

Elective Caesarean Section

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Purpose	
To provide a standardized level of care to all women who have a category 4 Caesarean Section	
Who should read this document?	
All Midwives All medical and theatre staff working within Maternity Services	
Key messages	
Maintenance of safe and effective patient care	
Accountabilities	
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Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff.

We will treat people with dignity and respect, actively promote equality and diversity, and eliminate all forms of discrimination regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/ maternity.

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1 Introduction

The maternity services provide an elective caesarean section list daily in maternity theatre. The allocated theatre staff supports these lists with midwifery input from the Central Delivery Suite (CDS).

2 Purpose

To provide a standardized level of care to all women who have a category 4 caesarean section.

3 Staffing

As a minimum, the caesarean section list will be attended by one midwife and ideally one maternity care assistant. Depending on the complexity of the lists further midwifery support may be required.

An allocated theatre team, encompassing obstetric and anaesthetic staff, will cover this list. They are rostered until 1300 hours when the staff will then change over to PM cover. If the list goes over 1300 hours the allocated registrar for CDS covers the list or if CDS very busy the week on service consultant covers either the remaining list or CDS depending on work load. There are times when patients are sent home if this is not possible.

4 Booking a Category 4 Caesarean Section

This is arranged in Day Assessment Unit (DAU), level 6.

The decision to perform elective caesarean section (CS) is usually made in the antenatal clinic following discussions between the woman and obstetric registrar and / or consultant.

The obstetric registrar or consultant should discuss the rationale for the decision, including benefits and risks with the woman to enable her to give informed written consent, using the appropriate form. Timing of delivery is to also be discussed; unless clinically indicated, women should be notified that delivery will be planned for the 39th week of their pregnancy.

In the case of women who require delivery before 39 weeks, antenatal steroids given ideally 24 hours apart should be prescribed (with the exception of insulin dependent diabetes mellitus (IDDM) who are 38 weeks). Additionally those who deliver beforehand following spontaneous events need to be removed from the diary to ensure accurate listing.

The mother will be contacted by a member of staff immediately prior to or after the onset of the 39th week and be given a date for the operation. The F1/F2 will contact the woman and arrange a pre-op appointment within the diary. A provisional date for surgery will also be given. These appointments are issued very last minute to ensure minimal disappointment should the date need to be adjusted. This process is supported by the week on service (WOS) consultant.

N.B. There is only one copy of the CS booking form so it is imperative that it is taken to Day Assessment Ward and placed in the folder.

5 Pre-operative booking appointment

This appointment is arranged on Day Assessment Unit following contact by the F1/F2.

A routine pre-operative assessment is performed including:

- A full set of clinical observations, issuing anti-embolism stockings and taking bloods (FBC and Group and save).
- A full explanation of care pathways will be given both written and verbally and if required ensure a translator is available.
- Elective CS Patient Information Leaflet (P.I.L) given and discussed.
- Discuss if the patient chooses an intrauterine device or sterilization. This needs to be added to the consent form and theatre procedures list.
- Screening for Methicillin Resistant Staphylococcus Aureus (MRSA) if appropriate (health care workers or previous isolation) Please refer to AN guideline 5: Antimicrobial guidelines for obstetrics, including MRSA screening.
- Reiteration of nil by mouth from 2am on the morning of CS and only clear fluids until 6am when taking last pre-op medication. If a planned afternoon theatre timings and dates will be adjusted appropriately.
- Check the patient consent form is appropriately signed and dated with all procedures clearly written.
- An anaesthetic review and dispensing of pre-medication is required by on call anaesthetist (or office on 39207). Pre-medication is prescribed on a 'Patient's Discharge Note' that is particular for Day Assessment Unit.
- Ensure the ranitidine is prescribed and the patient is fully aware that these need to be taken around 2200hours the night before their CS and at approximately 0600hours on the morning of their CS.

NB If any pre-medication is given in hospital on the day of the operation this is prescribed on a regular prescription sheet.

- Auscultate the fetal heart and perform an ultrasound to confirm fetal presentation if CS being undertaken for breech or unstable lie.
- If pre-op pubic hair removal is required the patient should be advised not to shave their pubic area before surgery. Waxing and depilatory cream is acceptable but ideally to be left for **10-14** days in advance. If women choose to shave, they must be informed that this must be done on the day of CS.

