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To be read in conjunction with	Enhance recovery pathway SOP 8 V1 Thromboprophylaxis G22V5.1 Recovery after obstetric surgery G31V4 Major Obstetric Haemorrhage (including postpartum haemorrhage G15) Placenta Praevia, Placenta Accreta and Vasa Praeviae:- interventional radiology to prevent major haemorrhage G61 Vaginal Cleaning SOP 57 Patient Information Leaflet: Skin-to-skin Caesarean births Skin-to-skin Caesarean Birth: Theatre Guide 'ELHT OG03 Caesarean Section' leaflet

SUPPORTING REFERENCES	NICE Caesarean section CG132 Aug 2012 RCOG Classification of urgency of caesarean section – a continuum of risk (Good practice No 11) 2010 Antenatal corticosteroids for maturity of term or near term foetuses: systematic review and meta-analysis of randomized controlled trials BMJ 2016; 355 RCOF press: The national sentinel caesarean section audit report RCOG clinical effectiveness support unit Oct 2001 pg 80-81 FSRH Clinical Guidance: Male and female sterilisation Sept 2014 CREST study Peterson HB, Xia Z, Hughes JM, Wilcox LS, Tylor LR, Trussell J. The risk of pregnancy after tubal sterilization: findings from the U.S. Collaborative Review of Sterilization. Am J Obstet Gynecol 1996; 174: 1161–1170. Smith J, Plaat F, Fisk NM. The natural caesarean: a woman-centred technique. BJOG 2008; 115(8): 1037-1042.

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21.1 Caesarean Section Grading and Requirement for Documentation.

Table 1: Caesarean Section Grading

CAESAREAN SECTION GRADING (CLASSIFICATION AND TIMINGS).
Grade 1: (Crash Section) IMMEDIATE THREAT TO THE LIFE OF THE WOMAN OR FETUS The CS must be performed as quickly as possible but within a maximum target time limit of 30 minutes from decision. The decision regarding method of anaesthesia used will be discussed between the decision-making obstetrician and the anaesthetist. **Examples:** • **Pathological CTG**, • FBS ≤ 7.20, bradycardia, • Failed instrumental birth, • Presumed uterine rupture, • Cord prolapse, • Antepartum haemorrhage with fetal or maternal compromise
Grade 2: MATERNAL OR FETAL COMPROMISE WHICH IS <u>NOT</u> IMMEDIATELY LIFE-THREATENING. The CS must be carried out as quickly as possible but within a maximum target time limit of 75 minutes from decision Example: • Suspicious FCTG, • Failure to progress in labour • Malpresentation in labour
Grade 3: NO MATERNAL OR FETAL COMPROMISE BUT NEEDS EARLY DELIVERY Example: • Planned elective LSCS in early labour or with SROM • Unsucessful induction of labour, • planned LSCS for severe IUGR maternal complications e.g diabetes
Grade 4: DELIVERY TIMED TO SUIT THE WOMAN AND STAFF Example: Elective Section at 39 weeks for breech presentation

- The examples given are not an exhaustive list.
- The decision for a caesarean section and the grading of the caesarean section is made based on the clinical decision making of the obstetrician.
- The decision for an emergency caesarean section must be made by the senior obstetrician oncall (ST3+) and where appropriate discussed with the consultant oncall.

Document the indication for performing Grade 1 and 2 Caesarean Sections in the health records by the person making the decision*:*

The indication, grading (priority), who made the decision and surgeon will be entered into the electronic maternity records. (see Maternity Records Guideline 38).

Documentation of any delay in the undertaking the Caesarean Section.

Once a decision has been made, delivery should be carried out with urgency appropriate to the risk to the baby and the safety of the mother.

Inform theatre and the anaesthetist by ringing 2222, stating the grade of caesarean section and the patient location (grades 1-3) .

ELHT maternity team should strive to perform urgent and emergency caesarean sections within the recommended time schedules as in Table 1.
A target decision to delivery interval (DDI) for caesarean section for 'fetal compromise' of 30 minutes is an audit tool that tests the efficiency of the whole delivery team. It should not be used to judge the performance of the MDT for any individual caesarean. (NICE 2011)

● Certain clinical situations will require a much quicker DDI than 30 minutes and we should work towards improving efficiency
● Undue haste to achieve a short DDI can introduce its own risk, both surgical and anaesthetic, with the potential for maternal and neonatal harm.

