CLASSIFICATION AND COMMUNICATION FOR CAESAREAN SECTION AND ASSISTED DELIVERIES IN THEATRE

PURPOSE

The purpose of this guideline is to describe the process of categorisation of Caesarean Section (C/S) and assisted deliveries in the operating theatre and outline the principles of multidisciplinary communication in Birthing Suite which underpin the smooth, safe and rapid transition to the operating theatre when indicated in Christchurch Women's Hospital.

BACKGROUND

Communication is often highlighted as an area for improvement in health care, including obstetric practice.[1] Effective communication is central to enabling efficient decision making and ensuring clear processes in management and avoidance of unnecessary risk to the woman and her baby during emergency interventions, including Caesarean Section and assisted delivery.

The time taken for a woman to reach the operating theatre is a critical predictor of the decision to delivery interval. Such delay can be minimised by excellent communication both before and after decision making.[2]

TEAM WORK

The Caesarean Section/assisted delivery team in theatre comprises many disciplines. The importance of forward planning and senior involvement cannot be over emphasised. In many cases factors that may contribute to an additional risk during labour are identified in the antenatal period. In such cases a clear and coherent management plan for labour should be clearly documented.

Once in Birthing Suite it is recommended that teamwork is enhanced by multi-disciplinary involvement at ward rounds. This, and ongoing regular dialogue between key disciplines, is required to identify those cases at high risk of intervention.

PARTNERSHIP

In the event of an emergency the purpose of the classification system is to confer an immediate and unequivocal signal to all team members with respect to the degree of urgency.

The decision for mode and urgency of delivery is the responsibility of the most senior Obstetrician available. The decision for mode of anaesthetic is the responsibility of the Anaesthetist Registrar and

it is not the intention of the classification system to influence this. It is possible that the most urgent category of delivery may be accomplished with a regional anaesthetic.

On making the decision regarding the need for urgent delivery in theatre and the categorisation it is expected that the Obstetrician will immediately liaise with the Anaesthetist Registrar on call to summarise the clinical situation.

In many cases the Anaesthetist Registrar will wish to assess the woman before transfer to theatre to formulate the most expedient plan for delivery.

The team looking after the pregnant person should contact the neonatal team. This communication will be according to the category of delivery (see below) and refer to the Neobar Handover tool on the back of the QMR0044 (green Newborn Record form) to assess risk factors which may impact neonatal resuscitation.

MINIMISE DELAY

Once a decision to deliver has been made, delivery should be carried out with urgency appropriate to the situation and maintaining the safety of the woman and the wellbeing of her baby.

No 'target' time frame has been quoted for Category 1 and Category 2 deliveries.

Most delays between decision and delivery result from delays in transfer from the Birthing Suite room to the operating theatre. For Category 1 deliveries it is the responsibility of all members of the team to ensure rapid transfer to theatre once a plan has been made.

Delay can be minimised through clear identification of the roles and responsibilities of health care practitioners to ensure tasks are performed concurrently whilst preparing for the delivery in theatre. This process should be streamlined.

PROCEDURE

When there is a need for in theatre delivery, the Obstetric Registrar/Obstetrician will determine the clinical urgency and advise the Associate Clinical Midwife Manager (ACMM) for Birthing Suite. The Obstetrician will then inform the duty obstetric Anaesthetic Registrar and provide a clinical summary.

The on call obstetric specialist is to be informed of all transfers to theatre – see Registrar Supervision Guideline (GLM0019).

The Birthing Suite ACMM activates a Category 1 Caesarean page which alerts the Category 1 delivery team (see Appendix B for constitution of team). For Category 1 deliveries the neonatal team is contacted via a Text to the Pager of both the Neonatal ACNM and the NICU Registrar. This will action attendance at the designated room, as directed to verbally by ACMM, and allow a discussion with the attending neonatal team (Reg/ Nurse Practitioner (NNP) and ACNM), the Midwife (LMC or core) plus obstetric staff using the QMR0044 Neobar Handover tool. The Neonatal ACNM will then escalate to the Neonatal SMO on call to request attendance if required, according to the risk assessment.

For Category 2 and 3 deliveries the Birthing Suite ACMM calls the theatre team and neonatal team (see Appendix A) and using the QMR0044 Neobar tool conveys the clinical picture to allow the neonatal

Reg/NP to determine who should attend to support the delivery (Reg/NNP or Reg/NNP and ACNM) and escalate to the neonatal SMO on call if required .

CALL PROCESS

The call process is outlined in Appendix A.

