Obstetric theatres and intervention room operational policy

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Key Amendment

Date	Amendment	Approved by
17th Jan 2020 21st August 2020	Updated document Updated document	Maternity Governance Meeting

Introduction

The obstetric theatres are dedicated to providing elective and emergency obstetric procedures. Obstetric theatre complex consist of:

- Worcestershire Royal Hospital (WRH): One anaesthetic room, one scrub room, one main operating theatre, a recovery room and an intervention room adjacent to the main obstetric theatre.

Scope of this document

This policy provides an overview of the obstetric theatre service provided.

Definitions

CPD	Continuous professional development
DS	Delivery Suite
HCA	Health care assistant
IR	Intervention Room
MSW	Maternity support worker
ODP	Operating Department Practitioner
RM	Registered Midwife
RN	Registered Nurse
ATP	Assistant Theatre Practitioner

Responsibility and Duties

- To provide and ensure a safe, effective and timely obstetric surgical service.
- To provide dedicated suitable facilities and equipment to enable the appropriate procedures to be carried out with minimal delay when required.
- Maternity Inpatient Matrons are responsible for operational, governance and finance management

- Governance arrangements will be discussed and agreed via obstetric and anaesthetic directorate governance committee meetings and labour ward forum.
- To use the WHO surgical checklist on 100% of obstetric theatre and intervention room cases in line with Trust protocol
- The Lead consultant anaesthetist and consultant obstetrician will take a key role in overseeing the day to day operational management in obstetric theatres and WRH intervention room.
- The Delivery suite coordinators will ensure the effective leadership, co-ordination and theatre utilisation, including the effective and timely delivery of emergency surgical procedures
- The Obstetric theatre nurse is responsible for day to day management of theatre / intervention room and staff in liaison with the delivery suite coordinator and Delivery Suite and Obstetric Theatre Ward Managers.
- The obstetric theatres and intervention room have an establishment of staff including scrub practitioners, anaesthetic assistants , recovery practitioners and circulating HCA/ MSW
- Clinical responsibility remains with the consultant surgeon and consultant anaesthetist who are either involved with, or directly or indirectly supervising the care of the patient.

Training:

- Experienced Obstetric Anaesthetic, midwifery and nursing staff are responsible to provide relevant education and training to junior/ new staff.
- The main obstetric theatre staff are employed and managed by the Women's and Children's Directorate; their Maternity line managers will perform PDRs and agree leave
- Intervention room staff are employed and managed by SCSD. The staff's PDRs are carried out by the main theatre staff and their leave is agreed and covered by main theatre

WRH Intervention Room (IR)

The intervention room service is designed to minimise the risk to mothers and babies requiring emergency Caesarean section and minor procedures when the obstetric theatre is in use. The risk will be mitigated but not eradicated due to lack of 24 / 7 staffing model for the intervention room. The use of the intervention room is intended to minimise interruptions to the elective caesarean section list.

There are two theatre teams provided all day (8am-6pm) from Monday to Thursday to enable safe management of emergency obstetric cases within the Maternity department alongside an elective operating list.
On a Friday there is only one theatre staffed for emergencies. Provision of staff for any additional operating on a Friday would be not guaranteed but, as with out-of-hours provision, early communication with main theatres is essential to find a safe solution.

Emergency delivery out of hours should aim to prioritise safety of mother and baby. All out of hours maternity cases should occur in the maternity department, using the IR if the main obstetric theatre is in use. It is inherently safer to move main theatre staff to maternity rather than transfer a compromised mother and or baby out of the department. Any deviation to this should be discussed with and agreed with senior obstetrician and anaesthetist as well as decision maker filing a Datix report to monitor use out of policy

WRH Intervention Room Inclusion criteria

Any **Obstetric** procedure deemed necessary by Consultant Obstetrician and Anaesthetist covering Delivery suite to either facilitate the smooth running of the elective Caesarean section list or mitigate harm to mother and/or baby in labour. Examples will include:

- Category one, two or three caesarean section
- Perineal tears which require repair under spinal or general anaesthesia
- Management of breech delivery
- Management of Twin delivery
- Trial of assisted delivery
- Manual removal of placenta
- Examination under anaesthesia (EUA) /management of primary PPH
- Dural tap blood patch

WRH Intervention Room Exclusion criteria.

The following cases would not be appropriate:

- Any gynaecology elective or emergency procedures i.e. termination of pregnancy
- Evacuation of retained products of conception (ERPC).
- Hysterotomy at any gestation

Staffing and operational details:

All obstetric emergencies requiring surgical intervention should be performed in obstetric theatres. The Obstetric theatres are available 24 hours a day, 7 days a week.

WRH Obstetric Theatre

When the Obstetric theatre is in use emergency cases will be done in the intervention room. If allocated Maternity staff are not available then appropriate staff from main theatre and or delivery suite will need to be redeployed. If any staff are from main theatre then they will be required to report to the Intervention room rather than the patients being transferred upstairs to main theatre – both during working, as well as out of hours.

