Caesarean Section (CS)
Clinical Guideline

V4.2

April 2022
1. **Aim/Purpose of this Guideline**

1.1. This guideline gives guidance to all Obstetricians, Obstetric Anaesthetists, Midwives and Delivery Suite Nurses on the booking and management of Elective and Emergency CS at all gestations.

1.2. This version supersedes any previous versions of this document.

1.3. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

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Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust  rch-tr.infogov@nhs.net

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2. **The Guidance**

2.1. **Maternal Request for Caesarean Section (NEW 2021)**

2.1.1. When a woman with no medical indication for a caesarean section requests a caesarean birth, explore, discuss and record the specific reasons for the request.

2.1.2. Any woman who is requesting a caesarean birth with no medical indication should be booked into an obstetric clinic to explore the reasons for the request and ensure the woman has accurate information.

2.1.3. At this appointment they should be given the opportunity to discuss the overall benefits and risks of a caesarean birth compared with vaginal birth this with someone who can answer their questions and understand their concerns in a supportive manner.

2.1.4. The Personalised Care Plan should be used to support all discussions.
2.1.5. Ensure healthcare professionals providing perinatal mental health support to women requesting a caesarean birth have access to the planned place of birth during the antenatal period in order to provide care.

2.1.6. For women requesting caesarean birth during labour with no medical indication, a discussion should take place with an obstetrician with all shared information documented so that informed consent is obtained.

2.1.7. When information sharing has been undertaken and a decision made by the woman for a caesarean section birth, this informed decision must be respected.

2.1.8. A planned caesarean birth with no medical indication should ideally not be performed before 39 weeks to reduce the risk of respiratory morbidity in babies.

2.2. **Elective Caesarean Section**

2.2.1. **Booking an Elective Caesarean Section**

2.2.1.1. The woman will be seen in the Obstetric Clinic and a plan for delivery made. At this time the Doctor should book the CS on the electronic diary ensuring that all relevant details are given. These include: indication, gestation, person authorising CS, priority to go 1st, BMI, risk of bleeding and any anaesthetic risk. A third CS should only be booked if clinically indicated and there is no other availability. We should aim for 2 CS per day.

2.2.1.2. During this Obstetric Clinic appointment, the benefits and risks associated with both vaginal and caesarean birth should be discussed during the antenatal period, taking into account their circumstances, concerns, priorities and plans for future pregnancies and documented on the woman’s electronic maternity records and consent for the CS should be taken and filed in the notes.

2.2.1.3. All caesarean sections should be booked for >39 weeks, unless there are fetal reasons for earlier delivery. If <39 weeks, requires a detailed discussion with the obstetrician about the risks and benefits of steroids specific to their circumstances.

2.2.2. **Pre-Operative Assessment for Elective Caesarean Section**

2.2.2.1. The order of the operative list will be agreed the night before the planned list by the Obstetrician and Anaesthetist and the woman contacted by telephone.

2.2.2.2. Anaesthetic assessment should take place and observations taken by the Maternity Support Worker with a MEOWS score recorded.
2.2.2.3. Full Blood Count (FBC), COVID swab and Group and Save (G&S) should be sent. The results should be checked and followed up by the midwife in the Day Assessment Unit.

2.2.2.4. A COVID-19 swab should be offered and undertaken with consent.

2.2.2.5. The woman should be given Omeprazole 40mg to be taken orally as per the written instructions and two pre-op drinks provided (diabetic women should NOT be given pre-op drinks).

2.2.2.6. Give the letter detailing admission times, fasting times and times to take the Ranitidine and pre op drink.

2.2.2.7. At the pre-op visit the woman should be advised of options during the procedure and an isotonic drink for recovery.