CATEGORIES

The urgency will be classified according to the following categories:

Category 1: Urgent delivery with immediate threat to life of woman or fetus

Category 2: Maternal or fetal compromise requiring rapid delivery

Category 2'U': Maternal or fetal compromise requiring rapid delivery which cannot wait for current theatre case to be completed (see later information)

Category 3: Maternal or fetal compromise requiring early delivery

Category 4: Delivery at a time to suit maternity services and the woman

The category of urgency will be clearly indicated on the theatre suite wall

GENERAL ANAESTHETIC

NB: for any category of delivery where a general anaesthetic is administered a Neonatal SMO must be notified at the time the decision is made for general anaesthetic if the Reg /NNP is not credentialled for attendance. This does not mean a change in the Category of Caesarean Section and any decision to change the urgency will be decided by the Obstetrician after review of the clinical situation.

CATEGORISATION

CONTEXT

Ensure that the categorisation and communication process consider all of the antenatal and perinatal 'red flags' that may increase the risk of the newborn requiring skilled resuscitation, eg. Primigravida with reduced or absent fetal movements and meconium-stained liquor with a cardiotocograph (CTG) abnormality may be considered as warranting a Category 1.

The categorisation of Caesarean Section classification does not relate to the acuity of Birthing Suite, and, at times, additional operating theatre resource may be needed to manage flow.

The use of the Neobar handover tool on the QMR0044 will help facilitate and guide the appropriate neonatal support according to these risk factors.

CATEGORY 1

For Category 1 deliveries the aim is to deliver with minimum delay. The team should liaise and mobilise as quickly as possible to facilitate delivery. All non-essential steps which might delay transfer of the woman to the obstetric theatre should be removed.

EXAMPLE INDICATIONS FOR CATEGORY 1 – IMMEDIATE THREAT TO LIFE OF WOMAN OR FETUS

1. Fetal bradycardia with FHR < 100 bpm for > 5 minutes duration with no return to the baseline.
2. Absent CTG variability (with no other explainable causes, eg. Magnesium Sulphate infusion or beta blockers (Labetalol).
3. Sinusoidal trace
4. Fetal scalp lactate ≥ 5.8
5. Cord prolapse with bradycardia
6. Suspected uterine scar dehiscence or uterine rupture
7. Major APH/placenta praevia with maternal or fetal compromise
8. Maternal cardiorespiratory arrest
9. Any other indication as determined by the Obstetrician

The categorisation and therefore urgency may be upgraded at any time to Category 1 should new concerns arise.

- If this occurs prior to the woman being transferred to theatre, the Birthing Suite ACMM activates the Category 1 page.
- If the upgrade occurs in theatre, the change in classification is communicated verbally to the team present by the obstetric team. The core midwife urgently alerts the ACMM via phone or pager regarding the developing situation.
- The ACMM activates the Category 1 page (in discussion with the Neonatal Reg/ NNP) to contact the Neonatal ACNM urgently to attend. Neonatal SMO presence can then be decided according to the Neobar communication tool.
- If the category is downgraded the obstetric team discuss this with the neonatal team present in theatre and any staff activation/request for attendance can be deactivated as required.

CATEGORY 2 AND CATEGORY 2'U'

(URGENT SECOND THEATRE ACTIVATION)

For Category 2 deliveries the aim is to deliver rapidly. The categorisation may be upgraded at any time should new concerns arise.

EXAMPLE INDICATIONS FOR CATEGORY 2 – MATERNAL OR FETAL COMPROMISE REQUIRING RAPID BIRTH

1. CTG abnormality, eg. complicated variable decelerations, reduced variability, persistent fetal tachycardia with or without scalp lactate 4.8 – 5.7
2. Breech presentation in active labour unsuitable for vaginal birth
3. Chronically abnormal CTG
4. APH/abruption unsuitable for vaginal delivery with concern for fetal compromise
5. Fetal abnormality with impact on cardiorespiratory stability, eg. gastroschisis, diaphragmatic hernia, large omphalocele
6. Multiple births < 30 weeks
7. Any other indication as determined by the Obstetrician

INDICATION FOR CATEGORY 2'U' – URGENT SECOND THEATRE ACTIVATION

Category 2'U' occurs if a Category 2 delivery is called while another case is proceeding in the Birthing Suite theatre.

For this situation the following steps are to be followed:

- The Obstetric Consultant determines whether the new case can wait for the current case to be finished (with the Consultant expediting the first case if possible).
- If the new case cannot wait, the Obstetric Consultant (or their representative) calls the theatre coordinator and advises that they are calling a Category 2'U' (urgent second theatre activation) and require a second theatre to be staffed.
- The Obstetric Anaesthetic Registrar can be contacted for a discussion and to assist in facilitating this if there are any difficulties.
- From a main theatre perspective, the second theatre will be staffed as if it was a Category 1 call.
- From an obstetric perspective, management will be an urgent Category 2 (Category 2'U').
- The Obstetric Consultant (or their representative) are responsible for ensuring the woman is rapidly prepared for and moved to theatre, minimising the time main theatre staff are away from their other work.
- NICU team to be called and will use Neobar tool of QMR0044 to decide what level of NICU staff attendance is required.

