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<b>Department:</b>	Obstetrics and Gynecology (Ward)		
<b>Document:</b>	Departmental Policy and Procedure		
<b>Title:</b>	Management of Elective Caesarean Section		
<b>Applies To:</b>	All Obstetrics and Gynecology Staff		
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## 1. PURPOSE:

1.1 To describe the management of elective caesarean section (CS).

## 2. DEFINITIONS:

2.1 **Caesarean Delivery (C-section)-** is a surgical procedure used to deliver a fetal through incisions in the abdomen and uterus.

## 3. POLICY:

3.1 The physician will decide if the patient is to be admitted for elective caesarean section or not.

3.2 Planned CS should not routinely be carried out before 39 weeks.

3.3 Written and signed consent will be obtained by the obstetrician.

## 4. PROCEDURE:

### 4.1 Preoperative:

#### 4.1.1 Nurses Role:

4.1.1.1 Welcome patient and orient to environment.

4.1.1.2 Ensure that the valuable forms are explained and signed.

4.1.1.3 Ensure the patient has a good understanding of the procedures involved leading up to the LSCS.

4.1.1.4 Complete the hospital admission form.

4.1.1.5 Complete Operating Room documentation and prepare the patient (neonate) notes.

4.1.1.6 Perform abdominal palpation and perform baseline CTG.

4.1.1.7 Perform baseline vital signs.

4.1.1.8 Collect urine specimen for analysis.

4.1.1.9 Inform the physician for admission and ensure OR notification has been send and consent has been explained and signed.

4.1.1.10 Ensure all blood work is up to date and repeated as necessary. Take blood for blood grouping and cross-matching.

4.1.1.11 Ensure patient is seen by anaesthetist.

4.1.1.12 The patient will remain NPO for 8 hours prior to surgery.

4.1.1.13 Ensure that pediatrician is aware of transfer of patient operating room.

4.1.1.14 Assist patient onto OR bed ensuring that the patient privacy is maintained.

4.1.1.15 Once documentation is completed legibly and signed, accompany any patient to OR and hand-over patient to OR personal checking all patient details against the patient ID band.

- 4.1.1.16 If the pregnancy is less than 37 weeks and there is suspected problem with the neonate the neonatal intensive care unit nurse will receive the neonate for the OR nurse.
- 4.1.2 Anesthetist Role:
  - 4.1.2.1 Pregnant women having a CS should be given information on different types of post-CS analgesia so that analgesia best suited to their needs can be offered.
  - 4.1.2.2 Women who are having CS should be offered regional anaesthesia because it is safer and results in less maternal and neonatal morbidity than general anaesthesia. This includes women who are diagnosed with placenta previa.
  - 4.1.2.3 Women who are having induction of regional anaesthesia for CS should be cared for in OR because this should increase patient anxiety.
  - 4.1.2.4 Women who are having a CS under regional anaesthesia should be offered with intravenous ephedrine or phenylephrine, and volume pre-loading with crystalloid or colloid to reduce the risk of hypotension occurring during CS.
  - 4.1.2.5 Each maternity department should have a drill for failed intubation during obstetric anaesthesia.
  - 4.1.2.6 To reduce the risk of aspiration pneumonitis women should be offered antacids and drugs (such as H2 receptor antagonists or proton pump inhibitors) to reduce gastric volumes and acidity before CS.
  - 4.1.2.7 Women having a CS should be offered anti-emetics (either pharmacological or acupuncture) to reduce nausea and vomiting during CS.
  - 4.1.2.8 Intravenous ephedrine or phenylephrine should be used in the management of hypotension during CS.
  - 4.1.2.9 The OR table for CS should have a lateral tilt of 15 degrees, because this reduces maternal hypotension.
- 4.1.3 Surgical Techniques for CS:
  - 4.1.3.1 Healthcare professionals should wear double gloves when performing or assisting at CS on women who have tested positive for HIV/HBV/HCV
  - 4.1.3.2 General recommendations for safe surgical practice should be followed at CS to reduce the risk of HIV infection of staff.
  - 4.1.3.3 CS should be performed using transverse abdominal incision because this is associated with less postoperative pain and an improved cosmetic effect compared with a midline incision.
  - 4.1.3.4 When there is a well formed lower uterine segment, blunt rather than sharp extension of the uterine incision should be used.
  - 4.1.3.5 Intraperitoneal repair of the uterus at CS should be undertaken.
  - 4.1.3.6 The uterine incision should be sutured with two layers.
  - 4.1.3.7 Neither the visceral nor the parietal peritoneum should be sutured at CS.
  - 4.1.3.8 In the rare circumstances that a midline abdominal incision is used at CS, mass closure with slowly absorbable continuous sutures should be used because this results in fewer incisional hernias and less dehiscence than layered closure.
  - 4.1.3.9 Routine closure of the subcutaneous tissue space should not be used, unless the woman has more than 2 cm subcutaneous fat, because it does not reduce the incidence of wound infection.
  - 4.1.3.10 Obstetricians should be aware that the effects of different suture materials or methods of skin closure at CS are not certain.
  - 4.1.3.11 Women having a CS should be offered prophylactic antibiotics, such as single dose Ampicillin or the first generation Cephalosporin, to reduce the risk of postoperative infections.
  - 4.1.3.12 Women having a CS should be offered thromboprophylaxis because they are at increased risk of venous thromboembolism. The choice of method of prophylaxis.
- 4.2 Postoperative:
  - 4.2.1 The Nurse should check:

