Mid Essex Hospital Services NHS
NHS Trust

ROLES AND RESPONSIBILITIES OF STAFF WHEN ARRANGING AN ELECTIVE LOWER SEGMENT CAESAREAN SECTION (EL.LSCS)	CLINICAL GUIDELINES Register No 09044 Status: Public

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4.1	Sam Brayshaw – clarification to 13.9	26th April 2018

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26. Audit and Monitoring

27. Communication

28. References

Appendix A - Chart to illustrate the Consultant Responsible for the Elective LSCS Theatre List each week day

Appendix B - Flowchart for failed block

1.0 Purpose

1.1 The purpose of this guideline is intended to be a guide for obstetric, midwifery and anaesthetic staff in the management of women presenting for elective caesarean section.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Background

3.1 Caesarean section is the commonest major operation performed on a woman worldwide. Women are over four times more likely to have a caesarean birth now than they were thirty years ago. In 2014-15, the estimated caesarean rate for England shows the caesarean section rate at 26.5% with a 0.3% increase from 2013 -14.

3.2 Elective caesarean section lists take place every weekday morning in Labour Ward's obstetric theatre with the following obstetric and anaesthetic consultants having responsibility on that day
(Refer to Appendix A)

3.3 A maximum of 3 patients may be booked for each operating session with extra patients being shared between the other lists.

4.0 Anaesthetic Pre-assessment Clinic

4.1 Consultant anaesthetists run these clinics on the following days as follows:

- Tuesday afternoon
- Wednesday afternoon

4.2 A maximum of 10 patients can be booked per clinic.

4.3 In general, referrals should be made according to the respective operating list with patients being shared between the clinics.

4.4 The anaesthetist should ensure that the following patient information leaflet is discussed and given to the patient and that the following is documented in the 'Antenatal Care Record' booklet:

- Obstetric Anaesthetists' Association booklet on Caesarean section.

5.0 Referrals for Elective Caesarean Section

5.1 The following patients should be seen in the Anaesthetic Pre Assessment clinic:

- Previous caesarean section (clinically indication); if repeat LSCS is planned
- Multiple pregnancies
- Breech or malpresentation
- Placenta praevia (after confirmation at 32 week scan)
- Low anterior placenta (after confirmation at 32 week scan)
- Cephalo-pelvic disproportion
- Cardiac, respiratory or neurological disease

- Clotting Disorders or women on Anticoagulants
- Any others at clinician's discretion

5.2 VBAC patients who have had an uncomplicated anaesthetic for their first caesarean section are not routinely referred to the anaesthetic clinic.

5.3 Patients can be referred at any gestational age above 28 weeks and should be seen at least **one** week prior to LSCS.

5.4 Patients who have had one previous caesarean section should be routinely given an appointment to attend the 'vaginal birth after caesarean section' (VBAC) clinic for consultation.
(Refer to the Guideline for the management of patients with a previous uterine scar; register number 05091).

5.5 **Caesarean Section for Non-clinical Indications**
(Women who request a Caesarean section will be managed according to NICE Guidance)

5.5.1 Maternal request caesarean section will not be offered routinely, only caesarean section for clinical indications will be offered i.e. complex co-morbidities, malpresentation and placenta praevia.

5.5.2 When a woman requests a Caesarean section explore, discuss and record the specific reasons for the request.

5.5.3 If a woman requests a Caesarean section when there is no other indication, discuss the overall risks and benefits of Caesarean section compared with vaginal birth and record that this discussion has taken place. Include a discussion with other members of the obstetric team (including the obstetrician, midwife and anaesthetist) if necessary to explore the reasons for the request, and ensure the woman has accurate information.

5.5.4 For women requesting a Caesarean section, if after discussion and offer of support (including perinatal mental health support for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, offer a planned Caesarean section.
An obstetrician unwilling to perform a Caesarean section should refer the woman to an obstetrician who will carry out the Caesarean section.

