LSCS when COVID-19 infection suspected or confirmed

Midwife – actions

- Surgical mask and standard PPE throughout
- Use call bell to seek assistance from co-ordinator or another staff member.
- Establish IV access and urinary catheter in room prior to transfer.
- Ensure patient's personal belongings are left in room including mobile phone.
- Partner will not be accompanying the patient even if regional anaesthesia planned.
- CTG should be discontinued for transfer. Avoid taking other equipment from room.
- CTG can be re-established in theatre, however a change of plan for a quicker delivery is likely to result in more delay.

Midwifery co-ordinator - actions

- Inform all Team 20 members highlighting infection risk.
- Verbally confirm their readiness to accept patient and declare to transferring team.
- Delegate a staff member to move designated resuscitaire kept in Room E to theatre 6. Alert neonatal staff.
- Ensure corridors are clear and theatre staff room doors are closed.
- Address the need for a 'non-touch' transfer (transferring persons must not touch walls or doors).
- Oversee transfer and PPE including mother's: limit personnel to two – ideally anaesthetist and midwife. Both must doff and re-don when leaving the room.

Obstetrician - actions

- Complete consent process
- In case of foetal distress initiate intra uterine resuscitation measures – supplementary O_2 at 4litres, intravenous fluids, left lateral position of mother and stop oxytocin infusion
- Conduct WHO checklist outside the room in CDS with NICU team present.
- Be clear on decision to accept regional anaesthesia as the safest option.
- Identify a suitably trained assistant
- Proceed to theatre 6 and be ready with standard PPE

Key points

- **The strict time limit expected for Category 1 caesarean delivery is unachievable**
- **Time taken to prepare for GA section will be longer than for a standard spinal**
- **Obstetric team must adopt "an early safer Category 2 rather than a late high risk Category 1" approach**
- **Theatre 6 is our designated COVID-19 theatre**
- **Do not rush a patient with infection risk to theatre before confirming with all Team 20 members**

Theatre team

- Midwife*
- Anaesthetist*
- ODP – check essential equipment and drugs for planned anaesthetic
- Obstetrician*
- Scrub nurse*
- Surgical assistant*
- Theatre runner
- NICU personnel and midwifery co-ordinator on standby outside theatre
- All members should wear Standard PPE with eye protection throughout procedure + surgical gown*

New born care

- Delayed cord clamping is safe provided there are no neonatal concerns
- Skin to skin can be provided as normal practice
- Seek support from neonatal team early if any signs of distress
- Transfer incubator if needed must only be brought up to the doffing area

Recovery

- Mother will be recovered in theatre 6
- Midwife and runner must stay with mother
- Recovery nurse must be in standard PPE with eye ptrotection
- Newborn can be reunited with mother in theatre if there are no concerns
- Follow same process of doffing and re-donning before returning back to Room C

Anaesthetist - actions

- Establish effectiveness of regional analgesia if epidural in situ. If in doubt, decide on spinal early
- Re-check FBC, clotting and fast issue availability
- Exchange information with ODP and surgical team
- Maintain standard PPE
- Ensure IV access and monitoring are adequate
- Prepare and perform spinal anaesthetic under full asepsis
- Supplementary oxygen only if SpO2 < 94%

GA LSCS

- GA should only be given if there is significant maternal compromise or a strong contra-indication for spinal anaesthesia (thrombocyptopaenia)
- Verbal check of essential team members prior to induction of anaesthesia – confirm full AGA PPE (RED – fluid resistant long sleeved gown, fit tested FFP3, eye protection, second pair of gloves) for all including surgical and neonatal team.
- Surgical team must be scrubbed and ready to skin prep and drape patient. Once draped, they must wait in the donning area with midwife, runner and neonatal staff.
- Maintain loud, clearly worded closed loop communication.
- Pre-oxygenation must only be commenced after AGP donning of all three members.
- Close fit face mask to minimise aerosolisation. Avoid high flow oxygen.
- Intubation using videolaryngoscopy
- Ventilate only after confirmation of cuff inflation by ODP.
- Newborn care to be handed over to NICU team
- Full team to remain in full PPE until end of surgery.
- Extubation with anaesthetist, ODP and runner.
- Allow 15 minutes before doffing.
- All equipment including resuscitaire must be deep cleaned before moving.