Royal Hospital for Women (RHW)
BUSINESS RULE
COVER SHEET

Health
South Eastern Sydney
Local Health District

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SUMMARY	Clear pathway and guidance for a caesarean birth and consistent practice across the multidisciplinary team
Key Words	Caesarean, birth to chest, skin to skin

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Caesarean Birth **RHW CLIN066**

Contents

This Clinical Business Rule (CBR) is developed to guide safe clinical practice at the Royal Hospital for Women (RHW). Individual patient circumstances may mean that practice diverges from this Clinical Business Rule. Using this document outside RHW or its reproduction in whole or part, is subject to acknowledgement that it is the property of RHW and is valid and applicable for use at the time of publication. RHW is not responsible for consequences that may develop from the use of this document outside RHW.

Within this document we will use the term woman, this is not to exclude those who give birth and do not identify as female. It is crucial to use the preferred language and terminology as described and guided by each individual person when providing care.

1 BACKGROUND

The aim of this CBR is to provide a clear pathway for the arrangement of a caesarean birth and the consistent practice of the multidisciplinary team. A caesarean birth is an operation in which a neonate/s is/are born via an incision (cut) made through the woman's abdominal wall and uterus[1]

2 RESPONSIBILITIES

2.1 Medical staff:

Obstetrics:

- counselling, consenting, and performing caesarean birth
- support of woman-focused care and facilitation of skin-to-skin between the woman and neonate as appropriate

Neonatology:

- attendance at caesarean birth for neonate(s) with identified fetal risk factors antenatally and at birth for timely resuscitation if required

Anaesthetist:

- antenatal anaesthetic review, neuraxial anaesthesia, care and monitoring of the woman
- support of woman-focused care and facilitation of skin-to-skin between woman and neonate(s) as appropriate

2.2 Midwifery and nursing staff:

Nursing staff:

- provision of clinical care, support, and monitoring of the woman during caesarean birth and in recovery
- support of woman-focused care and facilitation of skin-to-skin between woman and neonate(s) as appropriate

Midwifery staff:

- preparation, support and clinical care of a woman having a caesarean birth
- facilitation of immediate and undisturbed skin-to-skin between the woman and neonate(s)
- receiving and assessment of the neonate, supporting neonatal medical team if resuscitation is required
- support and facilitate breastfeeding as per the woman's preference

3 PROCEDURE

3.1 Elective caesarean birth

3.1.1 Consent and Booking – obstetric team

- Ensure appropriate counselling regarding caesarean birth option, supporting shared decision-making and encouraging use of the BRAIN tools (see education notes) with consultation documented in the medical record[10,14] including:
  - surgical details
  - anaesthetic details
  - reason/indication for caesarean birth
  - expectation
  - alternatives
  - risks and benefits
  - short term outcomes
  - long term outcomes
  - impact on future pregnancies
  - birth to chest caesarean opportunity and steps with consideration of agreed exclusion criteria:

Maternal risk factors/exclusion criteria to 'Birth to Chest caesarean'

Risk Factor
Placental concerns: praevia, placenta accreta spectrum (PAS)
General anaesthetic
Coagulopathy complexities
Cardiac/medical complexities requiring closer observation

- Ensure woman and support person are aware cameras and smart phones in the operating theatre are ONLY allowed for still photography of family unit only and must not include staff. Videos, telephone/video calls, or live streaming on social media are NOT permitted
- Offer woman opportunity to ask questions as part of informed decision making and consent.
- Complete Recommendation for Admission (RFA) form and RHW Caesarean Section Booking form including signed consent and client registration section
- Forward completed RFA with RHW CS Booking form to the booking office
- Provide woman with pathology request forms (Full Blood Count (FBC), Group and Hold (G+H), chlorhexidine wash (with instructions for use on morning of planned caesarean) and instructions on pubic hair removal (clipping)
- Advise woman to attend pathology at Prince of Wales Hospital (POWH) < 72hrs before planned caesarean birth. If caesarean birth is arranged for Monday, attend pathology before 11am on the Saturday prior as POWH pathology collection centre is closed Saturday afternoon, Sunday, and public holidays.
- Advise woman she should receive email confirmation that her RFA has be received, but that an allocated date will not be provided until 1-2 weeks preoperatively
- Explain the following:
  - booking will not proceed without completion of the RFA/RHW CS Booking forms
  - elective caesarean date is allocated with consideration to medical indication, priorities and intended for ≥ 39 weeks gestation
  - the booking office will contact woman to advise the allocated date of her caesarean birth 1-2 weeks prior to the preoperatively, but this is still at tentative booking only and the date may need to be changed due to safety and staffing issues