5.5.5 Women with a previous traumatic birth experience and/or fear of childbirth (tocophobia) should be managed as follows:

- Refer to a Specialist Midwife Counsellor or Perinatal Mental Health Midwife as appropriate for support to help her address her anxiety in a supportive manner what is available to support the woman through natural childbirth that she currently may be unaware of
- Refer to the VBAC (vaginal birth after Caesarean section) clinic
- Refer to points 5.5.4 and 5.5.5

6.0 Antenatal Clinic

6.1 The obstetrician should ideally arrange an elective caesarean section after 39 completed weeks of gestation but delivery may be considered at 38 weeks gestation in singleton pregnancies.

6.2 It may be necessary to perform an elective lower segment caesarean section (LSCS) earlier in multiple pregnancies and at the obstetrician's discretion. In such cases the

obstetrician booking the caesarean section should ensure that the neonatal (NNU) and paediatric team have been informed, giving the reason for caesarean section, gestation and date of planned delivery.

6.3 All patients having a planned LSCS should have MRSA Screening so that the MRSA status is available on the day or surgery.
(Refer to MRSA Policy; register number 04075)

7.0 Roles and Responsibilities of Staff Booking the Elective LSCS

7.1 **The Obstetric Consultant** or **Registrar** - the date for LSCS should be decided by the obstetric consultant or registrar and entered in the antenatal clinic diary (in the section designated for caesareans).

7.2 The reason for the Caesarean section; the risks and benefits should be documented in the patient's maternity records and on the consent form. At this point the obstetrician should give the patient the facts about the possible risks to the baby following an elective caesarean section.

7.3 The patient and obstetrician should sign the 'consent form1' at the time of decision for LSCS.

7.4 For patients with placenta praevia, previous uterine surgery i.e. myomectomy, multiple abdominal surgery or previous complex Caesarean section, the following should be undertaken:

- The Caesarean section should be booked after ensuring that the Consultant Obstetrician responsible for the Caesarean section list is informed and is available. If the Caesarean section list is Obstetric Registrar only list, the 'Hot week' Obstetric Consultant must be informed

7.5 Patients with **placenta praevia** should have a full blood count (FBC) and should be cross-matched for 2 units of blood. In the case of anterior placenta praevia, the patient should be cross-matched for 4 units of blood and in the case of a patient with a history of a previous section with an anterior placenta praevia, 6 units of blood should be cross-matched.

7.6 The Antenatal Clinic Team Leader should **review** the **LSCS book each day** and look ahead to ensure that no more than three LSCS are booked on one day; particularly in view of management and utilisation of the second Obstetric Theatre. If an Obstetric Consultant has a valid reason for booking an additional LSCS above three then arrangements must be made to reschedule an existing booked Caesarean section to another day where there is a gap.

7.7 Any Obstetric Consultant/Registrar wanting to add a fourth LSCS, must discuss it first with the Antenatal Clinic Team Leader (or clinic midwife in the Team Leaders absence) to help address this and reduce the incidents of overbooking.

7.8 Venous thrombo-embolism (VTE) forms embedded in the adult drug prescription and administration record charts should be completed by the obstetrician booking the elective **Caesarean section** at **36 weeks** gestation.

7.9 The clinic midwife should ensure that the following patient information leaflets are discussed and given to the patient and that the following is documented in the 'Antenatal Care Record' booklet:

- Admission procedure for caesarean section
- Caesarean section leaflet
- Pre-Admission MRSA Screening Form

7.10 The clinic midwife should ensure that the patient has been given the completed blood request forms for a full blood count (FBC) and group and save, giving instructions as to when and where she should go to have her bloods taken (within 72 hours of the operation date).

7.11 For bookings made at the Midwife-led Units at either Maldon, Braintree; or Witham, the **midwife in charge** of the Midwife-led Unit is responsible for phoning the midwife at Broomfield Hospital, Antenatal clinic directly; to book the case in the diary.