2.2.3. Admission for Elective CS

2.2.3.1. All CS are admitted to Delivery Suite at the time agreed the night before.

2.2.3.2. On admission document a full set of observations on a MEOWS chart. The fetal heart should be auscultated.

2.2.3.3. The patient must have a valid group and save.

2.2.3.4. Patients are required to abstain from food and drink prior to elective surgery, to minimise the risk of aspiration of gastric contents. Increasingly it has been shown that small amounts of water prior to elective surgery are safe and are unlikely to increase the risk of aspiration. Patients may experience delays whilst waiting for surgery. Such delays, where fasting is maintained, may contribute to thirst, dry mouth, headache and reduction in general wellbeing (NEW 2022).

2.2.3.5. On arrival, all patients can be offered up to 50ml of water (drawing a line on a plastic cup may be useful) (NEW 2022)

2.2.3.6. Anaesthetist to see patient and clarify if isotonic fluids or water can be given freely up until a certain time, for example, isotonic drink until 10:00 then cease. If a time cannot be given, every effort should be made by the anaesthetist to inform DS staff once list orders have been determined (New 2022)

2.2.3.7. After the specified time, to cease free isotonic drink/water, or for patients where a time has not been stated, patients should be offered 50ml of isotonic drink/water every hour whilst waiting to be called for surgery. This applies to all patients, unless the anaesthetist or obstetrician informs the midwife otherwise (NEW 2022)
2.2.3.8. Any additional water or isotonic drink consumption (greater than 50 ml per hour or 50ml for medication administration or fluid after specified cessation time) should be stated in the handover to theatre (NEW 2022)

2.2.3.9. The time the patient is called for surgery can occur at any time after the 50ml of water is given (New 2022)

2.2.3.10. For further clarification on pre-operative oral fluids please see flow diagram (appendix 4) (New 2022).

2.2.3.11. The Obstetrician planning to perform the CS should see the woman, confirm that she still wishes to proceed, sign the confirmation on the consent form and review notes for any additional surgical risk factors e.g. placental site.

2.2.3.12. The Obstetrician should decide if a Neonatologist should be present at delivery.

2.2.3.13. All CS performed for breech should have a presentation scan prior to being taken into theatre. A Neonatologist should be present for all breech deliveries including elective cesarean section (NEW 2021).

2.2.4. Elective CS in Theatre

2.2.4.1. The WHO team brief will be performed prior to the patient being taken to theatre.

2.2.4.2. The WHO checklist sign in will be completed by the anaesthetist.

2.2.5. Skin to skin contact

2.2.5.1. The Midwife/Maternity Nurse looking after the woman on the day of the CS should explore the woman’s wishes regarding skin to skin contact and seeing the baby being born. Skin to skin contact should be encouraged. If the woman prefers not to have skin to skin contact during her CS then the partner may consider doing this. The decision regarding skin to skin contact and seeing the baby being born can be communicated to all staff during the ‘sign in’ of the WHO checklist.

2.2.5.2. If the woman wishes skin to skin contact with her baby, then the cannula should be sited in the woman’s non dominant arm to enable access.

2.2.5.3. For women who wish to have skin to skin contact, the gown should be freed from her top half when preparing the woman on the operating table and a blanket used to cover her for privacy and dignity (see Family Centered Caesarean Section Standard Operating Procedure).

2.2.5.4. Once the regional anaesthetic has been administered, the midwife should auscultate the fetal heart and any concerns voiced to the obstetric team.
2.2.5.5. The woman should be catheterised, cell salvage should be made available.

2.2.5.6. WHO checklist must be completed with all members of the team present including any required neonatal presence.

2.2.5.7. A sterile baby wrap should be placed, by the scrub nurse, carefully over the cot covering all the edges of the cot prior to commencing the caesarean section.

2.2.5.8. An alcohol-based chlorhexidine skin preparation should be used to reduce the risk of wound infections.

2.2.5.9. When draping, the surgeon should check with the woman whether she wishes to see the baby being born. The surgeon should indicate to the anaesthetist when it is appropriate to lower the drape further enabling the woman and her partner to see the birth.