CATEGORY 3

For Category 3 deliveries the aim is to deliver at the first convenient opportunity. The categorisation may be upgraded at any time should new concerns arise.

EXAMPLE INDICATIONS FOR CATEGORY 3 – MATERNAL OR FETAL COMPROMISE REQUIRING EARLY BIRTH

1. Delay in progress of labour with no evidence of maternal/fetal compromise.
2. Women booked for elective section who present in active labour, presuming indication for caesarean still exists and birth is not deemed to be imminent.
3. Failed induction of labour presuming indication for induction still exists.
4. Pre-eclampsia at term unsuitable for vaginal birth.
5. Suspected IUGR unsuitable for vaginal birth with normal CTG.
6. Multiple births ≥30 weeks with normal CTG.
7. Any other indication as determined by the Obstetrician.

CATEGORY 4

For Category 4 Caesarean Sections the aim is to deliver at the convenience of the obstetric, anaesthetic and neonatal services and the woman, and her lead maternity carer (LMC). The categorisation may be upgraded at any time should new concerns arise.

EXAMPLE INDICATIONS FOR CATEGORY 4 – NO MATERNAL OR FETAL COMPROMISE, BIRTH AT A TIME TO SUIT THE WOMAN AND MATERNITY SERVICES

1. Planned elective Caesarean Section delivered in scheduled elective C/S time slot.

2. Planned for elective Caesarean Section and delivered **outside** usual elective time slot and with no other complicating factors, which would require a change in Category.

Note, however, that these cases are "time sensitive". EDD and gestational timing of birth, as well as the risk of labour, need to be considered when Caesarean Section is being booked

HIGH VOLUME WORKLOAD POTENTIALLY REQUIRING ADDITIONAL THEATRE ACTIVATION

Examples of this include:

1. A number of cases waiting for theatre, some of which cannot safely wait for completion of other cases, eg. 3rd or 4th degree perineal tear awaiting repair with no other complicating factors, manual removal of placenta – not actively bleeding but with unreasonable delay due to current Birthing Suite acuity and operating theatre occupation.
2. 2 or more C/S waiting where further delay increases obstetric risk.
3. Patients are being held up on Birthing Suite impacting flow in and out of Birthing Suite.

Prioritisation in this situation should be managed differently, as it may be possible to delay a less urgent main theatre case to staff an obstetric theatre at a mutually agreeable time.

Prioritisation discussions will be required with the theatre coordinator; it is appropriate to involve the labour ward and main theatre anaesthetists in these discussions.

Whilst awaiting delivery close surveillance of mother and baby must continue.

NEONATAL TEAM

It is vital to ensure appropriate neonatal team presence at the time of birth.

The use of the Neobar tool of the QMR0044 will be used by the obstetric and midwifery team to communicate with the Neonatal ACNM, Registrar and NNP to decide whether the Neonatal SMO should also be called in advance of delivery for Category 1 and 2 deliveries. NICU credential experienced Regs and NNPs for general anaesthetic and vaginal breech, but they may still call for SMO support if high risk is identified (Appendix B).

If a planned regional anaesthetic is converted to a general anaesthetic BEFORE DELIVERY OF THE BABY, this will be communicated by the obstetric team to the attending neonatal team, who will escalate to the Neonatal Consultant if deemed necessary.

Category 1: for Category 1 deliveries the neonatal team is contacted via a text to the pager of both the ACNM and the NICU Reg/NNP (Pagers 5019, 5025 and 5088) This will action attendance at the designated room, as directed to verbally, and allow a discussion once the neonatal team (Reg/NNP and ACNM) arrive with a key midwife (LMC or core) plus obstetric staff who will share their concerns using the QMR0044 Neobar Handover tool. The Neonatal ACNM will then contact the Neonatal SMO on call to request attendance if required according to the risk assessment.

Category 2 & 2'U': The Birthing Suite ACMM calls the theatre team and neonatal team (ACNM 5088 and Reg/NNP 5019) (see Appendix A) and using the QMR0044 Neobar tool conveys the clinical picture to the first member of the team to answer. The second member who calls back can be told that the information has been conveyed for the delivery and to please attend the location. This will allow the

Neonatal Registrar or NNP to determine who should attend to support the delivery (Reg/NNP or Reg/ NNP and ACNM) and escalation to the Neonatal SMO if attendance is required.

