Poole Hospital
NHS Foundation Trust

The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

CAESAREAN SECTION (CS) GUIDELINE

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A) SUMMARY POINTS
This policy details:
• Definition of CS
• Indication for CS
• Maternal Request CS care pathway
• Thromboprophylaxis
• Classification of CS
• Emergency CS (Cat 1-3)
• Elective CS (Cat 4)
• Postoperative care
B) ASSOCIATED DOCUMENTS
• Booking Appointments and Antenatal Care Pathway
• Pre-existing diabetes
• Care of Women in Labour
• Recovery guidelines
• Vaginal birth after caesarean section
• Modified early Warning system in Obstetrics (MEOWS)
• Bladder care
• Immediate care of the Newborn
• Postpartum haemorrhage
• Venous thromboembolism guideline
• Transfer policy

C) DOCUMENT DETAILS	
Author:	Updated by [redacted] & [redacted] (august 2019,) [redacted] (April 2020)
Job title:	Consultant Midwife & Matron for Inpatient Services
Directorate:	Women and Children
Version no:	4.1
Target audience:	Maternity and neonatal staff
Approving committee / group:	EDMAD/RBH Maternity Open Risk Meeting/ Clinical Policies and Procedures Group
Chairperson:	[redacted]
Review Date:	August 2022

D) VERSION CONTROL						
Date of Issue	**Version No.**	**Date of Review**	**Nature of Change**	**Approval Date**	**Approval Committee**	**Author**
April 2010	1	Dec 2013		19.4.10	EDMAD	[redacted]
Feb 12	1.2	Dec 13	Amendment to antibiotic prophylaxis and re-phrase of timing of elective cases	22/2/12	EDMAD	[redacted]

April 12	1.3	Dec13	Removal of LMWH dose table to comply with Trust-wide management. Correction to reference numbers of associated documents (Induction of labour and Recovery guidelines)	14/3/12	EDMAD	[redacted]
Jun 2013	1.4	Jun 2016	Changes to decision to delivery interval as per NICE Using LMWH for 1 week postnatally	16/6/13	EDMAD	[redacted]
June 14	2.0	Jun 2017	Restructuring of layout. Rewriting of Definition, Indications and Classification Inclusion of Maternal Request Caesarean section pathway. Inclusion of appendices	20/6/14	EDMAD	[redacted]
May 2018	3.0	May 2021	Review	15/5/2018	EDMAD	[redacted]
August 2019	4.0	August 2022	Updated Trust format, Addition of documenting pain score on MEOWS chart, cell salvage, CS categorisations & changes to administration of pre-meds		EDMAD Clinical Policies and procedures group	[redacted] & [redacted]
April 2020	4,1	August 2022	Addition of section 4.5 re other procedures at time of LSCS	22/04/2020	EDMAD/ CPPG	[redacted] [redacted]

E) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
4	August 2022	[redacted] & [redacted]	Maternity and neonatal staff
4.1	August 2022	[redacted] [redacted]	EDMAD group

CONTENT **PAGE No.**

1. Introduction

This guideline applies to all staff involved in the care of women and babies in Poole and Bournemouth Maternity Unit and Community settings.

2. Purpose

The purpose of this guideline is to provide guidance on the operational and clinical management of CS within the Maternity Service. The multi-professional team will ensure that the care for any woman requiring information about caesarean section or has a caesarean section within the Maternity Services will be evidence-based in order to ensure safety of the woman and her unborn child.

3. Definition

A Caesarean section is a surgical procedure in which an incision is made through a mother's abdomen (laparotomy) and uterus (hysterotomy) to deliver one or more babies. Caesarean section is recommended when vaginal delivery might pose a risk to the mother or baby.