2.2.5.10. All women should be given appropriate prophylactic antibiotics prior to incision.

2.2.5.11. Once the baby is born, and following Deferred Cord Clamping of 60 seconds (where appropriate and where there is no excessive bleeding – see Optimal Cord Clamping Guidance), it should be placed in the cot onto the sterile baby wrap by the surgeon. The cot should then be taken immediately to the woman and birth partner where the baby is dried and assessed for the need for resuscitation.

2.2.5.12. If the parents request immediate skin to skin this should be facilitated if possible.

2.2.5.13. Once the assessment and any resuscitation needs have been completed, skin to skin contact can commence. The blanket should be placed over both baby and mother without obscuring the baby’s face.

2.2.5.14. A photograph of baby +/- woman and birth partner should be allowed during the CS. The family should be made aware that photos and videos cannot be shared beyond personal use without the consent of all those in the video.

2.2.5.15. WHO sign out should be completed at the end of the procedure.

2.2.5.16. At the end of the elective caesarean section list there should be a WHO theatre debrief with all members of the team.

2.2.6. **Elective Post-operative Care**

2.2.6.1. Skin to skin contact should be resumed as soon as possible in recovery. Support infant feeding with skin to skin contact.

2.2.6.2. Encourage oral fluid intake.
2.2.6.3. Care to continue as per RCHT Recovery Guideline.

2.3. Decision to delivery time for unplanned Caesarean Section

2.3.1. Classification of Urgency of Emergency CS

Perform category 1 and 2 as quickly as possible after making the decision, especially category 1. Perform category 2 in most situations within 45 minutes of making decision and ensure time of decision is clearly documented. It is recognized that in some circumstances these time frames may not be achievable. If the CS falls out of the agreed timeframe the reasons should be documented in the health records.

Category I = Immediate threat to the life of the woman or fetus – aim for decision to delivery time of 30 minutes

Category II = Maternal or fetal compromise which is not immediately life threatening – Aim for decision to delivery time of 30 minutes and should be delivered within 45 minutes.

Category III = No maternal or fetal compromise but needs early delivery. For this category the time to delivery must be decided by the Obstetrician and communicated clearly to all those involved and documented in the health records.

Maternal request for caesarean birth during labour with no medical indication should be categorized depending on the clinical picture.

Category IV = Delivery timed to suit woman or staff with no urgency for delivery.

2.3.2. A senior obstetrician on call should be involved in the decision making.

2.3.3. The time of decision to proceed, the indication for section and Category should be clearly documented in the health records and communicated to all staff.

2.4. Emergency CS Procedure

2.4.1. Obtain written consent. For Category I caesarean sections verbal consent alone is appropriate and must be documented in the health records.

2.4.2. Send blood for FBC and Group and Save if not already done.

2.4.3. Cross match blood if indicated.

2.4.4. Cell salvage should be made available whenever possible.

2.4.5. Transfer woman to theatre in left lateral position and ensure a fetal monitor is available to record the fetal heart in theatre.
2.4.6. In theatre if there is improvement in the fetal heart rate, consideration should be given to re-classification of urgency.

2.4.7. If there is fetal distress, consider the use of Terbutaline 250 mcg s/c to relax the uterus and increase placental perfusion. Transfer to theatre should not be delayed because of this.

2.4.8. If caesarean section is for fetal bradycardia which then resolves, the need for CS should be reconsidered.

2.4.9. If there is the potential for rapid labour progress and therefore vaginal delivery a vaginal examination should be repeated in theatre prior to the commencement of the CS section.

2.4.10. The Neonatologist or ANNP must be called to attend and should be informed of the category of the CS.

2.4.11. The decision regarding the method of anaesthesia should be made by the Anaesthetist after discussion with the Obstetrician.

2.4.12. The woman should not be left alone after the decision to perform a category 1 or 2 caesarean section has been made.