Category 3/Category 4: for all other deliveries the neonatal presence will be determined by the accompanying neonatal team criteria for attendance document. (Refer to Appendix B).

THEATRE LOCATION

All operative deliveries will normally take place in Birthing Suite Theatre 26 or 27. If both theatres are occupied then main theatres will be used.

If one obstetric theatre is already in use, then the second on call Anaesthetist and another theatre team may need to be mobilised.

TRIAGE IN THEATRE

Categorisation of urgency should be reviewed by the multidisciplinary team when the woman arrives in the operating theatre.

In most cases it is useful to continue monitoring fetal wellbeing with a CTG in theatre whilst preparing for delivery. In some Category 1 situations, when the need for rapid caesarean section is inevitable, it may not be helpful to undertake further fetal monitoring. In these settings attempts at further monitoring may simply delay delivery.

The urgency of a situation may change between transfer from an assessment room or birthing room to the theatre suite. It may be necessary to adjust the plan for delivery.

CONSTITUTION OF TEAMS

The constitution of teams is outlined in Appendix B.

OBSTETRIC SURGICAL SAFETY CHECKLIST

The Obstetric Surgical Safety Checklist is used for all categories of delivery in theatre. A locally agreed checklist is mounted on the wall in theatre and requires visual and verbal engagement by all in people theatre. Refer to Appendix C.

The SIGN IN is initiated by the Anaesthetic Registrar or Anaesthetic Technician after arrival in theatre. In the case of a Category 1, SIGN IN is led by a theatre Nurse during positioning of the woman.

TIME OUT is initiated by the Obstetrician after positioning and before skin incision.

SIGN OUT is led by the theatre Nurse at the end of the procedure before the woman leaves theatre.

ROLES AND RESPONSIBILITIES

With respect to communication, the roles and responsibilities of the various team members are outlined in Appendix E. It is expected that ISBAR principles are used throughout.

CATEGORISATION AND PREPARATION OF CAESAREAN SECTION AND ASSISTED DELIVERY IN THEATRE PROCESS

For a summary of the classification and communication process refer to Appendix F.

REFERENCES

1. Joint Commission on Accreditation of Healthcare Organizations. JCAHO sentinel event alert #30. 2004.
2. Mode of anaesthetic for category 1 caesarean section and neonatal outcomes. Beckmann M, Calderbank S. ANZJOG 2012: 52: 316-320.

APPENDICES

Appendix A	Call process
Appendix B	Constitution of teams
Appendix C	Obstetric surgical safety checklist
Appendix D	Neonatal team criteria for attendance
Appendix E	Roles and responsibilities
Appendix F	Categorisation and preparation for theatre delivery process
Appendix G	Summary of classification and communication for theatre delivery

APPENDIX A CALL PROCESS

CATEGORY 1

ACMM pages (22) 5333 4# and activates Category 1 delivery team.

The categorisation and therefore urgency may be upgraded at any time to Category 1 should new concerns arise:

- If this occurs prior to the woman being transferred to theatre, the Birthing Suite ACMM is informed, activates the category 1 page
- If the upgrade occurs in theatre, the change in classification is communicated verbally to the team present by the obstetric team. The core midwife urgently alerts the ACMM via phone or pager regarding the developing situation. The ACMM activates the Category 1 page
- The ACNM decides with the NICU Reg/NNP if the neonatal SMO should be called

CATEGORY 2

ACMM calls theatre team and neonatal team. Obstetric specialist to liaise with Anaesthetic Registrar.

CATEGORY 2'U'

Urgent second theatre activation for a second Category 2 case that cannot wait

If a Category 2 is called while another case is proceeding in the Birthing Suite theatre, the following steps are to be followed:

- The Obstetric specialist (or their representative) calls the theatre coordinator and advises that they are calling a Category 2'U', stating "Urgent second theatre activation", and require a second theatre to be staffed (see process on page 5). ACMM calls neonatal team, as usual process, for Category 2 delivery.

CATEGORY 3

ACMM calls theatre team and neonatal team. Obstetrician to liaise with Anaesthetic Registrar.

CATEGORY 4

Book through elective system.

FOR HIGH VOLUME WORKLOAD

Obstetric SMO or their delegate to discuss with the Obstetric anaesthetic team and theatre coordinator and to determine the timing of the case. ACMM to then contact the neonatal team according to delivery category.

GENERAL ANAESTHETIC

NB: for any category of delivery where a general anaesthetic is administered a Neonatal SMO must be notified at the time the decision is made for general anaesthetic if the Reg /NNP is not credentialled for attendance.