4. Procedures/Document Content

4.1 Indication for Caesarean Section

Complications arising during pregnancy:

- Placenta praevia/accreta (a Consultant Obstetrician or Completion of Certificate of Training (CCT) holder must be present at caesarean section performed for placenta praevia)
- Twin pregnancy with complications, mal-presentation, twin to twin transfusion, IUGR
- PET / HELLP
- Failed induction of labour
- Antepartum Haemorrhage
- Breech presentation
- Other maternal / fetal compromise – e.g. RTA

Complications arising during labour

- Significant fetal compromise due to complications of labour (see 6.3.1)
- Significant maternal compromise due to complications of labour / deteriorating maternal condition
- Failure to progress in 1st or 2nd stage of labour
- Failed instrumental delivery

Other

- Previous Caesarean section – not suitable for VBAC
- Maternal Request

Use of cell salvage

In all cases of CS consider use of cell salvage dependant on individual risk factors. In the event of ongoing bleeding in excess of 1000mls follow PPH and MOH guideline.

Maternal request for Caesarean section (MRCS) – Care pathway

Elective caesarean section (ELCS) should only be recommended when the risks of caesarean section are outweighed by the potential risks of vaginal birth. Whilst the majority of caesarean sections are undertaken for clear clinical indications there are women who request a caesarean section for personal choice, because of a previous birth experience or for psychological reasons. Women with severe anxiety about childbirth should be given additional support and in these cases a specific pathway should be followed (Appendix 1) and referral to the Birth Choices Clinic ensuring consistency of advice and clinical care to enable the woman to make an informed decision to be made on mode of birth. The RCOG (2015a) information leaflet titled "Choosing to have a caesarean section" which can be accessed here should be given as appropriate.

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, a planned Caesarean section should be considered.

Thromboprophylaxis

All women having a caesarean section should wear compression stockings and have thromboprophylaxis unless contraindicated (see Appendix 2) with subcutaneous low molecular weight heparin (dose according to body weight table, see Guideline on Venous thromboembolism)

The first dose must be administered between 4 - 6 hrs after spinal or removal of epidural.

4.2 Classification of Caesarean Section

Emergency Caesarean Section

- The decision to perform, categorisation of caesarean section and time called must always be recorded prospectively in the clinical records by the Obstetrician
- Reasons for any delay in undertaking an emergency CS must be recorded in the clinical records. To minimise delays, the High Risk Pathway must be completed when caring for women in labour (see Appendix 3).
- The surgeon must ensure that the anaesthetist and Labour Ward Co-ordinator are fully informed, giving precise details regarding the category.
- If clinically safe, the reason for the emergency CS will be discussed with the woman and / or her partner and written in the labour record

Actions to be performed as soon as the decision is taken if not already completed as part of High Risk Pathway (see Appendix 3):

- The Obstetrician making the decision must inform the shift leader on Labour Ward
- The shift leader will inform the duty anaesthetist and the obstetric theatre coordinator, stating the degree of urgency of the case (see categories below)
- The midwife must administer antacid therapy as per PGD

- Blood samples for group and save (cross matching to be performed at the discretion of the surgeon) must be taken and sent to the lab if Electronic Issue is not available
- In cases of Category 1 section, the obstetrician is personally responsible for ensuring that all other parties understand the urgency of the situation. The requirement of a general anaesthetic should be discussed by the Obstetrician with the duty anaesthetist.
- Written consent is not required for a Category 1 caesarean section, but the fact that the mother has been informed of risk factors and agreed to the procedure must be recorded in the notes
- The duty ANNP/neonatologist should be present at ALL emergency sections. It is the responsibility of the midwife performing the care to contact the ANNP/neonatologist for the birth
- For all categories of CS, the cardiotocograph (CTG) monitor should be reconnected with the minimum possible delay, and should be continued for as long as practical in theatre
- Any delay must be documented in the maternal labour record and recorded in the Datix system
- Antibiotic prophylaxis should be given in theatre (see below)
- For all procedures, whether elective or emergency, operators must complete the Operative Delivery workflow on Medway

