



## C-Obs 14

### Categorisation of urgency for Caesarean section

The decision to delivery interval (DDI) of 30 minutes, decreed as necessary in many legal judgments seems based on custom and practice, rather than on objective evidence in relation to condition of the newborn. Therefore it is recommended that there be a four-grade **RANZCOG endorsed** classification system for emergency caesarean section. These are:

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| <b>RANZCOG Category 1</b> | Urgent threat to the life of a woman or fetus.   |
| <b>RANZCOG Category 2</b> | Maternal or fetal compromise but not immediately life threatening.   |
| <b>RANZCOG Category 3</b> | Needing earlier than planned delivery but without currently evident maternal or fetal compromise.                                      |
| <b>RANZCOG Category 4</b> | At a time acceptable to both the woman and the caesarean section team, understanding that this can be affected by a number of factors. |

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommend that there should be no specific time attached to the various types of caesarean section. Each case should be managed according to the clinical evidence of urgency, with every single case being considered on its merits. For example, a RANZCOG Category 2 caesarean section can become urgent if recurrent delays for other emergencies in a labour ward repeatedly postpone surgery. Institutions should use these RANZCOG categories, and the recommendations that follow. It is imperative that there is sufficient staffing and resourcing to meet the requirements of these recommendations. Any attempt to disguise or justify inadequate resourcing of Obstetric theatres is strongly condemned.

Judgement on the appropriateness of DDIs should be made on the basis of information available to the clinician making the decision for caesarean section before delivery and not on the condition of the baby at birth nor on the time required to access a functional and staffed operating theatre.

The DDI for emergency caesarean sections should be subject to regular audit based on the clinician's assessment of RANZCOG category prior to birth.

RANZCOG expressly recommends that 1 theatre per 4000 deliveries or part thereof be available at all times and staffed to deal with obstetric emergencies, in line with international standards. Staff allocated to obstetric theatres should receive obstetric specific training and be able to effectively deal with situations that require urgent and timely attention.

Ideally, theatre staff should be onsite and co-ordinated by a supernumerary member of the caesarean section team, this team member is not required to scrub for cases.

Hospitals providing intrapartum maternity care must be able to provide timely access of obstetric cases to an emergency theatre. In a large teaching hospital, this will necessitate at least one dedicated obstetric theatre which is quarantined from non obstetric cases in all but the most dire of clinical circumstances. It is expected that instruments, sutures etc. required for emergency obstetric procedures be stored in close proximity to the theatre designated for emergency cases.

All maternity services conducting deliveries should be staffed and equipped to perform a caesarean section promptly within the above guidelines. Where, by virtue of remote location or resource limitations, such onsite services cannot be provided, patients should be informed of the limitations of services available and the implications for intrapartum and postpartum care.

In these situations, antenatal transfer to a centre with more comprehensive services should be offered and an audit of the number of women transferring care because of these limitations, be kept so health services may make future recommendations regarding need for staffing and facilities.

Remote location units with limited facilities must have ready access to appropriate medical transport when intra or post partum transfer to another hospital is required.

## References

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### **Links to other related College Statements**

[C-Gen 2: Guidelines for consent and the provision of information regarding proposed treatment.](#)

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