- the booking office will arrange and inform woman of pre-operative anaesthetic appointment or telephone call
- Advise woman she will be contacted one business day prior to her caesarean birth to confirm time and place of admission

3.1.2 On admission - Midwifery

- Ensure the following admission paperwork and documentation is available and complete:
  - RFA
  - Consent form signed
  - Pathology attended (FBC, valid G+H)
  - Medical records (hard copy and electronic)
- Secure identification bands x 2 on woman (red bands if known allergy) – one on ankle and one on wrist as per Patient Identification Bands PD2021_033
- Explain and confirm process to woman and partner/support person, including intention for "Birth to Chest Caesarean birth" for woman who is eligible
- Perform, complete and document admission including:
  - abdominal palpation
  - fetal presentation – confirm with ultrasound if indication for caesarean is for non-cephalic presentation. Escalate promptly for obstetric medical review if presentation now cephalic (ultrasound can be performed by medical officer or an accredited midwife)
  - auscultation of fetal heart rate (FHR) with hand-held doppler or CTG
  - maternal observations as per CEC Health- Standard Maternity Observation Chart
  - pre-operative checklist including verbal or written consent for neonatal Vitamin K and Hepatitis B vaccination
  - discuss and confirm if woman wishes cord blood donation and arrange appropriately
- Provide woman with oral sodium citrate (pre-filled bottle)
- Ensure woman has showered with Chlorhexidine Pre-Op (Chlorhexidine gluconate 40mg/mL) wash the morning of birth
- Clip pubic hair prior to the woman's transfer to operating theatre (OT) (if required)
- Clean abdomen with aqueous chlorhexidine wipe or appropriate alternative[8] as per Procedure management of a perioperative adult patient CBR
- Provide woman with hospital gown to change into and instruct need for removal of underwear
- Ensure multidisciplinary team attend morning safety huddle in OT, confirming woman's suitability and intention for "Birth to Chest Caesarean Birth" if this is woman's preference
- Transfer woman and partner/support person to theatre
- Direct partner/support person to change into theatre attire, own clothes to be placed in a bag and tied to end of woman's bed
- Ensure partner reads and signs 'Consent for the presence of a support person' (Caesarean section SEI020.122)
- Ensure woman and support person are aware cameras, and smart phones are ONLY allowed for still photography of family unit only and must not include staff. Videos, telephone/video calls, or live streaming on social media are NOT permitted

3.1.3 Birth - multidisciplinary team

- Accompany woman to anaesthetic bay
- Ensure woman is covered with sheet/gown/bedding until commencement of procedure

- Assist woman into appropriate position for neuraxial anaesthesia
- Remove woman's arm/s from hospital gown prior to connection of intravenous drip and blood pressure cuff
- Have partner/support person remain in anaesthetic bay whilst neuraxial anaesthesia is sited
- Reposition woman into supine position once neuraxial anaesthesia is sited
- Ensure privacy sheet is in place prior to positioning the woman for insertion of indwelling catheter (IDC) including minimising number of staff present/observing IDC insertion
- Ensure multidisciplinary team attend safety huddle and 'time out', checking woman's details, allergies, blood group, and risk factors
- Confirm plan of care with multidisciplinary team regarding intention for "Birth to Chest Caesarean" and/or facilitation of skin-to-skin (see educational notes)
- Repeat abdominal wipe with aqueous chlorhexidine[8] and ensure administration of antibiotics as per Procedure management of a perioperative adult patient CBR
- Direct partner/support person to sit beside woman (at head of operating table)
- Ensure woman is central, informed and supported at her birth
- Ensure ambient noise is kept to a minimum to enable a supportive birth environment
- Ensure woman and support person are aware cameras, and smart phones are ONLY allowed for still photography of family unit only and must not include staff. Videos, telephone/video calls, or live streaming on social media are NOT permitted

3.1.4 "Birth to Chest" Caesarean Birth (Appendix 1 for exclusion criteria)

