CLASSIFICATION AND COMMUNICATION FOR CAESAREAN SECTION

PURPOSE

The purpose of this guideline is to outline the principles of multi-disciplinary communication in Birthing Suite which underpin the smooth, safe and rapid transition to Caesarean Section when indicated in Christchurch Women’s Hospital.

BACKGROUND

Communication is often highlighted as an area for improvement in obstetric practice.¹ In the setting of interventions, particularly emergency Caesarean Section, excellent communication is central to effective management and avoidance of unnecessary risk to the woman and her baby.

The time taken for a patient to reach the operating theatre is a critical predictor of the decision to delivery interval. Such delay can be minimised by excellent communication both before and after decision making.²

TEAM WORK

The caesarean section team comprises many disciplines. The importance of forward planning and senior involvement cannot be over emphasised. In many cases risk factors are readily identified in the antenatal period well before labour. In such cases a clear and coherent management plan for labour should be clearly documented.

Once in Birthing Suite it is recommended that team work is enhanced by multi-disciplinary involvement at ward rounds. This, and ongoing regular dialogue between key disciplines, is required to identify those cases at high risk of intervention. Thus appropriate pre-emption will minimise the necessary steps in the event of an emergency.

PARTNERSHIP

In the event of an emergency the purpose of the classification system is to confer an immediate and unequivocal signal to all team members with respect to the degree of urgency.

The decision for mode and urgency of delivery is the responsibility of the most senior obstetrician available. It is not the intention of the classification system to determine the mode of anaesthetic. Conversely, the choice of anaesthetic must not be interpreted as a
reflection of the urgency of the situation. The decision for mode of anaesthetic is the responsibility of the anaesthetist. It is possible that the most urgent category of caesarean section may be accomplished with a regional anaesthetic.

On making the decision, it is expected that the obstetrician will immediately liaise with the anaesthetist on call to summarise the clinical situation.

In many cases the anaesthetist will wish to assess the woman with the obstetrician before transfer to theatre in order to formulate the most expedient plan for delivery.

**MINIMISE DELAY**

Once a decision to deliver has been made, delivery should be carried out with urgency appropriate to the situation. This will take into account the safety of the woman and the wellbeing of her baby. The aim is the shortest safely achievable decision to delivery interval.

No “target” time frame has been quoted for Category 1 and Category 2 caesarean sections.

Most delays between decision and delivery result from delays in transfer from the birthing suite room to the operating theatre. For Category 1 and Category 2 caesarean sections it is the responsibility of all members of the team to ensure rapid transfer to theatre once a plan has been made.

Delay can be minimised through clearly identifying the roles and responsibilities of health care practitioners to ensure tasks are performed concurrently whilst preparing for caesarean section. This process should be streamlined to omit steps which are not essential for safety.

**PROCEDURE**

When there is a need for caesarean section the obstetric registrar/obstetrician will determine the clinical urgency and advise the clinical co-ordinator (CCO) for birthing suite. The obstetrician will then inform the duty obstetric anaesthetist and provide a clinical summary.

The Birthing Suite CCO activates a Category 1 caesarean page which alerts Category 1 caesarean section team (see Appendix c for constitution of team). For category 2 and 3 the Birthing Suite CCO calls the theatre team and neonatal team (see Appendix A).
CALL PROCESS

The call process is outlined in Appendix A.

CATEGORIES

The urgency will be classified according to the following categories:

**Category 1:** Urgent caesarean section with immediate threat to life of woman or fetus.
**Category 2:** Maternal or fetal compromise requiring rapid delivery.
**Category 3:** Maternal or fetal compromise requiring early delivery.
**Category 4:** Delivery at a time to suit the woman and maternity services.

The category of caesarean section will be clearly indicated on the theatre suite whiteboard.

For Category 1 caesarean sections the aim is to deliver with minimum delay. The team should liaise and mobilise as quickly as possible to facilitate delivery. All non-essential steps which might delay transfer of the woman to the obstetric theatre should be removed.

The categorisation and therefore urgency may be upgraded at any time to Category 1 should new concerns arise:

- If this occurs prior to the woman being transferred to theatre, the birthing suite CCO activates the Category 1 page.
- If the upgrade occurs in theatre, the change in classification is communicated by the obstetric team to the attending neonatal team in theatre who will contact the on call Neonatal SMO to attend.