Category 1

- Target time: perform as quickly as possible after making the decision but within 30 minutes for the following indications:
    - Profound fetal compromise
    - Prolapsed cord
    - Fetal compromise with cord prolapse of second twin
    - Failed forceps delivery for fetal compromise
    - Failed trial of forceps (woman will already be in theatre and appropriately anaesthetised)
    - Significant maternal compromise
    - Major obstetric haemorrhage where fetus is alive and viable. The decision must be taken in consultation with the on call Obstetric Consultant, maternal welfare being the most important consideration. (see Postpartum Haemorrhage guideline)
- If the duty anaesthetist is confident of providing a suitably quick spinal anaesthesia or epidural top-up this may be used
- They must ensure that woman is ready for “knife to skin” within 25 minutes; if not a general anaesthetic may need to be used
- Attempts at regional anaesthesia should be abandoned after one attempt if unsuccessful (consider pre-oxygenation whilst attempting regional anaesthesia)
- The woman will be catheterised in theatre.

On decision to call for a Category 1 CS, the shift leader will dial [redacted] stating ‘Obstetric Medical Emergency Team to Obstetric Theatres’. The shift leader

must also bleep the neonatologist on [redacted] to advise that a Category 1 CS is under way.

If possible a Category 1 CS will be reviewed by a consultant within 24 hours.

Category 2

- Target time: perform delivery within 75 minutes
    - Fetal compromise in first stage
    - Failed forceps delivery without evidence of fetal compromise
    - Failure to progress in second stage considered unsuitable for instrumental delivery
- Caesarean section for failure to progress in the first stage of labour with a reassuring CTG may be classified as Category 2 but could be performed outside the 75 minute interval
- The anaesthetist must be sure that if regional anaesthesia is used delivery interval will not be exceeded; this will depend on the experience and judgement of the anaesthetist.
- The woman will be shaved and catheterised in the room or in theatre
- As far as possible, a continuous CTG recording should be maintained until the procedure commences

Category 3

- Target time decision – delivery interval and timing of delivery is at the clinician's discretion with discussion involving the multi-disciplinary team for the following indications:
    - Failure to progress in first stage with no maternal or fetal compromise
    - Non-urgent indication for delivery of fetus at discretion of obstetrician
    - Booked elective section in early labour
    - Undiagnosed breech in early labour
    - Failed induction of labour (may be up to 24 hours depending upon workload)
    - Regional anaesthesia will be used unless contra-indicated due to maternal condition

Elective Caesarean Section - Category 4

- The decision to perform an ELCS is taken by the woman's Consultant, deputy or as per VBAC Guideline
- Unless there are exceptional circumstances this should be performed from 39 weeks of pregnancy. The risk of respiratory morbidity in babies born by CS pre-labour decreases significantly after 39 weeks.
- If delivery is planned prior to 39 weeks gestation, consideration must be given to the administration of corticosteroids on a case by case basis

4.3 Booking Category 4 Caesarean sections

- The reason for an ELCS must be discussed with the woman and documented in her hand held notes

- ELCS sections are performed on weekday mornings with a maximum of 3 cases per day and emergency activity will take precedence at all times
- Women are booked for the elective list, using the computer database
- Additional bookings may be arranged following discussion with the CS override admin team or put onto a holding list if no space available. This list is checked daily by the override team and dates given accordingly when they become available.
- Where a specific consultant wishes to do the operation personally or there are medical reasons for a woman being on a particular list this should be clearly indicated to the maternity and theatre staff
- In the event of an ELCS list over running and the absence of additional theatre slots (when there is a clinical need to perform an ELCS) the named consultant or their deputy is responsible for liaising with theatre and anaesthetic colleagues for the operation to be done outside the usual time
- Occasionally it may be possible to postpone a less urgent case to another day

4.4 Preparation for Surgery

- Women are asked to attend Postnatal Annexe for midwifery pre-operative assessment and consenting, usually two days before the operation
- Women are admitted at 07.30 hours on the morning of their surgery having been nil by mouth from midnight.
- NB This pathway of care does not apply to insulin dependent diabetics (See Guideline on Pre-existing diabetes)
- Women undergoing ELCS at gestation of 38+6 weeks or less must receive 2 doses of steroids prophylaxis at least 48 hours before delivery.
- The appropriate antacid regimen should be prescribed on the drug chart by the obstetric anaesthetist or midwife prescriber and administered by the midwife when the woman is prepared for surgery.
- Selected women may follow the Enhanced Recovery Programme for Obstetrics Guideline.

