Mid Essex Hospital Services NHS Trust

MANAGEMENT OF EMERGENCY LOWER SEGMENT CAESAREAN SECTION (LSCS)	CLINICAL GUIDELINES Register no: 04264 Status: Public

Developed in response to:	Intrapartum NICE Guidelines RCOG guideline, High Impact Intervention
CQC Fundamental Standards:	11, 12

Consulted With:	Post/Committee/Group:	Date:
Anita Rao/ Alison Cuthbertson	Clinical Director for Women's and Children's Division	March 2018
Vidya Thakur	Consultant for Obstetrics and Gynaecology	
Alison Cuthbertson	Associate Director of Midwifery/Nursing	
Paula Hollis	Lead Midwife Acute Inpatient Services	
Chris Berner	Lead Midwife Clinical Governance	
Ros Bullen-Bell	Lead Midwife Community Services	
Sarah Moon	Specialist Midwife Guidelines and Audit	
Susie Denhart	Practice Development Midwife	
Claire Fitzgerald	Pharmacy	
Deborah Lepley	Senior Librarian, Warner Library	

Professionally Approved By:		
Miss Rao	Lead Consultant for Obstetrics and Gynaecology	March 2018

Version Number	5.0
Issuing Directorate	Women's and Children's
Ratified By	DRAG Chairmans Action
Ratified On	10th April 2018
Implementation Date	21st May 2018
Trust Executive Sign Off date	June 2018
Next Review Date	March 2021
Author	Anita Dutta, Obstetric Consultant
Policy to be followed by	**Midwives, Obstetricians, Paediatricians**
Distribution Method	Intranet & Website. Notified on Staff Focus
Related Trust Policies (to be read in conjunction with)	09044 Roles and responsibilities of staff when arranging an elective LSCS 04080 Consent to Examination or Treatment Policy 04266 Guideline for the management of diabetes in pregnancy 09007 Guideline for the management of bladder care in pregnancy 09114 Guideline for postnatal care of mothers and babies 09113 Guideline for calling paediatric staff and obtaining paediatric referral 09095 Management of the severely ill pregnant patient

Document History Review:

Review No:	Reviewed by:	Issue Date:
1.0	Julie Bishop	February 2009
2.0	Hayley Hume	October 2009
2.1	Clarification to 3.2, 4.4	February 2010
2.2	Sarah Moon - change to clexane and timings of LSCS	September 2011
3.0	Sarah Moon	May 2012
3.1	Sarah Moon – clarification to 10.3, 4.17	July 2012
3.2	Sarah Moon – clarification to 4.5	November 2012
3.3	Sarah Moon – clarification to point 4.1, 4.2 and Appendix A	November 2013
3.4	Anita Rao - clarification to point 3.2	December 2014
4.0	Madhu Joshi, Obstetric Consultant	6th July 2015
4.1	Sam Brayshaw - clarification to point 10.0 and 11.0	August 2015
4.2	Anita Rao- clarification to point 10.5 and 10.9	21 March 2017
5.0	Anita Dutta – Full review	21 June 2018

INDEX

1.0 Purpose

1.1 The purpose of this guideline is intended to be aimed at the actions that the Labour Ward staff working in the Maternity Unit should take when the decision has been taken to perform an emergency LSCS. The midwife has a professional responsibility to the patient which continues during the pre, peri and post-operative periods, despite any medical intervention.

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 Criteria for Emergency LSCS

3.1 The decision to perform an emergency LSCS should be made by the obstetric registrar or consultant on call. If the obstetric registrar has made the decision he/she should inform the obstetric consultant on call to discuss his decision unless the criterion is grade 1(Refer to point 3.2).

