Caesarean Birth Guideline

Guideline information

Guideline number: 638
Classification: Clinical
Supersedes: Previous version of 638 and 630 Classification of Caesareans
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Summary of document: This guideline is to support staff when providing a consistent quality of care to all patients who have caesarean birth

Scope: For use by Hywel Dda healthcare professionals to consistent quality care for women who have decided to have a planned caesarean birth. This policy uses the term “women” to reflect that maternity and reproductive care are sex-based health needs. It applies equally to all people who are pregnant or have recently given birth, including trans men and non-binary people. Care must be delivered in an inclusive, respectful and responsive way.

To be read in conjunction with:

- 371. Prevention and Management of Meticillin Resistant Staphylococcus Aureus (MRSA) Policy -opens in new tab
- NICE guideline **Caesarean birth** NG192 Caesarean birth | Guidance | NICE -opens in new tab
- 278 Transfusion Policy -opens in new tab

Owning group: Maternity Guideline, Audit and Research Group
Executive Director job title: Chief Operating Officer
Keywords: Planned caesarean birth , Unplanned caesarean birth

Contents

Scope
Guidance for healthcare professionals to support consistent quality care for women who have a planned or unplanned caesarean birth.

Aim
The aim of this document is to support the provision of consistent and safe quality of care to all patients who have a planned or unplanned caesarean birth.

Objectives
The aim of this document will be achieved by the following objectives:

- To ensure that all staff are aware that, within each category, the degree of risk in individual cases can vary
- To reiterate that consideration of the degree of risk requires an **individual, case-by-case approach** in deciding the specific decision-to-delivery interval (DDI)
- Understand that once classification of caesarean DDI has been stated plan for birth aim wherever possible for less intervals time.
- Understanding of the process when arranging a planned or unplanned caesarean birth.
- Provide consistency of care and experience across the health board.

Introduction
The National Maternity and Perinatal Audit (NMPA) State of the Nation report 2025 reported major shifts in how women and pregnant people are giving birth, including rising caesarean births which have increased considerably between 2018/19 and 2023 (unplanned caesarean birth from 15.5% to 23.1%; planned caesarean births from 12.1% to 16.4%). Within Hywel Dda University Health Board between May 2025 and June 2006 43% of births were undertaken by caesarean birth. 20.7% of women having planned caesarean and 22% having unplanned caesarean. This guideline has been developed to help to ensure consistency and quality of care experience by the women within these groups.

Classification of Caesarean Section
The traditional classification of caesarean section into ‘planned’ and ‘unplanned’ is of limited value for data collection and audit of obstetric and anaesthetic outcomes. This is because the spectrum of urgency that occurs in obstetrics is lost within a single ‘emergency’ category.

A target Decision to Delivery Interval (DDI) for caesarean births is an auditable tool allows testing of the efficiency of the whole delivery team and has now become accepted practice.

It is important for staff to recognise that in the most compromised fetuses, 30 minutes is too long an interval, while others can wait ≤75 minutes without apparent harm. it is therefore essential for all of the multidisciplinary team to recognise that:

- **The** time stated between decision for and delivery is the **upper** limit of time interval. **Wherever possible aim for less intervals time**.
- Setting a specific time for delivery during an emergency caesarean birth can be challenging due to the unpredictably of the situation and will need ongoing review until the caesarean have commenced.
- Certain clinical situations will require a much quicker DDI than 30 minutes or 75 minutes
- Undue haste to achieve a short DDI can introduce its own risk, both surgical and anaesthetic, with the potential for maternal and neonatal harm

The following classifications should be used to describe and communicate the urgency of caesarean births with the decision to delivery timing undertaken within this Health Board.

CATEGORY	DEFINITION	DECISION TO DELIVERY *NICE Auditable Standard*
1	**Immediate threat to life of woman and or fetus e.g abruption, cord prolapse, severe fetal distress, suspected uterine rupture.**	**Within 30 mins of decision**
2	**Maternal or fetal compromise which is not immediately life threatening**	**Within 75 mins of decision**
3	**No maternal or fetal compromise but requires early delivery**	**24hrs**
4	**Elective or planned at a time to suit the woman and the maternity team as scheduled list**	**Delivery timed to suit woman and person and service provision**

Timing of caesarean births.

Timing of unplanned caesarean births (Category 1 and 2)

Important The time stated between decision for and delivery is the **upper** limit of time interval. And wherever possible aim for less intervals time.