- Patient notes to be returned to maternity reception and be collected by triage staff on the day of CS– care plans and baby notes to be commenced by Day Assessment Ward midwife and blood results and final note preparations to be completed in triage when the allocated CS midwife is preparing to take to theatre.
- E-theatre lists to be printed by theatre ODP and administration for theatres the morning of surgery and copies to be available in triage, CDS and maternity theatres.
- Explain that only one birth partner will be able to visit whilst in recovery. (Duration of stay in recovery is approximately 1 hour but will depend on clinical situation at time)
- If raised BMI >40 to calculate need for bariatric equipment and order from the equipment library in a timely manner to be available.
- Please reiterate to all women, should they experience any contractions, change in fetal movements, spontaneous rupture of membranes, bleeding or any clinical concerns, regardless of planned admission and details of CS, they should contact maternity triage on 01752 430200 seeking advice and review.

6 Day of Surgery

Order of events

- **At 07.15am** the patient arrives in triage, CDS Level 4.
- The patient is transferred to a room where the triage midwife will check all paperwork is completed, ensuring the patient has taken the pre-medications and is nil by mouth and is physically prepared for theatre.
- The theatre check list is completed, ensuring results are checked to assess the suitability for electronic cross match. If blood is requested for cross match ensure the recommended number of units is available and present in CDS blood fridge.
- Auscultate the fetal heart and repeat ultrasound to confirm presentation if CS undertaken for breech or unstable lie.
- The patient will be reviewed by the obstetric registrar or consultant and an obstetric anaesthetist.

The allocated midwife should:

- Inform maternity reception or the CDS ward clerk when the patient is transferred to theatres.
- Review the notes to ensure completion of antenatal, paperwork and all preoperative checks have been documented clearly and to prepare postnatal notes as much as possible.
- Check the latest HB result.
- Emergency procedures will have priority over planned, and it is important that if the ward is busy with emergency procedures that the women and her birth

partner are informed and kept up to date as to delays in a timely manner. If there is a prolonged delay liaise with the anaesthetist as to whether patient able to drink water. If necessary intravenous fluids may be commenced.

- Escort the woman to theatre.
- Ensure that the appropriate ward is prepared to accept the woman & infant following CS.
- Support the patient's birthing partner; they may be present if CS is performed under spinal/epidural. All other relatives to wait in reception level 5.

Ideal start time for elective list is 08.30hrs in absence of any delays

- Theatre list preview and briefing to take place in labour ward office or theatres – midwife to be in attendance.
- Theatre to call for 1st patient.
- Anaesthetic time. The theatre nurse or midwife is to catheterise the patient, depending on workload and staffing. The midwife must check the neonatal resuscitaire ensuring that it is cleaned and restocked between patients.
- Auscultate fetal heart again post spinal anaesthesia prior to pre-theatre cleaning and application of drapes.
- Procedure length varies greatly depending on each individual patient.
- Dry, wrap and take baby to mother and birth partner to hold **if mother is awake**. If the mother remains awake, skin to skin should be encouraged unless she wishes otherwise. If the mother has a general anaesthetic, baby labels must be checked with the mother prior to anaesthetic allowing the baby be taken to the birth partner in recovery to facilitate skin to skin should they wish, transferring to the mother in recovery when able and safe.
- Examine placenta and membranes in dirty utility room in theatre. Take a full blood count, bilirubin and blood group from the cord if woman is rhesus negative. Dispose of placenta and membranes if not requiring microbiological or histopathological testing.
- For rhesus negative women who receive cell salvage blood – please refer to the anti-D guideline or consult with blood bank re timing of kleihauer testing.
- Move baby and partner to theatre recovery, reassuring woman that she will join you shortly.
- Patient to recovery – the baby is under the care of the midwife and parents.
- Theatre cleaned. Midwife or MCA to clean and restock the neonatal resuscitaire. However, it is the midwife's responsibility to recheck the equipment to ensure it is in working order prior to the next patient before leaving theatre. This must be done as a priority to ensure patient safety and smooth handover between cases.
- The midwife should transfer the patient and infant to the ward, if able, or complete a comprehensive handover in the form of the Trust recognised SBAR format verbally to the receiving midwife on the postnatal ward. The

patient must be transferred by a registered member of staff either allocated from CDS or from the receiving postnatal ward.

- Inform reception or the CDS ward clerk when the patient is transferred to the ward ensuring Salus is updated with patient location.
- Theatre to call for next patient following discussion with midwife/doctor/and anaesthetics.

7

Record Keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Policy. This is in line with standards set by professional colleges, i.e. NMC and RCOG

All entries must have the **date and time** together with **signature and printed name**.

8

References

Use in association with; CLI.MAT.GUI.732.9 Operative Delivery Ventouse forceps and CS