In the event of a Category 1 being downgraded to another category the obstetric team communicates the change in category to the neonatal team who will contact the on call Neonatal SMO.

For Category 2 caesarean sections the aim is to deliver as soon as possible taking into account other priorities in Birthing Suite.

Whilst awaiting delivery close surveillance of mother and baby must continue. If the woman’s clinical condition is stable delivery may be delayed in the event other more urgent emergencies supervene. These decisions will be the responsibility of the obstetric registrar or SMO.

For Category 3 caesarean sections the aim is to deliver at the first convenient opportunity. The categorisation may be upgraded at any time should new concerns arise.
For Category 4 caesarean sections the aim is to deliver at the convenience of the woman, her lead maternity carer (LMC), and the obstetric and neonatal services. The categorisation may be upgraded at any time should new concerns arise.

**EXAMPLE INDICATIONS FOR CAESAREAN CATEGORIES**

Example indications for the four categories are outlined in Appendix B.

**NEONATAL TEAM**

*It is vital to ensure appropriate neonatal presence at the time of birth.*

The neonatal consultant will be automatically called to attend all Category 1 Caesarean Sections.

The neonatal consultant should also be called in advance of delivery whenever a general anaesthetic is required and where significant fetal compromise is anticipated (Appendix C).

In the event that a planned regional anaesthetic is converted to a general anaesthetic BEFORE DELIVERY OF THE BABY, this will be communicated by the obstetric team to the attending neonatal team, who will contact the on call Neonatal Consultant and request their attendance.

The Neonatal Associate Clinical Nurse Manager (ACNM) and Clinical Nurse Specialist (CNS) (Advanced Neonatal Practice) or Neonatal Resident Medical Officer (RMO) will attend all Category 1 and 2 Caesarean Sections.

For all other caesarean sections the neonatal presence will be determined by the criteria set out in the accompanying neonatal team criteria for attendance document. (Refer to Appendix C)

**THEATRE LOCATION**

All operative deliveries will normally take place in Birthing Suite Theatre 26 or 27. In the event that both theatres are occupied then main theatres will be used.

If one obstetric theatre is already in use then the second on call anaesthetist and reserve theatre team will need to be mobilised.
TRIAGE IN THEATRE

Categorisation of urgency should be reviewed by the multidisciplinary team when the woman arrives in the operating theatre.

In the majority of cases it is vital to continue monitoring fetal wellbeing with cardiotocograph (CTG) in theatre whilst preparing for delivery.

The urgency of a particular situation may alter between transfer from an assessment room or birthing room to the theatre suite. It may be necessary to adjust the plan for delivery.

In some Category 1 situations, when the need for rapid caesarean section is inevitable, it may not be helpful to undertake further fetal monitoring. In these settings attempts at further monitoring may simply delay delivery.

CONSTITUTION OF TEAMS

The constitution of teams is outlined in Appendix D.

WHO OBSTETRIC SURGICAL SAFETY CHECKLIST

The Obstetric Surgical Safety Checklist is appropriate for all categories of caesarean section. A locally agreed checklist is available in this situation. Refer to Appendix E.

For a Category 1 caesarean section the criteria highlighted in red in Sign In and Time Out must be completed and all of Sign Out.

The SIGN IN is performed by the anaesthetist or anaesthetic technician.

TIME OUT is initiated by the obstetric team to ensure that the WHO Obstetric surgical safety checklist is performed.

SIGN OUT is performed by the theatre team at the end of the procedure.

ROLES AND RESPONSIBILITIES

With respect to communication, the roles and responsibilities of the various team members are outlined in Appendix F. It is expected that ISBAR principles are used throughout.