Perform **Category 1 and 2** caesarean births as quickly as possible after making the decision (particularly for Category 1), taking into account the condition of the woman and person and the unborn baby when making decisions about rapid delivery. Remember that rapid delivery may be harmful in certain circumstances

In the case of a Category 1 CS for severe fetal or maternal compromise, the Consultant should be informed as soon as possible

Category 3 No maternal or fetal compromise but needs early birth within 24 hours . This is mainly where there is already an Obstetrics indication for Caesarean that requires early delivery due to change in Maternal or fetal condition

Category 4 Planned Caesarean birth: The risk of respiratory morbidity is increased in babies born by caesarean section before labour, but this risk decreases significantly after 39 weeks. Therefore, planned caesarean section should not routinely be carried out before 39 weeks.

"Improving birth experience"

Family Centred Caesarean

Traditionally, caesarean births were associated with a clinical and detached approach, focusing primarily on the medical aspects rather than the emotional experience or emotional wellbeing of the woman. Over time the increasing recognition of the profound impact of birth experiences has highlighted the need for a more compassionate approach where the focus is on creating a more calm and peaceful birthing environment, whilst still maintaining clinical safety and there has been increasing exploration of ways to make the procedure more emotionally supportive for mothers and families.

'Family-centred caesarean birth' (also dubbed 'the natural caesarean' or 'gentle method caesarean ') aims to further transform this surgical procedure into a more inclusive, intimate and personalised family-centred birth experience while also ensuring the safety of the surgery.

To provide a family centred caesarean requires clear communication, the increased involvement of the mother and her birth partner, and creating a calm and soothing atmosphere in the operating room

There are 4 core principles to family centred caesarean:

1. Promotion of holistic birth experience.

2. Slow birth of the neonate's body, without fundal pressure
3. Optimal cord clamping
4. Early skin-to-skin contact

This generally refers to one or all of the following: a slow physiological birth of the baby, optimal cord clamping and birth into skin-to-skin. A version of these adaptations to the traditional caesarean procedure was first described in BJOG in 2008. Studies conducted to date have shown that this adaptation of the traditional caesarean birth is not associated with any increased rate of complications for woman or baby

NICE recommend that women's preferences for birth such as de-medicalisation of the birth experience should be facilitated where possible [4]. Many women and their partners wish to be actively involved in planning the birth experience at caesarean, which include discussing and facilitating the principles of family centred caesarean if so desired. The option of family centred caesarean birth may be particularly useful for women who have experienced a traumatic birth in the past and are now contemplating a planned Caesarean, or for women who feel anxious about birth to allay birth fear
A family centred caesarean should be made available to all women who are deemed surgically appropriate or suitable.

Discussion

- Offer and briefly discuss the option of family centred caesarean birth in the antenatal clinic at the booking appointment for any women who are considering birth by caesarean at this point. Family centred caesarean should then be discussed again, more fully in the third trimester for all women choosing a planned caesarean birth.

- The decision to perform a lower segment caesarean birth (LSCB) will be made in accordance with the wishes of the woman, by a ST3 trainee level or above, ensuring more complex cases are discussed with a consultant.

- The obstetric speciality trainee or consultant should discuss and document in detail the rationale for the decision, including benefits and risks with the woman to support informed written consent.

- Women should understand that a family centred caesarean birth may not always be possible in entirety even where desired, and it may become apparent during the surgery that continuation is inappropriate.

- When the caesarean is unplanned then a family centred caesarean birth can be considered dependent on clinical picture, e.g. fetal bradycardia that has recovered, concerns re: fetal distress but baby born in good condition. Provided heart rate is palpated >100bpm, the baby can be delivered into skin to skin and assessed on the mother's chest for neonatal team input if required.

Maternal Choice
Whilst promoting an enhanced birth experience by facilitating family centred caesarean birth understand that some woman may choose an alternative approach, and this should also be supported as it their choice.

Planned Caesarean Birth

Timing of birth is to also be discussed; unless clinically indicated, surgery should be planned for the 39th week of their pregnancy. Where birth is indicated prior to 39 weeks' gestation, personalised care plans will be discussed, and agreed, with a consultant obstetrician to ensure consideration is given to any additional required intervention, for example the administration of corticosteroids. Care planning should consider liaison with the neonatal team as appropriate.