APPENDIX B CONSTITUTION OF TEAMS (MINIMUM)

CATEGORY 1

Obstetric Registrar and House Surgeon, Anaesthetic Registrar, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife, Neonatal Team (ACNM *and* Reg/NNP x2). Escalation to call Neonatal SMO will be made by Neonatal team present.

CATEGORY 2 & 2'U'

Obstetric Registrar and House Surgeon, Anaesthetic Registrar, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife, Neonatal Team (ACNM *and* Reg/NNP x1) Escalation to call Neonatal SMO will be made by Neonatal team present.

CATEGORY 3

Obstetric Registrar and House Surgeon, Anaesthetic Registrar, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife. Neonatal Team (Reg/NNP) if indicated.

CATEGORY 4

Obstetric registrar and house surgeon, Anaesthetic Registrar, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), Midwife. Neonatal Team (Reg/NNP) if indicated.

APPENDIX C SURGICAL SAFETY CHECKLIST

OBSTETRIC SIGN IN

Led by anaesthetist after arrival in theatre*

1. **Patient has confirmed:**
   - Identity
   - Procedure and consent
2. **Caesarean section category?**
3. **Appropriate NICU support called?**
4. **Allergies?**
5. **Difficult airway?**
6. **Group and screen or blood available?**

***Category 1:** SIGN IN led by nurse during patient positioning

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OBSTETRIC TIME OUT

Led by obstetrician before skin incision

1. **Team members introduced by name and role.**
   (**Category 1 minimum:** obstetrician, anaesthetist, nurse, core midwife, neonatal doctor / nurse)
2. **Team has reconfirmed:**
   - Correct patient
   - Correct procedure
3. **Antibiotics given.**
4. **Concerns or anticipated critical events?**
   - Obstetrician
   - Anaesthetist
   - Nurse
   - Midwife
   - Neonatal doctor / nurse

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District Health Board
Te Poari Hauora o Waitaha

OBSTETRIC SIGN OUT

Led by nurse before patient leaves theatre

1. **Instrument, swab and needle counts are correct.**
2. **Correct procedure/s recorded.**
3. **Specimens correctly labelled / sent?**
4. **Postoperative VTE prophylaxis?**
5. **Equipment issues?**
6. **Concerns for post-op management?**
   - Surgeon
   - Anaesthetist
   - Other

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APPENDIX D NEONATAL TEAM CRITERIA FOR ATTENDANCE

NEONATAL TEAM ATTENDANCE AT BIRTH

Neonatal staffing for emergencies - note times below when there are less staff available.

Weekdays/Weekends/ Public Holidays 1630-0830 hrs following day	Two Registered Medical Officers (Reg) or Nurse Practitioners (NNP) on duty with the Associate Clinical Nurse Manager (ACNM). Two ACNM on duty 0830-2030hrs One may be called out on retrievals

The Neonatal Consultant ***is called in advance*** of a delivery when a senior clinician is appropriate or there is a reasonable chance that advanced resuscitation is possible using the Neobar tool for assessment of risk.

The Neobar tool indicates 3 criteria in red – cord prolapse, scar rupture/dehiscence and sinusoidal trace, where the Neonatal SMO should always be called.

NICU SMO should also be called for any maternal cardiorespiratory arrest, fetal abnormality at risk of causing cardiorespiratory compromise, multiple births < 30 weeks and placenta praevia and/or major haemorrhage with maternal compromise/fetal compromise.

NEONATAL ATTENDANCE AT THEATRE DELIVERY

The tables below are not meant to be exclusive and it should be known that the ACNM ***may*** attend a birth instead of the Reg/NNP if they are busy on the Neonatal Unit or already attending a birth.

Please **note** that there may be antenatal diagnoses that require a Neonatal SMO presence regardless of Category.

CLASSIFICATION FOR BIRTH		NEONATAL ACNM)/NNP/REG	ACNM	NEONATAL CONSULTANT
Any general anaesthetic		Yes	Yes	Yes If Reg/NP not credentialled

CLASSIFICATION FOR BIRTH	EXAMPLES *(not an exhaustive list)*	NEONATAL ACNM/NNP/REG	ACNM	NEONATAL CONSULTANT
Category 1		Yes	Yes	Not routinely – according to Neobar and via ACNM
	Maternal arrest cardio-respiratory	Yes	Yes	Yes ACNM will call
	Fetal bradycardia of < 100 bpm for > 5 minutes duration with no return to the baseline	Yes	Yes	Not routinely – according to Neobar and via ACMM