CATEGORISATION AND PREPARATION OF CAESAREAN SECTION PROCESS

For a summary of the classification and communication process refer to Appendix H.
REFERENCES


APPENDICES

Appendix A Call Process
Appendix B Example Indications for Caesarean Categories
Appendix C Constitution of Teams
Appendix D Obstetric Surgical Safety Checklist
Appendix E Neonatal Team Criteria for Attendance
Appendix F Roles and Responsibilities
Appendix G Categorisation and Preparation for Caesarean Section Process
Appendix H Summary of Classification and Communication for Caesarean Section
APPENDIX A: CALL PROCESS

CATEGORY 1
CCO pages (22) 5333 4# and activates Category 1 Caesarean Section team, Birthing Suite ward clerk phones neonatal consultant on call and asks if the neonatal consultant would like to speak to the Birthing Suite CCO. The neonatal consultant will contact the NICU ACNM to inform them that they have received the message and are on their way.

The categorisation and therefore urgency may be upgraded at any time to Category 1 should new concerns arise:

- If this occurs prior to the woman being transferred to theatre, the birthing suite CCO activates the category 1 page.
- If the upgrade occurs in theatre, the change in classification is communicated by the obstetric team to the attending neonatal team in theatre who will contact the on call Neonatal consultant to attend.

CATEGORY 2
CCO calls theatre team and neonatal team. Obstetrician to liaise with anaesthetist.

CATEGORY 3
CCO calls theatre team and neonatal team. Obstetrician to liaise with anaesthetist.

CATEGORY 4
Book through elective system.

General anaesthetic
NB: for any category of caesarean where a general anaesthetic is administered a Neonatal Consultant must be notified at the time the decision is made for general anaesthetic
APPENDIX B: EXAMPLE INDICATIONS FOR CAESAREAN CATEGORIES

1. IMMEDIATE THREAT TO LIFE OF WOMAN OR FETUS
   1. Fetal bradycardia of FHR<100bpm for >5 minutes duration with no recovery
   2. Fetal scalp pH <7.0 or lactate ≥ 5.8
   3. Cord prolapse with bradycardia
   4. Suspected scar dehiscence or uterine rupture
   5. Any other indication as determined by the obstetrician

2. MATERNAL OR FETAL COMPROMISE REQUIRING RAPID BIRTH
   1. CTG abnormality with scalp pH ≤ 7.20 or lactate 4.8-5.7
   2. Breech presentation in active labour unsuitable for vaginal birth
   3. Any other indication as determined by the obstetrician

3. MATERNAL OR FETAL COMPROMISE REQUIRING EARLY BIRTH
   1. Failed induction of labour presuming indication for induction still exists
   2. Pre-eclampsia at term unsuitable for vaginal birth
   3. Suspected IUGR unsuitable for vaginal birth with normal CTG
   4. Delay in progress of labour with no evidence of maternal/fetal compromise
   5. Women booked for elective section who present in active labour, presuming indication for caesarean still exists and birth is not deemed to be imminent
   6. Any other indication as determined by the obstetrician

4. NO MATERNAL OR FETAL COMPROMISE BIRTH AT A TIME TO SUIT THE WOMAN AND MATERNITY SERVICES
   1. Planned elective caesarean section
APPENDIX C: CONSTITUTION OF TEAMS

CATEGORY 1
Obstetric registrar and house surgeon, Anaesthetist, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife, Neonatal Team (ACNM and RMO or CNS) and on call Neonatal Consultant.

CATEGORY 2
Obstetric registrar and house surgeon, Anaesthetist, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife, Neonatal Team (ACNM and RMO or CNS).

CATEGORY 3
Obstetric registrar and house surgeon, Anaesthetist, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife. Neonatal Team (ACNM and RMO or CNS) if indicated.

CATEGORY 4
Obstetric registrar and house surgeon, Anaesthetist, Anaesthetic Technician, Theatre Coordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), Midwife. Neonatal Team (ACNM and RMO or CNS) if indicated.
## Obstetric Surgical Safety Checklist for ALL Maternity Cases

### SIGN IN (to be said out loud after the arrival of the woman)
- **CATEGORY 1**: complete only
  - Woman has confirmed her identity, procedure and consent
  - Instrumental delivery
  - Caesarean section category *(please circle)*
    - 1 2 3 4
  - NICU team have been informed
  - Category 1 – Has NICU consultant been called?
  - Other Categories – Should NICU consultant be called?
  - Anaesthesia safety check completed
  - Appropriate recent antibiotic prophylaxis given
  - Does woman have a known allergy?
    - No
    - Yes
  - Is there a difficult airway risk?
    - No
    - Yes
  - Group and hold or appropriate blood available

