Standard Operating Procedure (SOP) Number: 210

SOP Title: When a second Obstetric emergency theatre is required

Classification:	Standard Operating Procedure		
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Authors Division:	Women's Health		
Departments/Group this Document applies to:	Maternity and Theatres		
Approval Group: Women's Health Guideline Review Group		**Date of Approval:**	07 March 2023
		Last Review:	Jan 2023
		Review Date:	Jan 2024
Unique Identifier: GENM/SOP/210	**Status:** Approved	**Version No:** 3	
Scope: Maternity and Theatre staff		**Document for Public Display:** Yes	
To be read in conjunction with the following documents:			

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SOP Statement

This is a new SOP to formalise the procedure when a second emergency obstetric theatre is required.

Executive Summary

Each month at Milton Keynes University Hospital, we carry out an average of 50 elective caesareans and 73 emergency obstetric procedures in theatre (of which 50 are emergency caesareans, including 13 category 1 caesareans).

We have 6 theatre sessions per week dedicated to elective obstetrics (in *Theatre 1*). On a morning session, which is staffed until 2pm rather than the usual 12.30pm finish, there is capacity to do up to 3 caesareans (depending on the complexity of the case as described by the ELECTIVIST score). On an all-day session, there is capacity to do up to 5 caesareans.

We have another theatre (*Theatre 3*) which is dedicated to emergency obstetric procedures. This is available and staffed 24 hours a day.

Obstetric emergencies are unpredictable and occasionally a second emergency theatre is required. Out of hours, there is a theatre team dedicated to obstetrics and an anaesthetist in the hospital dedicated to obstetric anaesthesia.

This SOP outlines the procedure for utilising a second operating environment and staff to carry out the second emergency case.

1.0 Roles and Responsibilities:

Obstetrician:
Obstetric emergencies are not always predictable. When taking a case to theatre, if the level of activity on labour ward is high and there is a potential of multiple clinical situations to escalate simultaneously, the middle grade should inform the on-call consultant.

The Consultant Obstetrician must be involved with the decision to open a second theatre and should alert and liaise with the wider MDT.

Ensure that the appropriate obstetric staffing is on site to carry out the procedure in the second theatre – the consultant must be called to labour ward if not already present.

Anaesthetist:
Carry out the processes and procedures as outlined below in 3.4 to 3.6.

Labour Ward Co-Ordinator:
The escalation of the need for a second Obstetric theatre can be made initially by the Labour Ward Co-Ordinator and the Obstetric Reg on call to the Obstetric Consultant. An MDT decision is made with the Obstetric Consultant, Anaesthetist, Obstetric Registrar, Labour Ward Co-Ordinator, and Theatre Co-Ordinator if a second theatre is required.

Phase 1 Theatre Co-Ordinator (Band 6 or Band 7) bleep 1327:
The responsibility of the Theatre Co-Ordinator is to ensure that if a second Obstetric emergency theatre is requested then another theatre in Phase One should be used. If this is not possible then the operation will be carried out in the Post Anaesthetic Recovery, Phase One. Please see chart displayed in the Post Anaesthetic Recovery. The co-ordinator will report any simultaneous obstetric emergencies in theatres via the incident reporting system (see 3.7).

An ODP, a scrub nurse and circulator will be arranged by the Phase 1 Theatre Co-Ordinator. Recovery staff will move patients from Bay 5 (designated bay) to another bay or to an available anaesthetic room. All available staff help to set up the recovery area to receive the patient.

2.0 Implementation and dissemination of document

This document will be published on the Trust Intranet.

3.0 Processes and procedures

3.1 Locations

Phase 1 Theatres are located across the main corridor from Labour Ward. There are 4 operating theatres:

- Theatre 1 is used for elective caesareans during morning session except on Tuesdays when it is in use for the whole day. When not in use by obstetrics, it may occasionally be used for ECMO cases, paediatric intubation and emergency cases.
- Theatre 2 is used for Orthopaedic trauma cases. It is used during normal working hours and on Saturday and Sunday mornings.
- Theatre 3 is the emergency Obstetric theatre, staffed 24h per day.
- Theatre 4 is the general emergency theatre.

Each operating theatre has an anaesthetic room attached. The anaesthetic room for theatre 3 does not have an anaesthetic machine.

The recovery area is used by all the theatres. The last bay in recovery is used for recovery after caesareans. This bay has also been set up as an area capable of providing emergency Obstetric anaesthesia.

3.2 Medical Staffing

Anaesthetics

During normal working hours, there is at least one anaesthetist allocated to each theatre. The anaesthetist allocated to theatre 3 is the duty anaesthetist for Labour Ward. Theatre 4 will have the on-call consultant and two other anaesthetists, one of whom may be competent in Obstetric anaesthesia.