Midwifery team

- Attend safety huddle and confirm suitability and intention for Birth to Chest Caesarean
- Ensure resuscitaire is equipped and in working order, including heater on warm as per CEC Neonatal Resuscitation Equipment Checklist
- Attend social hand wash and don pre opened sterile gloves using aseptic non-touch technique (ANTT)
- Remain at the woman's head, ensuring all barriers to skin-to-skin are removed and a warm blanket is covering the upper chest of the woman
- Position the woman as best possible in a semi-recumbent position and her support person beside her head to see the neonate from birth
- Provide direction to the woman and support person to locate hands on her chest refraining from entering the sterile field or touching sterile drapes
- Facilitate skin-to-skin between woman and her neonate
- Cover woman and neonate with warm blankets
- Assess and monitor neonate's condition throughout remaining time in the OT
- Continue steps as below for 3.3.1 'receiving of the neonate'

Obstetric Team

- Attend safety huddle and confirm suitability for Birth to Chest Caesarean
- Double/triple glove or have additional sterile gloves available on theatre trolley
- Direct team to lower sterile drape at appropriate time and lay a second sterile drape across initial drape, leaving the woman's upper chest bare
- Aim to bring the neonate promptly to the woman's chest initiating skin-to-skin as umbilical cord length permits
- Clamp and cut cord, leaving considerable length to cord if possible
- Remove top gloves, discard, and replace with new sterile gloves

Anaesthetic and theatre clinicians

- Attend safety huddle and confirm suitability for Birth to Chest at Caesarean

- Ensure ECG leads and SpO2 monitors are attached on the woman's back or ear, leaving her chest free
- Position woman as best possible in semi-recumbent that allows for visualisation of neonate at birth
- Rearrange the warm blanket from the woman's chest to above her head to facilitate skin to skin with the neonate
- Lower the sterile drape at the direction of the obstetric team, ensure second drape protects initial drape
- Raise original drape back into position following birth, cord clamping and cutting. Ensure the second drape continues to the maternal side of the sterile field

3.1.5 Midwifery Practice

Receiving of the neonate

- Ensure resuscitaire is equipped, oxygen & air cylinders full and in working order, including heater on warm
- Review maternal history to assess risk factors for the neonate
- Contact appropriate neonatal team member(s) for attendance as per Neonatal Resuscitation at Birth CBR. **NB:** Where neonatal team presence is required (see Appendix 1), there should be prior discussion and agreement between the midwifery and neonatal teams regarding the immediate initiation of skin-to-skin contact. For newborns born in good condition, facilitation of skin-to-skin should occur based on clinical assessment at birth and agreed management between the neonatal and midwifery teams.
- Prepare resuscitaire as per Neonatal Resuscitation GL2025_003 for neonate(s). **NB:** Panda Resuscitaire should always remain operative whilst the neonate is present in OT
- Prepare personal protective equipment (once woman is draped, midwife to ready self)
- Ensure sterile impervious drape on theatre trolley (scrub nurse to prepare and set up)
- Attend social hand wash and put on pre-opened sterile gloves using ANTT
- Position self in theatres for scrub nurse to cover with sterile impervious drape, ensuring sterility is maintained
- Receive neonate from obstetric medical officer and note time of birth
- Assess neonatal condition[6,7]
- Initiate and maintain skin-to-skin between the stable woman and stable neonate(s), if woman's preference and safe to do so [3, 15]
- Place neonate(s) directly on woman's chest and cover both with dry, warm blanket[16]
- Continue to assess neonatal condition throughout remaining time in theatre (midwife is to remain with the neonate(s)). If the neonatal condition deteriorates, explain to parents and transfer neonate(s) to resuscitaire for further assessment and support
- Support with breastfeeding as per woman's preferences[3, 4]
- Register the birth of the neonate/s via admissions
- Attend neonatal observations and Apgar score whilst skin-to-skin.
- Secure 2 x identification bands to neonate's ankles as per Identification and Security of Neonate CBR.
- Remove neonate(s) for transfer of woman to recovery bed
- Attend measurements and neonatal assessment including vitamin K and or immunisation as per parent's preferences:
  - during last stage of suturing and/or maternal transfer to recovery bed, OR
  - in recovery unit
- Return neonate(s) skin-to- skin with woman prior to transfer to recovery unit

3.1.6 Recovery

- Transfer woman and neonate on bed to recovery unit
- Allow partner/support person to continue with woman and neonate
- Support breastfeeding preferences ideally within the first hour of birth
- Attend neonatal measurements and assessments, including vitamin K and/or immunisations if not previously completed

