Western Cape Government

TYGERGBERG HOSPITAL
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14 February 2025

Standard operating procedure: EMERGENCY CAESAREAN DELIVERIES

→ENSURE THAT THERE IS A VALID INDICATION FOR ALL CAESAREAN DELIVERIES

→ALL WOMEN SHOULD BE ADEQUATELY COUNSELLED REGARDING THE INTENDED PROCEDURE

CAESAREAN DELIVERY: MOST COMMON INDICATIONS FOR EMERGENCY CS

- Previous C/S x 2, or Classical C/S in labour
- Failure to progress during labour
- Fetus not tolerating labour, non-reassuring fetal status, fetal distress
- Failed induction of labour
- Abnormal Placentation (Placenta Previa, Vasa Previa, Placenta Accreta)
- Mechanical obstruction to vaginal birth (Abnormal pelvis/spine, large leiomyoma)
- Maternal Medical Condition
- Multiple Gestation
- Big baby (>4,5kg in non-diabetic mother)
- Breech in labour (Failed ECV, ECV Contraindicated, mother not prepared to do vaginal breech delivery)
- Fetal malpresentation (i.e. Transverse lie) in labour

CAESAREAN DELIVERY: BOOKING of EMERGENCY CASES:

1. Duty of the MO or Registrar in Labour Ward

- All parties (surgeons, anaesthetist, midwife, theatre nurses, paediatrican) should be **invested in effective theatre time and patient flow management.**
  - Enquiring about elective cases that can be done and managing theatre and patient flow remains the primary responsibility of the obstetric doctor covering theatre, as they are the point of communication with obstetric colleagues and wards.
- All emergency CS decisions should be made by **two clinicians; of which one is the consultant on duty** for the labour ward (day or night).
- The clerking, consent and prescription chart is the responsibility of the attending Dr in labour ward, including:
  - Prescribe premedication, including prophylactic antibiotics
  - Evaluate for thromboprophylaxis (TED stockings and/or Heparin)
- Refer to SOP for Counselling for Caesarean Delivery of a patient.
- Refer below for perioperative issues for Caesarean Delivery of a patient
- Patients being booked for emergency CS must be
  - Discussed with the anaesthetist (on call for labour ward)

- Correctly **coded according to urgency of the CS** and booked at 4849
- Discussed with the paediatrician (on CS bleep)

- All 3 pages of the sterilisation consent **including the counselling checklist** must be completed if sterilisation requested
- Cases should be triaged according to the Urgency of CS triage recommendations:

Urgency of Caesarean Section Classification

Category	**Clinical scenario**	**Aimed timing (as a guide only) from decision to incision**
Category 1 - Red	Immediate threat to the life of the woman or fetus (for example, suspected/confirmed uterine rupture, major placental abruption, cord prolapse, recurrent late decelerations that does not respond to IPR ,or persistent fetal bradycardia)	Within 30min
Category 2 - Orange	Maternal or fetal compromise which is not immediately life-threatening (for example cephalo-pelvic disproportion, malposition/malpresentation in active labour, abnormal CTG that responds to IPR or recovers, delivery of the second twin when vaginal delivery fails)	Within 75 min
Category 3 - Yellow	No maternal or fetal compromise but needs early birth (for example malposition/malpresentation in latent labour, poor progress in labour, failed induction for medical conditions,	Within 6 hours
Category 4 - Green	The next available non-emergency slot (usually not on the emergency list, but some cases that need constant fetal monitoring e.g. fetal anomalies, or complex cases waiting for daylight delivery due to may fall in this category)	Within 24 hours

See TBH CS Triage document for full details.

- These cases should be documented on the labour ward board in the corridor and communicated with the team
- If there is more than one "Red" case, discuss it with the labour ward consultant to assist with triage and opening of a second theatre or interruption of the planned CS list.
  - See opening of second theatre SOP for details.

2. Duty of Sister in charge of the Emergency Theatre (labour ward west theatre)

- If no emergency case has been booked by 07h00 (and there are no elective/planned cases ready to be done) then J5 should be contacted to find out whether any post-partum sterilisations are ready
- Orders for gowns and linen, and instruments etc. must be placed the day before so that there are no undue delays in the morning

3. Duty of Nursing staff in the labour ward

- Patients must be fully prepared, and the patient's valuables must be written up
- Urinary catheter needs to be sited if the patient doesn't have one yet
- The MO/Reg must immediately be notified if a patient's ward Hb is < 10g/dl