Any delay must be documented in the case records with a reason, and an incident report completed to monitor though CBS forum

Epidural Top ups

Where epidural analgesia is already in place the epidural may be deemed the most appropriate anaesthetic for the LSCS. The anaesthetist should give the necessary top- up.

21.2 Consent

Written consent should be sought and an appropriate consent form completed. This will include the proposed procedure including any other additional procedures planned, intended benefits and the associated risks.
In certain situations e.g. Grade 1 CS verbal consent may be appropriate.

Table 2: RCOG consent advice no 7

Frequent risks	Serious Risks	Future pregnancies
Maternal - persistent wound and abdominal discomfort in the first few months after surgery(9/100) - increased risk of repeat caesarean section when vaginal delivery attempted in subsequent pregnancies (1/4) - readmission to hospital (5/100) - haemorrhage (5/1000) - infection, (6/100) **Fetal** - Lacerations (1-2/100)	- emergency hysterectomy (7-8/1000) - need for further surgery at a later date, including curettage (5/1000) - admission to intensive care unit (highly dependent on reason for caesarean section), (9/1000) - thromboembolic disease (4–16/10,000) - bladder injury(1/1000) - ureteric injury (3/10,000) - death (1/12,000)	- increased risk of uterine rupture during subsequent pregnancies/deliveries, (2-7/1000) - increased risk of antepartum stillbirth (1-4/1000) - increased risk in subsequent pregnancies of placenta praevia and placenta accrete (4-8/1000)

21.3 Elective cases

21.3.1 Booking

The Consultant Obstetrician must be involved in the decision making process and approval sought before a woman is booked to have a Caesarean section. The timing of elective CS should ideally be from 39+0 weeks gestation (grade 4) unless there are fetal or maternal indications to deliver earlier.

Discuss the risks and benefits of Caesarean Section with the woman taking into account her circumstances, concerns, priorities and plans for future pregnancies. When a woman requests CS explore, discuss and record the specific reasons for the request, discuss the overall risks and benefits of CS compared with vaginal birth. Referral should be made to a consultant obstetrician and a discussion should take place before any decision is made about mode of delivery.

If a woman requests a caesarean birth but her current healthcare team are unwilling to offer this, refer the woman to an obstetrician willing to perform a caesarean birth (NICE Caeserean birth NG192). If after discussion and offer of support , a vaginal birth is still not an acceptable option, offer a planned CS.

Delivery by scheduled cesarean delivery should be delayed until the 39th week whenever possible to reduce the risk of respiratory morbidity. When it is necessary to deliver before 38[6] weeks' gestation, parents can be counseled about the benefits of a single course of antenatal corticosteroids, such as a reduction in RDS from 6.7% to 2.7% (BMJ).

21.3.2 Enhanced recovery SOP

Nearly all women are suitable for enhanced recovery, with a few exceptions as stated in the pathway, Please refer to the pathway SOP for assessing the suitability of each patient.
Please give patients the enhanced recovery diary, discuss expected length of stay and advise them to obtain simple analgesia prior to admission

21.3.3 Caesarean list

Women having elective caesarean sections should be booked on an appropriate list via the Theatre Man System. Ensure an even spread of cases on the elective list as much as possible with no more than 3 cases on each list. Please highlight any high-risk procedures when booking.
Please inform the CBS co-ordinator of any planned category 3 caesareans so they can be added to the CBS diary.

21.4 Skin-to-skin caesarean birth

There is increased awareness of the principles of family-centred or skin-to-skin Caesarean birth amongst expectant mothers. NICE recommend that women's preferences for birth such as de-medicalisation of the delivery experience should be facilitated where possible.

Many women and their partners wish to be actively involved in planning the delivery experience at Caesarean, which include discussing and facilitating the principles of skin-to-skin Caesarean if so desired.

Evidence suggests that initiation of early skin-skin contact is associated with improved bonding, infant feeding, breastfeeding outcomes, and infant crying. It may also assist maintaining infant normothermia.

There is increased awareness of the principles of family-centred or skin-to-skin Caesarean birth amongst expectant mothers. NICE recommend that women's preferences for birth such as de-medicalisation of the delivery experience should be facilitated where possible.

