TYGERGBERG HOSPITAL
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14 February 2025

Standard operating procedure: PLANNED CAESAREAN DELIVERIES

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

→ALL WOMEN SHOULD BE ADEQUATELY COUNSELLED REGARDING THE INTENDED PROCEDURE

→IN CASES OF A PLANNED CAESAREAN DELIVERY A "C/S SAFETY CHECKLIST" MUST BE COMPLETED AND SIGNED BY THE RESPONSIBLE CONSULTANT

The terminology "Elective Caesarean Section" will be replaced with "Planned Caesarean Section", as Caesarean Sections are not elective procedures.

Obstetric planned procedures, unlike most other planned procedures, are not cold cases and can usually not be postponed for more than 72 hours as there may be a risk of the patient going into labour. The morbidity of a planned CS is much lower than for an emergency CS.

To organise a planned CS, to start at a specific time needs coordination from 9 different role players (anaesthetist, surgeon, assistant, theatre sister, theatre manager, porter, midwife, paediatrician, ward sister). This protocol is to help each one involved to streamline the process so that we optimize theatre time.

PLANNED CAESAREAN DELIVERY: MOST COMMON INDICATIONS:

- Previous C/S x 2, or previous Classical C/S
- Previous C/S x 1 (VBAC contra-indicated, or declined)
- Failed induction of labour
- Abnormal Placentation (Placenta Previa, Vasa Previa, Placenta Accreta)
- Mechanical obstruction to vaginal birth (Abnormal pelvis/spine, large obstructive leiomyoma)
- Maternal Medical Condition
- Multiple Gestation
- Big baby (>4,5kg in non-diabetic mother)
- Breech (Failed ECV, ECV Contraindicated, decline vaginal birth)
- Fetal malpresentation (i.e. Transverse lie)

CAESAREAN DELIVERY: BOOKING of CASES:

1. **Duty of the High-Risk Clinic**
   A. Booked cases (on the HRC list) is **only for women who need to deliver on that exact date, due to medical, fetal, or anaesthetic concerns.** For the rest; see point B below
      - The clerking, consent and prescription chart is to be done by the admitting Dr in HRC
        - Including: CS Safety Checklist
      - Prescribe premedication, including DUAL prophylactic antibiotics
      - Evaluate for thromboprophylaxis (TED stockings and/or Heparin)
      - Refer to SOP for Counselling for Caesarean Delivery of a patient.
      - Refer to Section D for perioperative issues for Caesarean Delivery of a patient.
      - Contraceptive counseling and consent should be part of CS consent discussion and indicated on the consent form, it this is either an intra-uterine contraceptive device or tubal ligation.
      - All relevant pages of the perioperative consent document should be completed
      - The minimum number of clients that can be accommodated on one day are as follows:

Admission on	List on	Total **Number** of Cases
Sunday	**Monday**	**6**
Monday	**Tuesday**	**6**
Tuesday	**Wednesday**	**4 – unless anaesthetic and theatre team available**
Wednesday	**Thursday**	**6**
Thursday	**Friday**	**6**

- The consultant responsible for the clinic should book the cases in the folder at the appropriate gestation and slot and include information on the due date and contact number.
  - If the booking list is full, ask the clerk to check if someone may have already delivered
  - Do not book any additional cases on the planned CS list (see point B below).
- If the patient has severe medical comorbidities or the fetus may need constant fetal monitoring before the operation, admit to ward F2. Otherwise, to ward J4.
  - Please ask patients to come in early on the day of admission.
  - After obtaining their folder they must go to Fetal Evaluation Clinic for a CTG and then present at F2 or J4 on the latest at 09h00.

B. Cases that have an indication for a planned CS but **without specific maternal, anaesthetic or neonatal risks**, including those with 1 or 2 previous CS but normal BMI and otherwise healthy will **not be booked on the list.** They are usually only referred at 36 weeks**.**
Instead:
   - Do all the booking paperwork as above
   - Book a 38-week visit to their local clinic, for BP/Urine check
   - Ask them to present to the labour ward admissions (C2A, NOT HRC) area at 07h00 on 39 weeks 0 days (give them the exact date, even if it is a weekend or public holiday; and note this date in their folder as well as on their clinic card).
     - They must arrive NPO and with the necessary clothes, in case they can be done that day.

- The labour ward consultant will review them after the labour ward round in the morning and decide, according to the capacity on the labour ward emergency and planned CS lists, if there is the capacity to do the CS THAT day.
    - If not, the patient will then not be admitted but will return the next day for another review.
    - Make a note in the folder, explaining the situation (RED Status)
    - When she presents for the third day, she will then be admitted regardless of the capacity in the obstetric theatres.
- Patients will receive a letter and be counselled regarding the CS capacity.