3.1.7 Following birth

- Check placenta:
  - Swab and send to histopathology if required. Please ensure request form has comprehensive clinical details to assist pathologist e.g. gestation at delivery, indication for CS, a reason placental histopathology requested, antenatal or intrapartum risk factors or medical issues, as outlined in Placental Examination and Indications for Referral to Pathology CBR
  - Retain or dispose of placenta as per parent's wishes
- Collect cord blood for:
  - arterial and venous pH, lactate, and base excess (required for any emergency caesarean or neonate in poor condition) as outlined in Umbilical cord blood gas sampling CBR
  - Group and Direct Antiglobulin Test (DAT) if woman *rhesus negative* OR *O positive* as per NSW Health GL2026_002 Neonatal – Jaundice Identification and Management in Neonates ≥ 32 weeks Gestation
  - Group and DAT, Full Blood Count (FBC) and Serum Bilirubin (SBR) if woman *O negative blood group* as per NSW Health GL2026_002 Neonatal – Jaundice Identification and Management in Neonates ≥ 32 weeks Gestation
- Return any surgical instruments to scout nurse
- Restock resuscitaire

3.2 Emergency Caesarean Birth

- Determine timeframe of caesarean as outlined in table below and document decision to birth interval[9]

Category	Reason	Action
Within 30 minutes	• immediate threat to woman or neonate • cord prolapse • sustained fetal bradycardia • major antepartum haemorrhage (APH)	• Place 2222 call to switch stating "Rapid Response 30-minute CS" (as below)
Within 60 minutes	• scalp pH < 7.2 • scalp lactate > 4.8 • failed instrumental birth • abnormal 'red' Fetal Heart Rate (FHR) pattern • fully dilated	• Place 2222 call to switch stating "Rapid Response 60-minute CS" (as below) • Aim to be in anaesthetic bay in 15 minutes, on operating table within 40 minutes, CS commenced by 45 minutes
Within 120 minutes	• lack of adequate cervical dilatation with normal or abnormal 'yellow' FHR pattern • bleeding placenta praevia with stable maternal and fetal observations	• Communicate with theatre, anaesthetic, ward, NCC staff, and Access Demand Manager (ADM)/After-hours Nurse

	• booked CS with uterine activity/contractions	manager (AHNM) and postnatal • Complete Randwick Campus Operating Suite (RCOS) booking form ('blue sheet') or online emergency booking via eMR
Within 4 hours	• booked CS with ruptured membranes and no uterine activity/contractions • severe pre-eclampsia without fetal compromise	
Add to elective list	• induction process has not resulted in active labour, followed by maternal consent to caesarean • fetal growth restriction requiring CS not in labour	

- Place 2222 call to switch, state "Rapid Response, the emergency category and location". A Rapid Response will then be activated as a CS 30/60 minutes going to:
  - Theatres
  - Anaesthetics Registrar
  - Anaesthetic CIC (Consultant in Charge) (pager carried between 07:30 and 5pm)
  - Obstetric Registrar and Senior Resident Medical Officer (SRMO)
  - Newborn Care Centre (NCC)
  - Access and Demand Manager (ADM)/After-Hours Nurse Manager (AHNM)
  - Porter
- Site intravenous (IV) cannula where possible and collect pre-operative bloods, if not already taken
- Obtain consent and if time permits complete pre-operative checklist[10]
  - 30- or 60-minute caesarean; verbal consent is preferred
  - ≥ 60min caesarean; written consent is recommended
- Ask woman to put on gown if time allows
- Administer oral sodium citrate
- Clip pubic hair prior to the woman's transfer to OT depending on category (Note: clippers can
- Transfer woman to allocated operating theatre (for 30-minute CS do not stop at "red line"). Primary midwife to remain with woman, ensuring most accurate handover of information and continuity of care
- Revisit indication and "re-group" in anaesthetic bay for 30 or 60-minute CS with the multidisciplinary team depending on any change in clinical picture. This involves the woman and her partner/support person, obstetric, midwifery, anaesthetics, neonatal and theatre teams. Communicate any change clearly to the woman, her partner/support person and obtain verbal consent[14]
- Perform theatre checklist and anaesthetic review. Anaesthetic team will determine the type of anaesthesia following collaboration with obstetric team and the woman
- Insert IDC on operating table, if not already in situ
- Consider vaginal examination with consent prior to proceeding with caesarean to confirm appropriate mode of birth (if woman is in labour)
- Continue to monitor FHR until skin preparation is commenced. If in situ, remove fetal spiral electrode (FSE) immediately prior to commencement of surgery

If additional theatre needs to be made available after hours (1800-0700)