2.4.13. An aqueous chlorhexidine vaginal preparation before caesarean birth in women with ruptured membranes should be used to reduce the risk of endometritis. If aqueous iodine vaginal preparation is not available or is contraindicated, aqueous chlorhexidine vaginal preparation can be used (NEW 2021).

2.4.14. Paired cord blood samples should be taken for all Emergency CS’s and results filed in Safe Store envelope.

2.4.15. Consideration should be made on the storage of the placenta and sent to histology if required (NEW 2021).

2.4.16. If Diclofenac and/or vaginal swabbing is required, consent should be gained first.

2.4.17. All Category I CSs should be reported by completing a Datix.

2.5. Uterotonics for all Caesarean Sections

2.5.1. Following the birth of the baby Carbetocin 100mcg (diluted in 10mls of saline) should be given over a minute intravenously. Carbetocin requires caution with hyponatraemia, cardiovascular disease and severe hypertension. Do not use Carbetocin before delivery of the baby, or if previous hypersensitivity has occurred.

2.5.2. Carbetocin should be used on all CS unless a Syntocinon infusion is already in progress. If a Syntocinon infusion is in progress, a single dose of Syntocinon 5IU, IV is given and the Syntocinon infusion increased to 125ml/hr of 40IU in 500mls.
2.5.3. If further uterotonics are required due to uterine atony, proceed to Post-Partum Haemorrhage Guideline and do not give a second dose of Carbetocin.

2.6. Additional considerations for CS of Preterm infants

2.6.1. **Neuroprotection with magnesium sulphate is indicated for gestations <34 weeks. Ideally this should be administered more than 4 hours prior to delivery.**

2.6.1.1. A maintenance dose of 10 grams (20ml magnesium sulphate), diluted with 30 ml of saline 0.9% (total 50 ml) is set up to deliver 1 gram per hour (5mls/hr) using a syringe driver, until delivery.

2.6.1.2. If delivery is imminent it is appropriate to give only the loading dose.

2.6.2. **Management at Delivery**

2.6.2.1. Ensure the neonatal team are present at WHO time out prior to delivery.

2.6.2.2. Ensure umbilical cord is kept long to allow venous access.

2.6.2.3. Liaise with Neonatologist regarding use of placing the baby in a plastic bag and using other thermoregulation equipment such as a Transwarmer to reduce neonatal hypothermia.

2.6.2.4. Aim to ensure optimal cord clamping for at least 60 seconds with respiratory support if required. Cord milking should only be done in infants over 28 weeks when clinical concerns overrides optimal cord management e.g. abruption and vasapraevia.

2.7. **Post Procedure Care**

2.7.1. A CS proforma must be completed.

2.7.2. Thromboprophylaxis should be prescribed refer to RCHT Venous Thromboembolism Risk Assessment Clinical Guideline.

2.7.3. Removal of the urinary catheter should be carried out once mobile but no sooner than 12 hours, unless instructed to leave in for a longer time by the surgeon. The time of the removal of the catheter should be documented on the catheter care plan and the notes, followed by the timing and amount of the next void which should be documented in the notes.

2.7.4. The dressing should be observed each day for soiling or damage. The dressing should be removed 12 to 24 hours before post operatively.

2.7.5. Appropriate analgesia should be prescribed.
2.7.6. Indications for CS, procedure and implications for future pregnancies should be discussed postoperatively with all women by an Obstetrician prior to discharge home.

