Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Guideline Obs 103

Division of Surgery
Directorate of Obstetrics and Gynaecology

Care of women undergoing emergency caesarean section

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Ratified by SIT: 18th July 2012
Latest date for review: July 2015

Definition

Emergency caesarean section (CS) should be undertaken where the health professional concerned suspects maternal or fetal compromise. Guidelines on electronic fetal monitoring recommend that delivery should occur as soon as possible, ideally within 30 minutes taking into account fetal heart rate and maternal factors.

Grades

GRADE 1: Immediate threat to the life of the mother or fetus. Needs to de done within 30 minutes from decision. Paediatrician should be present for in all cases.

Examples

- Prolonged fetal bradycardia,
- Cord prolapse
- Uterine rupture
- APH/abruption
- Cord PH <7.20
- Pathological CTG

GRADE 2: Maternal or fetal compromise that is not immediately life-threatening. Needs to done within 75 minutes from decision to avoid any deterioration of maternal or fetal condition.

Examples

- Suspicious CTG with slow progress in labour
- Failure to progress in labour

GRADE 3: No maternal or fetal compromise but needs early delivery.

Example

- Previous c/section or breech presentation in labour but planned for elective caesarean section

GRADE 4: These are planned and delivery is timed to suit mother and staff.

Procedure

	Action	Rationale
1.	Classify CS into one of the above categories and document this together with the reason for decision to perform emergency CS.	To facilitate communication between professionals and enable smooth flow of events while ensuring safety of mother and baby.
2.	Inform the consultant on call and document this	To reduce the likelihood of caesarean sections
3.	Inform labour ward shift leader so that a theatre team and porter can be organised Contact the paediatrician	To avoid any delays that could further compromise the health of the mother and baby.
4.	Contact on call anaesthetist (Bleep 5107) and explain the situation including the level of emergency for this delivery	
5.	Informed consent should be obtained and documented in the patient's notes.	Outline the benefits of the procedure and alternatives, as well as risks so that the patient makes an informed choice.
6.	Obtain blood for FBC, Group and Save	To ensure pre-operative haemoglobin will be known and blood is ready for cross-matching if required.
7.	Catheterize	To empty the bladder and reduce likelihood of bladder injury during the operation
8.	Record clearly the time of decision for caesarean, when the patient arrived in theatre and delivery time of baby. Reasons for any delays should be documented on Page 16 of the Perinatal Institute intrapartum notes.	As part of risk management, the delivery interval for emergency caesarean sections for fetal distress should be subject to continuous audit.
9.	Offer prophylactic antibiotics (see also Guideline Obs 26 prophylactic antibiotics at the time of caesarean section)	To reduce the incidence of post operative infection

10.	Thromboprophylaxis should be prescribed and given for up to 7 days or till patient is mobile (see also Guideline Obs 18 - Thromboprophylaxis)	To reduce morbidity from thromboembolism
11.	Cord pH should be done for all cases. (See also Guideline Obs 49 – Paired cord blood gases)	To provide additional information about the baby's welfare before delivery.
12.	A clear operation note should be written in the Perinatal Institute intrapartum notes.	To provide documentation of the procedure.
13.	Complete the on line proforma for the audit of emergency caesarean sections This is found in the labour_ward_handover drive of My Computer after you have logged on. Open caesarean section audit (a Microsoft access application) and complete on line.	To allow an ongoing continuous audit of emergency caesarean sections
14.	Post operative care of the woman will be as set out in Guideline Obs 91 -Immediate post operative care of maternity patients.	To provide adequate postoperative care
15.	The patient should be visited before discharge from hospital to discuss the reasons for the caesarean section and any implications for future deliveries. The discussion should be documented in the Perinatal Institute postnatal case notes.	To make sure patient understands the reasons for the caesarean section as often all information is not absorbed at time of emergency caesarean section.

References

1. National Evidence based clinical guidelines, RCOG 2004
2. The National Sentinel Caesarean Section Audit Report from the RCOG 2002

Process for audit

- A continuous audit will undertaken which will be presented and reviewed quarterly at the monthly departmental multidisciplinary audit meeting which will evaluate

    a. the interval between decision and delivery for all emergency caesarean sections

    b. the classification of all caesarean sections as agreed by the maternity service and following the guidance of NICE

    c. whether there has been discussion with a consultant and whether the consultant was in attendance

    d. any reasons for delay in undertaking the caesarean section

    e. whether prophylactic antibiotics were offered and given

    f. whether thromboprophylaxis was given

In addition to this

- An audit will be undertaken at least every 3 years which will audit compliance with this guideline. The audit will include as a minimum set of standards the following criteria

    a. the requirement to document the reason for performing emergency or urgent caesarean sections in the health records by the person who makes the decision

    b. the need to include a consultant obstetrician in the decision making process unless doing so would be life threatening to the women or the fetus

    c. whether prophylactic antibiotics were offered and given

    d. the requirement to discuss with women the implications for future pregnancies before discharge

- The audit will be presented at a monthly departmental multidisciplinary audit meeting following which an action plan will be formulated to correct any deficiencies identified and a date for re-audit planned.
- The implementation of the action plan will be reviewed at the monthly audit meeting 3 months after presentation