- Confer with obstetric consultant and teams regarding clinical priority

- Contact theatres, anaesthetics, and AHNM, notifying of additional theatre need, including allocation of additional staff as per Escalation for Birthing Services CBR

3.3 Post Caesarean Birth placement/location

- Ensure that the accepting clinical area (Postnatal (PNW) and Antenatal wards (ANW), Birth Unit (BU) or Close Observation Unit (COU)) can safely care for post caesarean women, supported by appropriate staff, skill mix and environment
    - **PNW** - first preference
    - **ANW** - acceptable alternative
        - Appropriate where postnatal capacity is exceeded and care needs can be safely met
    - **COU**- acceptable alternative
        - Appropriate for post CS women requiring:
            - Increased monitoring or clinical surveillance
            - Higher acuity care that exceeds standard postnatal ward capacity
            - Use here is supported where staffing and skill mix are appropriate and monitoring requirements align with COU capacity
    - **BU** - supported with conditions
        - Appropriate for post CS women when:
            - No PNW/ANW capacity OR
            - Clinical need requires higher observation or proximity to acute services
        - Mandatory criteria for placement in BU as follows:
    - A midwife is clearly allocated and accountable for the woman's care and is not concurrently responsible for the primary care of a second woman in active labour. This does not imply 1:1 care: however, workload allocation must ensure the midwife can safely meet post operative care requirements
        - Unit workload and acuity allow safe care provision
        - Appropriate physical space and equipment for postnatal care are available
        - Clear plan for ongoing care and review
- Escalate if appropriate placement cannot be achieved to the Nurse Unit Manager (NUM)/After Hours Nurse Manager (AHNM) or Bed Manager
- Consider the following:
    - Assess staffing levels and skill mix
    - Current acuity and workload
    - Availability of safe physical environment
    - Reallocation of staff
    - Redistribution of women across units
    - Delayed transfer where clinically appropriate
- Escalate to Executive-on-call if unresolved
- Document all decisions

4 DOCUMENTATION

- Electronic Medical Record (eMR) - woman and neonate
- Neonatal blue book
- Birth registration papers

5 EDUCATION NOTES

- BRAIN tool is a simple shared decision-making framework that helps women and support person/s make informed choices about their care. BRAIN stands for:
  - **B**- Benefits. What are the benefits of the options presented? How might this help me?
  - **R**- Risks. What are the possible risks of the options presented? How likely are these risks to occur?
  - **A**- Alternatives. Are there alternative options? What are the benefits and risks of those alternatives?
  - **I**- Intuition. What does my gut tell me? How do I feel about this option and my decision?
  - **N**- Nothing. What happens if I do nothing for now? Is it safe to wait and review later?
- RHW is now offering a woman/family "Birth to Chest Caesarean" if her clinical circumstances allow. This practice is designed to enhance the emotional and physical well-being of both woman and neonate by facilitating immediate and uninterrupted skin-to-skin contact[15,20,21]. As part of this initiative, the neonate is brought directly to their woman's bare chest within seconds of birth in the operating theatre, fostering early bonding and supporting the natural initiation of breastfeeding. In alignment with Baby Friendly Health Initiative (BFHI) standards, this practice upholds key principles of evidence-based maternity care, including the promotion of breastfeeding, maternal-infant attachment, and the reduction of neonatal stress[22].
- Chlorhexidine wash and wipes have been shown to reduce surgical site infections
- Caesarean section is one of the most common interventions in pregnancy and is safer now than in the past, however, a small risk of serious morbidity and mortality for both the mother and the neonate remains, and the benefits need to be weighed against the risks[13]
- Increased risks to the mother include postoperative infection, haemorrhage, and complications during future pregnancies[11]
- Long term complications arising for women having caesarean births include uterine rupture, placenta accreta, surgery for adhesions and/or surgery for anterior abdominal wall hernia[1]
- Some studies suggest a reduced risk of urinary incontinence and pelvic organ prolapse requiring surgery later in life for women birthing only by caesarean[19]
- Risks to the neonate for planned caesarean section at less than 39 weeks' gestation can include increased rates of neonatal respiratory issues, asthma, obesity and developmental issues[12]
- Immediate and continued skin to skin contact is associated with reduced maternal pain perception, greater uterine contraction with reduced blood loss, increased maternal/neonatal bond, decrease in neonate crying, thermoregulation of the neonate, early breastfeeding initiation, and duration of overall breastfeeding[16]
- Women's experiences during caesarean birth are positively influenced by factors including regional anaesthetic, opportunity to view their neonate from birth, immediate & uninterrupted skin to skin contact with their neonate and continued family unit from theatre to recovery to postnatal unit[17,18]