Role of Obstetrician at time of booking of planned caesarean birth.
The obstetrician booking the caesarean is required at the time of booking to:

- Use the 'Antenatal discussion for Planned Caesarean Birth form' (appendix 1) discussing the principles of family centred caesarean"
- Give and discuss; "Planned Caesarean Birth" patient information leaflets (see appendices
- Confirm place of birth (GGH/BGH). Planned caesarean births for woman cared for within Hywel Dda University Health Board are undertaken in Glangwili and in Bronglais.

Note. Explain to the women that whilst we would aim to book for woman's preferred place of birth on occasion clinical priority needs may result in woman being booked for CB elsewhere within HDuHB e.g. even if woman has had all care in Glangwili the planned caesarean birth may be booked in Bronglais (or vice versa)

- Contact relevant DAU to arrange date and time for a preoperative assessment.
- Complete Consent form 1 and file in handheld notes.
- Prescribe TTH preoperative medication for woman to then be dispensed by the hospital pharmacy:
    - Advise to take Omeprazole 20mgs one tablet at 10pm the night before the operation and one tablet at 6am the morning of caesarean.
- If antenatal corticosteroids required- booking obstetrician to prescribe and arrange with DAU in GGH/WGH or BGH.
  NOTE All Diabetics requiring corticosteroids will require inpatient admission to antenatal ward.
- If woman is declining blood or blood products for personal or religious belief's refer to 278 Transfusion Policy for guidance. Ensure completion of the Jehovah Witness directive form confirming personal wishes and Consent form 5.
- Perform MRSA screening if required (see).

The Planned Caesarean Birth Booking form needs to be completed at the time of booking to support the appropriate and effective of planned caesarean lists to avoid inappropriately complex case mix lists that may then overrun. (see Appendix 1)

To effectively book the planned caesarean list

- The booking form lists all potential risk factors that affect surgical complexity.
- Having identified what risk factors patient is then allocated complexity score
- Scoring system –low risk factors scoring 1 and highest risk factors scoring 6.
- The final score for each case is determined by the highest scoring risk factor and NOT by adding all identified risk factors scores together
- For Example: If woman with one previous caesarean birth and a BMI of 59 would score 2 for previous CB and 5 for BMI. The most important surgical risk factor is the BMI>50 and therefore final score allocated is 5.
- Maximum score for any one patient is 6 and the maximum score for any one planned caesarean birth is 6 with a maximum of 2 cases per list .e.g. High-risk case of 4 and Low risk of 1

Note: At the time of booking if the proposed planned caesarean list date is already either full or with the addition of the patient the planned list is then overbooked, i.e. total score of a 7 or more (e.g. risk score of 4 and 3 on one list), then seek input of a consultant obstetrician who can review the cases booked, consider re-arranging caesarean lists to accommodate or whether request for additional list is required.

The booking doctor must explain to patient that date of planned birth is provisional, and they would be contacted should date need to be changed.

Note. Category 3 caesareans should not be booked until all other options for preforming on planned list have been explored

Information required by DAU in order to book preoperative assessment.

- Name
- Contact number.
- Hospital number,
- Consultant,
- EDD and gestation
- Indication for CS,
- Medical/ obstetric history, social concerns.
- Most recent Hb result
- Blood group /Presence of maternal antibodies
- BMI.
- Any latex allergies/allergies.
- Whether woman has requested insertion of contraceptive coil or sterilisation at time of Caesarean.

All information recorded on the CS list within the caesarean file/excel sheet.

Preoperative Assessment Appointment
Woman Attends the Day Assessment Unit

Role of DAU Midwife at preoperative assessment.

- Confirm Name, Hospital number, Address and date of birth on records.
- Check gestation at time of proposed birth date, aim for 39 weeks by EDD. Inform and agree care plan with a consultant obstetrician if <39+0.
- If prior to 39 weeks gestation review whether elective corticosteroids steroids required.
- If BMI >40, review the requirement for bariatric equipment and order from the equipment library. Porters will arrange delivery in a timely manner to be available for the planned admission date.
- Clinical observations; pulse, blood pressure and temperature. CO reading on all women.
- Abdominal palpation,
- Enquire if normal pattern of fetal movements- auscultate with sonicaid. Any concerns perform CTG.
- Bloods taken for FBC and Group and Save. Additional blood test may be required e.g. if diabetic - U&E's, if hypertensive -clotting.
- Check USS report and blood results recorded in handheld notes.
- Check MRSA results if taken.
- Check premedication TTH has been prescribed, dispensed, and understands when to take.
- Check Consent Form 1 is completed. (If not completed requires completion on day of planned birth)
- Signpost to QR code Labour pains .org for anaesthesia information. Advise that Anaesthetist will see morning of LSCB
- Ensure that main Hospital notes available.
- Antenatal discussion form completed.