### TIME OUT (to be said out loud before skin incision)
- **CATEGORY 1**: complete only
  - Confirm the woman’s name and NH number?
  - NICU team status confirmed
  - Confirm all team members have introduced themselves by name and role
  - Obstetrician:
    - Are there any patient specific concerns?
    - What additional procedure(s) are planned?
    - Are there any critical or unusual steps you want the team to know about?
    - Are there any concerns about the placental site?
  - Anaesthetist:
    - Are there any patient specific concerns?
  - Scrub Practitioner:
    - Are there any equipment issues or concerns?
  - Circulating Nurse:
    - Confirm fixed body supports correctly in situ
    - Confirm the urinary catheter draining
  - Midwife:
    - Are cord samples needed?
    - Has the FSE been removed?
    - Is the resuscitator checked and ready?
    - NICU team:
    - Any specific requests?

### SIGN OUT (to be said out loud before the woman leaves theatre)
- Nurse verbally confirms with the team
  - The name of the procedure and any additional procedures recorded
  - The instruments, swabs and needle counts are correct
  - How the specimen is labelled
  - Blood loss has been recorded
- Obstetrician, Anaesthetist and Midwife review the key concerns for recovery and management of this patient.
  - Post-operative VTE prophylaxis been prescribed
  - Antibiotics been given
  - Have any equipment problems been identified that need to be addressed?
- Midwife:
  - The baby/babies have been labelled
  - Have cord bloods been taken, if relevant?
  - Have cord gases been recorded, if required?
  - Has the placenta been sent – if required?
APPENDIX E: NEONATAL TEAM CRITERIA FOR ATTENDANCE

Neonatal team attendance at birth
Neonatal staffing for emergencies: *(note times below when there are less staff available)*

<table>
<thead>
<tr>
<th>Week days/Weekends/ Public Holidays</th>
<th>Two Registered Medical Officer (RMO) or Clinical Nurse Specialist/Advanced Neonatal Practice (CNS/ANP) on duty with the Associate Clinical Nurse Manager (ACNM) One may be called out on retrievals</th>
</tr>
</thead>
</table>

The Neonatal Consultant *is called in advance* of a delivery when a senior clinician is appropriate or there is a reasonable chance that advanced resuscitation is possible.

Neonatal attendance at caesarean section
The tables below are not meant to be exclusive and it should be known that the ACNM *may* attend a birth instead of the RMO/CNS(ANP) if the RMO/CNS are busy on neonatal or already attending a birth.

Please *note* that there may be antenatal diagnoses that require a Neonatal Consultant presence regardless of Category. Those with the potential to cause cardiorespiratory compromise for example and as soon as a decision is made for a general anaesthetic.

<table>
<thead>
<tr>
<th>CLASSIFICATION FOR BIRTH</th>
<th>NEONATAL CNS(ANP)/RMO</th>
<th>ACNM</th>
<th>NEONATAL CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any general anaesthetic</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLASSIFICATION FOR BIRTH</th>
<th>EXAMPLES (not an exhaustive list)</th>
<th>NEONATAL CNS(ANP)/RMO</th>
<th>ACNM</th>
<th>NEONATAL CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 Caesarean section</td>
<td>Maternal arrest cardio-respiratory</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Fetal bradycardia of &lt;100bpm for &gt;5 minutes with no recovery</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Fetal scalp pH &lt; 7.0 and/or lactate ≥5.8</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Cord prolapse with bradycardia</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Suspected scar dehiscence or uterine rupture</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Classification for Birth