7.12 Special attention should be made by the obstetrician arranging the caesarean section to identify those women at risk of **placenta accreta.** These include:

- Previous LSCS
- Anterior low lying placenta, especially with previous LSCS
  (Refer to the guideline entitled 'Antenatal management of low lying placenta (08017)
- Multiparity
- Maternal age > 35 years

7.13 Discussion of these cases should take place with senior clinicians to determine mode of anaesthesia and place of delivery. An obstetric registrar should perform the caesarean section with direct obstetric consultant and consultant anaesthetic involvement.

7.14 The obstetrician/anaesthetist will prescribe Ranitidine 150 mg orally (milligrams) TTA (tablet to take away) to be taken at bedtime the night before the LSCS; and Ranitidine 150 mg orally and Metoclopramide 10 mg orally to be taken at 07.30 hours on the day of the LSCS.

7.15 The clinic midwife will ensure that this has been dispensed and that the patient is given clear verbal and written information regarding when to take the medication and that she should be **nil by mouth** for food (to include avoiding chewing gum and sucking boiled sweets) from midnight the night before surgery, allowing unlimited still water until 06.30 hours on the day of surgery (i.e. 2 hours pre-operatively).

7.16 Elective lower segment caesarean section should normally be performed at or after 39 weeks and 0 days of gestation to reduce respiratory morbidity of the newborn.

7.17 Corticosteroids should be given to reduce the risk of respiratory morbidity in all babies delivered by elective caesarean section prior to 38 weeks and 6 days of gestation. (Refer to the guideline entitled 'Administration of antenatal steroids' (07065)

7.18 The risk of respiratory distress (RDS) at 37, 38 and 39 weeks is 3.9, 3.0 and 1.9 per 100 babies respectfully. At MEHT the use of steroids prior to 39 weeks gestation will be assessed on an individual basis at the discretion of the obstetric consultant. The obstetric consultant requesting the steroids should be responsible for documenting the plan of care in the woman's health care records and prescription chart.

7.19 Women with a history of **ruptured membranes** who have a planned Caesarean delivery should be advised to come to hospital immediately.

8.0 Infection Prevention

8.1 Infection prevention to comply with High Impact Intervention number 4 (HII 4).

8.2 All patients who have a planned LSCS should be screened for methicillin resistant staphylococcus aureus (MRSA), at 36 weeks gestation. Both lower nostrils should be swabbed with the same swab, then both groins with the remaining swab. Both swabs will be clearly labelled and sent to the microbiology laboratory for MRSA screening on just one form.
(Refer to the guideline for 'MRSA in Maternity'; register number 07002)

8.3 The patient should be given octenisan wash to be used every day for five days prior to the planned LSCS date if she is MRSA negative then the octenisan washes should be discontinued once the wound has healed.
(Refer to the guideline for 'MRSA in Maternity'; register number 07002)

8.4 If the patient is found to be MRSA positive then she should be advised to use Bactroban ointment in both nostrils for five days prior to the planned surgery date and to continue using octenisan postnatally until the wound is healed.
(Refer to the guideline for 'MRSA in Maternity'; register number 07002)

8.5 The patient will be advised that she should not shave or wax the area to be operated on for at least five days prior to the planned LSCS.
(Refer to the guideline for 'MRSA in Maternity'; register number 07002)

8.6 Patient should be reassured that if the need for the LSCS arises before the planned date then we will proceed with the LSCS.

8.7 All staff should ensure that they follow Trust guidelines on infection prevention. All invasive devices must be inserted and cared for using high impact intervention guidelines (Refer to Saving Lives policy guideline, DoH, 2007) to reduce the risk of infection and deliver safe care. This care should be recorded in the Saving Lives High Impact Intervention Monitoring Tool Paperwork (Medical Devices).