CLASSIFICATION FOR BIRTH	EXAMPLES *(not an exhaustive list)*	NEONATAL ACNM/NNP/REG	ACNM	NEONATAL CONSULTANT
	Absent variability (with no other explainable causes, eg. Magnesium Sulphate infusion, beta blockers (Labetalol))			
	Fetal scalp lactate ≥ 5.8	Yes	Yes	Not routinely – according to Neobar and via ACMM
	Cord prolapse with bradycardia	Yes	Yes	Yes ACNM will call
	Suspected scar dehiscence or uterine rupture	Yes	Yes	Yes ACNM will call
	Sinusoidal trace	Yes	Yes	Yes ACNM will call
	Placenta praevia and/or major haemorrhage with maternal compromise/fetal compromise	Yes	Yes	Yes ACNM will call

CLASSIFICATION FOR BIRTH	EXAMPLES *(not an exhaustive list)*	NEONATAL ACNM/NNP/REG	ACNM	NEONATAL CONSULTANT
Category 2 & 2"U"		Yes	Yes	Not routinely
	CTG abnormality (eg. late decelerations) +/- with scalp lactate 4.8 - 5.7	Yes	Yes	Not routinely – according to Neobar and via ACNM
	Breech presentation in active labour deemed unsuitable for vaginal birth	Yes	Yes	No Unless CTG concerns
	Chronically abnormal CTG	Yes	Yes	Not routinely – according to Neobar and via ACNM
	Significant fetal anomalies at risk of causing cardiorespiratory compromise	Yes	Yes	Yes ACNM will call

CLASSIFICATION FOR BIRTH	EXAMPLES (not an exhaustive list)	NEONATAL ACNM/NNP/REG	ACNM	NEONATAL CONSULTANT
Category 3 Caesarean section		Yes	Not routinely	No
	Failed induction of labour presuming indication for induction still exists	Yes	No	No
	Pre-eclampsia at term unsuitable for vaginal birth	Yes	No	No
	Suspected IUGR unsuitable for vaginal birth with normal CTG	Yes	No	No
	Delay in progress in labour with no evidence of maternal/ fetal compromise	Yes	No	No
	Women booked for elective section present in active labour, presuming indication for caesarean still exists and birth is not deemed imminent	Review reason for elective caesarean section as below		
	Delay in progress in labour	Yes	Yes	No

CLASSIFICATION FOR BIRTH	EXAMPLES (not an exhaustive list)	NEONATAL ACNM/NNP/REG	ACNM	NEONATAL CONSULTANT
Category 4 Elective caesarean section		Yes	Not routinely	No
	Twin/Triplet/higher multiple birth ≥30 weeks	Yes	Yes	Consider calling at other gestations
	Significant fetal anomalies or other fetal risk, eg. Rhesus disease	Yes	Yes	ACNM/REG/ NNP to consider calling SMO
	Infant of a diabetic mother	Yes	No	No
	Birth at 37-38 weeks in line with Ref.6971 Neonatal Attendance at Caesarean Section	Yes	No	No

Please note Cat 4 deliveries that are scheduled outside of an elective CS session should still be appropriately categorised at Cat 4 and not upgraded to Cat 3 merely because they are commonly referred to as 'acute' electives (ie. done by the acute team due to lack of elective capacity).

APPENDIX E ROLES AND RESPONSIBILITIES

MIDWIFE IN ATTENDANCE

- Care for woman and baby according to Multidisciplinary Caesarean Section Care Pathway
- Communicate with ACMM for Birthing Suite
- Communicate with Theatre team
- Document contemporaneously any resuscitation. Delegate this task if necessary

OBSTETRIC REGISTRAR/OBSTETRICIAN IN ATTENDANCE

- Inform ACMM for Birthing Suite
- Communicate with on call Anaesthetic Registrar
- Inform consultant Obstetrician
- Communicate with neonatal team or ensure that ACMM for Birthing Suite has done so
- Obtain informed consent for surgery and blood transfusion and document where practicable
- Supervise woman and ensure timely transfer to theatre
- Arrange for a surgical assistant
- Initiates TIME OUT as per the Obstetric surgical safety checklist

ASSOCIATE CLINICAL MIDWIFE MANAGER (ACMM) BIRTHING SUITE

- Communicate with theatre team, PACU Nurse and neonatal team
- For Category 1 the procedure is to page (22) 5333 4# so a call goes out for a "Category 1 Caesarean Section"
- Alert the teams if the woman's clinical condition is stable and delivery may be delayed in the event other more urgent emergencies supervene
- Ensure appropriate staffing and safety of other women in Birthing Suite
- Ensure that the category status has been clearly marked on the whiteboard and in theatre

ACNM OR NEONATAL REG/NP

- Attend in timely manner if called for Cat 1 delivery and confirm category status with Obstetric Reg/SMO and MW team
- For Cat 2 delivery assess and discuss as above
- Assess need for Neonatal SMO attendance according to Neobar tool risk assessment
- Inform Neonatal SMO and request attendance if appropriate
- Inform Neonatal SMO and request attendance if there is a change from regional anaesthetic to general anaesthetic before delivery of the baby and the Reg/NNP is not credentialled