4.5 Other Procedures to be Carried Out at the Time of CS

- Ideally any additional procedures to be performed at the time of **elective** caesarean section should be discussed and consented for in the antenatal period by an appropriately trained doctor. A record of these discussions should be documented in the patients notes and/or electronic record. The Faculty of Sexual and Reproductive Healthcare recommend that if tubal occlusion is performed at the same time as a caesarean section, counselling and agreement should be given at least 2 weeks in advance of the procedure.

- If a woman requests a sterilisation on the day of the operation or at her pre op assessment they should be reviewed by a consultant and the request considered carefully on an individual basis.

- Consent for any additional procedures should be documented on a separate consent form rather than added to the pre printed consent form Caesarean section. In cases where the woman wishes to be sterilised there is a pre printed sterilisation consent form that must be used. Consent for additional procedures should be taken by an adequately trained professional.

- Any additional procedures should be added to the caesarean section database at the time of booking the caesarean section or when adding the procedure.

- Consent should be confirmed on the day of the caesarean section.

Day of Surgery

- Women on the ELCS list should be seen before the operation by the senior obstetrician who will be supervising the surgery; they are responsible for ensuring that the operation is appropriate. The anaesthetist must also review the women prior to surgery to ensure the anaesthetic assessment is complete and confirm anaesthetic options.
- If the woman is requesting sterilisation, the obstetrician must ensure that the woman has had appropriate counselling and has been consented for the procedure. This must be fully communicated to the theatre team at the Team Brief.
- Women having an ELCS section for breech presentation alone (i.e. no other indication), must have an ultrasound scan on the morning of their operation. If the presentation is no longer breech the operation should usually be cancelled and the woman referred to their consultant
- The WHO checklist should be completed and a team discussion should take place before the elective list to highlight any potential problems with each individual case
- All women should be offered prophylactic antibiotic therapy at anaesthetic induction (Cefuroxime 1.5g and Metronidazole 500 mg i.v).
- The fetal heart should be monitored following insertion of spinal anaesthetic on a CTG (if the woman is not contracting then it is not necessary to monitor with the cardiotocograph)
- Cord gases should be taken for all ELCS.
- Operators must complete the Operative Delivery workflow on Medway and print/sign a copy to file in the notes

De-briefing post Caesarean Section

Post emergency caesarean section

It is desirable that any woman who has undergone an emergency LSCS should be debriefed by an obstetrician the following day (if the woman's condition is stable). She should be informed of the following:

- Reason for the LSCS

- Impact of the LSCS upon future pregnancies and mode of birth for future pregnancies should be discussed and documented
- Information should be given about the positives of vaginal birth after caesarean section (VBAC) and the information leaflet should be provided.
- This information is generated by Medway on discharge and given to the patient
- Surgeons must document whether suitable for VBAC in subsequent pregnancies in the operative notes.
- Where appropriate for VBAC in a subsequent pregnancy, a RCOG (2016) VBAC information leaflet will be given prior to discharge which can be accessed here.
- The GP is sent a copy of the Medway discharge summary
- If appropriate and meets criteria, consider referral to Outpatient Postnatal Clinic

Post Elective Caesarean Section

- Women post ELCS section will be given information prior to discharge from the postnatal ward
- Where appropriate for VBAC in a subsequent pregnancy, a RCOG (2016) VBAC information leaflet will be given prior to discharge which can be accessed here.

