Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: CAESAREAN BIRTH GUIDELINE

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Approved by (committee/group):	Maternity & Gynaecology CG Group	**Date Approved:**	12/02/2024 *(virtual – no comments by 19/2/24)*

Scope/ Target Audience: (delete as applicable and/ or describe)	**Speciality/ Department** (for the minority) • Maternity
Evidence Base/ References:	• See Section 3
Lead Division:	Women and Children's
Lead Specialty/ Department: **(Or Division if 'divisionally' owned)**	Maternity
Lead Author: **(position/ role and name)**	[redacted] – Consultant Obstetrician
Co-Author(s): **(position/ role and name if applicable)**	Amendments by Claire Allison Interim maternity matron for Outpatient Dept Oct.'24
Sponsor (position/ role):	Service Director Obstetrics and Gynaecology

Name the documents here or record not applicable *(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)*	
Associated Policy	N/A
Associated Procedure(s)	N/A
Associated Pathway(s)	N/A
Associated Standard Operating Procedure(s)	N/A
Other associated documents e.g. documentation/ forms	• Planned Caesarean Birth Checklist

Consultation Undertaken:	• Senior Obstetricians • Senior Midwifery staff • Senior Anaesthetists

Template control:	v2.0 September 2023

Amendments from previous version(s)

Version	Issue Date	Section(s) involved (author to record section number/ page)	Amendment (author to summarise)
9.0	March-2024	Whole document – planned review undertaken	• Evidence base updated • Statistics updated in line with updated evidence base • Monitoring compliance and effectiveness section removed (was section 6) • Caesarean section checklist removed (now an associated document) (was Apx B) • Caesarean audit proforma removed (was Apx D)
9.1	October 2024	Minor amendments	• Updated carbohydrate loading drink product option. • Added *Bromage score* to post op observations • Added Obstetric anaesthetic clinic referral details for post birth follow up • Updated the booking process of a planned Caesarean birth

CONTENTS

1 INTRODUCTION / BACKGROUND

The National Institute for Health and Care Excellence (NICE) shows that the caesarean birth rate in the United Kingdom is currently 34%. The current local rate is 33.9% in 2023. The following guideline has been written to incorporate the key points of the NICE Caesarean Birth guidelines which were updated in 2023.

2 AIMS / OBJECTIVES / PURPOSE (including Related Trust Documents)

The aims of these documents are to reduce potential risk and complications for women, birthing people and their babies, and to help ensure health professionals provide appropriate, evidence-based information. The full guidelines can be viewed at www.nice.org.uk.

Women/birthing people should be given evidence-based information about caesarean birth during the antenatal period, as about 1 in 3 will have a caesarean birth. This should include information about caesarean birth such as:

- The indications for caesarean birth (such as presumed fetal compromise).

Delay in progress in labour, breech presentation):

- What the procedure involves
- Associated risks and benefits
- Implications for future pregnancies and birth after caesarean birth

A woman /birthing person who has capacity is entitled to refuse the offer of treatment such as caesarean birth, even when the treatment would clearly benefit them or their baby's health.

This clinical document applies to:

Staff group(s)

- Obstetricians
- Anaesthetists
- Midwives
- Theatre Staff
- Neonatal Staff

Clinical area(s)

- All maternity areas

Patient group(s)

- Women/birthing people who are pregnant

Exclusions

- None

Related Trust Documents

- Maternity guidelines as applicable but in particular
  - Immediate Post-Operative Care in Maternity Standard Operating Procedure.

3 EVIDENCE BASE/ REFERENCES

1. National Institute for Health Care Excellence. September 2023. Caesarean Birth (NG192)

2. MBRRACE-UK. October 2023. Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal deaths and Morbidity 2019-21

3. RCOG Roles and Responsibilities of Consultant. RCOG Workforce Report. 2022.

4. RCOG Thrombosis and Embolism during Pregnancy and the Puerperium, Reducing the risk; RCOG Green-top Guideline 37a, April 2015

5. Department of Health (DOH) 2009 Reference Guide to Consent for Examination or Treatment. 2nd Edition DOH London

6. National Institute for Health and Care Excellence. April 2021. Postnatal Care (NG194)

7. Enhanced Recovery in obstetrics - a new frontier? International Journal of Obstetric Anaesthesia (2013)22 92-95 Editorial

8. http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/enhanced_recovery_programme.html (Accessed July 2014)