9.0 Operating List Details

9.1 The clinic administration staff are responsible for entering LSCS patient details onto the computer prior to 16:00 hours on a daily basis and theatre staff will then produce a printed LSCS list the day before each section list.

9.2 Monday morning's list will be printed out the Friday before.

9.3 Three copies of the list will be produced for the Labour Ward, Obstetric Theatre Recovery and the Anaesthetic Room.

9.4 On the morning of the surgery the designated obstetric theatre midwife will be responsible for checking the following:

- The patients booked for elective caesarean section that morning have had a full blood count (FBC) and have been X-matched for surgery
- That the FBC results are available and that the group and save has been confirmed
- Lilac maternity notes are available and prepared for admission

9.5 If a pre-operative blood test has not been obtained or requested it is the responsibility of the designated obstetric theatre midwife to inform the anaesthetic and obstetric team.

10.0 Day of the Surgery

10.1 Patients should arrive for admission by 07:00 hours on the morning of surgery.

10.2 The designated obstetric theatre midwife responsible for admitting patients prior to LSCS.

10.3 The designated obstetric theatre midwife is responsible for carrying out the following observations and recording them on the MEOWS chart that is incorporated in the Antenatal Care Record, informing the Labour Ward Co-ordinator of any abnormalities:

- Pulse
- Respirations
- Blood Pressure
- Temperature (maintaining a temperature above $36^{.0\ c}$ in the pre, peri, and post-operative period has been shown to reduce infection rates (HII 4)
- Urinalysis

10.4 Patients should be measured and provided with anti-embolism stockings on admission to the Postnatal Ward. It is recommended that anti-embolism stockings are fitted prior to the elective LSCS and removed once the patient is fully mobile.

10.5 The pubic clipper procedure (if required) is carried out on the day of surgery by the obstetric theatre staff to comply with HII 4 (refer to Saving Lives policy guideline, DoH, 2007). The patient should not shave the area to be operated on for 5 days prior to the planned date of surgery. Clippers with a disposable head should be used.

10.6 Ensuring the patient has a theatre gown.

10.7 Confirming the patient's identity and applying the appropriate name band (red if the patient has an allergic condition).

10.8 Ensuring that the following equipment has been assembled by the patient's bedside prior to return from theatre:

- Sphygmomanometer /Dynamap
- Genius thermometer
- Drip stand
- Catheter stand/support
- Portable oxygen and suction should be easily accessible and ready for use.
- Drinking water

10.9 The designated obstetric theatre midwife is responsible for the following:

- Ensuring all the above has been carried out
- Identifying any special needs the patient may have including documenting a plan of care
- Carry out an abdominal palpation, listening to the fetal heart rate (via pinnard / sonicade) for 1 minute ensuring normality
- Check the consent form has been signed

- Confirm that blood results are available and that any abnormal results have been reported to the anaesthetist and obstetrician
- Confirm that any cross-matched blood is on site (located in the blood fridge on Antenatal Ward) if required
- That the administration of prescribed ranitidine 150mg orally and metoclopramide 10mg orally pre-medication is given at 7.30am to the first patient on the list

10.10 The designated obstetric theatre midwife will see all patients on the morning of surgery and is responsible for ensuring that the patient has been fully prepared for her caesarean section, confirming the following, which should be recorded in the 'Operative Delivery and Theatre Care Record':

- Consent has been signed
- Name band applied
- Allergy status checked and any allergies identified on theatre check list & medication chart
- Bloods and blood tests are available
- If cord bloods are required (i.e. rhesus negative status)
- How the patient wants to feed her baby
- That verbal consent has been obtained for her baby to have vitamin K
- That any special instructions are followed (paediatric/anaesthetic/obstetric)

10.11 When a caesarean section has been arranged for a breech presentation the obstetrician should perform an ultrasound scan in order to confirm presentation.

10.12 The list order is normally determined according to the time of booking of LSCS but should be reviewed by the senior obstetrician and anaesthetist on the morning of surgery with changes in order being made according to clinical priority.

