Categorisation of urgency for caesarean section

Objectives: To provide health professionals and health care facilities providing intrapartum maternity care with information and recommendations regarding the various categories for urgency of caesarean section.

Target audience: Health professionals and health care facilities providing maternity and perinatal care.

Values: The evidence was reviewed by the Women’s Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

Background: This statement was first developed by Women’s Health Committee in July 2002 and reviewed in July 2015.

Funding: The development and review of this statement was funded by RANZCOG.

This statement has been developed and reviewed by the Women’s Health Committee and approved by the RANZCOG Board and Council.

A list of Women’s Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

Disclaimer This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

First endorsed by RANZCOG: July 2002
Current: July 2015
Review due: July 2018
Judicial opinion in Australia and New Zealand supports a so-called “optimal” decision-to-delivery interval (DDI) of 30 minutes. This optimal DDI is based on custom and historic practice rather than on objective evidence in relation to condition of the newborn. While acknowledging that legal opinion may guide professional practice, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) considers that a more nuanced approach to determining urgency is required. RANZCOG therefore recommends and endorses usage of a four-grade classification system for emergency caesarean section. The four categories are:

**RANZCOG Category 1**  
Urgent threat to the life or the health of a woman or fetus.

**RANZCOG Category 2**  
Maternal or fetal compromise but not immediately life threatening.

**RANZCOG Category 3**  
Needing earlier than planned delivery but without currently evident maternal or fetal compromise.

**RANZCOG Category 4**  
At a time acceptable to both the woman and the caesarean section team, understanding that this can be affected by a number of factors.

RANZCOG recommends there be no specific time interval attached to the various categories of urgency 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, and access to, obstetric theatres is strongly condemned.

Judgement on the appropriateness of DDI’s 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 one dedicated operating theatre for every 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. It is acknowledged that it is not possible in rural hospitals to have in hospital staff for 24 hours a day.

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

Where the likelihood of requiring an urgent caesarean section in labour is increased and circumstances are such that a timely caesarean section is unlikely to be achievable, early recourse to caesarean section should be considered.

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, and associated clinical requirements (such as misoprostol, and tamponade)
balloons) 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 of the implications for intrapartum and postpartum care imposed by such limitations.

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. Access is determined by retrievable service availability and weather conditions.
Other suggested reading


Steer PJ. The 30 minute decision to delivery interval for caesarean section. Is there an evidence base? Healthcare risk resources INT 2001; 3: No. 3.


Links to other College statements

Consent and the Provision of Information to Patients in Australia regarding Proposed Treatment (C-Gen 02a).

Consent and Provision of Information to Patients in New Zealand regarding Proposed Treatment (C-Gen 02b).

(C-Gen 15) Evidence-based Medicine, Obstetrics and Gynaecology

Patient information

A range of RANZCOG Patient Information Pamphlets can be ordered via:

https://www.ranzco.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets
Appendices

Appendix A Women’s Health Committee Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position on Committee</th>
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<tbody>
<tr>
<td>Associate Professor Stephen Robson</td>
<td>Chair and Board Member</td>
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<tr>
<td>Dr James Harvey</td>
<td>Deputy Chair and Councillor</td>
</tr>
<tr>
<td>Associate Professor Anusch Yazdani</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Associate Professor Ian Pettigrew</td>
<td>Member and Councillor</td>
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<tr>
<td>Dr Ian Page</td>
<td>Member and Councillor</td>
</tr>
<tr>
<td>Professor Yee Leung</td>
<td>Member of EAC Committee</td>
</tr>
<tr>
<td>Professor Sue Walker</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Lisa Hui</td>
<td>General Member</td>
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<tr>
<td>Dr Joseph Sgroi</td>
<td>General Member</td>
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<tr>
<td>Dr Marilyn Clarke</td>
<td>General Member</td>
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<tr>
<td>Dr Donald Clark</td>
<td>General Member</td>
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<tr>
<td>Associate Professor Janet Vaughan</td>
<td>General Member</td>
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<tr>
<td>Dr Benjamin Bopp</td>
<td>General Member</td>
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<tr>
<td>Associate Professor Kirsten Black</td>
<td>General Member</td>
</tr>
<tr>
<td>Dr Jacqueline Boyle</td>
<td>Chair of the ATSIWHC</td>
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<tr>
<td>Dr Martin Byrne</td>
<td>GPOAC representative</td>
</tr>
<tr>
<td>Ms Catherine Whitby</td>
<td>Community representative</td>
</tr>
<tr>
<td>Ms Sherlyn Elworthy</td>
<td>Midwifery representative</td>
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<tr>
<td>Dr Nicola Denton</td>
<td>Trainee representative</td>
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Appendix B Overview of the development and review process for this statement

i. Steps in developing and updating this statement

This statement was originally developed in July 2002 and was most recently reviewed in July 2015. The Women’s Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- Structured clinical questions were developed and agreed upon.
- An updated literature search to answer the clinical questions was undertaken.
- At the July 2015 face-to-face committee meeting, the existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix B part iii)

ii. Declaration of interest process and management

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women’s Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women’s Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.
Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

iii. Grading of recommendations

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines. Where no robust evidence was available but there was sufficient consensus within the Women’s Health Committee, consensus-based recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

<table>
<thead>
<tr>
<th>Recommendation category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Evidence-based</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Body of evidence can be trusted to guide practice</td>
</tr>
<tr>
<td>B</td>
<td>Body of evidence can be trusted to guide practice in most situations</td>
</tr>
<tr>
<td>C</td>
<td>Body of evidence provides some support for recommendation(s) but care should be taken in its application</td>
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<tr>
<td>D</td>
<td>The body of evidence is weak and the recommendation must be applied with caution</td>
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<tr>
<td>Consensus-based</td>
<td>Recommendation based on clinical opinion and expertise as insufficient evidence available</td>
</tr>
<tr>
<td>Good Practice Note</td>
<td>Practical advice and information based on clinical opinion and expertise</td>
</tr>
</tbody>
</table>
Appendix C Full Disclaimer
This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.