9. Sherwood Forest Hospitals Foundation Trust (2024) Fasting Guidelines for Adults and Children Undergoing Procedures Under General Anaesthesia or Sedation showcontent.aspx [accessed 21/10/2024]

4 GUIDELINE DETAILS (INCLUDING FLOWCHARTS)

Caesarean birth may be classified as

- Emergency/unplanned
- Elective/planned

Emergency/Unplanned Caesarean Birth

Emergency caesarean birth may be further subdivided according to the urgency of the delivery:

1. Immediate threat to the life of the woman/birthing person or fetus
2. Maternal or fetal compromise which is not immediately life-threatening
3. No maternal or fetal compromise, but needs early delivery
4. Delivery timed to suit woman/birthing person and/or staff

The classifications of caesarean births are outlined below

Category 1

Immediate threat to the life of the woman/birthing person or fetus and expedited birth is needed now.

This category is only for cases where the emergency team must assemble and perform surgery as soon as possible. A second team must be called if the theatre is currently in use. Effective anaesthesia should be provided within the time constraints, the decision to time of birth should be as soon as possible and within 30 minutes.

Reasons for performing a Category 1 caesarean birth may be:

- Prolonged fetal bradycardia,
- Major Antepartum haemorrhage,
- Fetal pH <7.20
- Cord prolapse with fetal compromise

Category 2

Maternal or fetal compromise which is not immediately life-threatening.

This category covers cases where there should not be undue delay in expediting birth. If the obstetric theatre is already in use, a second team may be called at the discretion of the most senior obstetrician and anaesthetist. Perform as soon as possible, and in most situations within 75 minutes of making the decision.

Reasons for performing a Category 2 caesarean birth may be:

- Abnormal CTG where pH >7.20 (if known)
- Delay in progress in labour
- Malpresentation in late established labour

Category 3

Needing early birth, but with no maternal or fetal compromise

This category covers cases where it is deemed safe to wait for the birth of the baby if the team is already busy. This could include waiting for the theatre team if there is another emergency in main theatres.

Reasons for performing a Category 3 caesarean birth may be:

- Unsuccessful induction of labour
- Onset of labour where a caesarean birth was planned
- IUGR
- Breech in early labour

Category 4 – planned

At a time to suit the patient and maternity team

This category covers cases where caesarean birth is planned, but should only take place under optimal circumstances i.e., fasted conditions, mostly regional anaesthesia, sufficient

staffing. These are cases that must make way if emergencies should arise, and families should be supported to understand that a specific time for birth cannot be promised.

Reasons for performing a Category 4 caesarean birth may be:

- non-cephalic presentation including breech
- uterine scar
- need to avoid vaginal birth
- maternal request

Decision-to-delivery interval for unplanned caesarean birth

- Perform category 1 and 2 caesarean birth as promptly as safely possible after making the decision, particularly for category 1 which should be within 30 minutes.
- Perform category 2 caesarean birth in most situations within 75 minutes of making the decision.
- Take into account the condition of the woman/birthing person and the unborn baby when making decisions about rapid delivery. Remember that rapid delivery may be harmful in certain circumstances.

Documentation of the indication for performing a caesarean birth must be made by the person making the decision for delivery. This should be recorded within the intrapartum records.

Where possible there should be direct communication from the obstetric team to other teams involved of the category of caesarean birth and anticipated time to birth of the baby:

- Anaesthetist
- Operating Department Practitioner
- Neonatal team

In an emergency situation, the teams should be called by the emergency bleep systems and all teams must attend obstetric theatre immediately.

The decision to perform an emergency caesarean birth must be discussed with the on-call Consultant Obstetrician unless doing so would be life-threatening to the woman/birthing person and/or fetus. Under those circumstances, it may be prudent to delegate this to the co-ordinating midwife, or to contact the Consultant after the acute situation has been dealt with.

If there has been an unanticipated delay in performing the caesarean birth, the reason(s) for this must be documented in the intrapartum records.

Planned Caesarean Birth

Planned caesarean birth should be carried out after 39 weeks' gestation to decrease the risk of neonatal respiratory morbidity except where there are fetal or maternal indicators such as pre-existing diabetes or gestational diabetes, significant antepartum haemorrhage or multiple pregnancies. In these cases, refer to individual guidelines.

Do not routinely carry out planned caesarean birth before 39 weeks as this can increase the risk of respiratory morbidity in babies.