2.7.7. Women, who are recovering well, from an uncomplicated caesarean section, should be offered discharge from hospital after 24 hours. For an uncomplicated Elective CS with no concerns a midwifery discharge is appropriate.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detail of process and methodology for monitoring compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Element to be monitored</td>
<td>EI LSCS</td>
</tr>
<tr>
<td></td>
<td>• If a patient is having a planned LSCS and she is &lt;39 weeks were steroids given (except in the case of a diabetic woman)</td>
</tr>
<tr>
<td></td>
<td>• Were MRSA swabs taken and the results appropriately actioned</td>
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<td></td>
<td>• On admission were a full set of observations taken and plotted on a MEOWS chart and the fetal heart auscultated and documented.</td>
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<tr>
<td></td>
<td>• If breech, was a presentation scan performed prior to going to theatre</td>
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<tr>
<td></td>
<td>• Was the WHO Checklist thoroughly completed?</td>
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<tr>
<td></td>
<td>Em LSCS</td>
</tr>
<tr>
<td></td>
<td>• Was the Em LSCS performed within the time that the category dictates?</td>
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<td></td>
<td>• Was Terbutaline given if fetal distress thought to be from contractions?</td>
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<tr>
<td></td>
<td>• Was the neonatologist/ANNP present at delivery</td>
</tr>
<tr>
<td></td>
<td>• Was MgS04 given if the gestation was &lt;34+6 (and appropriate)?</td>
</tr>
<tr>
<td>Lead</td>
<td>Audit midwife</td>
</tr>
<tr>
<td>Tool</td>
<td>Excel spreadsheet to calculate % compliance</td>
</tr>
<tr>
<td>Frequency</td>
<td>1% or 10 sets, whichever is the greater, of all health records of women who have delivered by LSCS over the lifetime of this guideline. (3 years)</td>
</tr>
<tr>
<td>Information Category</td>
<td>Detail of process and methodology for monitoring compliance</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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</table>
| Reporting arrangements                    | • A formal report of the results will be received over the lifetime of this Guideline (3 yearly)  
• During the process of the audit, if compliance is below 95% or other deficiencies identified this will be highlighted and an action plan agreed  
A re-audit will be required at 6 months if improvements are required                                                                                                                          |
| Acting on recommendations and Lead(s)     | • Any deficiencies identified will be highlighted at the next Maternity Forum and an action plan developed.  
• Action leads will be identified and a time frame for the action to be completed by.  
The Action plan will be monitored by the audit team and concerns escalated to the matrons                                                                                                      |
| Change in practice and lessons to be shared| • Required changes to practice will be identified and actioned within a time frame agreed on the action plan.  
• A lead member of staff will be identified to take each change forward where appropriate.  
The results of audits will be distributed to all relevant staff via the Patient Safety Newsletter or other appropriate route                                                                          |

4. **Equality and Diversity**

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
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<tbody>
<tr>
<td>Document Title:</td>
<td>Caesarean Section (CS) Clinical Guideline V4.2</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Caesarean Section (CS) Clinical Guideline V4.1</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>April 2022</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>April 2022</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>July 2024</td>
</tr>
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</table>
| Directorate / Department responsible (author/owner): | Dr Sophie Haynes  
Consultant Obstetrician |
| Contact details:     | 01872 25 0000 |
| Brief summary of contents: | This guideline gives guidance to all Obstetricians, Obstetric Anaesthetists, Midwives and Delivery Suite Nurses on the process and procedure for all grades of Caesarean Section. |
| Suggested Keywords:  | Skin, normalising, normal, caesarean, section, elective, emergency, uterotonics, pre, meds, operative, care, deferred, CS |
| Target Audience:     | RCHT: Yes  
CFT: No  
KCCG: No |
| Executive Director responsible for Policy: | Medical director |
| Approval route for consultation and ratification: | Maternity guideline group  
Care Group Board |
| General Manager confirming approval processes: | Mary Baulch |
| Name of Governance Lead confirming approval by specialty and care group management meetings: | Caroline Amukusana |
| Links to key external standards: | UNICEF Baby Friendly initiative |
| Related Documents:   | • RCHT Recovery and Post-operative Care in the Maternity Setting  
• RCHT Deferred Cord Clamping |
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|                      | • RCHT Infant Feeding Policy  
|                      | • RCHT Bladder Care Intrapartum and Postpartum Bladder Care  
|                      | • RCHT VTE Risk Assessment in Pregnancy, Labour and Postpartum Period  
|                      | • NICE CG132 Caesarean Section  