It cannot be assumed that theatre staff would be able to provide a scrub team 24/7 and main theatre staffing accounts for one obstetric anaesthetic assistant for emergency theatre out of hours. Running 2 obstetric emergencies out of hours may not be possible and puts significant stress on staff in both Maternity and theatres. Prompt and early communication with main theatre staff is imperative if use of a second theatre cannot be avoided.

- Emergency obstetric cases from 7am onwards should be conducted in IR to prevent elective list delays.
- Scrub and circulating staff are provided by Maternity from 08:00-18:00 on days with morning and afternoon elective lists. Wherever possible one of the three staff will be a Band 4 Assistant Theatre Practitioner.
- Anaesthetic assistants/recovery staff provide cover from 0800-1800hrs. Between 6pm and 8pm one anaesthetic assistant is provided from main theatre
- Out of hours scrub cover is provided by scrub trained midwives and circulating staff (MSW) as identified on E-rostering.
- The anaesthetist covering delivery suite and available for the intervention room will carry bleep 701. The operating obstetrician will inform the 701 bleep holder about emergency cases to be performed in the intervention room. Patients whose surgery is performed in the intervention room will have their recovery in the same room, recovery room if available or transferred to delivery suite room. The elective caesarean section list will progress with a separate anaesthetist, theatre team and surgeon

WRH Intervention room:

Scrub and anaesthetic/recovery staff and circulating staff are provided by Main Theatre from Monday – thursday from 08:00-18:00hrs.

When the intervention room is not being used the staff will be expected to:

- Undertake checking and stocking of theatre anaesthetic room, recovery and anaesthetic equipment
- Maintain, manage and order stock levels in line with theatre requirements
- Assist anaesthetist in delivery suite when siting epidurals on labouring women
- Relieving the other theatre team for breaks
- Cross cover theatre staff for cases in both obstetric and Intervention room.
- Recovery of patients in obstetric theatre recovery.
- Assist anaesthetist when blood patch required post dural tap
- Participate in Audit

Midwifery staffing for ELCS

Midwives will be allocated to the role of ELCS midwife each weekday to cover morning and afternoon lists. Two midwives will be allocated to any list with more than one case.

- ELCS midwives welcome and admit the first case at 07.30 am. Both are told to attend delivery suite and then the first will be admitted to an observation room on DS by 1 midwife.
- The second patient is then allocated a bed on Postnatal Ward and prepared for theatre by the other midwife, who should carry the 405 bleep. Assistance to the first midwife should be provided to enable completion of documentation for the case if not completed antenatally as planned.

- Women on the afternoon list will then attend the delivery suite at 12pm and be greeted by the ELCS midwives as in the morning.

Escalation

- 2 Midwives should be allocated to any ELCS list with more than one patient. Those 2 midwives are allocated to the elective list and so should not be available for work outside this remit until complete. If the last patient of the day has been delivered and one of the remaining midwives can safely complete the case then one midwife could be repurposed but this should be after the wider team agree that this would not impair patient safety or timely completion of list.

- If only one midwife can be allocated from Delivery Suite to a two or more case list then this must be escalated via the Coordinator to the 223 Bleepholder. If ward staff cannot be redistributed, it must be accepted and understood that there will be a delay between the case. This may subsequently lead to postponement of cases if delays may result in lists potentially running on beyond 6pm.

- The midwife must ensure that the 1st woman she is caring for has had all of her and her baby's immediate care needs met and the notes have been completed. Only when she has transferred the mother and baby to the ward is she then able to safely take the 2nd ELCS woman to theatre.

- There must be a midwife in the recovery area at all times to attend to the mother, breast feeding or any concerns about the baby. Until appropriate equipment is available in the recovery area to enable completion of all admin tasks, the midwife will need assistance from colleagues on DS.

- In the event of bed capacity preventing elective workload, please refer to the maternity escalation plan.

Obstetric Surgeon & Anaesthetist:

- The Obstetric surgeon and anaesthetist for the elective list will be specified on the respective rotas. The pre-operative process should involve informed consent from both Obstetric and Anaesthetic teams and so no more than a few minutes should be required with each patient. This should enable all members of staff to have seen both patients and attend for a WHO meeting before 08.30. The first patient should be brought across from delivery suite at 08.30.

- The afternoon list should work similarly with WHO meeting shortly before first patient being brought across from DS at 13.30.

Appendix 1

Theatre Essential Equipment

Obstetric theatres will have as a minimum the following essential equipment.

- Surgeons panel
- Surgeons operating light
- Operating table
- Anaesthetic machines
- Diathermy machine
- Swab count containers
- Swab scales
- Surgeons stool
- Surgeons foot stool
- Suction apparatus,
- Swab count board,
- Clinical waste bins,
- PC, monitors,
- Piped medical gases,
- Recovery monitoring,
- Yellow Fins
- Lithotomy poles,
- Table width extenders, table attachments such as arm boards.
- Manual handling aids + Hover mattress,
- IV stands,
- Bowl stands,
- Suture rack,
- Anaesthetists chair/stool,
- Patient warming aids / blood warming aids.

Additional equipment

- Gratnell trollies
- Blood warmer
- Resuscitaire
- Neonatal advanced resuscitation trolley
- Incubator
- Cot
- Electric razor