ANAESTHETIC REGISTRAR

- Communicate with Obstetrician
- Communicate with ACMM for Birthing Suite
- Assess clinical situation and patient history to plan safe anaesthesia

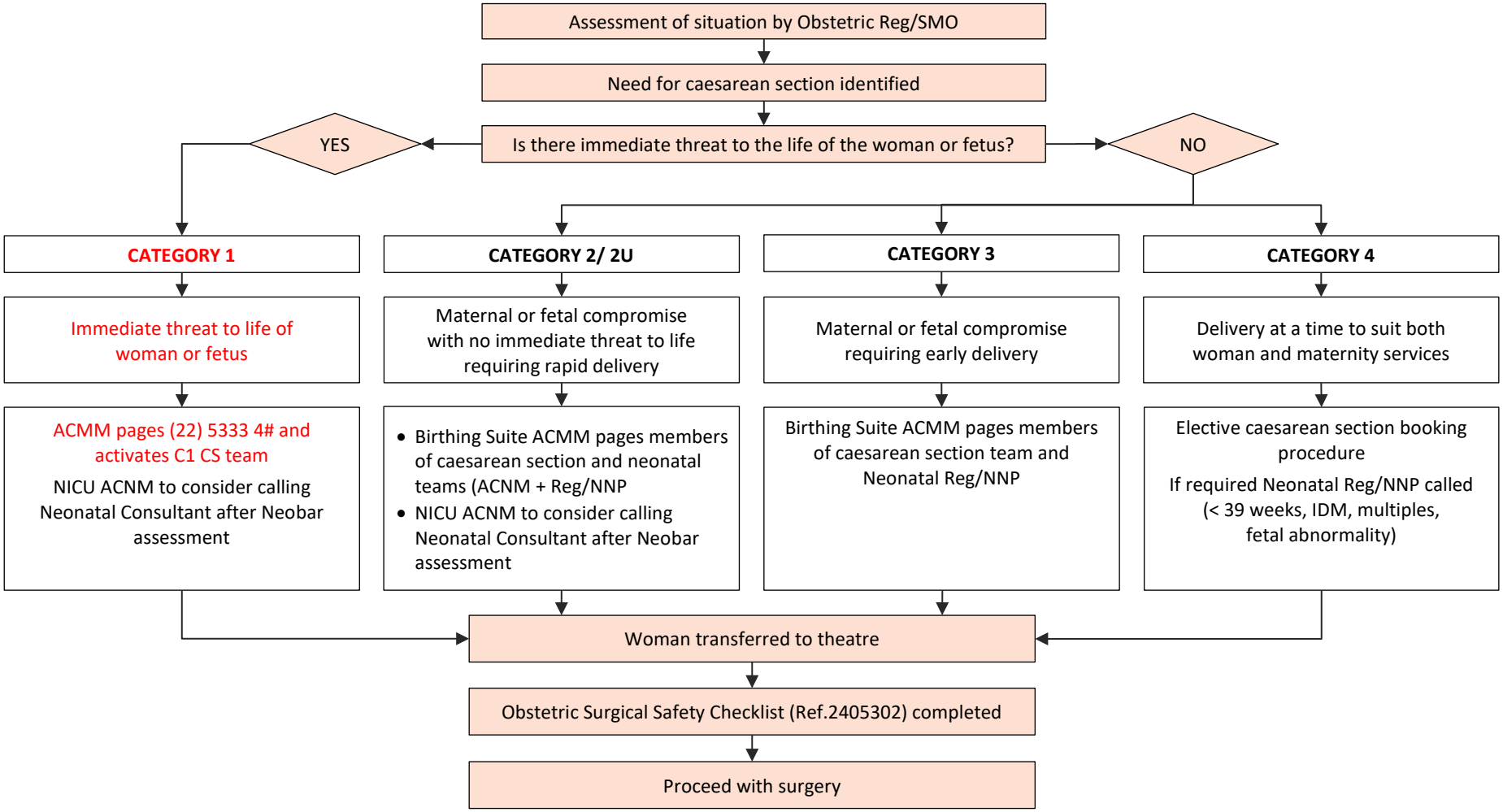
- Inform Anaesthetist Consultant on call if appropriate
- Liaise with Obstetric team and Anaesthetic Consultant re request and planning for Category 2'U'delivery, if requested
- Supervise woman and ensure timely transfer to theatre
- If anaesthesia changes from regional to a general anaesthetic, ensure that this has been clearly communicated to NICU team as they will need to request neonatal consultant presence
- Anaesthetic Registrar or Anaesthetic Technician performs SIGN IN as per the Obstetric surgical safety checklist, except for a Category 1