There is a duty anaesthetist for theatre 3 / labour ward 24 hours a day. Overnight this is a Middle Grade (SAS) doctor. During the day, the doctor will be either consultant or SAS.

The on-call Consultant Anaesthetist is resident on-call until 10pm on weekdays and on-call from home after 10pm. Overnight, the Consultant Anaesthetist is required to be present in hospital for cases in theatre 4 that are not appropriate for the first on-call theatre anaesthetist (for example based on the experience of that doctor in anaesthesia, and/or for complex cases) and is present for all paediatric intubations. They are also the Consultant on-call for obstetric anaesthesia.

There is a resident Doctor for intensive care 24/7. They will either be an anaesthetist competent in obstetric anaesthesia or an intensive care doctor without obstetric anaesthetic competencies. There is also a Consultant on call for intensive care, this consultant is not an Obstetric Anaesthetist, but will have competencies in emergency anaesthesia.

There is also a Consultant Anaesthetist allocated to the trauma list on Saturday and Sunday mornings.

Obstetrics

Consultant Obstetrician and Gynaecologist:
Weekdays: Onsite 08:00- 21:00, offsite and available in 30 minutes from 21:00-08:00
Weekends: Onsite 08:00-13:00, and onsite again 19:30-21:00 on weekends.
Offsite and available in 30 minutes from 13:00-19:30 and 21:00- 08:00

2 Middle grades 24/7 on weekdays and weekends.

2 SHOs 08:00-21:00 on weekdays and weekends
1 SHO 21:00-08:00 on weekdays and weekends.

Theatres

Theatre 3 is staffed with an ODP, One Scrub nurse & one circulator 24/7.

3.3 Planned use of the elective list for emergency Obstetric procedures.

If there is capacity and the case is clinically suitable to be performed on the Theatre 1 list, and midwifery staffing is available on the allocated AM/ PM elective list, it may be more appropriate to carry out procedures such as category 3 caesareans and cervical sutures on the planned list, leaving Theatre 3 available for a second emergency. The case should be ordered via requests and care plans on *eCare* and the Phase One Theatre Co-Ordinator on bleep 1327 must be informed. In this instance, the Theatre Co-Ordinator should allocate the case to Theatre 1 on eCare and write the details on the printed operating list, ensuring that the Theatre 1 team are aware of the additional case. The Elective Caesarean team should also be informed if a category 3 caesarean section is added to the elective list.

3.4 Second Emergency Obstetric Theatre – *normal working hours*

Communication with the Theatre Co-Ordinator as early as possible is important when there are concerns about a second maternity service user or fetus.

In the event of a 'category 1 caesarean' or 'major obstetric haemorrhage' bleep, the Theatre Co-Ordinator will identify an available theatre. The theatre staff and Anaesthetist for the allocated theatre will act as the team for the second emergency case.

If there is no empty theatre, the procedure will need to take place in recovery. However, this should be a last resort. The on-call Consultant Anaesthetist will be the anaesthetist for the procedure in recovery unless they can allocate another anaesthetist. (The on-call Consultant Anaesthetist does not carry an emergency baton bleep; they will need to be contacted via mobile.)

An ODP, a scrub nurse and circulator will be arranged by the Phase 1 Theatre Co-Ordinator. Recovery staff will move patients from Bay 5 (designated bay) to another bay or to an available anaesthetic room.

All available staff will help to set up the recovery area to receive the patient.

3.5 Second Emergency Obstetric Theatre – *out of hours*

Out of hours, an empty theatre will be available. Staffing rather than physical space is likely to be the limiting step.

In the event of a 'category 1 caesarean or 'major obstetric haemorrhage' bleep:

1. Where there is a delay due to waiting for on-call staff consideration should be given to the second emergency case immediately following the first emergency case as this could result in more timely access to intervention.
2. The Consultant Obstetrician will be called in from home, if not already in hospital. However, the procedure will not be withheld pending their attendance and should be carried out according to urgency by the most experienced Obstetrician available.
3. The duty Obstetric Anaesthetist will contact any other Obstetric competent anaesthetists in the hospital and will contact them to do the case and inform the on-call Consultant Anaesthetist. If there are no Obstetric competent anaesthetists available in hospital, the duty anaesthetist will call the on-call Consultant Anaesthetist to come in to do the case (they are available within 30 minutes). If the on-call Consultant Anaesthetist is already working in another theatre, they will decide if it is safe to leave their existing theatre case in the hands

of the junior theatre anaesthetist. They will call the Consultant on call for intensive care to come in. Available ICU and anaesthetic doctors without direct Obstetric anaesthetic competencies should attend, if possible, to provide support with general tasks. All of this is a significant undertaking, and the risk and urgency of Obstetric cases need to be balanced against clinical risk to the wider organisation.