6 RELATED POLICIES/PROCEDURES

- Recognition and management of Neonate who is clinically deteriorating outside of Newborn Care centre
- NSW Health GL2026_002 Neonatal – Jaundice Identification and Management in Neonates ≥ 32 weeks Gestation
- RHW CBR (2023) Umbilical Cord Blood Gas Sampling
- RHW CBR (2026) Placenta examination and indications for referral to pathology

- RHW CBR (2024) Placenta removal from Hospital by Parents
- RHW CBR (2023) Breastfeeding protection promotion and support
- RHW CBR (2025) Breastfeeding – First Breast Expression
- NSW Health GL2025_004 Fetal Heart Rate Monitoring
- RHW CBR (2024) Identification and Security of Neonate
- RHW CBR (2026) Surgical Bundle for Caesarean Birth
- RHW CBR (2026) Escalation for Birthing Services
- NSW Health PD2024_045 Prevention of Venous Thromboembolism

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8 ABORIGINAL HEALTH IMPACT STATEMENT DOCUMENTATION

- Considerations for culturally safe and appropriate care provision have been made in the development of this Business Rule and will be accounted for in its implementation.
- When clinical risks are identified for an Aboriginal and/or Torres Strait Islander woman or family, they may require additional supports. This may include Aboriginal health professionals such as Aboriginal Liaison Officers, health workers or other culturally specific services

9 CULTURAL SUPPORT

- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours
- If the woman is from a non-English speaking background, call the interpreter service: NSW Ministry of Health Policy Directive PD2017_044-Interpreters Standard Procedures for Working with Health Care Interpreters.

10 NATIONAL STANDARDS

- Standard 1- Clinical Governance
- Standard 2- Partnering with consumers
- Standard 3- Preventing and controlling infections
- Standard 5- Comprehensive Care
- Standard 6- Communicating for safety
- Standard 8- Recognising and Responding to acute deterioration

11 REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
Nov 2010		Approved Quality Council 20/02/06
Nov 2011		Approved Quality & Patient Safety Committee
April 2018		Replaced: Caesarean Birth- Maternal Preparation and receiving the neonate by Midwives & Nurses Guideline. Reviewed and endorsed by Obstetrics LOPs group
Oct 2018		Amendments by LOPs Chair
Feb 2019		Change 777 to 2222
Aug 2019		Change PACE to CERS
2/3/2024		Maternity CBR Committee
March 2025		Inclusion of new practice “Birth to chest” caesarean; responsibilities & clinical practice steps
March/April 2025	V1	Out for comments due to major changes
May 2025	V1	UAT
12/5/2025	V2	Transcribed to current template
30/6/26	V2	Formatting and editing. Changes from UAT incorporated. Renamed. Added 3.3 Post Caesarean Birth placement/location
6/7/26	V2	RHW BRGC

Appendix 1

Women and their newborns who meet any of the following criteria require neonatal attendance at birth and are therefore not eligible for the *Birth-to-Chest Caesarean* process.

Where neonatal attendance is required, facilitation of immediate skin-to-skin contact should be considered following discussion between neonatal and midwifery staff, taking into consideration the newborn's clinical condition at birth.

Risk Factor	**Minimum level of paediatric assistance**
Breech presentation	RMO
Intrauterine growth restriction	RMO
Trial of Instrumental birth	RMO
Emergency caesarean according to maternal/fetal risk factor	Depends on indication for caesarean - at least RMO
CERS - Maternal/Fetal	RMO/Registrar
CTG abnormality in 'red zone'	RMO/Registrar
General anaesthetic	RMO/Registrar
Intrapartum morphine ≤4hrs prior to birth	RMO/Registrar
Significant fetal abnormality	RMO/Registrar
Fetal scalp blood sampling: pH <7.20 or lactate ≥4.8	Registrar
Meconium	Registrar
Placenta and cord accidents (e.g. cord prolapse or placenta abruption)	Registrar
Prematurity 32-36+6 weeks	Registrar
Shoulder dystocia	Registrar
Multiple gestation	RMO & Registrar +/- neonatal intensive care nurse if indicated
Hydrops fetalis	Registrar and fellow/consultant
Prematurity < 32 weeks	Neonatal consultant/fellow/registrar and neonatal intensive care nurse