Mock Emergency Cesarean Section Drill – SAMPLE

Coverys Risk Management encourages participation in simulation activities, such as mock emergency cesarean section drills. Effective simulation involves the actual implementation of the emergency process. Coverys Risk Management recommends establishing an emergency drill team to plan and conduct regular drills (consider quarterly) on each shift (including both weekdays and weekends) for various high-risk presentations (e.g., hemorrhage, shoulder dystocia, precipitous delivery, preterm delivery).

For emergency cesarean section drills, consider repeating the drill at 30 days to monitor the time from decision to incision. Be sure to actually require staff members to come to the hospital. It is imperative that no one on the team (including obstetrician/surgeon) receives advanced notice of the drill. This will help ensure more accurate results. Comparing the actual arrival times to projected arrival times may help identify unforeseen barriers to the organization’s capability of beginning a cesarean delivery within 30 minutes (or sooner) of the decision to operate. If these drills indicate the entire team can be on-site and perform the emergency cesarean section within 30 minutes or less, it may be appropriate to perform mock emergency cesarean section drills bi-annually. If the entire team is unable to be on-site and perform the emergency cesarean section 30 minutes, a plan to correct the situation should be developed. In addition, monthly drills should be continued. If the organization offers VBAC delivery, Coverys Risk Management recommends conducting separate drills for emergency cesarean sections, as well as for VBACs which become emergency cesarean sections.

Monitoring the ability to perform emergency cesarean sections within the time frame established by current standards of care is a proactive risk management technique. The following is from the American Society of Anesthesiology (ASA):

ABSTRACT: Good obstetric care requires the availability of qualified personnel and equipment to administer general or neuraxial anesthesia. The extent and degree to which anesthesia services are available varies widely among hospitals. However, for any hospital providing obstetric care, certain optimal anesthesia goals should be sought. These include:

I. Availability of a licensed practitioner who is credentialed to administer an appropriate anesthetic whenever necessary. For many women, neuraxial anesthesia (epidural, spinal, or combined spinal epidural) will be the most appropriate anesthetic.

II. Availability of a licensed practitioner who is credentialed to maintain support of vital functions in any obstetric emergency.

III. Availability of anesthesia and surgical personnel to permit the start of a cesarean delivery in a timely manner in accordance with clinical needs and local resources.

IV. Because the risks associated with trial of labor after cesarean delivery (TOLAC) and uterine rupture may be unpredictable, the immediate availability of appropriate facilities and personnel, (including obstetric anesthesia; nursing personnel; and a physician capable of monitoring labor and performing cesarean delivery, including an emergency cesarean delivery) is optimal. When resources
for immediate cesarean delivery are not available, patients considering TOLAC should discuss the hospital’s resources and availability of obstetric, anesthetic, pediatric, and nursing staff with their obstetric provider (1); patients should be clearly informed of the potential increase in risk and the management alternatives. The definition of immediately available personnel and facilities remains a local decision based on each institution’s available resources and geographic location.

V. Appointment of a qualified anesthesiologist to be responsible for all anesthetics administered. There are many obstetric units where physicians or physician-supervised nurse anesthetists administer labor anesthetics. The administration of general or neuraxial anesthesia requires both medical judgment and technical skills. Thus, a physician with privileges in anesthesiology should be readily available.


From *Guidelines for Perinatal Care*, Seventh Edition:
The term vaginal birth after cesarean delivery (VBAC) is used to denote a vaginal delivery after a trial of labor in women who have had a previous cesarean delivery, regardless of the outcome. Trial of labor after cesarean delivery (TOLAC) provides women who desire a vaginal delivery with the possibility of achieving that goal—a vaginal birth after cesarean delivery. … Because of the risks associated with TOLAC and that uterine rupture and other complications may be unpredictable, it is recommended that TOLAC be undertaken in facilities with staff immediately available to provide emergency care. When resources for immediate cesarean delivery are not available, it is important that health care providers and patients considering TOLAC discuss the hospital’s resources and availability of obstetric, pediatric, anesthetic, and operating room staffs. Patients should be clearly informed of potential increased levels of risk and management alternatives. After counseling, the ultimate decision to undergo TOLAC or a repeat cesarean delivery should be made by the patient in consultation with her health care provider. The potential risks and benefits of both TOLAC and elective repeat cesarean delivery should be discussed. Documentation of counseling and the management plan should be included in the medical record.


Resource:
ACOG, *Preparing for Clinical Emergencies in Obstetrics and Gynecology*

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Updated: February 2017
SAMPLE – Mock Emergency Cesarean Section Drill

Mock Emergency Cesarean Section Drill Audit Tool

Date of Drill: ____________________  Shift: ____________________

VBAC Delivery: Yes ________  No ________

Time of Decision for Emergency Cesarean Section: ________

Name and Title of Person Initiating Calls to OR Staff:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Time of Initial Call</th>
<th>Staff Name</th>
<th>Estimated Time of Arrival</th>
<th>Actual Time of Arrival</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB-Gyn or Surgeon</td>
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<tr>
<td>Anesthesia</td>
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<tr>
<td>Pediatrician</td>
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<td>Circulating Nurse</td>
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<tr>
<td>Surgical Technician</td>
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<tr>
<td>Other:</td>
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Time Room Ready: _________  Time Patient Ready: _________

Time Patient in Room: _______  Incision Time: ______________

Time Elapsed Between the Decision to Perform a Cesarean Section and the Incision: __________

Reason for the cesarean section/maternal and fetal risk factors contributing to the decision: __________

Was the mock emergency cesarean section started in a timely manner (which may be less than 30 minutes, based on the maternal and fetal risk factors)? Yes _____ No _____

If the drill involved a VBAC delivery, was the mock emergency cesarean section performed within 18 minutes from the decision to perform an emergency cesarean section? Yes _____ No _____

Was a debriefing conducted to discuss what went well and what opportunities for improvement were presented? Yes _____ No _____
SAMPLE – Mock Emergency Cesarean Section Drill

(Insert name of appropriate peer review oversight committee) Recommendations for
Risk Reduction, Patient Safety, and Improvement Opportunities:
Mock Emergency Cesarean Section Drills

Date of Mock Emergency Cesarean Section Drill: ____________
Anticipated Date to for next Mock Emergency Cesarean Section Drill: ________
Identified Opportunities for Improvement:

1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9. 
10.

<table>
<thead>
<tr>
<th>Risk Reduction Strategy</th>
<th>Measurable Indicator</th>
<th>Responsible Party &amp; Timeline</th>
<th>Status/Date Completed</th>
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STATEMENT OF CONFIDENTIALITY: [Consult with counsel regarding the wording of an appropriate statement of confidentiality to be inserted on each page of this document.]

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