4.6 Postoperative Care – all caesarean sections

Observations:

- Refer to OBS 2.8 Modified Early Warning System in Obstetrics guideline here

Intravenous fluids:

- The woman may arrive on the ward with fluids still running which will require review to check flow rate and amount to be administered as per chart
- Normal fluids and diet should be encouraged as soon as they can be tolerated
- Once normal fluids and light diet tolerated, if no concerns with blood loss or pre-operative Hb, IV cannula to be removed and VIP chart updated.

Pain management:

- Adequate analgesia (see Appendix 2) after surgery leads to earlier mobilisation, fewer pulmonary and cardiac complications, reduced risk of DVT and earlier return of gastrointestinal function. It also improves the mother's experience, her ability to look after her newborn(s) and facilitates breastfeeding.
- Midwives caring for women post CS should therefore enquire about pain and document on the MEOWS (Modified Obstetric Early Warning Score) chart (see MEOWS Guideline)

Venous Thromboembolic (VTE) Prophylaxis:

- All women should have their VTE score reassessed and recorded in the clinical records.
- All women having a CS will require 10 days of LMWH prophylaxis (see Appendix 2)

Catheter care:

- Please refer to the Trust guidance on catheter and bladder care
- The catheter must be removed after 12 hours, unless contraindicated
- Once removed the woman must be advised that her first urine output must be collected in a disposable jug and the time and volume must be recorded in the clinical records.

Post-op Haemoglobin (Hb):

- A post-operative Hb should be taken in all women who have a pre-operative Hb <105 g/L (JPAC 2013) and/or >500mls blood loss (NICE 2015). Women with pre-operative Hb ≥105g/L or EBL <500mls do not need a post-operative Hb unless symptomatic
- Hbs are normally taken on day 1 unless clinically indicated sooner
- The result should be checked before discharge so ferrous sulphate can be prescribed if needed

Wound care:

- If there is a pressure dressing, it should be removed prior to leaving recovery or after 6 hours post op before mobilising unless there is a clinical need to leave it in place.
- 24 hours post-delivery the original wound dressing is removed using a sterile technique
- If the wound requires cleaning this should be cleaned with sterile normal saline
- The woman can shower after 12-24 hours as the dressing is waterproof.

Mobilisation

- Women should be actively encouraged to mobilise after 8 hours post-delivery or as soon as possible after 8 hours
- Patient information on wound care (Appendix 4) is given at the point of booking ELCS or in the case of emergency CS on the postnatal ward

5. Roles and Responsibilities

- Midwives and maternity care assistants should ensure that every opportunity is taken to provide the woman and her partner or other relevant family members with the information and support they need to make choices concerning their care
- Care and information should be appropriate and the woman's cultural practices should be taken into account
- All information should be provided in a manner that is accessible to women, their partners and families, taking into account any additional needs, such as physical, cognitive or sensory disabilities, and women who do not speak or read English

6. Training

Where applicable, staff will receive training through annual/ bi-annual mandatory training.

7. Monitoring Compliance and Effectiveness of the Document (Poole Hospital NHS Foundation Trust Only)

In order to provide Maternity Services with assurance of implementation of the guideline and the provision of safe clinical care the following process of monitoring will be utilised.

The Lead Obstetric Consultant for Audit is responsible for reviewing the audit results and developing action plans for any of the criteria that are less than 100%.

Caesarean section:

Audit Method	Lead responsible for audit and report submission	Frequency of audit
All category 1 and 2 caesarean sections	Lead Obstetrician for audit	Quarterly (continuous)

Audit criteria:

- ***All caesarean sections have been classified***
- ***The timing of each caesarean is within time limits***
- ***Reasons for category 1 and 2 caesarean sections has been documented***
- ***Wound surveillance audit completed when in place .***

The audit report will be submitted to the Labour Ward forum for monitoring to the Obstetric Consultants group meetings and to the obstetric directorate meeting.

The action plan and its implementation is the responsibility of the Obstetric Consultant for audit.

The Lead Obstetric Consultant for Labour Ward will monitor any action plans and ensure compliance of 100% is achieved.