10.13 All patients are to be seen by the anaesthetist and obstetrician on the morning of surgery and the list order decided.

10.14 The designated obstetric theatre midwife should ensure that all preoperative paperwork is completed and that the appropriate documentation has been recorded in the woman's handheld records.

10.15 The WHO Surgical Safety Checklist should be undertaken for each woman that is transferred to the Obstetric Operating Theatre for a surgical procedure; commencing with the team brief prior to the surgical list and calling for the first patient.

10.16 **The LSCS list** should **commence** with the first patient in theatre by **08:45 hours**.

10.17 The scrub practitioner / theatre midwife are responsible for calling for the patient and the theatre staff will collect the first patient on the list.

10.18 The midwife/HCSW will bring down subsequent patients if the theatre midwife is busy.

10.19 Collect the patient and partner together with the complete set of notes, consent form and one pillow.

11.0 Medical Cover for Elective Caesarean Section Lists

11.1 The list of anaesthetists responsible for the LSCS list is available from the weekly anaesthetic rota, located on Labour Ward.

11.2 There is always a separate duty anaesthetist available for Labour Ward.

11.3 A weekly list of surgeons solely responsible for the caesarean section list will be produced in advance.

11.4 They should not be reassigned to other duties without the consent of the Labour Ward manager or consultant obstetrician.

11.5 In absence of a named consultant for the CS list the Labour Ward consultant obstetrician is will be responsible for the LSCS list.

11.6 The Labour Ward Co-ordinator is responsible for providing a midwife for taking the baby in theatre. The Labour Ward Co-ordinator is responsible for informing the theatre team of any impending emergencies in order that any unplanned urgent operative procedures can be planned safely. If there are delays in carrying out the elective caesarean sections the midwifery staff on the Postnatal Ward should be notified by the CS list anaesthetist and the patients affected informed of the delay.

12.0 Insulin Dependent Diabetics

(This section should be read in conjunction with the 'Guideline for the management of diabetes in pregnancy'; register number 04266).

12.1 These mothers should be allowed clear fluids until 6.30am.

12.2 This should consist of still water unless she should feel hypoglycaemic and on checking, has a blood glucose level of <4mmol/l; at this point a non-carbonated sugar drink should be provided to include 10-20 grams of glucose in diluted squash. The blood sugar should then be checked again after 10 minutes.

12.3 To comply with HII 4 in the peri-operative period the woman should have a glucose level less than 11 mmol/l to reduce wound infection rates in diabetic patients

12.4 They should omit food and insulin on the morning of surgery and should be scheduled for first on the list.

12.5 They may have breakfast, together with a pre-pregnancy dose of insulin (as advised by the diabetic team) as soon after surgery as they wish.

12.6 They should be considered for a dextrose/insulin sliding scale if there is any delay, their diabetic control is very poor or they are unable to tolerate food or fluids.

13.0 Regional Blocks

13.1 One partner only is allowed to accompany the patient to theatre and may be the husband, fiancée, boyfriend, parent or friend.

13.2 The partner usually changes and waits in the recovery area during the initiation of the regional block. The partner is allowed in theatre and seated next to the head end after the women is draped and ready for the skin incision.

13.3 However, if requested, they may be present in theatre during the regional block, at the discretion of the anaesthetist, under exceptional circumstances.

13.4 Prior to commencement of surgery the anaesthetist should assess and document the level of block in the maternity records.

13.5 This should include the degree of motor block as well as the upper and lower levels of block height.

13.6 Motor blocks should achieve a modified bromage score of 1 or 2 (one; being unable to move one's legs at all and two; able to move one's legs but unable to raise them against gravity.

13.7 Upper block level should be to T6 for light touch or T4 to cold. The block may be inadequate if these parameters are not achieved.