Discussion of the risks and benefits of caesarean birth compared with vaginal delivery, specific to the woman/birthing person in this pregnancy should be carried out in the antenatal setting

and documented clearly on the electronic maternity records. Decisions should involve a Consultant or Specialty Registrar (StR).

All planned caesarean births should follow the planned care pathway as highlighted in Appendix A, the only exception to this are people with diabetes who are excluded from having the carbohydrate loading drinks.[7]

Carbohydrate loading drinks dosing:
These products are NOT meal replacements.

1. *Preload:* x2 sachets the evening before surgery and x1 at 6am on morning of planned surgery.
2. *Nutricia pre-Op:* 200ml bottles. x4 the evening before surgery and x2 at 6am on the morning of surgery.

Please advise that NO FIZZY DRINKS are permitted as per the Trust guidance: *Fasting Guidelines for Adults and Children Undergoing Procedures Under General Anaesthesia or Sedation* showcontent.aspx [9]

"4.2 Fluids - Two Hours Clear (non-carbonated) fluids can be safely consumed by most patients until two hours (2h) before planned surgery (there is no restriction on volume). For practical purposes, clear fluids include water, dilute squash as well as black tea or coffee (no 'fizzy' or carbonated drinks)."

It is also important to highlight to women/birthing people that discharge may be delayed if there are concerns regarding maternal or neonatal condition.

The pathway was created to help people be in the best physical condition possible prior to surgery and the structured postoperative and postnatal care will enhance recovery and, in the process, speed up discharge. However, women/birthing people should be informed that if there are concerns with regards their medical condition or neonatal health as discharge may be delayed depending upon the clinical situation.

Please see Appendix A for the planned caesarean birth pathway.

Maternal request

Women/birthing people may wish to consider a caesarean birth for many reasons. They should be supported to explore their options with the provision of unbiased, accurate information about the benefits and risks of all modes of birth. These discussions should also be recorded clearly including the specific reasons for the request.

People with a fear of vaginal birth or labour should be offered support from both midwifery and obstetric team members, including those with expertise in providing perinatal mental health, to allow them to discuss their fears, consider options for plan for birth and ensure that they can make an informed choice.

It would be appropriate for the woman/birthing person to see a named Consultant Obstetrician to help support their decision making. If that consultant does not feel able to support the person's choice, then they must be promptly referred to an alternate consultant to facilitate supportive care.

If vaginal birth is not an acceptable option after a full discussion and offer of support, then a planned caesarean birth should be offered.

Booking of planned caesarean birth

The booking of a planned caesarean birth is facilitated through the EPR Badgernet, using the 'Elective C-Section Booking' form. Complete the mandatory fields as a minimum, but more information can be added to the form if required.
Every Monday the referrals will be reviewed by a senior obstetrician and a date allocated. On completion of the booking process the pregnant/birthing person is informed of the date for birth via their EPR Badgernet app. They should be informed in ANC that if they haven't received a date by the following Tuesday they should contact the Birthing Unit for advice.

Planned work should be scheduled between Tuesday and Friday on the planned caesarean lists. In cases where difficulties are anticipated this should be following discussion with the paediatrician or anaesthetist as appropriate. In complex cases, an appropriate alert form should be completed.

Pre-operative Care

Pre-operative care is undertaken in PDC and the following is completed using the Planned Caesarean Birth checklist.

- Screened with consent for MRSA (nasal and perineum). If the individual has a history of MRSA other screening sites may need to be considered- see Trust MRSA policy.
- With consent take blood for a full blood count and group and save
- Prescribed medication is given to the woman/birthing person with instructions (verbal and written) for their administration.

- Naseptin nasal cream (for people with no nut allergies)
- Octenisan microbial body wash
- Omeprazole mg x2 tablets
- Metoclopramide 10mg x1 tablet
- Carbohydrate loading drink pack

Discuss the plan of care for day of caesarean birth and the care they can expect to receive in the postnatal period.

Antibiotic prophylaxis

Post-operative infection (endometritis, wound infection) occurs in approximately 8% of people after caesarean birth. Therefore, all women/birthing people (planned and emergency) should be offered intravenous antibiotics to reduce the incidence of post-operative infection. Those undergoing planned caesarean birth should receive intravenous antibiotics prior to skin incision. Those undergoing emergency caesarean birth should be given intravenous antibiotics after clamping of the cord if there is no time to administer prior to skin incision.