The IT Midwife will produce and disseminate 6 monthly reports to monitor compliance in line with the policies in line with the Medway clinical audit programme.

The Lead Obstetrician for Risk will discuss the findings and submit an action plan to the clinical leaders meeting annually.

8. References

JPAC, 2013. *Anaemia in Pregnancy* [online]. Norwich: TSO. Available from: https://www.transfusionguidelines.org/transfusion-handbook/9-effective-transfusion-in-obstetric-practice/9-2-anaemia-and-pregnancy [Accessed 17 June 2019].

NICE, 2011. *National Institute for Health and Care Excellence CG132 Caesarean Section (updated April 2019)* [online]. London: NICE. Available from: https://www.nice.org.uk/guidance/cg132 [Accessed 17 June 2019].

NICE, 2015. *Postnatal care up to 8 weeks after birth CG37* [online]. London: NICE. Available from: https://www.nice.org.uk/guidance/cg37/resources/postnatal-care-up-to-8-weeks-after-birth-pdf-975391596997 [Accessed 6 August 2019].

RCOG, 2015a. *Choosing to have a caesarean section* [online]. London: RCOG. Available from: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-choosing-to-have-a-c-section.pdf [Accessed 17 June 2019].

RCOG, 2015b. *Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium* [online]. London: RCOG. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-37a.pdf [Accessed 17 June 2019].

RCOG, 2016. *Birth options after previous caesarean section* [online]. London: RCOG. Available from: https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-birth-options-after-previous-caesarean-section.pdf [Accessed 17 June 2019].

Smaill & Grivell, 2014. *Routine antibiotics at caesarean section to reduce infection* [online]. London: Cochrane. Available from: https://www.cochrane.org/CD007482/PREG_routine-antibiotics-at-cesarean-section-to-reduce-infection [Accessed 17 June 2019].

9. Supporting Documents

See appendices

10. Review

The guideline will be reviewed every 3 years or sooner if additional guidance is released.

11. Equality Impact Assessment

Date of assessment:	June 2019
Care Group or Directorate:	Women and Children's
Author:	[redacted] & [redacted]
Position:	Inpatient Matron & Consultant Midwife
Assessment Area:	Guideline
Purpose:	This guideline is to assist Maternity Staff to provide consistent individualised care to all women undergoing caesarean section with Poole Maternity Services.
Objectives:	Women should be fully involved in planning and decision-making throughout this period and individual needs and choices must be respected.
Intended outcomes:	To ensure that the postnatal period marks the establishment of a new phase of family life for women and their partners

What is the overall impact on those affected by the policy/function/service?

Ethnic Groups	Gender groups	Religious Groups	Disabled Persons	Other
High/Medium/ Low	High/Medium/ Low	High/Medium /Low	High/Medium /Low	High/Medium/ Low
Low	Low	Low	Low	Low

Available information:

