Gynae Theatres Tips

Layout

We have 3 theatres;

OG1 – Our obstetric emergency theatre where any maternity emergency procedures are performed.

OG2 – This theatre has mostly elective caesarean sections and benign gynae cases. It is sometimes utilised an emergency gynae theatre when the need arises.

OG3 – Our complex case theatre that is mostly used for major/complex gynae cases (including oncology).

Each operating theatre consists of several **different areas**; a **scrub room** with sinks where the Scrub practitioner and surgeons get scrubbed up, an **anaesthetic room** where patients are given their anaesthesia, a **clean utility** with basic equipment and stock, a **dirty utility** (like a sluice on the wards) and the **theatre** itself. There are several doors that lead into all theatres. It is important that you enter through the correct door to ensure that airborne contaminants are limited. Please ensure that you only enter through a double door such as **the scrub room door or clean utility door**.

This may seem obvious, but **don't use your phone** in the operating theatre. Put it on **silent** and **leave it in your bag**. This is best practice. If there is an imminent reason you need your phone in theatre let the team leader know.

Our day starts with a team board meeting or huddle – this is where the whole theatre team come together to discuss the day's plans including the lists and any training requirements.

Theatre lists start with a **"team brief"** where **everyone** (e.g. surgeons, anaesthetists, nurses, ODPs, students,) introduces themselves and their role. The team, led by the surgeon and anaesthetist, then **discuss the cases** for the day, including the order of the list, the positioning, drugs and equipment that are required, and any specific issues/equipment and risks for each patient. Also due to covid we ask what PPE is to be worn.

After the team brief, the first patient will be **"sent" for** from the ward. The floor nurses and ODPs get the necessary equipment ready, and the

designated scrub nurse for the operation gets scrubbed to open and prepare the instrument trays and do the surgical counts.

Scrubs

Are found on the trolley in the recovery room – hopefully someone has already shown you.

There should be a coloured band around the collar of the scrub tops and the waistband of the scrub trousers to indicate what size they are. Yellow is small, brown is medium, blue is large, white is extra large, orange is XXL and red is XXXL.

Shoes

There should be a selection of clogs in the changing rooms. Please help yourself to a pair – if they have a name on they are normally owned by that person. If there aren't any or you need help, don't be scared to ask somebody who will be more than happy to help. It is very important that you don't wear your own shoes into theatre, for several reasons. Firstly, for infection control purposes no outdoor shoes should be worn but also for safety as theatre shoes are specifically designed to help stop you from slipping on wet floors. At the end of your shift please place your footwear in the linen bin for washing.

Hats

You will need to wear a **hat** to cover your hair. These can be several colours but blue or green are the normal colours. There are two types: stretchy elastic-backed ones, and ones that tie in a knot at the back of your head. Generally, the tie-backed ones are for men and the elastic-backed ones are for ladies. All hair should be contained within the hat please – no stray hairs!

Jewellery

The general rules for jewellery are the same in theatre as they are on the wards. You must be **"bare below the elbows"** with the exception of a plain wedding band if you're married. Earrings are permitted but only plain small studs should be worn. No necklaces are allowed to be worn.

Always ensure that your ID badge is clearly visible at all times (wear it on a lanyard or clipped to your scrub top lower pocket).

PPE

Covid has meant we are now using PPE during our working day. The PPE that you need to wear for each type of patient is clearly labelled on all theatre doors.

On induction you will be FIT mask tested to ensure that you wear the correct mask for you. You will also be taught how to don and doff full PPE.

Leaving the Department

If you want to leave the department for your break feel free to do so. If you are wanting to go to the canteen you are allowed to go in theatre scrubs but please ensure your footwear has been changed and you are not wearing your theatre cap.

If you are wanting to go outside the building on a break you should get fully changed to go outside and change again on entry to the department.

Also please ensure that the co ordinator is aware that you are leaving the department – this is for safety reasons.

Lockers

We normally have several spare lockers that can be accessed. Ask Pam on the front desk if there are any for you to keep your personal items and valuables in.

Off Duty

Our off duty is on an E roster system. You will need this to be set up for you. It's your surname plus your assignment number (this can be found on your wage slip in top left corner). Fulltime staff are allowed 6 duty requests each block of off duty. The requests can be used to request days off or specific shifts that you would like to work. If you need any help with this speak to Nadia or Michelle who will be more than happy to advise you.

For your first few months you will be buddied up with your mentor and you will follow their off duty.

Top Tips

ALWAYS have a bite to eat and something to drink before the first case starts. You will be surprised how tiring it is standing up and concentrating for long periods, and operations often take longer than expected for various reasons. Hunger and hypoglycaemia mean shaky hands and slowed reflexes. The prolonged standing, heavy scrub gowns, gloves, masks and hot bright lighting can mean you also get overheated and dehydrated very quickly.

Please make sure you talk in a low voice in theatre – many surgeons find it very distracting hearing our conversations when they are doing complex procedures. It's ok to ask questions to a fellow colleague but do not talk to the surgeon directly unless they have spoken to you. Instead go through the scrub nurse – they will know where the surgeon is up to in the procedure and will know when they can grab their attention.

Always be aware that there could be critical events happening that you are not aware of – for instance difficulties in the anaesthetic room (diffilcult airways or anxious patients) or a critical point in a case (major haemorage).