Table 1: Principles and actions to facilitate skin to skin Caesarean birth			
Involvement of woman and partner	**Early skin-skin contact**	**Delayed cord clamping**	**Promoting demedicalised birth experience**
Appropriate antenatal counselling (attention to explanation breech manoeuvres or possible use of Wrigley forceps)	Keep baby warm	Delayed cord clamping (1 minute) after birth . Document reason if variance.	Screen down for unobstructed view until point of birth
Birth partner offered to be present for spinal anaesthetic (at discretion of anaesthetist)	2 warm blankets for baby		Arm slipped out of theatre gown
Appropriately sited chair	Maintain skin-skin contact until transfer		ECG leads on posterior arms
Partner offered and assisted to cut cord	Weigh baby at bedside		Not necessary for midwife to scrub routinely

21.4.1 Antenatal counselling

Offer and discuss the option of skin-to-skin Caesarean birth in the antenatal clinic at 36 week mode of delivery discussion for all women choosing elective Caesarean section over 37 weeks and offer leaflet.
The option may be particularly useful for women who have experienced a traumatic emergency birth in the past and now contemplating repeat elective Caesarean or for very anxious women to allay birth fear.

Caesarean sections with predicted complications such as placenta praevia/accreta may be less suitable, however exercise discretion, taking into account the preferences of the woman and couple. This should be discussed by a ST5 or above.

It is important to counsel the woman and their partner adequately by discussing the principles and exceptions (see Antenatal Counselling Proforma). Provide the ELHT leaflet (PIL:Skin-to-skin Caesarean birth)

Women should understand that skin-to-skin Caesarean birth may not always be possible in entirety even where desired, and it may become apparent during the surgery that continuation is inappropriate.

Whilst promoting an enhanced delivery experience by facilitating skin-to-skin Caesarean birth some woman may choose an alternative approach and this should be supported.

21.4.2 Theatre checklist

Once in theatre, the midwife leading the case to take responsibility for completing all documentation on the skin-to-skin Caesarean birth proforma with input from the multidisciplinary team (see Theatre Checklist) after the theatre checklist and patient sign-in. All staff should be aware of their roles in relation to table 1.

It may be appropriate for a birth partner to be present during the spinal anaesthetic at the discretion of the lead anaesthetist.

If requested by the woman, drapes should be down at the beginning of the operation, folded to maintain sterility. The drape stand can be placed with the securing arm to the left side of the table and rotated outward, allowing ease of access to the woman and baby. Following birth, the drapes may be elevated with the baby positioned on the woman's chest to enable the operation to continue without compromising sterility.

It is unnecessary for the midwife to routinely scrub into the procedure, unless neonatal resuscitation is anticipated ahead of birth. Ideally the midwife should stand to the surgeons left to facilitate the skin to skin and minimise de-sterilisation of surgeon.
Partner cord cutting should be supervised by the midwife and surgeon. Where any breach of sterility occurs, this should be rectified immediately to maintain the operative field.

The named midwife should not leave theatre until completion of the procedure, to ensure responsibility for the baby. Communication between the anaesthetist and midwife is important post birth to ensure adequate monitoring of baby (e.g if midwife to leave theatre in order to check the placenta).

There are important exceptions to the principles where discretion is needed. If birth complications are encountered or the neonate requires immediate medical attention, the baby should be transferred to the resuscitaire. In practice these cases will be rare in an elective setting.

Skin-to-skin Caesarean birth is currently not routinely recommended for emergency Caesarean birth, but may be appropriate in some cases after full discussion with and at the discretion of the whole team.

All members of the multidisciplinary team should share in the same values, recognising that all staff play an essential role in supporting the desired birth experience.

21.5 Antacid Prophylaxis

Prophylactic antacids must be given to all women before emergency and elective CS.

Elective CS (AM operation)

Omeprazole 40mg orally, 22:00h night before
No solids from midnight, clear fluids until 5 am
Omeprazole 40mg orally at 7 am

Emergency CS

Ranitidine 50 mg Intravenous unless the woman has received oral ranitidine within the previous 6 hours

All women having General Anaesthesia will receive 30mls Sodium Citrate after arrival in the operating theatre prior to anaesthetic induction.

21.6 Shave / Catheter

Shaving around the planned incision site is not recommended. If hair needs to be cut, surgical clippers should be used. The clipper head is available in a separate pack and needs to be attached to the electric clipper base which is always kept on charge in Central Birth Suite theatre.