3.2 The classification of urgency is as follows:

- **Grade 1- Immediate threat to the life of the patient or fetus** (including lower segment caesarean section (LSCS) for acute severe bradycardia, cord prolapse, uterine rupture and fetal blood sampling pH less than 7.2)
  Timescale: (decision to delivery interval) - **Not to exceed 30 minutes**

- **Grade 2 - Maternal or fetal compromise which is not immediately life-threatening** (there is urgency to deliver the baby in order to prevent further deterioration of either mother or baby's condition i.e. antepartum haemorrhage, 'failure to progress' in labour with maternal and fetal compromise)
  Timescale: (decision to delivery interval) – **45 minutes to 75 minutes**

- **Grade 3 - No maternal or fetal compromise but needs early delivery** (including LSCS carried out where there is no maternal or fetal compromise but early delivery is necessary i.e. a patient booked for LSCS who is admitted with pre-labour spontaneous rupture of membranes (SROM) or 'failure to progress' with no maternal or fetal compromise **. Planned caesarean section, time agreed between multi-disciplinary team members**

- **Grade 4 - Delivery timed to suit the patient or staff** (including all LSCS carried out 'electively' at a planned time to suit mother and clinicians

4.0 Procedure

4.1 In the event of a Grade 1 emergency caesarean section the responsible midwife caring for the woman should instigate a **Code Red** procedure, to ensure that all key professional staff are summoned urgently; and that they are present for the emergency procedure.
(Refer to Appendix A)

4.2 The **midwife** caring for the patient should inform the Labour Ward Co-ordinator of the imminent caesarean section (either verbally if present in the labour room or via the Labour Ward Co-ordinator's bleep on #6555 2017), to enable the Labour Ward Co-ordinator to manage the obstetric team and to be aware of the activity within the department.

4.3 The **Labour Ward Co-ordinator** should then summon the following to enable the midwife to stay with the patient and continue with her pre-operative preparation.

- **Anaesthetic registrar** - is required to see patient pre-operatively and prescribe pre-medication, as well as administer anaesthesia
- **Obstetric registrar** – should complete the patient's consent form and ensure that the venous thrombo-embolism (VTE) form has been completed and attached securely to the drug chart
- **Midwife in theatre** – should wear a **yellow** hat to ensure immediate identification of the midwife in theatre
- **Theatre nurses** - should set up the obstetric theatre for the emergency LSCS
- **Recovery nurse** – should prepare to recover the patient post-operatively
- **Obstetric senior house officer** - should take the patient's venous blood for group and cross match if not already taken
- **Operation department practitioner** (ODP) - should assist the anaesthetist
- **Paediatric registrar and senior house officer** – should assess the baby's condition at birth
- Inform the Neonatal Unit of a potential admission
- Inform the **Neonatal Unit** if the baby is assessed to be severely compromised or is premature to enable them to prepare to receive the baby if necessary

4.4 Explain the pre-operative preparation to ensure that the patient is aware of the impending events.

4.5 A consent form must be completed appropriately and the reason for the caesarean section documented in the healthcare records the obstetric registrar/consultant in the patient's health care records.

4.6 The reason to perform a Grade 1 caesarean section must be documented by the obstetric registrar/ consultant on call, in the patient's health care records.

4.7 The obstetric registrar/consultant or the midwife providing care for the patient, must ensure that any reasons for delay in undertaking the emergency caesarean section are documented in the patient's health care records.

4.8 In order to comply with the Trust policy on 'consent to examination or treatment policy'; register number 04080) informed consent should be obtained at this point.

4.9 The anaesthetist should administer the pre-medication of intravenous (IV) metoclopramide 10mg and IV ranitidine 50 mgs.

4.10 Sodium citrate 30 mls orally should only be administered by the ODP/anaesthetist for patients undergoing an emergency caesarean section under general anaesthesia. This should be administered in the obstetric theatre to prevent Mendelsson's Syndrome.

4.11 To comply with HII4, prophylactic antibiotics should be given as soon as possible once the decision for an emergency caesarean section has been made prior to spinal/GA anaesthesia and minutes before 'knife to skin' to reduce the risk of post operative wound infection. The anaesthetist should offer and administer prophylactic antibiotics in the form of augmentin 1.2 g intravenously, in the obstetric theatre.
(Refer to Saving Lives policy guideline, DoH, 2007)

4.12 The Obstetric Registrar must ensure that the patient understands the explanation given concerning the indication(s) for the operation. The obstetric registrar should advise the anaesthetist regarding the urgency of the emergency caesarean section and agree on the mode of anaesthesia.