Phones are a big no no in theatres. Please do not use yours in theatre Use the coffee room to catch up with your phone. If you are needing your phone in theatre for an emergency or personal issue please let your team leader or co ordinator know.

Don't be afraid to ask questions! We are all here to help and support you so feel free to ask questions. No question is a silly one! Just one that has never been asked.

Procedures and Theatres – SGU

Theatre 1 – Emergency Obstetrics

Theatre 2 – Elective Obstetrics, Elective Gynaecology and Emergency Gynaecology.

(Back up theatre for emergency sections out of hours)

Theatre 3 – Elective Gynaecology and Gynae-oncology.

Emergency obstetrics :-

- Caesarean Sections
- Manual Removal of Placenta
- Repair of 3rd/4th degree tear.
- Trial of Forceps +/- Caesarean Section
- Controlled Artificial Rupture of Membranes (ARM)

Category 1 – Immediate threat to life for mum or baby. To be done within 30minutes (E.g. cord prolapse, foot/limb breech, placental abruption)

Category 2 – No immediate threat to life of mum or baby. To be done within 75 minutes. (E.g. Failure to progress)

Category 3 – No maternal or foetal compromise but requires early delivery. (E.g. breech, SROM,)

Category 4 – No maternal or foetal compromise, at a time to suit mum and maternity services.

Emergency gynaecology

Category 1 –Ruptured ectopic pregnancy, laparoscopic ovarian torsion, to be done within 1 hour.

Category 2a – Stable ectopic pregnancy, laparoscopic ovarian cystectomy, to be done within 6 hours.

Category 2b – Diagnostic laparoscopy, marsupialisation of Bartholin's cyst, unstable surgical management of miscarriage, unstable evacuation of uterus, to be done within 24 hours.

Category 3 – Added onto an elective list.

Important Contact Ext. Numbers for SGU Theatres

Theatres Sisters Office – 4564

Reception – 4870

Theatre 1 – 4871

Theatre 2 – 4872

Theatre 3 – 4873

Recovery – 4874

Porter – Bleep 4169

Co-Ordinator Bleep - 3194

Theatre Training Team – 2355

I.T – 2185

Car Parking/ – 8235

Blood Bank/Transfusion - 2605

WHO DO I CONTACT AND WHAT FOR?

Carly Belfield – SGU Learning Environment Manager

- Off Duty changes/requests
- Practice supervisor/assessor allocations
- PARE Support and concerns
- Any department/supervisor issues

Carly.Belfield@LTHTR.nhs.uk / 01772 524872

Education/Training Team – Main Theatres

- Allocation to departments
- Sign off assessors
- Department training
- Reporting sickness
- Liaise with University

Alexander.Dowling/Sarah.Haskell@LTHTR.nhs.uk / 01772 522355

STAPs Team – Clinical Placement Facilitators

- Support with PARE, University, Placement
- Liaise with University
- Clinical sessions for Proficiencies

- Any additional support required

Placement.support@lthtr.nhs.uk

Allocations@LTHTR.nhs.uk

CNT@LTHTR.nhs.uk

01772 52 8111/3242

Lancashire Teaching Hospitals
NHS Foundation Trust

“How To” for elective Caesarean Deliveries

MIDWIVES

When two midwives are rostered onto theatre shift one midwife to do first and third patient and one midwife to do second patient.

The midwife completing the second section to prep the third section whilst first section is in progress.

- Meet on Delivery Suite
  (1st and 2nd patients to arrive 0730 – 0800. 3rd patient to arrive 0900)
  Introductions
  Theatre WHO Checklist.
  Observations including FH
  Confirm bloods have been checked (G+S, FBC)
  Check COVID status (Mother and partner)
  Check MRSA Swabs
  Check documentation is present (Purples, TSE, anaesthetic chart, falls etc)
  Ensure paediatricians are aware of any cases for which they are required
  Gown
  Cannulate
  Hat and Nappy to take to theatre
  Admit on to K2
  Complete purple notes and risk assessments
  Discuss birth plan (sheet should be in front of notes)
  Attend team brief at 08:40
  Escort woman and partner to theatre
  Place belongings in locker on the way

- Theatre – Usually Theatre 2

  Assist partner with gown etc.
  Check resuscitaire (Including O2 and air cylinders)
  Collect teddy, name tag, clamp and scissors and vitamin K (stock midwives box)
  Support woman during siting of spinal
  When spinal in situ wash hands ready for catheter
  Check if anaesthetist happy for catheter insertion
  Insert as per ANTT
  Take part in time out
  Scrub following surgeon
  Receive and dry the baby well and place immediately in skin to skin with hat

Cover with warm towel
Apply name tag to ankle
Clamp and trim cord (partner to do this if wishes)
Check placenta
Remove baby from skin to skin for transfer onto ward bed
If the mother wishes can use this time to weigh, measure, top to toe check and give vitamin K and complete documentation including K2/Quadramed/Grow. However, commonly this is done in recovery.
You can now recommence skin to skin for transporting to recovery.