All women must be catheterised before CS:

Grade 1 & 2 cases: Woman to be catheterised in theatre before or after anaesthesia. In CS requiring GA it is ideal to catheterise prior to anaesthesia to limit the time the baby is exposed to the anaesthetic.

Grade 3 & 4 cases: Catheterisation may occur in theatre after the spinal anaesthetic is effective or on the ward if the woman prefers.

21.7 Potentially complicated cases

A consultant must be present in the following situations:

- Caesarean birth for major placenta praevia / abnormally invasive placenta
- Caesarean birth for women with a BMI >50
- Caesarean birth <28/40
- If their presence is requested

A Consultant must be informed in all situations listed below. Consultant presence will depend on the indication for CS, the level of experience/expertise of the on call obstetrician, and the activity level within the unit.

- Caesarean birth at full dilatation
- Caesarean birth for women with a BMI >40
- Caesarean birth for transverse lie
- Caesarean birth at <32/40

These lists are not exhaustive and good communication is required between the oncall team and the consultant oncall

21.8 Technique

- Aseptic precautions are followed while patient is cleaned and draped.
  - 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. See the NICE guideline on surgical site infections.
- Vaginal cleansing prior to caesarean section should be performed in line with SOP
- The recommended operation is a lower uterine segment Caesarean section through a Joel-Cohen incision (a straight skin incision, 3cm above the symphysis pubis) ; subsequent tissue layers are opened bluntly and, if necessary, extended with scissors and not a knife), because it is associated with shorter operating times and reduced postoperative febrile morbidity.
- When there is a well formed lower uterine segment, extension of the incision should be blunt rather than sharp because it reduces blood loss, incidence of postpartum haemorrhage and the need for transfusion at LSCS.
- Recourse to an upper segment incision (Classical Section) may occasionally be indicated e.g.
  a) Transverse lie with ruptured membranes
  b) Rarely in placenta praevia
  c) Cervical fibroids
  d) Adherent bladder
  e) No lower segment (eg: extreme prematurity)
- Forceps should only be used at LSCS if there is difficulty delivering the baby's head. The effect on neonatal morbidity of the routine use of forceps at LSCS remains uncertain.
- At LSCS, the placenta should be removed using controlled cord traction and not manual removal as this reduces the risk of endometritis.
- Syntocinon 5 units IV is given by slow intravenous injection by the anaesthetist once the baby is born to encourage contraction of the uterus and decrease blood loss
- The effectiveness and safety of single layer closure of the uterine incision is uncertain. Except within a research context, the uterine incision should be sutured with two layers.
- Perform intraperitoneal repair of the uterus for caesarean birth. Routine exteriorisation of the uterus is not recommended because it is associated with more pain and does not improve operative outcomes such as haemorrhage and infection.
- Any suspected injury to bowel, bladder or ureter must be notified to the Consultant on call during the operation, appropriate assistance from surgical team sought, and an IR1 form completed.
- Neither the visceral nor the parietal peritoneum should be sutured at LSCS because this reduces operating time and the need for postoperative analgesia, and improves maternal satisfaction.
- Superficial wound drains should not be used at CS because they do not decrease the incidence of wound infection or wound haematoma
- Consider using sutures rather than staples to close the skin after caesarean birth to reduce the risk of superficial wound dehiscence.

Consider a prophylactic Syntocinon infusion – 40 units in 500 mls Normal Saline at a rate of 125 ml per hour if there is a high risk of uterine inertia as in CS after prolonged labour, multiple pregnancy ,large placental site or multiparity. An alternative option would be to consider the use of misoprostol - 1g per rectally (see also ELHT Maternity Services Clinical Guideline 15: Major Obstetric Haemorrhage)

21.9 Sterilisation and Post Placental Contraception at time of Caesarean section

Tubal ligation at the time of caesarean section is effective with a low cumulative failure rate of 7.5/1000 procedures at 10 years. (CREST study)

The most recent guideline 'Male and Female Sterilisation' is from Faculty of Sexual & Reproductive Healthcare, 2014. (https://www.fsrh.org/documents/cec-ceu-guidance-sterilisation-cpd-sep-2014/)

Incidence of regret and dissatisfaction is increased when sterilisation has been performed concomitantly with caesarean section, particularly if women have felt pressured into the decision by a health professional.

Current national guidance recommends that sterilisation should **not** be performed concomitantly with caesarean section, **unless** counselling has taken place and the decision is made at a time separate from caesarean section or labour.
The decision should be documented **at least 2 weeks in advance of the caesarean section**.

