf

(4) Canadian Institute for Health Information. QuickStats: childbirth indicators by place of residence 2014-2015; what is the repeat Caesarean section rate in Ontario, 2014-2015? [Internet]. North York (ON): The Institute; 2016 [cited 2016 Jun]. Available from: https://apps.cihi.ca/mstrapp/asp/Main.aspx?Server=apmstrextprd_i&project=Quick+Stats&uid=pce_pub_en&pwd=&evt=2048001&visualizationMode=0&documentID=029DB170438205AEBCC75B8673CCE822

(5) Bickford CD, Janssen PA. Maternal and newborn outcomes after a prior Cesarean birth by planned mode of delivery and history of prior vaginal birth in British Columbia: a retrospective cohort study. CMAJ Open. 2015;3(2):E158-65.

(6) Society of Obstetricians and Gynaecologists of Canada. SOGC clinical practice guidelines. No. 382 - trial of labour after Caesarean [published correction appears in J Obstet Gynaecol Can. 2019 Sep;41(9):1395. doi: 10.1016/j.jogc.2019.07.010] [published correction appears in J Obstet Gynaecol Can. 2020 Nov;42(11):1452. doi: 10.1016/j.jogc.2020.09.003]. J Obstet Gynaecol Can. 2019;41(7):992-1011.

(7) Grzybowski S, Kornelsen J, Barclay L. Closing rural maternity services: is it worth the risk? Can J Rural Med. 2016;21(1):17-9.

(8) Munro S. Policy brief: access to maternity services: vaginal birth after Caesarean [Internet]. Vancouver (BC): Sarah Munro; 2016 [cited 2016 Dec]. Available from: https://static1.squarespace.com/static/555a1a87e4b07ba26dc3faf4/t/5769a1c203596e833237b8c4/1466540581450/Munro_VBAC+Policy+Brief+v1.5.pdf

(9) National Institute for Health and Clinical Excellence. Caesarean birth: clinical guideline [Internet]. London (UK): The Institute; 2021 [updated 2024 Jan; cited 2024 Apr]. Available from: https://www.nice.org.uk/guidance/ng192

(10) Wexler R. Six steps of shared decision making [Internet]. Boston (MA): Informed Medical Decisions Foundation; 2012 [cited 2016 Jun]. Available from: https://www.mainequalitycounts.org/image_upload/SixStepsSDM2.pdf

(11) National Institute for Health and Clinical Excellence. Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence [Internet]. London (UK): The Institute; 2009 [cited 2024 May]. Available from: https://www.nice.org.uk/guidance/cg76

(12) Leduc D, Biringer A, Lee L, Dy J, Azzam H, Barrett J, et al. Induction of labour: review. J Obstet Gynaecol Can. 2015;37(4):380-3.
(13) World Health Organization. WHO recommendations for augmentation of labour [Internet]. Geneva: The Organization; 2014 [cited 2016 Dec]. Available from: http://apps.who.int/iris/bitstream/10665/112825/1/9789241507363_eng.pdf
(14) Liston R, Sawchuck D, Young D. Fetal health surveillance: antepartum and intrapartum consensus guideline. J Obstet Gynaecol Can. 2007;29(9 Suppl 4):S3-56.
(15) Diabetes Canada. 2018 Clinical practice guidelines [Internet]. Toronto (ON): Diabetes Canada; 2018 [cited 2024 Jun]. Available from: https://guidelines.diabetes.ca/docs/CPG-2018-full-EN.pdf
(16) Ministry of Health, Ministry of Long-Term Care. French language health services: the *French Language Services Act*, 1986 (FLSA) [Internet]. Toronto (ON): Queen's Printer for Ontario; 2021 [cited 2024 Mar]. Available from: https://www.health.gov.on.ca/en/public/programs/flhs/flsa.aspx
(17) Keleher H, Armstrong R. Evidence-based mental health promotion resource. report for the Department of Human Services and VicHealth, Melbourne [Internet]. Melbourne (Australia): State of Victoria, Department of Human Services; 2006 [cited 2024 Mar]. Available from: https://www2.health.vic.gov.au/Api/downloadmedia/%7BC4796515-E014-4FA0-92F6-853FC06382F7%7D
(18) Health Quality Ontario. Taking stock: a report on the quality of mental health and addictions services in Ontario [Internet]. Toronto (ON): Queen's Printer for Ontario; 2015 [cited 2024 Mar]. Available from: https://www.hqontario.ca/Portals/0/Documents/pr/theme-report-taking-stock-en.pdf
(19) Kuehn BM. Trauma-informed care may ease patient fear, clinician burnout. JAMA. 202;323(7):595-7.
(20) Ravi A, Little V. Providing trauma-informed care. Am Fam Physician. 2017;95(10):655-7.
(21) Dowdell EB, Speck PM. Trauma-informed care in nursing practice. Am J Nurs. 2022;122(4):30-8.
(22) Fleishman J, Kamsky H, Sundborg S. Trauma-informed nursing practice. Online J Issues Nurs. 2019;24(2).

About Us

We are an agency created by the Government of Ontario to connect, coordinate, and modernize our province's health care system. We work with partners, providers, and patients to make the health system more efficient so everyone in Ontario has an opportunity for better health and well-being.

Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an Equity, Inclusion, Diversity and Anti-Racism Framework, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach.

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

For more information about Ontario Health, visit OntarioHealth.ca.

About the Provincial Council for Maternal and Child Health

Established in 2008, the Provincial Council for Maternal and Child Health (PCMCH) is a provincial organization that provides evidence-based and strategic leadership for perinatal, newborn, child and youth services in Ontario. PCMCH is funded by the Government of Ontario.

Vision

Optimal health and wellness for all pregnant women and individuals, newborns, children, youth and their families in Ontario.

Mission

To improve health outcomes and reduce inequities through effective leadership, collaborative partnerships and the use of evidence.

For more information about PCMCH, visit https://www.pcmch.on.ca/about-us/

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