- <u>Recovery</u>
  Tea and toast (and water)
  Paracetamol
  Help with feeding
  Print baby labels
  Apply printed baby label to baby's ankle
  Red Book
  Complete any outstanding documentation
  (Can put mum on maternity handover if time permits)
  Bleep porter when anaesthetic observations complete (Number for theatre porter on phone in room 12) to assist with transfer

- <u>Admit to Maty B</u>
  Orientation to ward
  Inform MSW to commence post op observations including observation of lochia and wound
  Apply security tag to baby
  Fluid balance
  Handover system, quadramed, patient whiteboard, Paed book
  Pain relief

<u>First Midwife then to attend theatre for third section.</u>

ANAESTHETIC ASSISTANT

- Prepare theatre

  Anaesthetic machine check

  Ensuring adequate drug and consumable stock.

  Ensure on top of anaesthetic machine there are tissues, vomit bowls, ECG stickers and oxygen face mask (Hudson type)

  Check airway trolley has:

  Oxygen mask and filter

  sodium citrate and straw,

  Laryngoscopes:- stubby handle with mac 3 and 4 blade,

  polio blade

  McCoy,

  Size 7 ET tube cut, tube tie and bougie is open.

  Ensure size 6.5 and 6.0 ETT are available

  Ensure supraglottic airway device is available as well as CI CV kit

  Ensure diamorphine prefilled syringe is available and in the fridge ready to start the first case.

  Ensure ethyl chloride spray full and spare cannister.

  Prepare Hartmanns infusion with Y connector

  Ensure oxytocin infusion 40 units in 500mls Saline is prepared (if anaesthetist and surgeon think it will be needed).

  Check if patients have been cross matched and blood is available if required.

- Team brief

- Check in patient

  2nd anaesthetic assistant/Midwife to help get birth partner ready.

- Theatre

  Settle mother on operating table.

  Sign in with anaesthetist.

  Monitoring on (if possible, put ecg dots on back of shoulders to enable for skin to skin).

  Open spinal set for anaesthetist.

Help position mother and assist with supporting mother and birth partner.
(Often if it helpful to tilt the operating table to the left a little to give the mothers more space for folding. Atop tip is that the mothers sometimes hunch rather than fold and this Is not helpful. Ask them to try and relax their shoulders. Another helpful comment is to relax into their hips or slouch with them almost sitting upright rather than folding up.)
Anaesthetist inserts spinal (or combined spinal epidural where indicated)
Help mother lie down and ensure monitoring cables and IV lines untangled.
Ensure table tilted to left.
Scrub staff usually at this point put on IPCDs and diathermy pad.
If the anaesthetist is happy for BP monitoring to be on the calf ensure that a BP cuff is placed underneath the IPCDs.
If skin to skin is require it is helpful to have an arm out of the theatre gown.
On occasions the flat arm board fixed parallel to the table at the head end gives the mother more space for when she is cuddling baby.
Screen up for catheterisation.
Screen down following catheterisation.
Anaesthetist will check the block level.
"Time out" is conducted and usually led by the surgeon (but it can be any member of staff).
If anaesthetist wishes, the BP cuff can then be transferred to a calf.
Proceed with CS
Be prepared to assist dropping the screen for watching the baby at delivery.
Whilst on going whichever anaesthetic assistant is looking after 2nd patient please go and do the check in.

- General anaesthetic
  Most commonly the elective Caesareans will be conducted under a regional anaesthetic. However, on occasions a general anaesthetic may be indicated or need to occur due to a failed regional.
  Help position mother.
  Ensure she is covered with a sheet.
  Birth partner - at team brief discussion about the attendance of the birth partner will have been had. If the GA is indicated sue to a failed regional please confirm with the anaesthetist the actions needed for supporting the birth partner.
  Ensure monitoring cables and IV lines untangled.
  Ensure table tilted to left.
  Scrub staff usually at this point put on IPCDs and diathermy pad.
  Preferably catheterisation will occur before anaesthesia begins. This may be before coming to theatre. If catherization is to occur after the induction of anaesthesia it should be discussed at team brief.

"Time out" is conducted and usually led by the surgeon (but it can be any member of staff) prior to induction of anaesthesia.
It is imperative that as little as possible of the anaesthetic passes through to baby therefore skin is prepped and drapes put in place before the mother goes to sleep. If there is any variation of this it should be discussed at team brief.
Surgery does not commence until the anaesthetist confirms it is appropriate to start.

SCRUB

- Prepare theatre

  A safety check of all theatre – this includes checking the lights, bed, suction and diathermy.
  Ensure that the scrub up room is fully stocked with gloves, gowns and that the scrub detergents are at a correct level.
  Make sure that the table is dressed with a blue slide sheet with a conti sheet over the top.
  At the foot of the table place a set of IPCDs/ flowtron leggings, a sheet and a towel
  Check the set up for the 1st case is in theatre.
    This should include a C Section Kimal pack, a C section instrument set, a 42 x 42 drape, catheter and sutures (2x 9377, 1x 9373 and a monocryl 3/0 on a straight)
  Check any other set ups that are in the clean utility for the list

- Team Brief

- Theatre
  Whilst the anaesthetic practitioner is assisting with the spinal the scrub nurse will wash their hands and gown up
  The TSW will open the pack and tray ready for them
  The scrub practitioner and the circulator then count the instruments, swabs and sharps. The count is placed on the board
  The Scrub practitioner will then place the instruments in order of use, before the case starts.
  Once the spinal is in, the circulator helps to position the lady on the table correctly and applies the IPCDS/flowtron leggings to the calf muscles
  Warm bottle of water is brought into theatre for catheter – shown to scrub nurse and poured into catheter receiver
  A sheet is placed over the lady until the spinal has taken a full enough effect to insert the catheter.