4.13 For **spinal anaesthesia**, repeated attempts should be avoided when considering a grade 1 emergency caesarean section Continuous CTG monitoring during the spinal anaesthetic will help with decisions regarding continuing with attempted spinal anaesthesia.
(Refer to the 'Guideline for the roles and responsibilities of staff when arranging an elective LSCS. Register number 09044).

4.14 **Epidural top-up** should be commenced at the patient's bedside on Labour Ward and the anaesthetist should accompany the patient to theatre. It is inappropriate to initiate epidural anaesthesia in an urgent situation.

4.15 **General anaesthetic** is a preferred choice when 'rapid' induction of anaesthesia is indicated.
(Refer to the 'Guideline for the roles and responsibilities of staff when arranging an elective LSCS. Register number 09044)

4.16 The **midwife** caring for the patient should be responsible for completing the theatre checklist as follows:

- The patient has been measured and fitted with anti-embolic stockings prior to surgery for Grades 3 and 4 caesarean section
- To ensure the client is wearing an identification band, with all the correct details
- Any allergies should be noted, identification label checked, and the theatre staff and anaesthetist informed, on transfer to the obstetric theatres
- Check when patient last had anything to eat or drink
- Ascertain that blood samples have been sent category 1 for full blood count (FBC) and group and save
- MRSA screen/swabs should be undertaken ideally prior to Grades 1 and 2 Caesarean section but if unable to due to time constraints the MRSA screen/swabs should be undertaken in the Recovery Room
- Change patient into theatre gown if possible

- Remove personal jewellery from patient and give to patient's relatives for safe keeping
- Pubic clippers should be used in the patient's room on labour ward by the theatre staff
- Record baseline maternal observations, including temperature, blood pressure, respirations and pulse; and fetal heart rate using either pinnard, sonicaid or cardiotocograph (CTG) as appropriate.
- Ensure that the consent form has been completed
- Ensure the patient's healthcare records are up to date

4.17 Ensure that there is transport available to convey the patient to theatre i.e. wheelchair or labour bed as appropriate.

4.18 When the patient is ready to be transported to the obstetric theatre, the midwife must accompany her patient and ensure that all the patient's hospital notes are presented to the anaesthetic team.

4.19 Continuous CTG monitoring should to be continued following transfer to obstetric theatre to ensure effective monitoring of fetal wellbeing and expedition of delivery if clinically indicated.

4.20 The **pre-operative check list** should be presented to the theatre staff and at this point a further handover can be given to check essential details.

4.21 If spinal or epidural anaesthetic is to be used, the patient's partner may accompany the patient in theatre.

4.22 The midwife should direct the patient's partner to the changing room and given appropriate theatre clothing to wear if he is to be present during procedure.

4.23 If general anaesthesia is to be used the partner is asked to remain by the patient's postnatal bed / or on labour ward or in the recovery room. The baby can be brought to the partner once delivered and in a good condition. The partner is not permitted in theatre if the patient is having a general anaesthetic.

4.24 The midwife should change into theatre clothes, a yellow hat, and appropriate footwear if he/she is to act in role of midwife receiving baby or assistant to paediatrician

4.25 The midwife should continue monitoring the fetal heart rate using a sonicaid or cardiotocograph (CTG) as appropriate and simultaneously record the maternal pulse. These findings should be relayed to the obstetric registrar whilst he/she is prepping for theatre.

4.26 The paediatric team should be alerted to attend, prior to the commencement of the emergency LSCS to assess the baby's condition at birth. (Refer to the 'Guideline for calling paediatric staff and obtaining paediatric referral'. Register number 09113)

4.27 The midwife's professional responsibility is to receive the baby at delivery. If another midwife is to take on this role (i.e. the end of a shift) then there should be full and adequate handover of notes, information and responsibility).

4.28 Cord blood samples should be taken for venous and arterial analysis at all emergency LSCS.

5.0 Insulin Dependent Diabetics

5.1 Patients who are insulin dependent diabetics will have 'sliding scale' insulin commenced, if this has not already been established.
(This section should be read in conjunction with the 'Guideline for the management of diabetes in pregnancy'. Register number 04266. Furthermore, refer to the 'Guideline for the roles and responsibilities of staff when arranging an elective lower segment caesarean section (LSCS)'. Register number 09044).