Training Need Identified?  
No

Publication Location (refer to Policy on Policies – Approvals and Ratification):  
Internet & Intranet

Document Library Folder/Sub Folder:  
Clinical / Midwifery and Obstetrics

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version Number</th>
<th>Summary of Changes</th>
<th>Changes Made by</th>
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<tr>
<td>10th Feb 2012</td>
<td>V1.0</td>
<td>Initial version</td>
<td>Karen Watkins Consultant Obstetrician</td>
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<tr>
<td>17th Dec 2015</td>
<td>V2.0</td>
<td>Merging of previous 4 Caesarean Section Guidelines into one guideline for all Grades of Caesarean Section. Includes advice upon normalising Caesarean Section and changes in preoperative medication.</td>
<td>Sophie Haynes Senior Obstetric Registrar</td>
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<tr>
<td>7th June 2018</td>
<td>V3.0</td>
<td>Timings for category 1 and category 2 updated in line with NICE CG132</td>
<td>Helen Odell quality and safety improvement lead</td>
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| 4th June 2020     | V3.1           | 1.3. Inclusion statement  
|                   |                | 2.1.4. Auscultation of fetal heart following regional anaesthetic administration Updated templates  | Dr Sophie Haynes Consultant Obstetrician |
| July 2021         | V4.0           | Full version review.  
|                   |                | 2.1.3 Updated guidance for Neonatalogist to be present for all breech deliveries including elective cesarean section  | Sophie Haynes Consultant Obstetrician  
<p>|                   |                | Julie Walton Audit Midwife                                                         |</p>
<table>
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<tr>
<td>July 2021</td>
<td>V4.1.</td>
<td>4.3. Guidance added on maternal request for CS and use of Personalised Care Plan.</td>
<td>Sophie Haynes, Consultant Obstetrician</td>
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<tr>
<td></td>
<td></td>
<td>4.4. Guidance added on booking process for ELCS and pre-operative process.</td>
<td>and Helen LeGrys Consultant Obstetrician</td>
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<td></td>
<td></td>
<td>4.5. Guidance added on WHO theatre checklist.</td>
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<td></td>
<td>Updated guidance re preterm management</td>
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<tr>
<td>April 2022</td>
<td>V4.2</td>
<td>Minor change 2.2 Guidance on pre-operative oral fluid intake</td>
<td>Layth Tameen Consultant Anaesthetist &amp;</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Katharine Sprigge Consultant Anaesthetist</td>
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This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Equality Impact Assessment

### Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity & Inclusion Team rcht.inclusion@nhs.net

<table>
<thead>
<tr>
<th>Information Category</th>
<th>Detailed Information</th>
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<tr>
<td>Name of the strategy / policy / proposal / service function to be assessed:</td>
<td>Caesarean Section (CS) Clinical Guideline V4.2</td>
</tr>
<tr>
<td>Directorate and service area:</td>
<td>Obs and gynae Directorate</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):</td>
<td>Dr Sophie Haynes Consultant Obstetrician</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 25 0000</td>
</tr>
</tbody>
</table>

### Information Category | Detailed Information

1. **Policy Aim - Who is the Policy aimed at?**
   (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)
   - This guideline gives guidance to all Obstetricians, Obstetric Anaesthetists, Midwives and Delivery Suite Nurses on the process and procedure for all grades of Caesarean Section.

2. **Policy Objectives**
   - To achieve a positive birth experience and safe delivery for a woman undergoing birth by Caesarean Section.

3. **Policy Intended Outcomes**
   - Safe delivery of a baby born by Caesarean Section.

4. **How will you measure each outcome?**
   - Compliance Monitoring Tool.

5. **Who is intended to benefit from the policy?**
   - All women and their babies undergoing birth by Caesarean Section.