Satellite may need to be turned on but just watch it isn't shining directly into ladies eyes.
If patient needs shaving – scrub nurse will ask circulator to counsel the patient and shave the incisional site area
The sheet is used as a temporary screen and the midwife will put the catheter in.
This is the start of surgery time.
Screen down following catheterisation and place catheter on the stand.
Surgeons informed that the patient is ready.
Anaesthetist will check the block level.
"Time out" is performed – normally led by the surgeon(but it can be any member of staff).
Surgeons scrub up
Diathermy plate attached to thigh after double checking patient metal work status
Operating theatre lights turned on
Scrub nurse will ask for prep and will to prep the abdomen
Nurse and surgeon then drape
Attach the diathermy lead and suction
Knife to skin (record time)
Knife to uterus (record time)
Baby born (record time)
Counts when scrub requires (on each closure of a cavity- uterus, sheath and skin)
Scrub cleans and dries incision and dresses
When dressing applied record operation finish time
Bottom half of drape are taken down
Surgeon then checks the uterus and swabs out vagina
Suppository given if prescribed
Scrub washes lady

CAESAREAN SECTION COMPLETE

"Sign out" to be undertaken which will detail information about recovery – "speedy or personalised". This should be ticked on the recovery handover aspect of the anaesthetic chart as well as documented in the patient's purple postnatal notes
Move to bed.
Midwife will take, swaddle the baby and pass to birth partner to hold prior to this.
Birth partner to be asked to sit away from the bed – usually near the scrub up area.
Roll off blue banana sheet and ensure patient clean.
Wash if needed, dry and check pressure areas.
May require new gown.
Transfer to room 12 or other designated recovery area.
Please give oral paracetamol in recovery if non given in theatre.

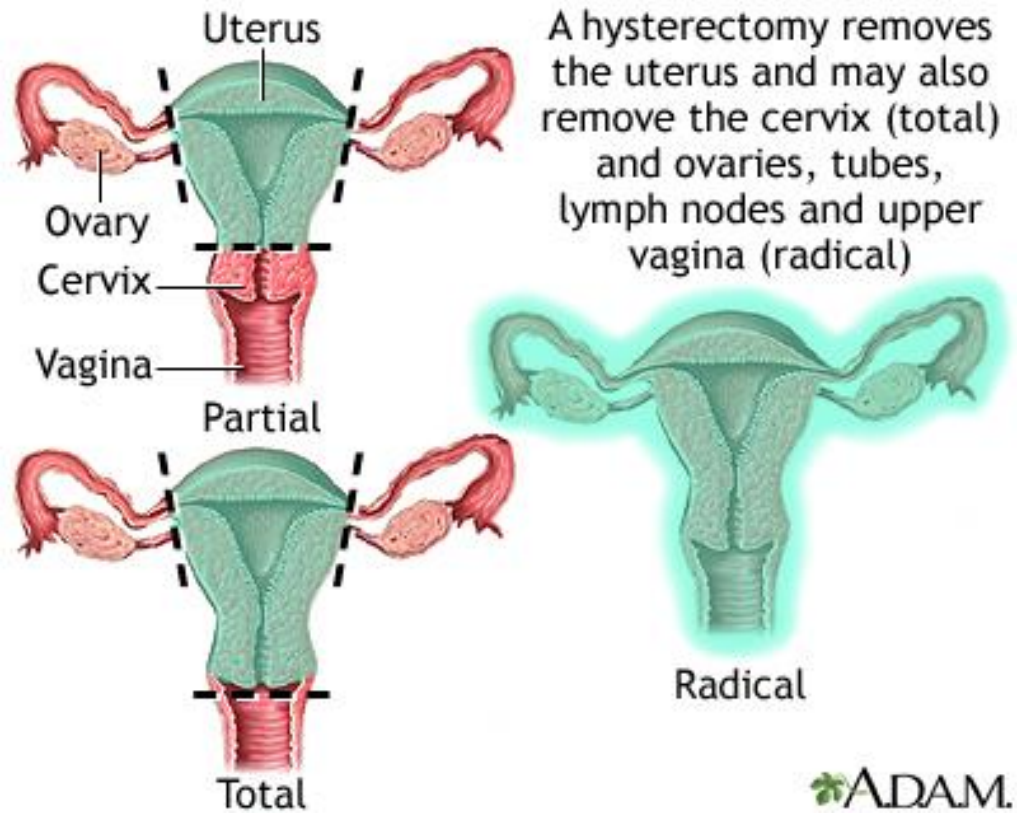
Patient leaves and theatre is cleaned and made ready for next patient