- 4.2.1.1 Vital signs (BP and Pulse) ½ hourly 2 hours, if stable record 1 hourly for 4 hours.
- 4.2.1.2 Temperature 4 hourly.
- 4.2.1.3 Lochia Color.
- 4.2.1.4 Wound site, if there is any bleeding.
- 4.2.1.5 Drainage, Hemovac and Catheter, Colour and Amount if in situ 4 hourly until discharge.
- 4.2.2 IV fluids to be as ordered by the physician.
- 4.2.3 The patient should be encouraged to mobilize as soon as possible.
- 4.2.4 Adequate analgesia to be given as ordered.
- 4.2.5 On day 1:
  - 4.2.5.1 Hemovac drain removed on physicians order in situ.
  - 4.2.5.2 Progress from liquid diet to full diet as tolerated.
  - 4.2.5.3 Mobilized.
  - 4.2.5.4 Observe that patient passes urine after catheter has been removed.
- 4.2.6 On day 2:
  - 4.2.6.1 Shower.
  - 4.2.6.2 Mobilization.
  - 4.2.6.3 Oral Analgesia.
  - 4.2.6.4 4 hourly vital signs (temperature, pulse and blood pressure).
- 4.2.7 On day 3:
  - 4.2.7.1 CBC.
  - 4.2.7.2 Shower.
  - 4.2.7.3 If Pfannenstiel incision, wound dry and clean, patient can go home.
- 4.2.8 On day 4, 5 and 6:
  - 4.2.8.1 Suture removal per physicians order.
  - 4.2.8.2 Exercise (observation only and demonstrate how to do neonates bath).
  - 4.2.8.3 Triflo or breathing exercises commenced soon after return from OR or respiratory Therapist (if indicated).
  - 4.2.8.4 Patients are discharged from hospital with a postnatal appointment to Gyne clinic.

## 5. MATERIAL AND EQUIPMENT:

N/A

## 6. RESPONSIBILITIES:

- 6.1 Physician
- 6.2 Nurses








## 7. APPENDICES:

N/A

## 8. REFERENCES:

- 8.1 National Collaborating Centre for Women's and Children's Health. Caesarean Section Clinical Guideline. London:RCOG press, April 2004.
- 8.2 Guidelines for Obstetrics & Gynecology, Ministry of Health, 2013.

9. APPROVALS:

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