When giving antibiotics before skin incision, do not use Co-amoxiclav.

Thromboprophylaxis

Women and birthing people are at increased risk of venous thromboembolism following caesarean birth, thus all people having a caesarean birth should be assessed for the need for prophylaxis. In people with no additional risk factors who have had a caesarean performed in labour, this should include:

- Early mobilisation and good hydration
- TED stockings
- Enoxaparin subcutaneously once daily for a minimum of 10 days (dose is dependent upon weight at booking)

A thromboembolism risk assessment form must be completed to determine the duration of prophylactic treatment.

Women and birthing people with additional risk factors e.g. obesity, grand multiparity, postpartum haemorrhage, may require enoxaparin prophylaxis for up to 6 weeks.

Please refer to the Trust Thromboprophylaxis guideline and the Management of venous thromboembolism in pregnancy and the puerperium guideline for more detailed information.

Antacids

Antacids reduce the risk of aspiration pneumonitis as they reduce gastric volumes and acidity before caesarean birth. To help reduce this risk, pre-operative medication is given out in PDC for the women to self-medicate the day prior to surgery and on the morning of the operation.

Those people undergoing emergency caesarean birth should receive Omeprazole 20mg orally pre-op if possible.

At the discretion of the anaesthetist, some women/birthing people may be given 30ml sodium citrate orally immediately pre-op.

Urinary catheter

All women/birthing people should have an indwelling catheter placed immediately pre-operatively. This minimises the risk of bladder injury intra-operatively and allows more accurate fluid balance assessment post-operatively. NICE advise that removal of the catheter can be carried out once mobile after the regional block and no sooner than 12 hours after the last epidural top up.

Breech presentation

Before carrying out a caesarean birth for an uncomplicated singleton breech pregnancy, carry out an ultrasound scan to check that the baby is in the breech position. Do this as late as possible before the caesarean birth procedure.

Mode of anaesthesia

The mode of anaesthesia should be decided by the anaesthetist in consultation with the woman/birthing person undergoing the procedure.

Methods to reduce infectious morbidity

Use alcohol-based chlorhexidine skin preparation before caesarean birth to reduce the risk of wound infections. If alcohol-based chlorhexidine skin preparation is not available, alcohol-based iodine skin preparation can be used.

Allow the skin preparation to dry on the skin rather than wiping it off to reduce infectious morbidity.

Use aqueous iodine vaginal preparation before caesarean birth with ruptured membranes to reduce the risk of endometritis. If aqueous iodine vaginal preparation is not available or is contraindicated, aqueous chlorhexidine vaginal preparation can be used.
Consider using a negative pressure dressing (e.g. PICO) for people with a BMI of 35 or over to reduce their risk of wound infection. These dressings can also be considered for use with a previous history of wound infection or other risk factors e.g. diabetes.

Consent

Written consent for the caesarean birth should be obtained after providing the woman/birthing person with verbal and written information about the procedure to include an adequate explanation and discussion of the procedure, the risks and benefits and implications for future pregnancies. There are consent stickers available in Antenatal clinic and Sherwood birthing unit which should be used to take consent by sticking them on the appropriate consent form. A sticker should be put on each page of the consent form.

Women should be warned of the risks of

- infection
- thrombosis
- heavy bleeding and the possible need for a blood transfusion
- damage to other organs (bowel/bladder)
- Fetal laceration (around 2%)

These risks should be documented on the consent form. A copy of the signed consent form should be given to the patient. Consent should be sought in line with the Trust's policy entitled Consent Policy and Information.

If the woman/birthing person has limited understanding of English consent regarding any invasive procedure should be discussed using official translation services (see Trust guidance Interpreting and translation services).

Written consent for an emergency caesarean birth should be obtained unless doing so would be life-threatening to the woman/birthing person or fetus. Under those circumstances verbal consent should be sought and documented.

Care following Caesarean Birth

Observations following transfer out of theatre:

The following observations should be recorded on the Post Operative model on Nervecentre; please see Appendix B for the Immediate Post-Operative Care (IPOC) Flow Chart.

In addition

1. Respirations should be recorded hourly for 12 hours following the administration of intrathecal diamorphine and for 24 hrs following the administration of intrathecal morphine.
2. *Bromage score* hourly after a spinal or epidural top-up for anaesthesia, and escalating anyone who can't straight leg raise at 4 hours to the SBU anaesthetist. Complete assessment on electronic patient record (Badgernet).