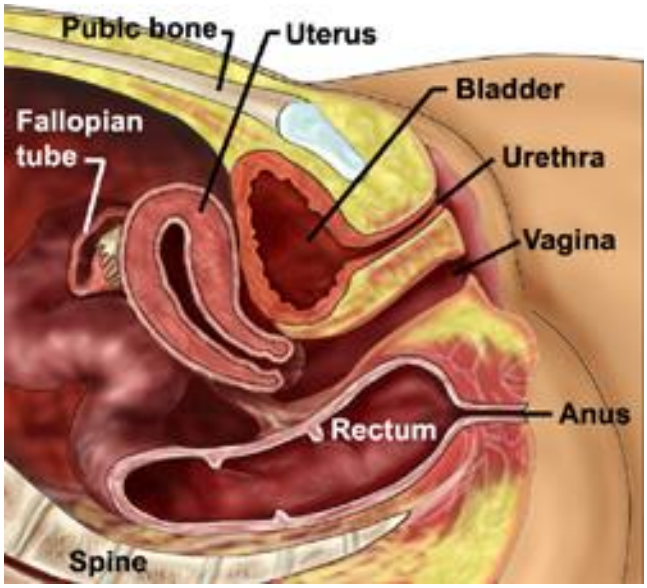
RECOVERY

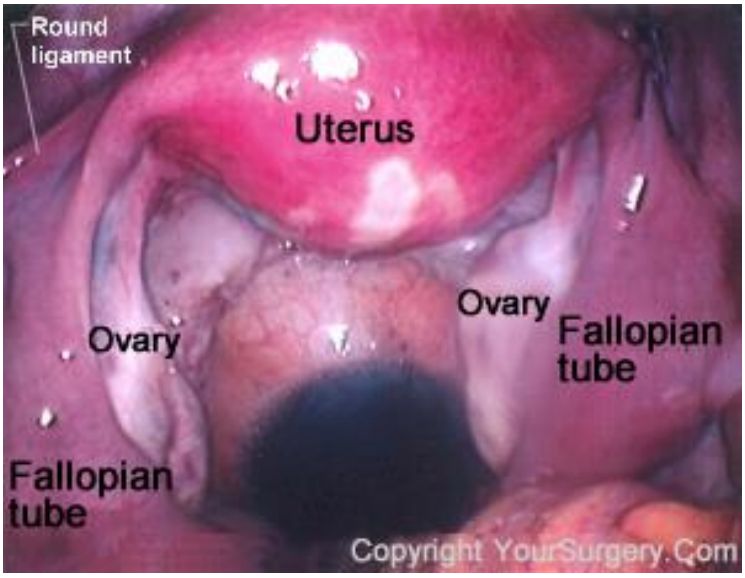
This is usually in room 12 but on occasions another delivery suite room is allocated. Rarely theatre 1s recovery is utilised. This is more likely if the mother has had a general anaesthetic and the main recovery is occupied.

Take monitoring brick with you.
Recovery grab bag (id room 12 or delivery suite).
Complete recovery observations on anaesthetic chart as per recovery guideline.

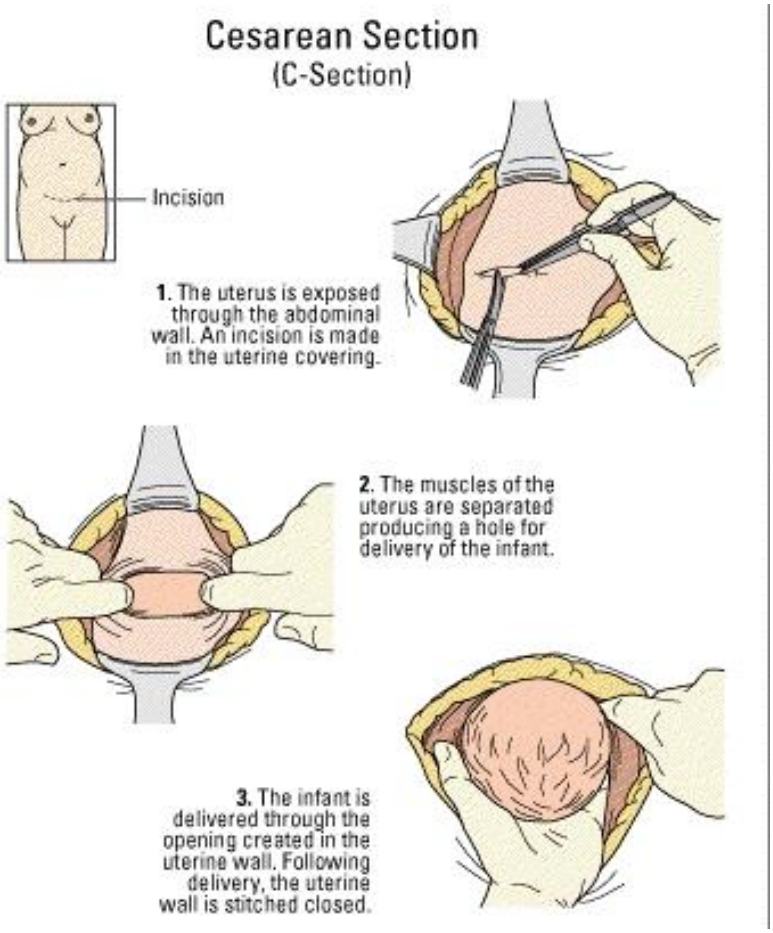
Hysterectomy – Can be done as a laparotomy (Open) or as a Laparoscopy (Keyhole)