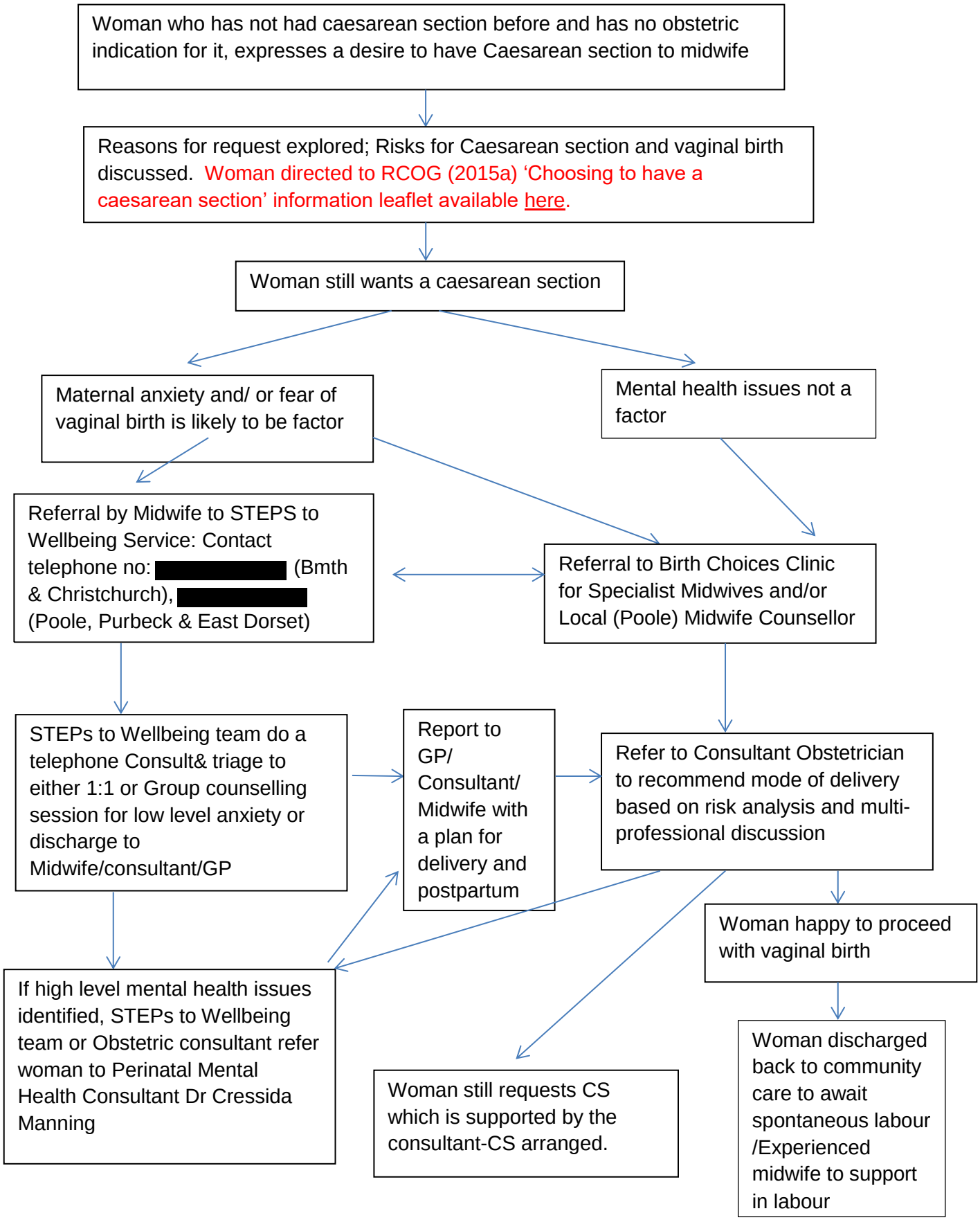
Assessment of overall impact: Low

Consultation: Maternity staff

Actions: None identified

Appendix 1

Maternal Request Caesarean Section Pathway



Appendix 2

Post Caesarean Section Medication

Elective and Emergency sections have the same medications prescribed after delivery.

These are a low molecular weight heparin (LMWH) for VTE prophylaxis, morphine sulphate oral solution, paracetamol and Ibuprofen.

Thromboprophylaxis

Subcutaneous low molecular weight heparin (LMWH) injections are used for VTE prophylaxis at PHFT- see Obstetric VTE guideline for details on dosing. The standard course length is 10 days total but extended thromboprophylaxis should be considered for individual patients based on local and national guidelines.

Analgesia - oral

Paracetamol and ibuprofen should be prescribed regularly for all except those with an allergy or sensitivity to the medication. If not contraindicated an opiate (e.g. morphine 10mg/5ml liquid) should be prescribed as required for up to 5 days after surgery.