13.8 Manage pain during a caesarean under regional block according to the flow chart in appendix B. Inhalational analgesia is in the form of nitrous oxide and oxygen, intravenous analgesia options include incremental boluses of Alfentanil (100mcg boluses) or Ketamine (5-10mg boluses). If there is no contraindication a general anaesthetic must be strongly considered.

13.9 During prolonged attempts at regional anaesthesia please consider stopping and listening to the fetal heart to reassure mother and anaesthetist.

14.0 General Anaesthesia

14.1 The partner waits by the bedside on Postnatal Ward but is allowed to see baby in theatre recovery and may be allowed to remain in recovery during the operation.

14.2 The theatre screen should remain in place throughout the procedure.

14.3 To comply with HII4, prophylactic antibiotics should be given in obstetric theatre once the cannula is in situ; about 20-30 minutes before 'knife to skin' for a spinal anaesthesia and 10 minutes before or less for a general anaesthetic to reduce the risk of post-operative wound infection.

15.0 Paediatricians

15.1 Paediatricians should be present for elective caesarean sections involving multiple pregnancy, a pre-term baby of less than 37 weeks gestation, if a general anaesthetic is required, any known fetal abnormality or at the surgeon's request.

16.0 Recovery

16.1 Post-operative observations should continue in the recovery area being carried out by the recovery nurse until discharge to the ward. In compliance with HII4, the patient's body temperature should be maintained above 36°C in the peri-operative period.

16.2 Patients are allowed sips of water in recovery and can commence a light diet and fluids on return to the ward. They should be encouraged to eat nutritious snacks and plenty of oral fluids to support their immune system.

16.3 Every effort should be made by the midwife to initiate skin to skin and early infant feeding.

17.0 Responsibilities of the Midwife Taking the Baby in Theatre

17.1 To check the resuscitaire and that it is ready for use. Also ensure the oxygen saturation monitor is ready for use, including the correct probes.

17.2 The midwife should be competent in resuscitation of the newborn.

17.2.1 Ensure that the baby is kept warm, wrapping the baby in warmed dry towels and placing a hat on the baby's head.

17.3 Introducing the baby to the patient and her partner.

17.4 Carrying out a full baby examination, giving vitamin K, weighing and labelling the baby.

17.5 Initiating feeding/skin to skin contact.

17.6 Documentation to include completing the delivery register, clinical data collection (CDC), NHS number request for the baby, maternity notes including times of events and staff involved.

17.7 The midwife should ensure that the resuscitaire is adequately decontaminated, equipment replaced and fresh linen provided.

17.8 Ensure that operative details have been completed by the obstetric registrar/ consultant on call.

17.9 In collaboration with the recovery nurse the midwife should ensure both the patient and baby are fit for transfer to the postnatal ward.

17.10 Providing face-to-face handover to the midwife either in recovery if the midwife has come to collect the patient and baby or on the Postnatal Ward.

18.0 Post-operative Fluids

18.1 Fluids to be continued on the ward until patients' condition is stable and they are tolerating adequate oral fluid intake. Fluids intake and output should be recorded accurately on the fluid balance chart.

18.2 Special fluid prescriptions such as syntocinon infusions should continue according to the clinician's instructions. The agreed regime for syntocinon infusion is 40 units in 500 mls (millilitres) of crystalloid to run at 125 mls per hour (via a volumetric pump if available).

18.3 The intravenous cannula should remain in for 4 hours post discontinuation of intravenous (IV) fluids, in the event of any post-operative complications.

19.0 Indwelling Catheter Device (ICD)

19.1 Once the anaesthetist has completed the administration of the anaesthetic the patient should be catheterised using an aseptic non touch technique to comply with HII 6

19.2 Remove ICD prior to mobilisation, which is usually 4-6 hours post-regional block. Record amount of urine on fluid balance chart and record the first void following removal on chart and in the maternity records.