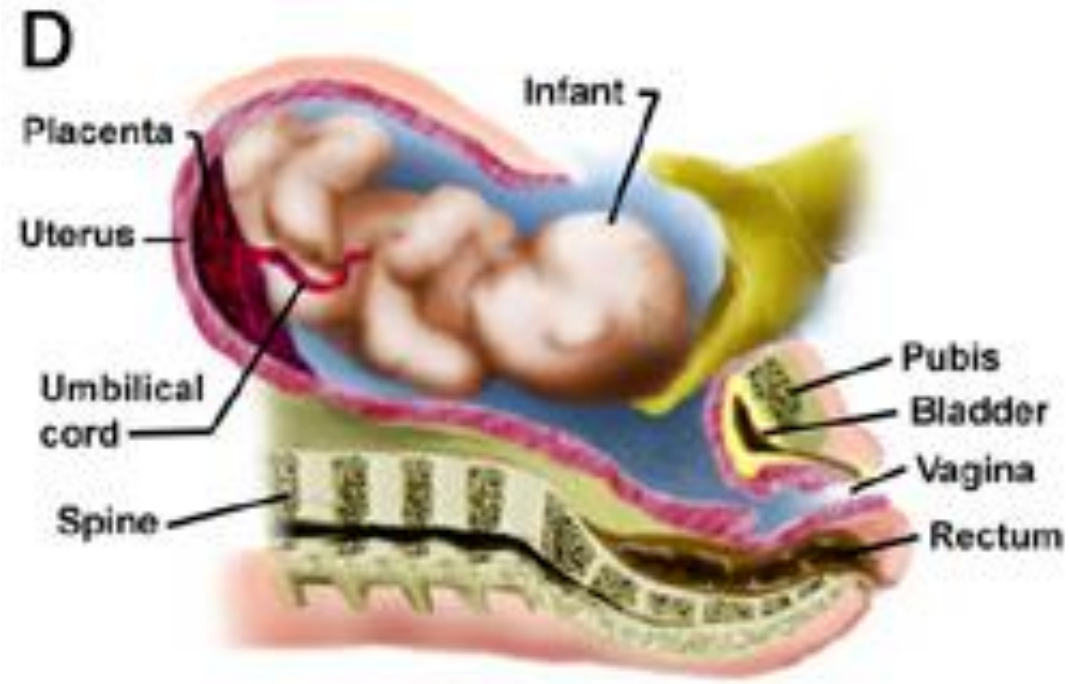




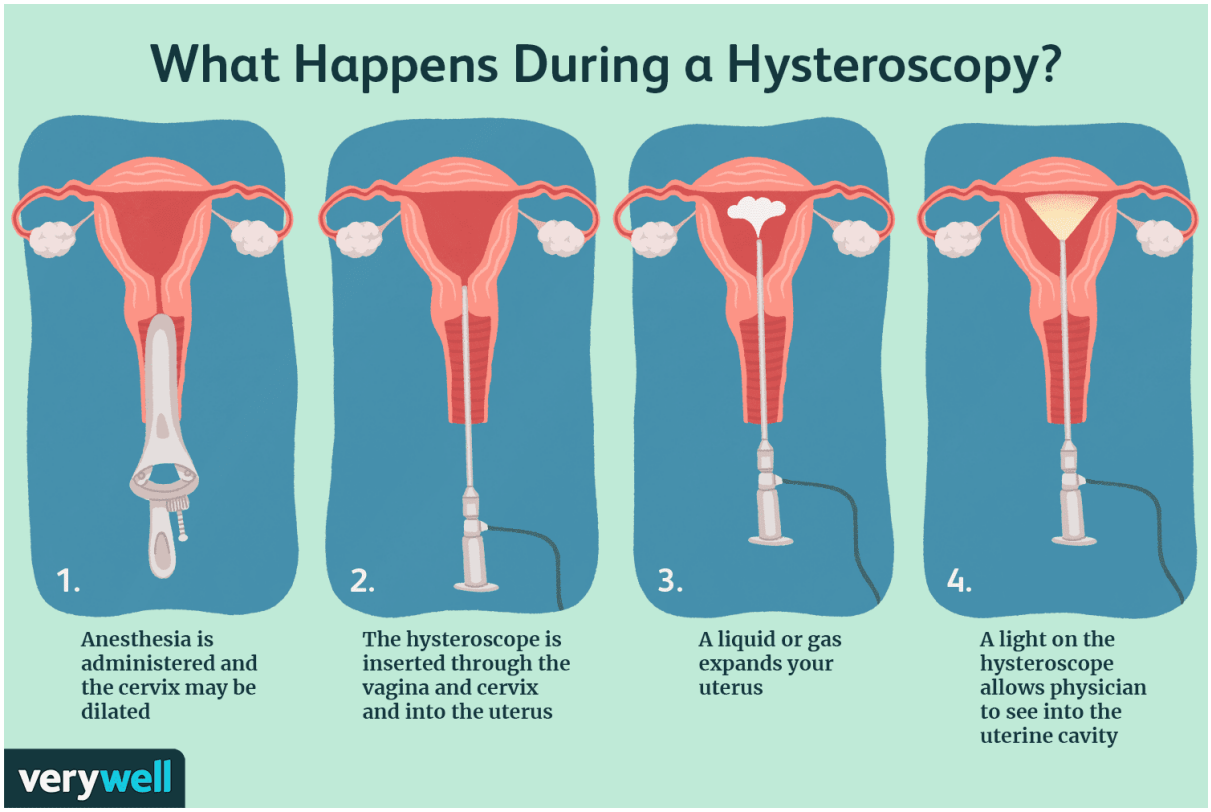


Caesarean Section – elective (planned) and emergency (unplanned)





Hysteroscopy – an endoscope is used to examine the inside of the uterus (womb). These can be done in an outpatients clinic but patients sometimes can't tolerate them so they are listed for a Hysteroscopy under anaesthesia.