If planned CB for breech presentation confirm presentation by portable USS on day of pre-op clerking in Day Assessment Unit and on day of LSCB.

Advise the woman that if cephalic presentation is confirmed on scan the planned caesarean will be cancelled as no longer indicated.

Additional information Given.

Bronglais Hospital,

AM list

Attend Gwenllian ward at 0700 on day of planned birth

Advise not to eat any food from 0300 (including milky drinks, sweets and chewing gum).

Encourage woman to drink clear fluids; which include water, black tea and black coffee until 0700 on the morning. Advise not drink to any 'fizzy' liquids**.**

PM list

Attend Gwenllian ward at 1130. Should have a light breakfast (such as tea and toast) before 0700 and then not to eat any food (including milky drinks, sweets and chewing gum).
Encourage drinking clear fluids; which include water, black tea and coffee up until 10am. Advise not to drink any 'fizzy' liquids.

Glangwili Hospital

AM list

Attend Labour Ward at 0730am on day of planned birth.
Note: if woman attends for planned CB on a Monday woman need to attend labour ward for 7am for preop bloods to be taken and sent to lab before birth
Advise not to eat any food from 0300 (including milky drinks, sweets and chewing gum).
Encourage woman to drink clear fluids; which include water, black tea and black coffee until 0700 on the morning. Advise not drink to any 'fizzy' liquids**.**

PM

Attend Labour Ward at 1130. Should have a light breakfast (such as tea and toast) before 0700 and then not to eat any food (including milky drinks, sweets and chewing gum).
Encourage drinking clear fluids; which include water, black tea and coffee up until 10am. Advise not to drink any 'fizzy' liquids.

- Confirm Place, date, and time to attend on day of caesarean
- Attend with one birthing partner.
- Will require venflon and IV infusion
- Pubic shave in theatre
- Catheter
- Will wear Anti thromboembolic deterrent (TED) stockings post caesarean birth.
- May require clexane injection.
- Following the birth:
  GGH: May spend some time to "Recover" in EMU on labour ward after theatre
  BGH: Will be recovered in theatres, supported by the midwife, and then transferred to ward.
- Advised to only shower only whilst in hospital – no bath
- Visiting hours and number of people able to attend at one time.
- Patients are informed that there may be a possibility that operation date may change due to clinical need and if this is the case, they will be contacted by telephone to rearrange the date of surgery.

All patients should be advised contact Maternity Triage, if they experience any contractions, change in fetal movements, spontaneous rupture of membranes, bleeding or any clinical concerns, regardless of planned admission.

Overview of caesarean list.

- In GGH the DAU midwives and the Consultant on service will review the caesarean booking list daily and revise/update list as required , for example: when women have already birthed prior to boked date or to make change to pending lists due to clinical indication. In BGH this is undertaken by the ward midwives and BGH week on service as required.
- The order of caesarean list is dependent on the complexity /clinical needs and gestation of the women.

Role of Midwife at Caesarean Birth

- Welcome woman when attends at appointed time when planned caesarean.
- Ensure woman admitted and enter details into Labour book if appropriate.
- Complete OBS CYMRU Stage 0.
- Check blood group suitability for electronic issue.
- Check Hb
- Ensure premedication administered.
- Consent form 1 signed and consent form 5 if required. Obstetrician to complete if not already done.
- Preoperative check list completed.
- Dress in Theatre gown
- Patient Identity bands x 2
- Generate baby ID bands x 2.
- Commence Maternity In-Patient Care Bundle
    - Clinical observations: BP, pulse, respirations and O2 sats charted on MEOWS.
    - Commence/ continue fluid balance chart.
- Medication chart (if not already commenced)
- Anaesthetic Chart & seen by Anaesthetist.
- VTE Risk Assessment tool (if not already started)
- If attending for planned caesarean enquire if normal pattern of fetal movements- auscultate with sonicaid. Any concerns perform CTG.
- For unplanned Caesarean monitor baby as appropriate to clinical situation
- Discussion around consent for catheter/ IV access
- Undertake Team Brief
    - Maternity and theatre team present
    - Discuss any medical / social concerns.
- Escort Midwife and partner to operating theatre.
- Auscultate Fetal heart after anaesthesia completed..
- Complete pubic shave if required.
- Medi Derma cream applied or consent to apply post birth. Document on medication/ drug chart.
- Resuscitaire: checked and stocked (sign on resus check form).