#### Examples (not an exhaustive list)

<table>
<thead>
<tr>
<th>Category</th>
<th>Classification</th>
<th>Case Scenario</th>
<th>NEONATAL CNS(ANP)/RMO</th>
<th>ACNM</th>
<th>NEONATAL CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2</td>
<td>Caesarean section</td>
<td>Placenta praevia and/or major haemorrhage with maternal compromise/fetal compromise</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significant fetal anomalies at risk of causing cardiorespiratory compromise</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CTG abnormality (eg. late decelerations) +/- with scalp pH 7.01 - 7.20 and/or lactate 4.8-5.7</td>
<td>Yes</td>
<td>Yes</td>
<td>NICU ACNM/RMO/CNS(ANP) to consider calling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Breech presentation in active labour deemed unsuitable for vaginal birth</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significant fetal anomalies at risk of causing cardiorespiratory compromise</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Category 3</td>
<td>Caesarean section</td>
<td>Failed induction of labour presuming indication for induction still exists</td>
<td>Yes</td>
<td>Not routinely</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-eclampsia at term unsuitable for vaginal birth</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suspected IUGR unsuitable for vaginal birth with normal CTG</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Delay in progress in labour with no evidence of maternal/ fetal compromise</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significant fetal anomalies at risk of causing cardiorespiratory compromise</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Women booked for elective section present in active labour, presuming indication for caesarean still exists and birth is not deemed imminent</td>
<td>Review reason for elective caesarean section as below</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Classification for Birth

<table>
<thead>
<tr>
<th>EXAMPLES (not an exhaustive list)</th>
<th>NEONATAL CNS(ANP)/RMO</th>
<th>ACNM</th>
<th>NEONATAL CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay in progress in labour</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLASSIFICATION FOR BIRTH</th>
<th>EXAMPLES (not an exhaustive list)</th>
<th>NEONATAL CNS(ANP)/RMO</th>
<th>ACNM</th>
<th>NEONATAL CONSULTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 4</td>
<td>Elective caesarean section</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twin/Triplet birth</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant fetal anomalies</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td>NICU ACNM/RMO/ CNS(ANP) to consider calling</td>
</tr>
<tr>
<td>Infant of a diabetic mother</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Birth at 37-38 weeks in line with Ref.6971 Neonatal Attendance at Caesarean Section</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX F: ROLES AND RESPONSIBILITIES

Midwife in attendance
- Care for woman and baby according to Multidisciplinary Caesarean Section Care Pathway
- Communicate with CCO for Birthing Suite
- Communicate with Theatre team
- Document contemporaneously any resuscitation. Delegate this task if necessary

Obstetric Registrar/Obstetrician in attendance
- Inform CCO for Birthing Suite
- Communicate with on call anaesthetist
- Inform consultant obstetrician
- Communicate with neonatal team or ensure that CCO for Birthing Suite has done so
- Obtain informed consent for surgery and blood transfusion and document where practicable
- Supervise woman and ensure timely transfer to theatre
- Arrange for a surgical assistant
- Initiates TIME OUT on the WHO surgical safety checklist is performed

Clinical Co-ordinator Birthing Suite
- Communicate with theatre team, PACU nurse and neonatal team
- For Category 1 Caesarean section the procedure is to page (22) 5333 4# and put a call out for a “Category 1 Caesarean Section”
- The Birthing Suite ward clerk will phone the neonatal consultant and connect call if required
- The birthing suite ward clerk will call the Birthing Suite CCO to notify them that contact has been made with the neonatal consultant
- Alerts the teams if the woman’s clinical condition is stable and delivery may be delayed in the event other more urgent emergencies supervene
- Ensure appropriate staffing and safety of other women in Birthing Suite
- Ensure that the category status has been clearly marked on the whiteboard and in theatre

ACNM or Neonatal RMO
- Confirm category status with obstetric RMO/SMO
- Assess situation and obtain history on arrival in theatre
- Inform neonatal consultant if appropriate
- Inform neonatal consultant and request attendance if the category of CS is upgraded to Category 1 after initial decision
• Inform neonatal consultant and request attendance if there is a change from regional anaesthetic to general anaesthetic before delivery of the baby

**Anaesthetist**

• Communicate with obstetrician
• Communicate with CCO for Birthing Suite
• Assess clinical situation and patient history to plan safe anaesthesia
• Inform consultant anaesthetist on call if appropriate
• Supervise woman and ensure timely transfer to theatre
• If anaesthesia changes from regional to a general anaesthetic ensure that this has been clearly communicated to NICU team as they will need to request neonatal consultant presence
• Anaesthetist or anaesthetic technician performs SIGN IN on the WHO surgical safety checklist