Spinal & Epidural Anaesthesia

Epidural anaesthesia involves the insertion of a hollow needle and a small, flexible catheter into the space between the spinal column and outer membrane of the spinal cord (epidural space) in the middle or lower back.

Spinal anaesthesia is done in a similar way. But the anaesthetic medicine is injected using a much smaller needle, directly into the cerebrospinal fluid that surrounds the spinal cord.

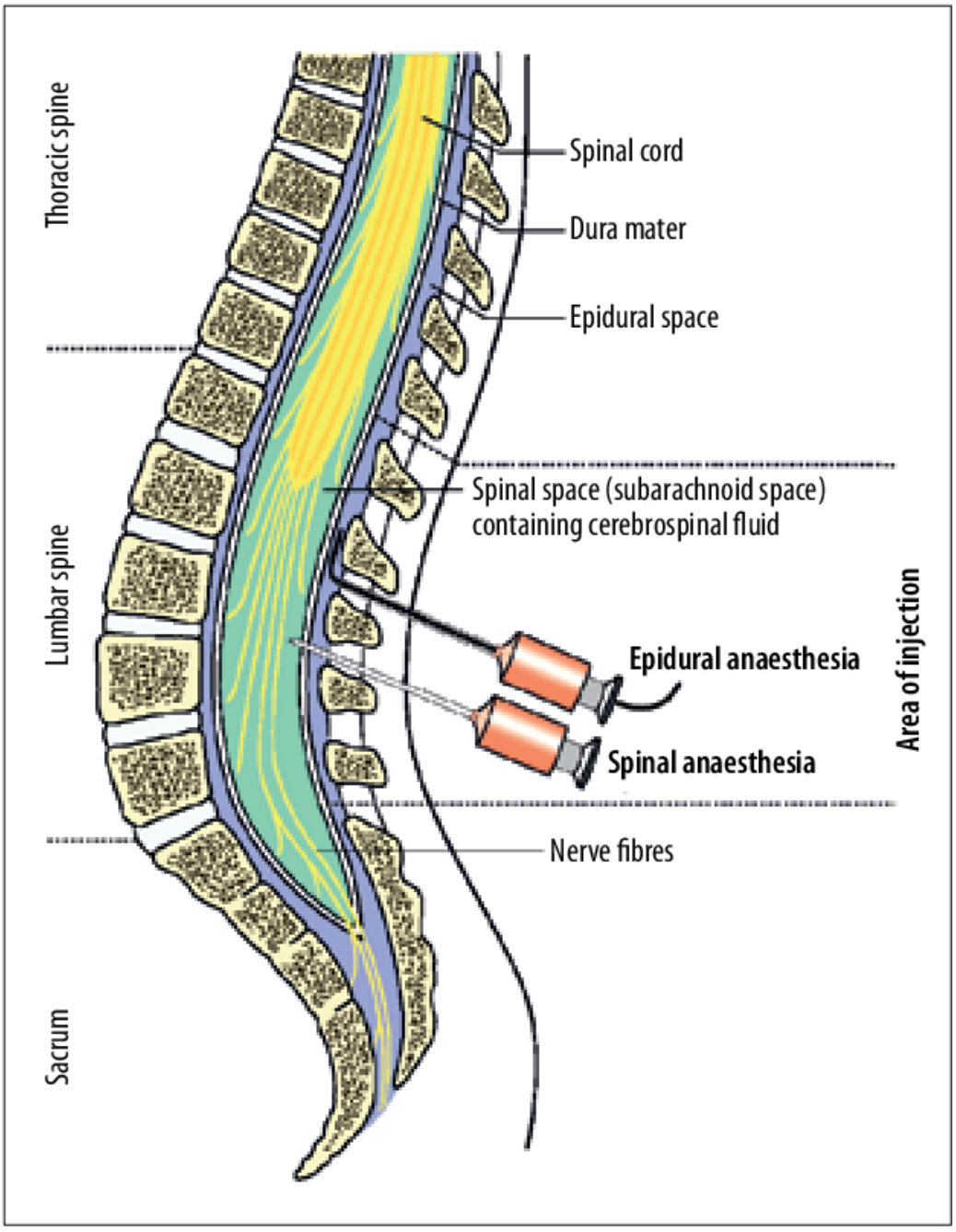
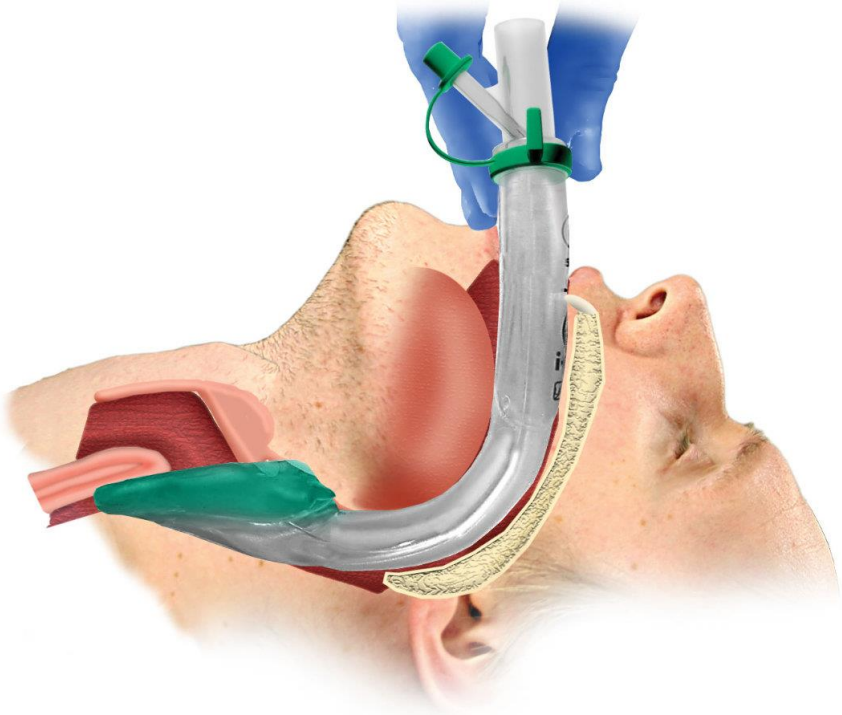