Medications to be prescribed on the inpatient chart

- Paracetamol 1g QDS (500mg if the patient weighs <50kg)
- Ibuprofen 600mg QDS for 48hours only then reduce to 400mg TDS
- Morphine sulphate 10mg/5mL liquid (Oramorph®) 10-30mg (5-15mL) every 4 hours PRN. If still an inpatient 48 hours after section, reduce to 10-20mg (5-10ml) every 4 hours PRN.
- LMWH SC dose must be based on a recent weight – if borderline 50/100/150kg recently, a stat dose can be prescribed on front of chart. Post-partum weight must be checked once patient is mobile on ward and THEN on-going and discharge dose prescribed as per table above.
- Consider dihydrocodeine when NSAIDs contraindicated (N.B. Dihydrocodeine is not to be given in conjunction with Oramorph®)

Medications to be prescribed for discharge

The medications prescribed for discharge are the same as an inpatient but morphine liquid and ibuprofen doses are reduced for discharge. Paracetamol and ibuprofen will not be supplied for elective admissions (patients advised to buy in advance) but small OTC packs from the ward can be given for those who have received an emergency C-section if they have no supply at home. If no contraindications and discharge expected within first few days following a C-section all the medications listed below should be on the IDS:

- Paracetamol 1g QDS regularly (500mg if the patient weighs <50kg) for 5 days
- Ibuprofen 400mg TDS regularly for 5 days
- Morphine sulphate 10mg/5mL liquid (Oramorph) 10-20mg (5-10mL) 4 hourly as needed for pain - PRN for 3 days (maximum 5 days)
- LMWH - dose based on post-partum weight based on Obstetric VTE guideline for the remainder of the 10 day (or prolonged - 6 week) course on discharge.
- Sharps box

*Alternatives to morphine considered on a patient by patient basis can include dihydrocodeine (significantly lower potency) and tramadol (controlled drug).

Appendix 3

HIGH RISK PATHWAY AND RESPONSIBILITIES

The aim of this document is to ensure efficient transfer to theatre if needed and responsibilities for women who are high risk or become high risk on CDS.

The key is to be prepared. The first box is to be done through labour (by the Midwife) where possible for those that are at higher risk of requiring intervention:

	Initial
Give oral ranitidine 6-8 hourly, metoclopramide 8 hourly.	
Change mother into gown (especially if on syntocinon/ epiduralised)	
Send bloods as appropriate to her care (check second sample G and S sent)	
Complete PPH risk assessment	
Record blood results on flow chart	
Check rhesus factor, antibody status and cross match if appropriate	
Clear fluids only	
Check if requires Hovermatt and it is available (weight + 115kgs)	
Consider removing jewellery- check for any tongue piercings	
Complete theatre checklist	
Consider anaesthetic assessment especially if known anaesthetic concerns	

Probable transfer to theatre- **anticipate**

	Responsibility:	
Establish IV access if none already	Obstetrician Midwife	
Ensure shift leader aware	Obstetrician	
Inform theatres, anaesthetist and NNU of theatre transfer	Shift Leader	
Anaesthetist assessment	Anaesthetist	
Complete theatre checklist if not done so already	Midwife	
Shave if required	Midwife/ MSW	
Potential for LSCS/ consent form	Obstetrician	
Discuss cell salvage with theatres if PPH risk factor	Anaesthetist	

Time of decision for Theatre – Emergency Caesarean Time: _____ Grade_____

Instrumental Time:_____ Grade_____

Category 1 or 2 (both Caesarean and Instrumental) should arrive in theatre as quickly as their condition indicates- **this will require coordination and teamwork from all** (including possibility theatre team help get the woman into theatre)

If category one decision made list below SHOULD ALL BE DONE IN THEATRE

	Responsibility	Initials
Record time decision made	Obstetrician/ Midwife	
Inform shift leader	Obstetrician	
Inform anaesthetist/ NNU/ Theatre	Shift leader	
Transfer mother on bed to theatre	**ALL**	
Document time in theatre	Theatre team	
Commence CTG	Midwife	
Catheterise in theatre (if not already done) check resuscitaire	Midwife	
Complete WHO checklist if cat 2/3	ALL	