Sterilisation should not be performed during emergency Caesarean sections, unless there is documented evidence (consent form) of this decision being made prior to onset of labour (Faculty of Sexual & Reproductive Healthcare, 2014).

Sterilisation at caesarean section is less likely to be amenable to successful future reversal of female sterilisation

For postpartum sterilisation, both Filshie clips and modified Pomeroy technique are effective. Filshie clip application is quicker to perform.

Post – Placental contraception
Post-placental intrauterine contraception (PPIUC) is a safe, convenient and effective option for postpartum contraception, that can be done at time caesarean birth.
For further information, refer to guidance G93 on trust intranet.

21.10 Prophylactic Antibiotics

All women undergoing emergency or elective Caesarean section must be offered prophylactic antibiotics. See: ELHT Maternity Services Clinical Guideline 10: Infection and Prevention of Infection, section10.1.1

21.11 Paired cord blood samples

All women undergoing any emergency caesarean section must have paired cord blood samples taken and these should be recorded on Athena/guardian. If they were not taken please document why not.

21.12 Prevention and management of hypothermia and shivering

- Warm IV fluids (500 ml or more) and blood products used during caesarean birth to 37 degrees Celsius using a fluid warming device.
- Warm all irrigation fluids used during caesarean birth to 38 to 40 degrees Celsius in a thermostatically controlled cabinet.
- Consider forced air warming for women who shiver, feel cold, or have a temperature of less than 36 degrees Celsius during caesarean birth.

21.12 Thromboprophylaxis

Thromboprophylaxis as per protocol
(see ELHT Maternity Services Clinical Guideline 22: Thromboprophylaxis).

Below knee TED stockings should be fitted in the room if time permits and if not flowtrons will be placed in theatre.

21.13 Postnatal care

See: ELHT Maternity Services Clinical Guideline 4: The Postnatal Period, section 4.6 for postnatal care

In addition:

- Catheter is usually removed the next day unless otherwise stated there is haematuria or low urine output
- If used, drains must be reviewed by the registrar and removed after 24hrs unless specified.
- Women **must be debriefed** and given written information about the reason for CS and birth options for future pregnancies, preferably by the surgeon, or the on call consultant team, in cases of Emergency Caesarean section..

- Advise women that some over-the-counter medicines contain codeine, and should not be taken while breastfeeding because this can lead to serious neonatal sedation and respiratory depression
- Inform women who have had a caesarean birth that they can resume activities such as driving a vehicle, carrying heavy items, formal exercise and sexual intercourse when they feel they have fully recovered from the caesarean birth (including any physical restrictions or pain).

21.14 Post-operative analgesia

All women should have adequate post-operative analgesia prescribed. If diclofenac has been given during the procedure it is the responsibility of the obstetrician to check that it has been clearly prescribed and written as given on the patient prescriptions chart. Regular non-steroidal analgesia (ibuprofen) can be commenced 10-12 hours later
For women with severe pain after caesarean birth when other pain relief is not sufficient:

1. Perform a full assessment to exclude other causes for the pain (for example, sepsis, haemorrhage, urinary retention)

2. Discuss with the woman that stronger pain relief medicines are available

Make sure the woman is aware that, if taken while breastfeeding, these medicines could increase the risk of neonatal sedation and respiratory depression. If the women chooses to take stronger medicines, consider a short course of tramadol or oxycodone at the lowest effective dose.

21.15 Monitoring Compliance with the Guideline

The guideline will be reviewed and audited when.
1) Clinical risk management dictates
2) National guidance is updated and implemented

Auditable standards for skin to skin CS

The following are areas of identified audit:
- Compliance with antenatal counselling proforma
- Uptake of skin-to-skin Caesarean birth
- Patient experience and satisfaction
- Rates of neonatal hypothermia with early skin-skin
- Implementation of the 4 core principles of skin-to-skin Caesarean birth

21.16 Maternity Dashboard

ELHT maternity services will monitor the caesarean section rate in the following categories:
a) Total caesarean section rate
b) Elective caesarean section rate
c) Emergency caesarean section rate

These will be against predetermined parameters decided by the service and / or the commissioners. This will be reported on a monthly basis through the Maternity Services Clinical Performance Dashboard. This forms part of the Integrated Quality and Performance Dashboard which is reported through the divisional governance systems and to the executive team, including the maternity

services lead executive at board level. Where performance is shown to be outside the predetermined range, the maternity service will identify the causes and / or deficiencies and make recommendations. An action plan will be developed by the Obstetric Lead for Central Birth Suite and its implementation monitored through the O&G Speciality Board and Women and Newborn Quality and Safety Board.