19.3 The date and time the catheter was removed and who removed it should be recorded on the HII (medical devices) paperwork

19.4 There may be a surgical indication for the catheter to remain in longer; in which case the on going care should be recorded in the HII medical devices paperwork and most importantly in the maternity records.

20.0 Administration of Clexane

20.1 It is important to correctly time the administration of an anticoagulant with a regional block to avoid an inadvertent spinal or epidural haematoma. Thus women who are on a treatment dose of clexane should have a regional more than 24 hours after clexane.

20.2 A period of 12 hours should elapse before performing a regional block on patients receiving a prophylactic dose of clexane (40mg subcutaneously (s/c) once a day, dosage dependant on maternal booking weight)

20.3 A prophylactic dose of clexane may be administered 4 hours after performing a regional block or 12 hours post block following a 'bloody' tap.

20.4 The risk benefit of regional versus general anaesthetic may need to be weighed up in those cases that fall outside these time intervals.

20.5 Patients should be encouraged to mobilise early, once the effects of the spinal anaesthesia/ general anaesthetic have diminished. Anti-embolic stockings can be removed once the patient is fully mobile, unless stated otherwise in the patient's individual care plan which should be documented in the healthcare records.

20.6 All elective caesarean section patients should be prescribed postnatal clexane daily for **ten** days (dosage dependent on maternal booking weight). An individual plan of care should be formulated by the patient's obstetric consultant for those patients that require or deviate from the standard practice.

20.7 Clexane dosages given s/c according to maternal booking weight:

- Less than 50Kg 20mg daily
- 50-90Kg 40mg daily
- More than 90kg 60 mg daily

20.8 The midwife should instruct the patient/partner on how to self administer the postnatal clexane and on discharge home, adequate supplies of postnatal clexane should be provided to complete the **ten** day period recommended. In addition, the midwife should provide a small sharps container to enable the patient to dispose of the sharps safely and the sharps box should then be collected by the community midwife on an appropriate visit thereafter.

20.9 If the patient is unable to administer the postnatal clexane once at home, the community midwife will need to administer the postnatal clexane either when visiting the patient at home or when the patient attends the postnatal clinic held at the Consultant-led Unit or Midwife-led Units. If this is the case, the discharging midwife should ensure that the

patient's medication chart is attached to the patient's healthcare records to enable the community midwife to administer subsequent doses of clexane as prescribed.

20.10 The discharging midwife should document in the community discharge book and the patient's healthcare records that postnatal clexane is to be self administered by the patient or not.

21.0 Post-operative Analgesia

21.1 100mg Diclofenac pr (rectally) should be given at the end of operation unless contraindicated (i.e. severe PIH, asthma, allergy to NSAID's or aspirin) and this should be prescribed on the front of the drug chart.

21.2 Patients should be prescribed oramorph10-20 mg 1-2 hourly, with Cyclizine 50mg IM/IV/orally 8 hourly as antiemetic.

21.3 Ondansetron is not licensed in breast-feeding patients.

21.4 A self-medication pack together with a record card is given to all mothers post-operatively.

21.5 Prescribe on the "Drugs to take home" (TTA's) section of the drug chart:

- All women should go home with Oramorph included in their TTAs unless there is a specific contra-indication. The dose is 10-20mg as required up to three times a day for 3 days. The women must be give a patient information leaflet entitled 'Pain relief following caesarean section' with these TTAs
- Ibuprofen 400mg qds (4 times a day); the first dose should be given 10 hours after the diclofenac in theatre
- Paracetamol 500mg - 1 gram qds (4 times a day)

21.6 Codeine is contra-indicated in breast feeding mothers. Mothers who are not breast feeding can take it with the above advice regarding laxatives.

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21.7 Patients receiving codeine containing analgesics should also be prescribed lactulose10 - 15mls orally 12 hourly as an inpatient. The midwife should give advice regarding diet, fluid intake and light exercise (as per patient information exercise sheet) in order to avoid constipation. At home the mothers are able to self-buy laxatives over the counter or go to their GP if issues regarding constipation present.