4. Duty of Anaesthetic Registrar on Duty

- Handover from night anaesthetist occurs in C2A emergency theatre at 06:45
- If no emergency caesarean cases and no postpartum sterilizations are booked, elective/planned caesarean sections can be done as booked by the obstetric team.
- Walk-in planned cases (see Planned CS SOP) can also be done on this list
- Familiarize yourself with high-risk patients in OCCU who may require emergency surgery and discuss with the senior registrar and /or consultant as needed.
- After hours, when no epidural person is on duty, assess patients referred for epidurals and plan epidural placement in conjunction with the senior anaesthetic registrar on call.
    - Planning should take into consideration the C2A emergency list, the state of other emergency lists and the availability of anaesthetic assistance should an emergency CS be booked during epidural placement.
- If assistance or consultation in OCCU is needed, it can be discussed with the registrar in C2A emergencies who will liaise with the anaesthetic consultant covering C2A or the senior registrar after hours.
- Assessing, consenting, planning and performing an epidural takes at least one hour.
    - During this time, the C2A emergency list can change dramatically.
    - Epidurals remain the primary responsibility of the epidural person.
    - An epidural that needs to be performed by the emergency theatre anaesthetist after hours requires careful planning in liaison with the senior registrar on call.
    - After hours with no epidural person on duty, assess OCCU referrals for anaesthetic evaluation, assistance with difficult intubations and assistance with difficult central IV access
- Ensure effective C2A recovery turnover as per the C2A recovery SOP
- Help with the flow of the pts and help to ensure good theatre management

5. Duty of Paediatrician on Call

- Once the paediatrician on for emergency CS is notified of a case, they should immediately present to the theatre

6. Duty of Intern in J5 (regarding post-partum sterilisations)

- As a priority, on arrival in J5 in the morning, identify any patients that have expressed a wish for post-partum sterilization
- If there is no space available on any list, offer post-partum IUD with an interval sterilization later (obtain a date from family planning clinic, X4447).
    - Determine Hb, check for co-morbidities that might influence anaesthetic risk as well as the number of days postpartum
    - Take consent after adequate counselling.
    - Call consultant or MO doing the emergency list for the day by 08h00 on the latest with a list of names (bleep or call 4700 in theatre)
    - If the patients are cancelled 2 days in a row due to lack of theatre time, consider booking them for an interval sterilization or insertion of an IUCD, 6 weeks post-partum with Family Planning Clinic (x4447)

7. Duty of J5 Nursing Staff

- Help identify patients for sterilization to help the Intern to prioritise them early in the morning
- Keep NPO from 00h00 if patient expresses a wish for T/L, even if not consented yet
- Do Hb on all patients awaiting T/L, inform the intern immediately if the Hb is < 10g/dl
- If theatre has not sent for a patient by 14h30, please call 4713 or 4707 to confirm with Dr in charge of the emergency list whether patients are possibly cancelled (due to lack of theatre time)

8. Duty of C2A midwives

- The shift leader must assign a midwife responsible for the Emergency Obstetric list
- This midwife must be in theatre by 07h30 to check the resuscitation equipment
- Notify the Paeds (if not present yet) once the spinal is sited.
- Do umbilical cord gas if indicated, as well as cord blood for chromosomes if requested by Geneticist or Fetal Medicine, and/or Rhesus status if mum Rh Neg.

See also the following SOPs

- Counseling for Caesarean Section
- Planned Caesarean Delivery SOP
- Caesarean section technique and steps
- Recovery R2 SOP
- Opening of second CS theatre SOP

Morning huddle

- The team involved with the emergency and planned CS list should meet at 7:30 in their respective theatres to discuss the plan for the day explicitly discuss the following, the responsible obstetric surgeon for the day will lead the huddle:
  - Number of cases
  - Expected complicated cases on the list
  - Post operative bed availability
  - Teaching and training plans for the day
  - Lunch break for theatre staff
  - Any shortages of staff, consumables or theatre packs.
  - Problems with theatre functioning and equipment

Teaching and Training

- Tygerberg is a training hospital and has a duty towards interns and registrars to allow opportunities for training, even on emergency lists.
- This must be balanced against service delivery.
- Patient safety remains the priority.
- All teams involved, anaesthetic registrars, interns and students, obstetric registrars, interns and students and nursing staff and students must explicitly communicate training intentions and needs for the day.
- **Training should not delay or extend any case by more than 20 minutes; if this happens, the senior responsible should take over the task (either spinal, scrub nurse or caesarean section). Any member of the team can point this out if the trainer trainee pair is not aware.**
- Ideally one case per list should be identified for training (obstetrics and anaesthetics), this should be clearly communicated.

Familiarise yourself with these additional SOPs:

- Emergency Caesarean Delivery SOP
- Counselling for Caesarean Section SOP
- Caesarean section technique and steps SOP
- Recovery R2 SOP
- Opening of second CS theatre SOP

AUTHORISED BY	GS Gebhardt
COMMITTEE RESPONSIBLE	L de Waard, GS Gebhardt,
DATE REVISED	11/02/2025
DATE EFFECTIVE	14 February 2025
REVIEW DATE	14 February 2028
EVIDENCE	Evidence basis for the above decision is available on request

Signed: GS Gebhardt

Head: general specialist services; Obstetrics and Gynaecology