21.17 Incident Reporting Process

As part of the risk management process, ELHT maternity services expects the following incidents to be reported (as outlined in the Maternity Services Trigger List)

- Decision to delivery by time not met
- Fetal laceration at caesarean
- Failed instrumental delivery proceeding to a caesarean delivery

Themes and trends will be identified by the Risk Management Midwife and discussed at the Risk Management Group. Where deficiencies are identified an action plan will be developed by the Obstetric Lead for Central Birth Suite and its implementation monitored through the O & G Speciality Board to ensure implementation of the recommendations. The minutes of the O&G Speciality Board will be received by the Womens and Newborn Quality and Safety Board.

Hospital Number ..... DOB.....
First Name ..... M / F.....
Last Name ..... Religion.....
Address.....
NHS Number .....

East Lancashire Hospitals NHS Trust

Antenatal Counselling when booking Elective Caesarean Birth

The following gives a list of considerations to be discussed with a woman booking ELCS at 36+ weeks gestation.

Immediate skin to skin in theatre can be facilitated for most healthy term babies. This involves no obstruction to mother's view during the procedure (drapes folded back without the pole in place) and when the baby is born placed immediately onto mother's chest at birth and skin-toskin maintained until the mother is transferred onto the trolley. Skin-to-skin is then recommenced on the trolley prior to leaving theatre. Alternatively, the woman may choose to have the drapes remain elevated, cord cut and clamped by the theatre team before the baby is passed to the midwife.

COUNSELLING CHECKLIST	TICK
Skin to skin Caesarean birth discussed if appropriate (most uncomplicated cases – if in doubt confirm with senior obstetrician)	
Patient information leaflet given	
Need for maintaining sterile field explained	
Manoeuvres associated with breech delivery explained	
Delayed cord clamping outlined.	
Partner to cut cord as per guidelines if they wish	
Possible need for resuscitation explained and that baby would need to go to resuscitaire	

Further comments and woman's wishes for birth:

Signed_____by Doctor .....Date .....

Name and Grade .....