DAILY LIST COORDINATOR

- Display category of theatre delivery on theatre whiteboard at start of procedure
- Remove category from theatre whiteboard at finish
- Lead SIGN IN for Category 1
  Please note Category 4 deliveries that are scheduled outside of an elective CS session should still be appropriately categorised as Category 4 and not upgraded to Category 3 merely because they are commonly referred to as 'acute' electives (ie. done by the acute team due to lack of elective capacity)

APPENDIX F CATEGORISATION AND PREPARATION FOR THEATRE DELIVERY PROCESS

NOTE: categorisation may be upgraded at any time according to clinical concerns



APPENDIX G SUMMARY OF CLASSIFICATION AND COMMUNICATION FOR URGENT DELIVERY IN THEATRE

CATEGORY	DESCRIPTION	EXAMPLE OF INDICATIONS FOR CS	CALL PROCESS	TEAM
Category 1	Urgent theatre delivery with immediate threat to the life of the woman or fetus	Fetal bradycardia of < 100 bpm for > 5 minutes duration with no return to the baseline Absent variability (with no other explainable causes, eg. Magnesium Sulphate infusion, beta blockers (Labetalol)) Fetal scalp lactate ≥ 5.8 Cord prolapse with bradycardia Suspected scar dehiscence or uterine rupture Sinusoidal trace Maternal cardiorespiratory arrest Any other indication as determined by Obstetrician	ACMM pages (22) 5333 4# and activates Category 1 Caesarean Section team	Obstetric Registrar and House Surgeon(H/S), Anaesthetic Registrar, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife NICU ACNM (pager 5088) and Reg/NNP (pager 5019) decide in discussion with ACMM and obstetric team if it is appropriate to call the Neonatal SMO based on Neobar risk assessment. ACNM will perform that task
Category 2	Maternal or fetal compromise requiring rapid delivery	CTG abnormality, eg. complicated variable decelerations, fetal tachycardia, reduced variability Scalp lactate 4.8-5.7 Chronically abnormal CTG APH/abruption with concern for fetal compromise Fetal abnormality with impact on cardiorespiratory stability, eg. gastroschisis, diaphragmatic hernia, large omphalocele Multiple births<30 weeks Breech presentation in active labour deemed unsuitable for vaginal birth Any other indication as determined by Obstetrician	ACMM call theatre and neonatal team Obstetrician liaises with Anaesthetic Registrar	Obstetric Reg and H/S, Anaesthetic Registrar, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife NICU ACNM and Reg/NNP decide in discussion with ACMM and obstetric team if it is appropriate to call the Neonatal SMO based on Neobar risk assessment. ACNM will perform that task
Category 2 'U'	Maternal or fetal compromise requiring rapid delivery where already occupied		Obs team call theatre and neonatal team Obstetrician liaise with Anaesthetic Registrar	As above

CATEGORY	DESCRIPTION	EXAMPLE OF INDICATIONS FOR CS	CALL PROCESS	TEAM
Category 3	Maternal or fetal compromise requiring early delivery	Failed induction of labour presuming indication for induction still exists Pre-eclampsia at term unsuitable for vaginal delivery Suspected IUGR unsuitable for vaginal birth with normal CTG Delay in progress of labour with normal CTG Women booked for elective section who present in active labour, presumed indication for caesarean still exists and vaginal birth is not imminent Any other indication as determined by Obstetrician	ACMM call theatre and neonatal team Obstetrician liaises with Anaesthetic Registrar	Obstetric Reg and H/S, Anaesthetic Registrar, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and second Caesarean Nurse), PACU Nurse, Midwife Neonatal Team (ACNM *and* Reg/NNP) if indicated
Category 4	No maternal or fetal compromise Birth at a time to suit the woman and the maternity services	Planned elective Caesarean Section Planned elective Caesarean Section and delivered outside usual elective time slot with no other complicating factors	Book through elective system	Obstetric Reg and H/S, Anaesthetic Registrar, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and second Caesarean Nurse), PACU Nurse, Midwife. Neonatal Team (ACNM *and* Reg/NNP) if indicated
High volume workload cases requiring second theatre activation	3rd/4th degree tear repair Manual removal of placenta To assist Birthing Suite flow		Obs team call Obstetric Anaesthetic Registrar and OT coordinator to determine timing of case and location. ACMM calls Neonatal team with details once confirmed	Obstetric Reg and H/S, Anaesthetic Registrar, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and second Caesarean Nurse), PACU Nurse, Midwife Neonatal Team (ACNM *and* Reg/NNP) if indicated