6.0 Responsibilities of the Midwife Taking the Baby in Theatre

6.1 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.

6.2 To be competent in resuscitation of the newborn.

6.3 To ensure that the baby is kept warm, wrapping the baby in warmed towels and placing a hat on the baby's head.

6.4 To introduce the baby to the patient and her partner.

6.5 To carry out a full baby examination, giving vitamin K (as indicated by the patient), weighing and labelling the baby.

6.6 To initiate feeding/skin to skin contact.

6.7 To complete documentation including completing the delivery register, clinical data collection (CDC), maternity notes including times of events and staff involved.

6.8 To ensure that operative details have been completed by the obstetric registrar/ consultant on call.

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

6.10 Provide 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.

7.0 Recovery

7.1 Post-operative observations should continue in the recovery area being carried out by the recovery nurse until discharge to the ward and documented on the MEOWS (Modified Early Obstetric Warning Score) chart located in the 'Operative Delivery and Theatre Care Record'
(Refer to the guidelines entitled 'Obstetric theatre recovery'; register number 00996; and 'Management of the severely ill pregnant patient'; register number 09095).

7.2 The recovery nurse should be responsible for ensuring that the patient has been measured and fitted with anti-embolic stockings on transfer to the recovery room for Grades 1 and 2 Caesarean section.

7.3 MRSA screen/swabs should be undertaken ideally prior to Grades 1 and 2 Caesarean section but if unable to due to time constraints the MRSA screen/swabs should be undertaken in the Recovery Room
Patients are allowed sips of water in recovery and can commence a light diet and fluids on return to the ward.

7.4 Every effort should be made by the midwife to initiate early infant feeding.

8.0 Post-operative Fluids

8.1 Intravenous fluids (IV) to be continued on the ward until the patients' condition is stable and they are tolerating adequate oral fluid intake.

8.2 Special IV 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).

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

9.0 Indwelling Catheter Device (ICD)

9.1 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 (refer to Saving Lives policy guideline, DoH, 2007).

9.2 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 health care records.
(Refer to the 'Guideline for the management of bladder care in pregnancy'. Register number 09007)

9.3 The date and time the catheter was removed and who removed it should be recorded on the HII (medical devices) paperwork
(Refer to Saving Lives policy guideline, DoH, 2007)

9.4 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.

10.0 Administration of Clexane

10.1 It is important to correctly time the administration of an anticoagulant with a regional block to avoid an inadvertent spinal or epidural haematoma.

10.2 A period of 12 hours should elapse before performing a regional block on patients receiving a prophylactic dose of clexane (20-40mg subcutaneously (s/c) once a day, dosage dependant on maternal booking weight).

10.3 Low weight molecular heparin should be administered 4 hours after use of spinal anaesthesia or after the epidural catheter has been removed; and for 6 hours if the procedure was traumatic.

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

10.5 All emergency and elective caesarean section patients should be prescribed prophylactic 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. For example a patient with an increased risk of postpartum VTE may have clexane prophylaxis up to 6 weeks duration. (Refer to the guideline entitled 'Roles and responsibilities of staff when arranging an elective lower segment caesarean section; register number 09044)

10.6 Clexane dosages given subcutaneously according to maternal booking weight:

- <50Kg 20mg daily
- 50-90Kg 40mg daily
- 90-130kg 60mg daily
- >130kg 80mg daily

10.7 All patients undergoing an emergency LSCS should be fitted with anti-embolism stockings. It is recommended that the anti-embolism stockings are fitted prior to the emergency LSCS and removed once the patient is fully mobile, unless stated otherwise in the patient's individual care plan which should be documented in their healthcare records.

10.8 Patients should be encouraged to mobilise early, once the effects of the spinal anaesthesia/ general anaesthetic have diminished.

10.9 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.

10.10 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.

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

11.0 Post-operative Analgesia

11.1 100mg diclofenac pr (rectally) should be given at the end of operation unless contraindicated (i.e. severe pregnancy induced hypertension (PIH), asthma, allergy to NSAI's or aspirin).