Theatre Check List for Skin to Skin Caesarean birth

Theatre Check List for Skin to Skin Caesarean birth

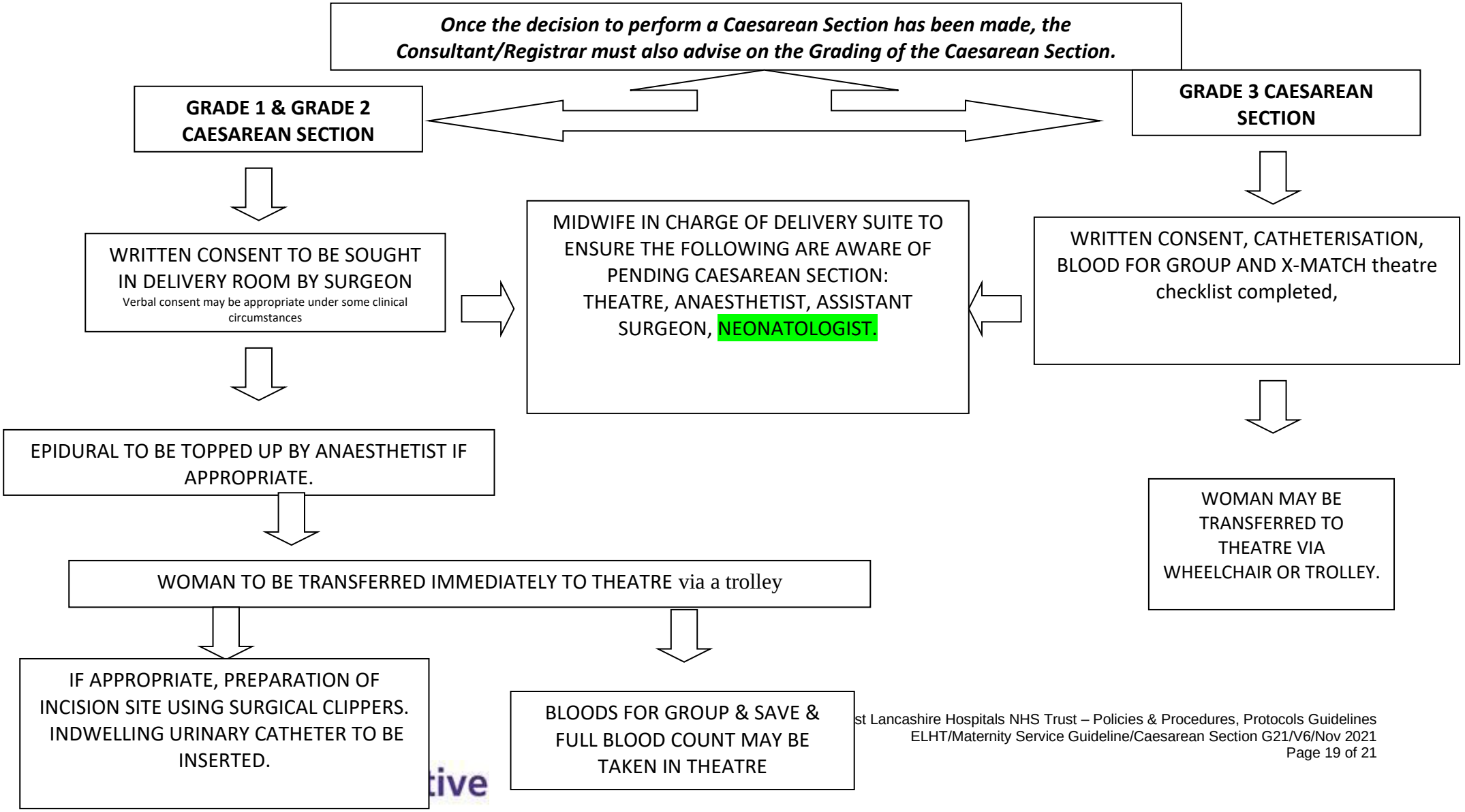
Before Birth

	tick
No contraindication identified by MDT	
If contraindicated, please specify reason	
Woman aware that skin to skin may not be possible if baby needs immediate attention	
Birth partner offered option of being present for spinal anaesthetic	
Arm slipped out of theatre gown	
ECG leads away from chest	
Drapes to be kept folded to maintain sterility	
Warm towel ready to place over baby	
Cord scissors ready if birth partner cutting cord	
Screen ready to be put up once cord is cut	
Delayed cord clamping?	
If not delaying please give reason	

After Birth:

	tick
Keep baby warm	
Maintain skin to skin until transfer to trolley	
If discontinued, please give reason	
Temperature. Vitamin K, name bands and measurements completed	
Weight – can bring scales to bedside	
Document if screen down in delivery notes	

APPENDIX 1 Flow chart for Caesarean Section (Grades 1-3)



APPENDIX 2: Process for Women undergoing Elective Caesarean Section

ANC
Give woman evidence based information during the antenatal period about CS thereby enabling them to make informed decisions e.g. risks and benefits, implications for future pregnancies, what the procedure involves
Once the decision is made for CS record all the factors that have influenced the decision. For women considering a VBAC commence VBAC pro-forma booking appointment and file in maternity records. Complete the appropriate sections as the pregnancy progresses. Assess suitability for enhanced recovery and **discuss** skin to skin caesarean birth.
Book CS on in diary Complete consent form and WHO Maternity Surgical Pathway MRSA swabs Book Pre-operative Assessment and inform woman of dates and times.
Pre-Operative Assessment Complete obstetric theatre Pathway FBC; Group and Save or X-match where required. Discuss prophylactic antibiotics Discuss thromboprophylaxis Advice re nil by mouth prior to admission and ranitidine Inform woman of date, time and where to attend on day of C/S

Admit to Postnatal Ward on day planned for CS Introductions by staff. ID Band Check consent and complete the reconfirmation. Review history Abdominal Palpation, Auscultation of Fetal Heart, MEOWS, Transfer to theatre, Prepare bed area. SBAR handover in Theatre Complete WHO surgical checklist
Care following Caesarean Section SBAR handover from recovery team to receiving midwife. Transfer to most appropriate care setting COU / PN Ward Care as per ELHT Maternity Services Clinical Guidelines: Formulate a Care Plan in conjunction with the woman and review and re assess as care changes