**Daily List Coordinator**

• Display category of caesarean section on theatre whiteboard at start of procedure
• Remove category from theatre whiteboard at finish
APPENDIX G: CATEGORISATION AND PREPARATION FOR CAESAREAN SECTION PROCESS

(NOTE: Categorisation may be upgraded at any time according to clinical concerns)

- Assessment of situation by Obstetric RMO/SMO
- Need for caesarean section identified
- Is there immediate threat to the life of the woman or fetus

**CATEGORY 1**
- Immediate threat to life of woman or fetus
- CCO pages (22) 5333 4# and activates C1 CS team
- Ward clerk phones Neonatal Consultant on-call and connect CCO
- Neonatal Consultant Mandatory

**CATEGORY 2**
- Maternal or fetal compromise with no immediate threat to life requiring rapid delivery
- Birthing Suite CCO pages members of Caesarean Section and Neonatal team (ACNM + RMO/CNS)
- Consider calling neonatal consultant

**CATEGORY 3**
- Maternal or fetal compromise requiring early delivery
- Woman transferred to theatre
- Obstetric Surgical Safety Checklist (Ref.6772) completed
- Proceed with surgery

**CATEGORY 4**
- Delivery at a time to suit both woman and maternity services
- Elective Caesarean Section booking procedure
# APPENDIX H: SUMMARY OF CLASSIFICATION AND COMMUNICATION FOR CAESAREAN SECTION

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
<th>EXAMPLE OF INDICATIONS FOR CS</th>
<th>CALL PROCESS</th>
<th>CAESAREAN SECTION TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>Urgent caesarean section with immediate threat to the life of the woman or fetus</td>
<td>Fetal bradycardia of &lt;100 bpm for &gt;5 minutes duration with no recovery</td>
<td>CCO pages (22) 5333 4# and activates Category 1 Caesarean Section team</td>
<td>Obstetric Registrar and House Surgeon, Anaesthetist, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife, Neonatal Team (ACNM and RMO or CNS) and on call Neonatal Consultant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fetal scalp pH &lt;7.0 or lactate ≥5.8 Cord prolapse with bradycardia Suspected scar dehiscence or uterine rupture Any other indication as determined by obstetrician</td>
<td>Birthing Suite ward clerk phones neonatal consultant on call and connects to Birthing Suite CCO</td>
<td></td>
</tr>
<tr>
<td>Category 2</td>
<td>Maternal or fetal compromise requiring rapid delivery</td>
<td>CTG abnormality with scalp pH 7.01-7.20 and/or lactate 4.8-5.7 Breech presentation in active labour deemed unsuitable for vaginal birth Any other indication as determined by obstetrician</td>
<td>CCO call theatre and neonatal team Obstetrician liaise with anaesthetist</td>
<td>Obstetric Registrar and House Surgeon, Anaesthetist, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife, Neonatal Team (ACNM and RMO or CNS)</td>
</tr>
<tr>
<td>Category 3</td>
<td>Maternal or fetal compromise requiring early delivery</td>
<td>Failed induction of labour presuming indication for induction still exists Pre-eclampsia at term unsuitable for vaginal delivery Suspected IUGR unsuitable for vaginal birth with normal CTG Delay in progress of labour with normal CTG</td>
<td>CCO call theatre and neonatal team Obstetrician liaise with anaesthetist</td>
<td>Obstetric Reg &amp; HS, Anaesthetist, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), PACU Nurse, Midwife Neonatal Team (ACNM and RMO or CNS) if indicated</td>
</tr>
<tr>
<td>Category 4</td>
<td>No maternal or fetal compromise. Birth at a time to suit the woman and the maternity services</td>
<td>Planned elective caesarean section</td>
<td>Book through elective system</td>
<td>Obstetric registrar and house surgeon, Anaesthetist, Anaesthetic Technician, Theatre Co-ordinator, Theatre team (Daily List Coordinator and Second Caesarean Nurse), Midwife, Neonatal Team (ACNM and RMO or CNS) if indicated</td>
</tr>
</tbody>
</table>

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Review Team: Maternity Guidelines Group

Classification and Communication for Caesarean Section
Maternity Guidelines
Christchurch Women’s Hospital
Christchurch New Zealand

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