- Measure for TED stockings (for post birth)
- Modified WHO check list completed in theatres

Post Birth

- Discuss “Dropped Babies “and PICO dressing (if insitu), patient information leaflets and commence Risk Assessment tool.
- Undertake patient assessment for self-administration of medicines.
- Complete Midwife Facilitated Discharge Form and sticker on page 21 of the Labour Ward pathway. Ensure baby has ID bands x 2 immediately after birth.
- Leaflet is given and explained

Unplanned Caesarean

Once a decision to deliver has been made, delivery should be carried out with an urgency **appropriate to the risk to the baby and the safety of the parent.** For instance, a Category 1 CS is not always achievable in cases of raised BMI or maternal co-morbidity due to issues of maternal and birthing parent safety. If there is delay for any reason; this must be documented

The term ‘crash caesarean section’ and ‘code red’ **are not to be used** as they are nonspecific terms that cause confusion

Communication for unplanned Caesarean
Good communication is central to timely delivery of the fetus, while avoiding unnecessary risk to the parent. The time taken between decision for caesarean birth and for the patient to reach the operating theatre is a critical predictor of the DDI

The consultant or associate specialist must be involved in the decision for emergency CB and the discussion documented clearly on Badgernet

In the case of a Category 1 CS for severe fetal or maternal compromise, the Obstetric Consultant and anaesthetist must be informed as soon as possible

All members of the multidisciplinary team must be informed of the need (or likely need) for caesarean birth as early as possible,

If Category 1 unplanned caesarean birth is required the obstetric team to discuss with anaesthetic team the most appropriate and fastest analgesia with clear communication on the degree of urgency using the classification of the caesarean required of urgency e.g. This baby needs to be born in 20 minutes .

Remember: The time stated between decision for and delivery is the upper limit of time interval. Wherever possible aim for less intervals time and not the upper stated time .

Effective and prompt communication within the team promotes that all tasks and preparations for caesarean section that can be performed concurrently should be done so and that, where appropriate, roles are interchangeable.

The categorisation of risk and urgency should be constantly reviewed by the multidisciplinary team reviewed until the parent arrives in the operating theatre and the caesarean birth is commenced.

Obstetrician to complete at end of birth/operation

Record keeping

The justification and classification of each caesarean section must be clearly documented in the Caesarean Section and operation within labour and birth on Badgernet by the senior obstetrician undertaking the caesarean section

The classification and justification for each caesarean section must be clearly documented in the Birth Register and on WPAS

- Application of PICO dressing when appropriate (see appendix 5)
- Upload patient information/ details to Surgical Site Infection (SSI) database.
- Complete Discharge Advice Letter (DALS).
- Information Sharing Following Caesarean Birth

Patient information

All women who have given birth by caesarean should have patient information (see below) and this should be accompanied by a discussion by a senior obstetrician.

Patient information leaflets:
1.The “Caesarean birth. Advice and support following a Caesarean birth”
2. via intranet :Link to EIDO bilingual / Translation and Easy Read patient leaflets in different languages Hywel Dda Patient information (via EIDO)

References

MBRRACE UK: Saving Lives, Improving Mother's Care 2015-2017. Reports | MBRRACE-UK | NPEU 2019Oxford : MBRRACE-UK

New NMPA report reveals significant shifts in birth trends in Great Britain | RCOG

National Maternity and Perinatal Audit. State of the Nation September 2025
Ref 545 SON 2023 data_VF.pdf

National Institute for Health and Care Excellence (NICE) Caesarean birth. NG192. March 2021
Overview | Caesarean birth | Guidance | NICE

National Institute for Health and Care Excellence (NICE) NG 121, March 2019.
Overview | Intrapartum care for women with existing medical conditions or obstetric complications and their babies | Guidance | NICE

RCOG Planned Caesarean Birth Consent Advice (No.14)
Planned Caesarean Birth (Consent Advice No. 14) | RCOG

RCOG GTG 37a
Reducing the Risk of Thrombosis and Embolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a) | RCOG

Appendix 1. Planned caesarean birth booking form

PLANNED CAESAREAN BIRTH (PCB) BOOKING FORM

Name: Hospital number: Date of Birth:	EDD: Gestation: Parity: Telephone: Named Consultant: Booking Doctor: **Indication for Caesarean:**