6a. **Who did you consult with?**
   (Please select Yes or No for each category)
   - Workforce: Yes
   - Patients/visitors: No
   - Local groups/system partners: Yes
   - External organisations: No
   - Other: No
6b. Please list the individuals/groups who have been consulted about this policy.

Please record specific names of individuals/groups:
- Maternity guidelines meeting
- Care Group Board

6c. What was the outcome of the consultation?

Agreed

6d. Have you used any of the following to assist your assessment?

National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:
No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>(Yes or No)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sex (male or female)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Gender reassignment (Transgender, non-binary, gender fluid etc.)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Religion or belief</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Dr Sophie Haynes

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:

Section 2. Full Equality Analysis
Appendix 3: Grade descriptions for Emergency CS

Category I - Immediate threat to the life of a woman or fetus:

Any Caesarean Section in which immediate delivery is required with every member of the team working to transfer the woman without any delay into theatre so that the Caesarean Section can commence immediately. Written consent would be inappropriate and verbal consent should be obtained. In most cases, a general anaesthetic would be indicated, however, if the anaesthetist has already started topping up an existing epidural or if the anaesthetist is experienced and feels confident to site a spinal, then these also may be indicated. The aim would be that the baby would be delivered within 30 minutes of the decision. Examples include:

- Cord prolapse with pathological CTG
- Fetal bradycardia
- Abruption with maternal collapse
- Woman attempting a VBAC with signs of uterine rupture
- Fetal blood sample with a pH of <7.00
- STAN events mandating delivery (New 2018)

Category II - Maternal or fetal compromise which is not immediately life-threatening:

These are urgent Caesarean Sections in which there is compromise, however not life threatening. Written consent is appropriate and transfer to theatre, although needing to be prompt, should be done in a calm and safe manner so that other patients on the delivery suite are not put at risk. The aim should be for the delivery to be completed within 30 minutes. Delivery should not be longer than 45 minutes from decision. Examples of these caesarean sections include:

- Fetal blood sample with a pH of <7.20
- Pathological CTG in which a fetal blood sample is not possible/contraindicated but where the pH would be expected to be <7.20
- Significant abruption without signs of shock/fetal compromise
- Cord presentation or prolapse without pathological CTG
- Secondary arrest in a women attempting VBAC
- Failure to progress in second-stage with pathological CTG
Category III – No maternal or fetal compromise but needs early delivery:

A set time frame has not been set for these and for each case the obstetrician should set a time which is appropriate depending to clinical condition and the other priorities on labour ward at the time. The time decided upon should be communicated clearly to the anaesthetist and may be between 45 minutes to next day. As a general rule, category 3 CS, in established labour, should be accomplished within 60 minutes. For example the decision to delivery interval for a woman who fails to progress in labour is likely to be less than a woman who has had a failed induction. It may be that the obstetrician will decide that the woman who has failed to progress needs to be delivered within 45 minutes. This should be communicated to the whole team.

Examples of these would include:

- Failure to progress in the absence of a pathological CTG
- Woman admitted in established labour who was booked for elective caesarean section
- Undiagnosed breech in labour who wishes a caesarean section and CTG normal
- Failed induction (for a medical indication)

Category IV – delivery timed to suit woman or staff:

This category basically includes all Elective Caesarean Section or other non-urgent CS’s e.g. when a woman booked for a CS is admitted with some uterine activity but not in labour or a failed induction for non-urgent reasons. These CS’s can be planned at any time and have no urgency.
Appendix 4. Preoperative oral fluid administration before elective caesarean section

Patient admitted to DS

Give up to 50 ml water

If the CS is likely to be delayed confirm with anaesthetist if patients can drink water / isotonic drinks freely until a set time

**CAN**
- drink freely until specified time

**CANNOT**
- drink freely

Offer water / isotonic drink every hour as above

Offer 50ml water / isotonic drink EVERY HOUR until called for surgery

(Unless 50ml given with medication)

After specified time reached

Hand over to theatre staff