

**PROTOCOL FOR: Cesarean Section: Immediate Preoperative and Intraoperative Care of the Patient**

- POLICY:**
1. A registered nurse will circulate on all cesarean sections.
  2. Permits must be signed before patient is transferred to OR, except in cases of extreme emergency.
  3. The Surgical Safety Checklist must be utilized with every cesarean section with the exception of an emergency cesarean section.

**DESIRED PATIENT**

- OUTCOMES:**
1. Safety of the patient and fetus(es) will be maintained. Patient will sustain no infectious processes during the postoperative period.
  2. Patient will be able to communicate an understanding of the cesarean delivery process.

**CLINICAL  
ASSESSMENT AND**

- CARE:**
1. Prepare Operating Room before the arrival of the patient:
    - a. Make sure equipment is functioning properly.
    - b. Assist scrub person when necessary; tie up scrub gown.
  2. Accompany patient to OR and assist in transfer from bed to delivery bed table.
  3. Position patient for spinal (if necessary) per request of anesthesiologist.
  4. Position patient for surgery (refer to PROTOCOL FOR: Supine Position: Cesarean Section).
    - a. Place foam pillow under patient's head.
    - b. Place arms on padded arm boards, abducted at an angle within the patient's normal range of motion and less than or equal to 90°.
    - c. Cover patient with a warm blanket and secure safety belt over thighs.
    - d. Place blanket roll under right hip.
    - e. If patient has chronic low back pain or arthritis in knees, place a small pillow or large roll under the legs superior to the popliteal space.
  5. OB Tracevue computer system: Transfer the "patient-in-focus" into the appropriate delivery room. Apply fetal/uterine monitor to patient as ordered by physician.
  6. When the surgical team is present in the OR a "time out" is called. Document "time out" checks on OR record.

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7. Assist during surgery by providing lap pads, suture, saline, irrigation, etc. as needed using aseptic technique. Refer to PROTOCOL/PROCEDURE FOR: Counts: Sponge, Sharp, Accessory Item and Instruments; and AORN Recommended Practices: Hand Antisepsis, Surgical.
8. Obtain cord blood gases following delivery of infant unless physician requests that no cord gases be drawn. The section of cord must be clamped at both ends immediately following delivery of infant. The gases must be drawn within 20 minutes after delivery. Label cord blood specimen, placenta and placental cultures.
9. Complete newborn identification (see PROCEDURE FOR: Identification and Security of Newborns; and PROTOCOL FOR: Safety and Security of Newborns).
10. Assist with cleansing patient and transferring the patient to recovery bed.

**PATIENT**

**TEACHING:** Refer to Teaching Plan for: Intrapartum/Post Partum (HCH-1375).

- DOCUMENTATION:**
1. Document maternal and fetal progress on MFICU Flowsheet until operative preop of patient is performed.
  2. Document exact time of delivery of infant and placenta on flowsheet and Nursing Operative Record under "Comments".
  3. Complete Nursing Operative Record with all times, counts and signatures present.
  4. Check that delivery information in log is completed by the physician.
  5. Complete Newborn Identification Sheet with delivery information per protocol.

**APPROVAL:** Nursing Standards Committee

**EFFECTIVE DATE:** 1/94

**REVISION DATES:** 3/97, 2/00, 8/03, 4/08, 6/09