Proposed date

…… sign……

Comments/amendments……sign……

Surgical Complexity and level of Risk	(Circle patient complexity score)
Risk- VERY HIGH	
Placenta accreta	Patient score 6
BMI>50	Patient score: 5
4 or more previous Caesarean Birth	
Risk-HIGH	
Multiple Pregnancy (Midwifery staffing)	Patient score 4
Previous midline laparotomy	
Placenta Praevia	
Large or clinically significant fibroids	
BMI >45	
Patient declining blood products/ cell salvage	
3 X Previous Caesarean Births	
Spinal Injury/ anticipated difficult spinal	
Recognised high risk of abdominal adhesions (previous notes)	
Risk – MODERATE	
Type 1 or 2 Diabetes	Patient score: 2
Prematurity 32-34 weeks	
1x Previous CS	
BMI>35	Patient score: 3
Ovarian cystectomy/other procedure excluding sterilisation.	
2x Previous Caesarean births	
Maternal Red cell antibodies requiring cross matched blood	
Risk – LOW	
Low risk with no other identified complexity risk factors identified	Patient score: 1
Maternal Request	
Previous Traumatic Birth	
Previous 3rd/4th degree tear	
Breech/unstable lie/ Transverse lie	

How to use the surgical complexity risk score

- Identify any risk factors and circle complexity score
- Lowest score will be 1 and maximum score for will be 6,
- Final score is the **highest scoring risk factor** of any circles (i.e. **do not** add risk factors scores together)
- Maximum total score to be booked on any one PCB list is 6
- Maximum 2 patients per PCB per list (score needs to be a total of ≤6)
- If CB list score exceeds 6 allocation of the list will require review.

1

Prematurity 34-36+6 weeks	

Special Features		**Specific Details**
Cross match/Cell Salvage (circle appropriately)		
Anaesthetic review needed pre-op		
Neonatal Cot		
Consultant Obstetrician		
Discussion with Consultant Obstetrician if birth planned under 39/40		
Other Speciality (e.g. General Surgery/Urology)		
Other Considerations		
Medical/ obstetric history, social concerns.		
Most recent Hb result		
Blood group /Presence of maternal antibodies		
BMI.		
Any latex allergies/allergies.		
Whether woman has requested insertion of contraceptive coil or sterilisation at time of Caesarean?		
Other Comments:		

UHBHDD V1. 2025

Appendix 2. Caesarean section wound care

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Caesarean Section Wound Care with a PICO 7 Dressing

You are being treated with PICO 7 Single Use Negative Pressure Wound Therapy. This system is used to reduce the incidence of post-operative wound complications. It consists of a negative pressure (or 'suction') dressing, which is connected to a small battery-operated pump (see picture below).

About your PICO dressing

Your PICO dressing will remain in place for seven days.

- The 'OK' light should be flashing green which indicates there are no problems with your PICO. You do not need to remove your PICO for any reason if the light is flashing green.
- If there is an orange light flashing, this indicates a problem with your PICO and your dressing may need to be changed. Please ring the Maternity Triage number on your postnatal notes

Green 'OK' indicator flashes

Orange 'leak' indicator flashes

Can I shower with a PICO dressing?

You can still shower with a PICO dressing, and it is important that you do. However please follow the steps below to ensure the longevity of your PICO dressing.

1. Turn off the pump by pressing the orange button.
2. Twist the connection closest to the dressing to detach the pump from the tubing. Place the pump somewhere safe. Ensure the end of the tubing attached to the dressing is facing down so that water does not enter the tube while the pump is disconnected.
3. Have a light shower, do not directly soak the dressing. Dry well afterwards.
4. Reconnect the pump.
5. Turn on the pump by pressing the orange button (it will vibrate for a few seconds, and green and orange will flash before the OK button flashes green).

Please do not put the pump itself in the shower

When will my PICO dressing be removed?

The midwife will remove your dressing on Day 7 after your caesarean section. They will follow the steps below to correctly remove your PICO dressing.

1. Press the orange button to stop the pump therapy.
2. Disconnect the pump from the dressing
3. Gently peel off the dressing, starting with the outermost adhesive strips.
4. Dispose of the batteries within the pump.
5. Dispose of the dressing and pump in your normal household waste.

How do I care for my wound after I've removed my PICO?