Post-Operative care should be made in line with the Trust's Immediate Post-Operative Care in Maternity Standard Operating Procedure.

On-going care, once IPOC criteria met.

- Assist with feeding and care of the baby/babies.
- Assessment of mobility prior to early mobilisation
- Assessment of Venous Thrombo-embolism (VTE) and prescription if required
- Assistance with hygiene and nutrition.
- Routine postnatal exercises and have an opportunity to see the Physiotherapist
- Assessment of dressing /wound
- Removal of urinary catheter once mobile – take CSU for microscopy
- MRSA decolonisation recording on screening sheet and prescription if required on administration chart
- Discussion of events surrounding the caesarean birth (obstetric review) and about mode of birth for future pregnancies - take into consideration:
- Maternal preferences and priorities
- General discussion of the overall risks and benefits of caesarean birth
- Risk of uterine rupture
- Risk of perinatal mortality and morbidity

These details must be documented in the medical notes:

- Analgesia to take home and Enoxaparin if required

Post-operative analgesia

Discuss options for pain relief after caesarean birth and explain that:

- pain after caesarean birth can be controlled using oral or injectable medicines
- their choice of pain relief medicines after caesarean birth will depend on:
    - the severity of pain
    - whether they had spinal or epidural anaesthesia, or general anaesthesia
    - if they wish to breast/chest feed, they will usually be able to do this and care for their baby while taking pain relief medicines

Use paracetamol and, unless contraindicated, a non-steroidal anti-inflammatory drug (for example, ibuprofen) in combination after caesarean birth, to reduce the need for opioids, and to allow them to be stepped down and stopped as early as possible. These should be prescribed to be taken regularly rather than as required.

Do not offer codeine or co-codamol (combination preparation of paracetamol and codeine) to people who are currently breast/chest feeding, because this can lead to serious neonatal sedation and respiratory depression.

In breast/chest feeding people, use opioid analgesics (for example, morphine, oral morphine) at the lowest effective dose and for the shortest duration, and not for more than 3 days without close supervision.

If, after a caesarean birth, a woman/birthing person is discharged home on opioids, advise them to contact their healthcare provider if they are concerned about their baby (for example drowsiness, breathing difficulties, constipation or difficulty feeding).

Consider laxatives for people taking opioids, for the prevention of constipation.

Consider anti-emetics for people taking opioids, if needed for nausea and vomiting.

Advise that some over-the-counter medicines contain codeine and should not be taken while breast/chest feeding because this can lead to serious neonatal sedation and respiratory depression.

For women/birthing people with severe pain after caesarean birth, when other pain relief is not sufficient:

- perform a full assessment to exclude other causes for the pain (for example, sepsis, haemorrhage, urinary retention)
- discuss that stronger pain relief medicines are available
- make sure the woman/ birthing person is aware that, if taken while breast/chest feeding, these medicines could increase the risk of neonatal sedation and respiratory depression.

  If they choose to take stronger medicines, consider a short course of tramadol or oxycodone at the lowest effective dose.

Follow-up care

People who have had complex problems may benefit from a further opportunity to discuss issues with the obstetric team and offered an appointment in the postnatal period. Most women/ birthing people however, having been debriefed prior to transfer home, should be offered post-natal follow up in primary care with their GP.

For anyone who has had pain in theatre, unplanned conversion to GA, and any complications relating to anaesthesia, they can be followed up in the obstetric anaesthetic clinic in the Antenatal Suite at King's Mill Hospital site.

5 EDUCATION AND TRAINING

No additional training is needed in the implementation of this guideline.

6 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an Equality Impact Assessment
- Sample completed form

Name of service/policy/procedure being reviewed: Caesarean Birth Guideline			
New or existing service/policy/procedure: Existing			
Date of Assessment: January 2024			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to

	known health inequality or access issues to consider?		eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	N/A	N/A
Gender:	None	N/A	N/A
Age:	None	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A
Pregnancy and Maternity:	None	N/A	N/A
Gender Reassignment:	None	N/A	N/A
Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out?

- None

What data or information did you use in support of this EqIA?