2. **Duty of J4 Medical Officer**
    - Get a copy of the BOOKING LIST from the HRC at 07h30 (before the ward round) and confirm with the ward clerk if any cases have already delivered.
    - Check with the Registrar in F2 for any patients admitted there, that are waiting for planned for CS.
    - Review each patient admitted for planned CS –check the gestation, indication, consent, prescription (premeds, TED stockings/Heparin, PMTCT meds, post- operative antibiotics), Hb and CTG (from FEC).
    - Women scheduled for Cerclage procedures are the responsibility of the doctor allocated to J4.
    - Compile the theatre list in consultation with the ward consultant before 13:00.
        - Triage according to waiting times and indication, only include women that are admitted to the hospital.
        - If there are cases that are likely not to have been done on the previous day's list, indicate their names clearly on the list for the next day, as they should get priority, if they were not done during the night.
    - The list should not exceed the numbers as outlined above
    - The list must be handed to the departmental admin clerk personally (not later than 13h00) so that it can be distributed to the theatres. If the clerk is not on duty, the list must be handed to the secretary at R2 personally.
    - The consultant on ward duty, theatre consultant, and Medical Officer or Registrar that will be doing the list should also receive a copy of the list.

C. Duty of nursing clerk (J4)

- Receive the FINAL list from the MO in J2
- Make five photocopies and distribute to the following: Labour ward (one copy for the maternity notice board and one for the nursing shift leader), and G2 baby ward.

D. Duty of Sister in charge of the Obstetric Elective Theatre [labour ward east theatre]

- The first elective case should be sent for at 07h00
- Ensure adequate staff allocation for the day.
- Electives need to start with anaesthetic preparation by 07h30
- Incision time should be at 8:00 at the latest.
- Orders for gowns and linen, instruments etc. must be placed the day before so that there are no undue delays in the morning.
- Communicate any staff or stock shortages clearly during the morning huddle.

E. Duty of Nursing staff in J2 (or J4 / J5 as necessary)

- Patients must be fully prepared the day before surgery.
- The MO in J2 must immediately be notified if a patient's ward Hb is < 10g/dl.
- The night staff must write up the patient's valuables, so that there are no delays when theatre sends for the patient.
- VTP Drugs should be administered by 5am the morning of elective CS if indicated.
- Pre-operative medication should be administered just before the patients leaves the ward.

F. Duty of surgeon on duty for the Obstetric Planned CS List (MO or registrar)

- Familiarise yourself with list of patients the day before.
- Discuss any complicated cases with the theatre consultant, as they are responsible to help you if needed.
- Discuss training plan for the list, your own training needs as well as those of the intern.
    - Ideally one case per list should be identified for intern training.
- Be punctual on the day of the list, the clinician should be present in theatre no later than 07h30.
- Call anaesthetist (6123 or bleep) if not in theatre already by 07h30
- Confirm with theatre sister that she has sent for patient and that the porter has indeed left to fetch the patient, before starting to scrub. Otherwise fetch the patient yourself.
- When scrubbing for a case that is already on the table, ask the floor nurse to send for the next case.
- As you are the person doing the caesarean section, you are also responsible for the decision and indication.
- Ensure there are beds in the post-natal wards, and clearly communicate this to the recovery room nursing staff.
    - If there are no post natal beds escalate the matter to the consultant on ward duty.
- As soon as you have done the WHO safety check, ask for confirmation that they have sent for the next case.
- Make sure there are proper post-operative instructions (observations etc) on the nursing instruction chart.
- Communicate al difficult cases to the doctor in charge of the post-natal ward, which the patient will be going to after the procedure.
- Do a post-operative round on all complicated cases.
- Familiarise yourself with the recovery room procedures (see below)

G. Duty of Intern assisting and training for C/S

- Familiarise yourself with patients the day before.
- Be punctual on the day of the list (be in theatre no later than 07h30).
- Familiarise yourself with the evidence-based C/S technique in the ESMOE training module, and ensure that you are able to tie a good surgical knot BEFORE coming to theatre.
- Once the patient is in theatre, inform the Sr in charge in C2A that an elective C/S is on the table and that a midwife is required for the delivery.
- Discuss your training plan from the day with the responsible registrar / consultant for the day as well as the rest of theatre team.

H. Duty of Anaesthetic Registrar on Duty

- The elective list will be available the day before, and the Registrar should familiarise themselves with the list.
    - If there are less than 6 cases booked per list, expect late additions during the morning (see above)
- The anaesthetist should be in theatre no later than 07h30.

- The anaesthetic team should manage effective C2A recovery turnover as per the C2A recovery SOP.
    - Recovery room holdup due to lack of ward beds needs to be communicated with the obstetric team.
    - Ongoing holdup needs to be reported the area manager of Obstetrics as well as the Obstetric consultant responsible for the theatres (6587) by 14:00 at the latest.
- The anaesthetist should help with the flow of the patients and help to ensure good theatre management.
- The labour ward consultant will liaise personally with the registrar in cases extra cases are added.

I. Paediatrician on Call

- A list will be available the day before surgery
- Arrive in theatre by 08h00 at the latest to familiarise yourself with the case.
- Introduce yourself to the surgeon and labour ward team and exchange contact details to ensure quick and easy communication.

J. Duty of Labour Ward Midwife

- The labour ward nursing shift leader must assign a midwife responsible for the Planned Obstetric Theatre List [Monday-Fridays].
- This midwife must be in the Planned Obstetric theatre (Labour Ward East) by 07h30 to check the resuscitation equipment and to prepare for the baby.
- Bleep Paediatrician on for CS (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.

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.
- 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 planned list should be identified for intern 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

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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