4. To maintain the emergency Obstetric service and perform immediate emergency surgery if required two members of staff are to be allocated an on-call shift of: 20:30- 08:00, in addition to the night team. The night team consists of 2 ODP's, 2 registered theatre scrub practitioners & one HCA.

   On call staff are required to confirm their contact details, ensure they are available during the on-call hours and clarify if they require a taxi, providing travel time will not exceed 30 minutes.

3.6 Carrying out a procedure in Phase 1 Recovery

1. Allocate staff.
2. If safe to do so, the discharge of other patients in recovery should be expedited. The last two bays need to be clear of patients. Curtains should be pulled round any other patients.
3. The operating table will need to be moved in to position.
4. The emergency anaesthetic drugs are kept in the fridge in theatre 3.
5. Staff will scrub up in theatre 3.
6. The emergency WHO checklist for a category 1 caesarean is on the wall in recovery.

3.7 Audit against SOP

Any case where a second emergency obstetric theatre is required (i.e., simultaneous emergency cases) should be reported by the Phase 1 Theatre Co-ordinator via the Trust's incident reporting system (RADAR).

A summary of reported incidents and learning from them should be presented to the appropriate governance forum within the Women's and Theatres Directorates at least twice per year, with onward reporting to the Maternity Assurance Group (at least annually).

4.0 Statement of evidence/references

References:

Department of Health. Children, young people and maternity services. Health Building Note 09-02: Maternity care facilities

National Quality Board Edition 1, January 2018 Safe, sustainable, and productive staffing an improvement resource for maternity services

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
1	Jan 2023		Created Document
2	March 2023		Comments from wide consultation incorporated and documents updated
3	March 2023		Simplification of language where possible. Review period reduced from 36 months to 12 months. Audit process articulated and incorporated.

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
	Anaesthesia	Feb 2023	Feb 2023	Comments on on-call anaesthetist consultant criteria. Comment on having a senior surgeon performing c-section	Text altered slightly in section 3 Text altered in section 3.5 section 2
	Labour ward	Feb 2023	Feb 2023	Noted only one obs/gynae SHO on overnight	Noted and section 3.2 altered to 1 SHO at night
	Midwifery	Feb 2023	Feb 2023	Comments made around tightening up wording within the document to reduce room for subjective interpretation.	Use of these "non-precise" terms through document has been reviewed. **Often** was used twice – and removed in both instances. **Sometimes** was used once and was explained in more detail. **Mainly** was used once and was removed. **Usually** was used 4 times and was removed or changed on three of these occasions. The word **may** was reviewed.

	Anaesthetics	Feb 2023	Feb 2023	Concerns over staffing level being complementary	This is described in SOP already.
	Anaesthetics / surgical divisional director	Feb 2023	Feb 2023	Suggested removal of a phrase which was judged superfluous.	Section removed
	ICU	Feb 2023	Feb 2023	ICU consultants may not also be anaesthetists. ICU consultant shouldn't be called before anaesthetic consultant for an obstetric emergency	Altered text to be clear referring to junior anaesthetic colleagues Text altered to be clear about not calling ICU consultant until the appropriate time
		Feb 2023	Feb 2023	Typographical error.	Corrected
	Anaesthetics /ICU	Feb 2023	Feb 2023	Non-obstetric anaes/ICU doctors should attend to help with general tasks/support Comment that using the second resident junior doctor (from ICU or theatres) will remove emergency airway/critical care cover from the rest of the hospital and the obstetric risk / urgency must be balanced against the risk to the rest of the hospital, **and** the consultant anaesthetist must be on their way in to address this risk	Sentence added to section 3.5 3 to that effect Sentence altered to reflect this risk and that the consultant anaesthetist must be informed early in process
	Maternity and Gynaecology Clinical Governance and Quality	Feb 2023	Feb 2023	Roles and responsibilities - DS changed to labour ward, consultant to be called if second theatre opened, word theatre spelt incorrectly Queried reason SHO not put 24/7 in obstetric staffing section Reference to absence	Altered, consultant to be called to labour ward added, theatre spelt correctly There are not 2 SHOs on 24/7 as per Becky Hobbs above, so not changed Skills and drills in

				of experience of operating in recovery Typographical error.	recovery suggested. Already corrected as per Natalie Payne
	Labour Ward Coordinator	Feb 2023	Feb 2023	Theatre spelt incorrectly Labour ward coordinator role no detail What about multiple cat 2 sections	Corrected already. Text added to describe their role. Whilst this SOP It cannot be a comprehensive discussion of all possible labour ward/obstetric scenarios, lots of category 2 sections (recommended 75 minutes decision to birth interval) may also trigger the scenario of need for a second theatre, but (although urgent) there will be more time to discuss – hopefully this SOP will help provide a framework for that discussion.