Figure 1. Differences between epidural and spinal anesthesia. In

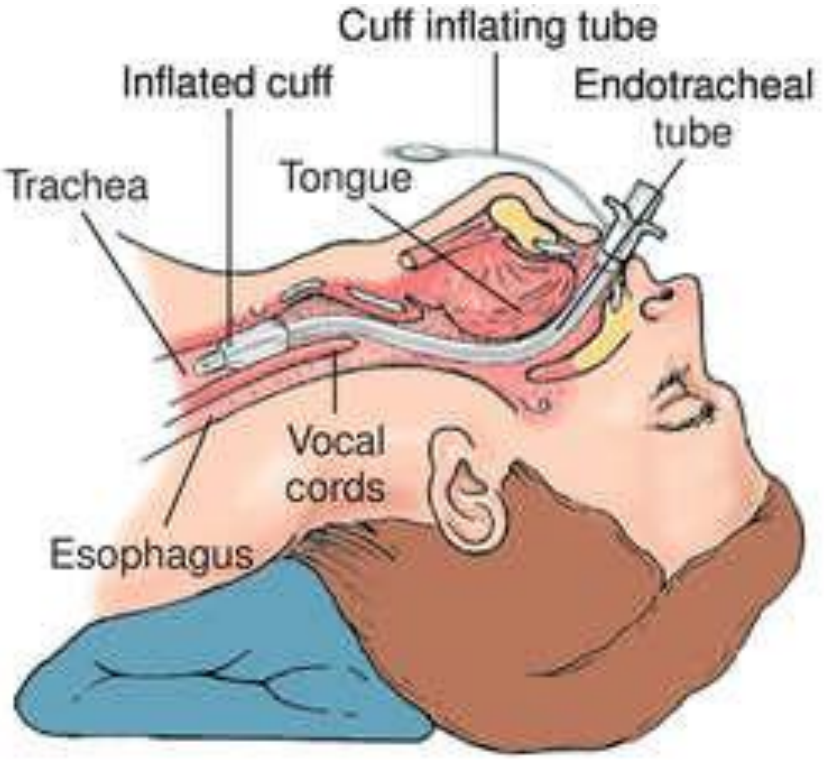
General Anaesthesia – Airways

Oropharyngeal airway (Guedel) - a medical device called an airway adjunct used to maintain or open a patient's airway

Supraglottic airway – (LMA/iGEL) - a group of airway devices that can be inserted into the pharynx to allow ventilation, oxygenation, and administration of anaesthetic gases, without the need for endotracheal intubation



Endotracheal intubation - An endotracheal tube is a flexible plastic tube that is placed through the mouth into the trachea (windpipe) to help a patient breathe.



Common Medical Suffixes Defined

Suffix	Meaning	Examples
-algia	pain	fibromyalgia, neuralgia
-cardia	of the heart	tachycardia, dextrocardia
-centesis	puncturing and draining	amniocentesis, pericardiocentesis
-cyte	cell	lymphocyte, splenocyte
-ectomy	surgery to remove	appendectomy, tonsilectomy
-emia	presence in the blood	anemia, hypoglycemia
-genic	causing	carcinogenic, pathogenic
-gram	recording	cardiogram, mammogram
-iatrics/-iatry	specialty	geriatrics, pediatrics, psychiatry
-itis	inflammation	arthritis, layrngitis, tendonitis
-lysis	deterioration or destruction	dialysis, paralysis
-ology	science of	necrology, pathology
-oma	swelling, tumor	blastoma, mesothelioma
-osis	condition, disease progress	diagnosis, prognosis
-otomy	surgical incision	lobotomy, tracheotomy
-oxia	oxygen level	anoxia, hypoxia
-pathy	disease	neuropathy, sociopathy
-phagia	swallowing	dysphagia, hyperphagia
-phasia	speech	aphasia, dysphasia
-philia/-philic	attraction to	hemophilia, hydrophilic
-phobia	fear	arachnophobia, agoraphobia
-plasty	surgical repair	angioplasty, rhinoplasty
-rrhea	flow, discharge	amenorrhea, diarrhea
-scopy	exam with an instrument	colonoscopy, endoscopy