- None

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None

Level of impact

From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Signature: Susie Al-Samarrai
Date: January 2024

8 APPENDICES

Appendix A – Planned Caesarean Birth Pathway
Appendix B – Immediate Post-Operative Care Flow Chart

Appendix A - Planned Caesarean Birth Pathway

Decision made for planned caesarean birth following discussion with obstetrician and woman/birthing person

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Obstetrician completes caesarean pack to include:

1. Consent completed & copy given to woman/birthing person
2. G&S form signed
3. Prescription chart: allergies completed & once-only medication signed for.
4. Send 'Elective C-Section booking' form within EPR Badgernet and advise birthing person that they will receive the date for their birth via the Badgernet app. If date not received by the following Tuesday to contact the Birthing Unit.
5. Pre op assessment appointment made in PDC prior to planned caesarean birth

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Pre op assessment appointment in PDC

1. PDC midwife to discuss process for planned caesarean birth
2. Take blood for G&S, FBC
3. Explain & perform MRSA screen. Issue Octanisen wash and Naseptin nasal cream.
4. Issue Omeprazole 20mg and Metoclopramide 10mg tablets with written instructions for use.
5. Issue carbohydrate loading drinks with instructions for use (excluding people with diabetes)
6. Advise to be fasted for 6 hours prior to caesarean birth and water up to 2 hours prior to surgery.
7. Complete planned caesarean birth proforma and record on Badger records.
8. Give instructions to ring SBU at 7am and a prearranged time to arrive on the Maternity Ward for their planned Caesarean Birth

↓

Maternity Ward

1. Welcome to ward and direct to bed, advice on buzzer system and give 'Welcome Information' pack. Put ID band on.
2. Liaise with SBU co-ordinator regarding time scale and order on theatre list.
3. Commence preparation for planned caesarean birth - palpation and listen to fetal heart, along with mother's pulse, temperature, blood pressure and weight. Consider CTG if high risk
4. If any allergies put red wrist band on.
5. Check blood and swab results from PDC pre-op assessment. If blood units requested, make sure units are ready with Blood Bank and Helpdesk rang to have delivered to SBU.
6. Gown, use clippers and put TEDS on woman/birthing person.
7. Anaesthetist and surgeon will come to ward to discuss procedure.
8. Gather baby clothing and nappy.
9. Once transferred to SBU, the bed is sent over to SBU theatre and room prepared for re-admission.
10. If any delays, keep in regular contact with SBU co-ordinator and ensure woman/birthing person and birth partner are kept up-to-date.

Sherwood Birthing Unit

1. Sherwood Birthing Unit to predict the time of operation and liaise with Maternity Ward.
2. Transfer to SBU prior to surgery time to allow anaesthetic and obstetric review.
3. If surgery time delayed consider a further carbohydrate loading drink administration up to 2 hours before predicted surgery time (excluding people with diabetes).
4. Post Operative Care as per SFH Post Operative Care Maternity Guideline.
5. Encourage oral fluids and diet as soon as condition allows.
6. Discontinuation of IVI as soon as tolerating diet and fluids.
7. Ensure all post op analgesia prescribed prior to transfer to Maternity Ward.
8. Transfer to Maternity Ward when IPOC discharge criteria met.

Maternity Ward Post Delivery transfer until discharged home.

1. Ward co-ordinator would be notified of transfer to ward.
2. Handover of care from Midwife to Midwife using SBAR proforma, any risks highlighted.
3. Admission checks on both mother/birthing person and baby/ies completed as soon as possible. Care plan explained; fluids and diet, early mobilization and removal of catheter, analgesia and proposed discharge plan.
4. Ideally placed in a side-room and partners invited to stay to offer assistance (no facilities for other children).
5. Routine post-operative care for caesarean birth
6. Remove catheter after 6 hours or as soon as mobile.
7. SHO review first morning.
8. If fit then discharge pm of Day 1*.
9. TTO of analgesia of Paracetamol and Codeine for those not breast/chest feeding.
10. TTO of analgesia of Paracetamol and Oramorph for those who breast/chest feed their baby/ies.
11. Clexane as required with provision of sharps box and TEDs worn until fully mobile between showers.
12. Wound dressing left intact until day 5 or if infection is suspected or dressing saturated.
13. Routine discharge completed.
14. No booked F/U with hospital doctors unless specified by doctors

***Discharge will be delayed if there are concerns regarding maternal or neonatal condition.**

Appendix B - Immediate Post-Operative Care Flow Chart