11.2 Patients should be prescribed oramorph10-20mg hourly, with cyclizine 50mg IM/IV/orally 8 hourly as antiemetic.

11.3 Ondansetron is not licensed in breast-feeding patients.

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

11.5 Prescribe on the "Drugs to take home" section of the drug chart:

- Paracetamol 1g QDS plus Ibuprofen 400mg QDS plus oramorph 10-20mg as required

11.6 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 must be encouraged to are able to self-buy laxatives and take them regularly or go to their GP if issues regarding constipation present.

11.7 Patients sensitive to codeine should be prescribed paracetamol orally 1gram qds.OMIT

12.0 Care of the Patient following Delivery

12.1 Following the patient's initial care in the recovery area of the obstetric theatre, the patient should be transferred to the postnatal ward for continuing care.
(Refer to the 'Guideline for postnatal care of mothers and babies'; register number 09114)

14.0 Discharge or Transfer of Care to Midwifery-led Unit

14.1 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.

14.2 All patients who have had an emergency section should be seen by the on call labour ward obstetric consultant for hot week, prior to discharge. The patient will be briefed about the case and counsel regarding future pregnancies i.e. VBAC (vaginal birth after caesarean section).

14.3 The on call labour ward obstetric consultant for hot week should complete the appropriate documentation in the patient's operative health care records under post procedure care and advice regarding the discussion regarding the patient's emergency caesarean section.

15.0 Staffing and Training

15.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training to include neonatal and maternal resuscitation.

15.2 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.

16.0 Infection Prevention

16.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

16.2 All staff should ensure that they follow Trust guidelines on infection prevention, using aseptic non-touch technique (ANTT) when carrying out procedures i.e. obtaining blood samples.

16.3 All invasive devices must be inserted and cared for using High Impact Intervention guidelines 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).

17.0 Audit and Monitoring

17.1 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.

17.2 The audit process will involve the use of an audit proforma which will be completed in the obstetric theatre recovery by the obstetric registrar/ consultant on call responsible for the delivery.

17.3 At any time during the completion of the proforma where deficiencies are identified, these will be address immediately with the health professional involved.

17.4 The completed audit proforma should then be placed in the designated filing tray in the recovery room.

17.5 As a minimum the following specific requirements will be monitored:

- Timing for Grade 1 classification of caesarean section as agreed by the maternity service
- Requirement to document the reason for performing a Grade 1 caesarean section in the health records by the person who makes the decision
- Need to include a consultant obstetrician in the decision making process unless doing so would be life threatening to the woman or the fetus
- Requirement to document any reasons for delay in undertaking the caesarean section
- Requirement for all women to be offered antibiotic and thrombo prophylaxis
- Care of the mother in the first 24 hours following delivery
- Requirement to discuss with women the implications for future pregnancies before discharge

17.6 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 16.4 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

17.7 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.

17.8 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.

17.9 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

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

18.0 Guideline Management

18.1 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.

18.2 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.

18.3 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.

18.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

19.0 Communication

19.1 A bi-monthly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

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

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

19.4 Regular memos are posted on the guideline 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.

20.0 References

Midwifery Digest (2008) Caesarean section and subsequent births. MIDIRS.

National Institute for Clinical Excellence Clinical (2012) Guideline Caesarean Section. NICE.(CG132)

Royal College of Obstetricians and Gynaecologists Good Practice 11 Published 2010

Department of Health (2007) Saving Lives. DoH.

Appendix A

Mid Essex Hospital Services NHS Trust
Women's and Children's Division

CODE RED

There are two types of emergencies (code RED) that require urgent 'crash call' responses using the new 4444 emergency call number.

Initiating an emergency

- Co-ordinator/senior staff member to initiate code
- Dial 4444
- Specify code **RED**
  (Refer to below criteria)
- Give location to switchboard (i.e. maternity obstetric theatre/delivery room)

Code RED for obstetric emergencies

- Grade 1 emergency section
- Major/ massive haemorrhage
- Maternal fitting

Code RED switchboard will fast bleep the following:

- Labour ward co-ordinator (#6555 2017)
- On call obstetric registrar
- On call obstetric SHO
- On call anaesthetist
- On call anaesthetic assistant
- On call paediatric registrar
- On call paediatric SHO
- Theatre scrub team

****** In the event of a cardiac arrest you will still need to dial 2222******

Amended March 2018