22.0 Care of Wound and Removal of Non-absorbable Suture Material Post-operative

(Refer to guideline entitled 'Management of Emergency lower segment caesarean section'; register number 04264))

22.1 It is the responsibility of the surgeon to document in the woman's health care records regarding the type of non- absorbable suture material and the plan for the removal of the suture material i.e. prolene, staples to skin and interrupted skin sutures with black silk. (Refer to the 'Operative Delivery and Theatre Care Record)

22.2 The midwife should observe the wound site on a daily basis whilst in hospital and document the assessment and care provision in the woman's health care records accordingly.

22.3 Non- absorbable suture material should be removed between days 5 to 7. Removal of clips should occur day 8-10 particularly in “repeats” and high BMI women to prevent potential wound breakdowns due to “early” removal of clips.

23.0 Discharge or Transfer of Care to Midwifery-led Unit

23.1 Patients, if they request, may be discharged from hospital or transferred to the low-risk units 24 hours post-caesarean section in accordance with the NICE (National Institute for Clinical Excellence) guidelines, provided there are no maternal or neonatal complications.

23.2 Patients who experience unforeseen complications should have a post-operative review by the obstetric registrar/consultant on call prior to discharge/transfer and arrangements should be made for an outpatients’ follow-up by the patient’s consultant where appropriate.

23.3 All patients with an **uncomplicated elective caesarean section** can be **discharged** by **midwife** as these patients should be aware of reasons for their caesarean section. The midwife should discuss and give the mother a leaflet about postnatal exercises following a caesarean section, give advice regarding the care of her wound/ dressing following the caesarean section and on going postnatal care provided by the community midwife in the community.
(Refer to the guideline entitled ‘Dissemination of information to patients in Maternity’; register number 10008; ‘Routine postnatal care of women and their babies’; register number 09127)

23.4 All emergency sections should be seen by the obstetric senior house officer and an explanation should be given for the reason for the caesarean section and finally, the patient should be offered a clinic appointment for 6 weeks time.
(Refer to the guideline entitled ‘Management of emergency lower segment caesarean section’; register number 04264)

24.0 Staffing and Training

24.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

24.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

25.0 Professional Midwifery Advocates

25.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

26.0 Audit and Monitoring

25.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women’s and Children’s Clinical Audit Group will identify a lead for the audit.

25.2 The following processes should be monitored outlined below:

- Patient details should be entered in the anaesthetic audit book and patients should be reviewed the following day by the duty anaesthetist
- Regular caesarean section audits are carried out to ensure compliance with the NICE Caesarean Section Guidelines
- Monthly audits to show compliance with HII care bundles 2, 4 and 6 should be completed by the staff doing the procedure

25.3 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

25.4 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

25.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

25.7 Key findings and learning points will be disseminated to relevant staff.

26.0 Guideline Management

26.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

26.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

26.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

26.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

27.0 Communication

27.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

27.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

27.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

27.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

28.0 References

National Institute for Health and Clinical Excellence (2011) Caesarean Section. NICE Guideline (CG132)

Royal College of Obstetricians and Gynaecologists (2015) Birth After Previous Caesarean Birth**.** 2nd edition. (Green top guideline No. 45)

Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. Department of Health.

Health and Social Care Information Centre (2015) Hospital Episode Statistics: NHS Maternity Statistics – England, 2014

Appendix A

Chart to illustrate the Consultant Responsibilities for the elective LSCS theatre list each day

	Obstetrician	Anaesthetist
Monday	**Mr Spencer/ Miss Joshi**	**Dr Walton**
Tuesday	**Mr Gangooly**	**Dr Fenton**
Wednesday	**Miss Rao**	**Dr Philpott**
Thursday	**Miss Sharma**	**Dr Philpott**
Friday	**Mr Fiadjoe**	**Dr O'Hara**

Appendix B

Flowchart for failed block