It is preferable to shower instead of bathe. Soaking the wound for a long period of time can soften the scar tissue and inhibit healing.

Use the shower head to clean the wound well with water then use a non-scented soap / body wash if possible (such as Dove, Sanex or Simple) and let the soapy water gently wash over the wound. Do not put any bath or shower products directly onto the wound.

Afterwards, pat the wound dry with a clean towel until it is completely dry. Wounds are more likely to become infected if wet. Do not use toilet roll or tissue as the fibres can stick to the wound. Do not apply any talc, lotion or moisturiser to the wound whilst it is healing.

Expose the wound to air every day to assist wound healing.

What are signs of infection?

Usually, patients who have had a PICO dressing do not experience problems with their wound healing. Sometimes, patients can develop a wound infection.

Signs of infection can include:

- Redness or new pain around the wound
- The wound leaking pus or other fluid
- An offensive smell coming from the wound
- Feeling generally unwell or having a temperature above 38 degrees C.

If you think your wound is infected call your GP or the Maternity Helpline, details at the bottom of the leaflet.

How do I look after my wound once it is healed?

Completed wound healing usually takes 4-6 weeks. A scar will be left once the wound has healed. The visibility of the scar differs from person to person and will continue changing over time. It will always be more fragile than it was before the operation so needs protection.

Scarred skin can be thick, lumpy, dry and itchy. To combat this, scar massage and moisturising can be started as soon as the wound is healed at six weeks. It is recommended that you massage the scar two to three times a day for 5-10 minutes each time to help soften it, to prevent skin breakdown and improve appearance.

Massage the scar with both circular and up and down movements. Use a non-perfumed moisturising cream or an emollient cream such as 50/50 paraffin or E45.

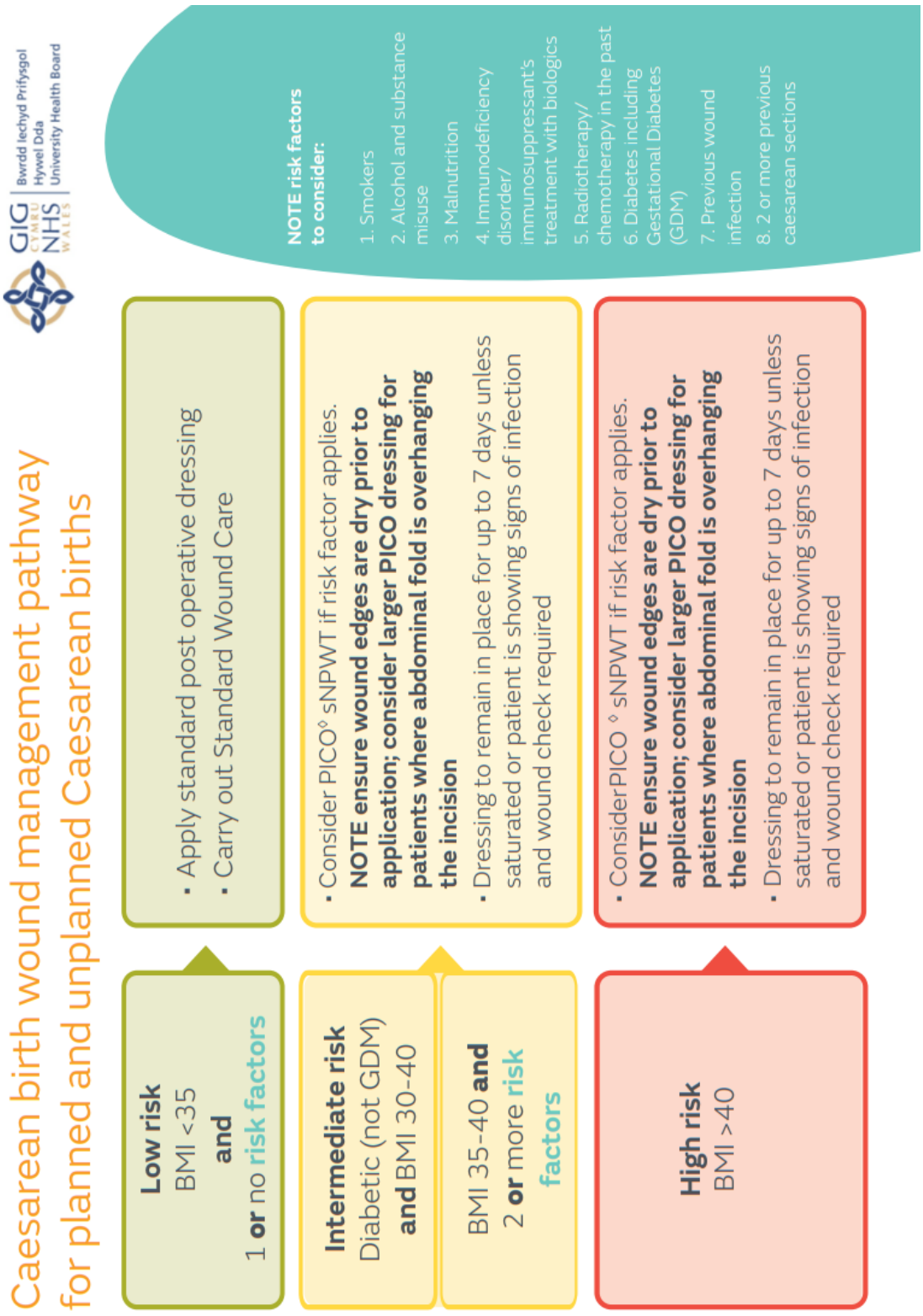
It is important to keep your scar away from direct sunlight. Scars are especially sensitive and can burn easily in the sun. We recommend that you always use a high factor sun cream on your scar when exposed in direct sunlight.

Useful sources of information

PICO negative pressure wound dressings for closed surgical incisions
www.nice.org.uk/guidance/mtg43

Version 1 October 2025 LR.

Appendix 3.Caesarean birth wound management pathway



Caesarean section wound management pathway

Dressings are kept on Labour Ward External: 01267 283317

PICO® 7 sNPWT contraindications

The use of PICO 7 sNPWT is contraindicated in the presence of:

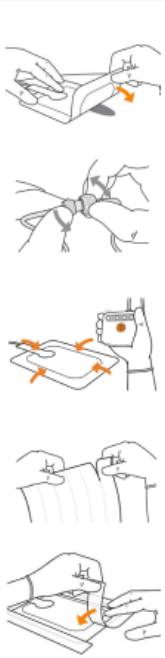
- Patients with malignancy in the wound bed or margins of the wound (except in palliative care to enhance quality of life)
- Previously confirmed and untreated osteomyelitis
- Non-enteric and unexplored fistulas
- Necrotic tissue with eschar present
- Exposed arteries, veins, nerves or organs
- Exposed anastomotic sites

PICO 7 sNPWT should not be used for the purpose of:

- Emergency airway aspiration
- Pleural, mediastinal or chest tube drainage
- Surgical suction

Dressing	Size	S+N Code	NHSSC Code
	10cm x 30cm	66802013	ELZ890
	10cm x 40cm	66802014	ELZ892
	15cm x 20cm	66802017	ELZ894

Application



Dress

1. Clean and prepare wound according to local protocol. Refer to PICO 7 Instructions for Use for details on application.
2. Peel off the central release handle and place the dressing centrally over the wound. The port should be uppermost from the wound (depending on the patient's primary position).
3. Remove the other two handles and smooth the dressing around the wound to prevent creasing.

Press

4. Insert the batteries into the pump. Following this all four indicators should illuminate for 3 seconds.
5. Join the pump to the dressing tubes by twisting together the connectors.
6. Press the orange button to start the application of negative pressure. The green OK indicator and orange air leak indicator will start to flash together.

Depending on the size of the wound, the pump should take up to 65 seconds to establish NPWT. If after 65 seconds the system has not established NPWT, just the orange air leak indicator will flash (See Pump Status and troubleshooting).

Go

7. Apply the fixation strips all the way around the dressing border.
8. The pump has a seven-day life and the dressing may be left in place for up to seven days depending on the level of exudate.*[1-2]
9. When a filler is used, the filler and the PICO 7 dressing should be changed two to three times a week.

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References 1. Kirsner R, Dove C, Reyzelman A, Vayser D, Jaimes H. A Prospective, Randomised, Controlled Clinical Trial on the Efficacy of a single-use Negative Pressure Wound Therapy System, compared to Traditional Negative Pressure Wound Therapy in the Treatment of Chronic Ulcers of the Lower Extremities. Wound Repair Regen. 2019;27(5):519 - 529. **2.** Smith+Nephew. July 2018.PICO 7Y Non-NPWT Wound Model Summary. Internal Report. DS.18.260.R.