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ABSTRACT Open Access

An Audit of the Decision to Delivery Interval During Emergency Caesarean Section at Mansa General Hospital, Zambia

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Background

Emergency caesarean section can be a lifesaving procedure for both the mother and the baby. The time it takes between the decision to perform a caesarean section and the time the baby is delivered is known as the decision to delivery interval. The standard of a decision to delivery interval of 30 minutes has not failed to attract controversy. Many argue that assessing the decision to delivery interval alone without an analysis of other factors that may contribute to early perinatal morbidity and mortality may be flawed. Ostensibly, the decision to delivery interval falls within the bracket of the third delay and at Mansa General Hospital, Luapula province of Zambia, there have been attempts to associate obstetric outcomes with the decision to delivery interval. We conducted an audit of the emergency caesarean sections at Mansa General Hospital in Zambia and the factors associated with the decision to delivery. The aim of the study was to describe the factors associated with the decision to delivery interval during emergency caesarean section at Mansa General Hospital in Zambia.

Material and Methods

Using a cross sectional study, we enrolled, a total of 209 pregnant women who were indicated for emergency caesarean section. Data was collected from patients' files, registers and doctors' audit records between July and October, 2019. We reported descriptive statistics of the data collected. The process and timing of the delivery were recorded.

Results

The mean age of the pregnant women studied was 24 years and 53% of them were nulliparous, with a mean parity of two. The mean decision to operating room interval, decision to incision interval and decision to delivery were 39, 87, and 94 minutes respectively. Only 1.49% of the patients had a decision to delivery interval of less than 30 minutes and 55% had a decision to delivery Interval of more than 75 minutes. 43% of the caesarean section were done for cephalopelvic disproportion, 30% for foetal distress while 26% were done for other indications including previous caesarean section, antepartum haemorrhage and breech presentation. Lack of theatre space was the cause of delay in 35.8% of the cases. Anaesthesia related delays contributed to 19% of the cases while 19% of the delays occurred on the labour ward during the preparation of the patients. Laboratory problems, extraction of the baby and lack of human resource accounted for 25% of the delays.

Conclusion

The set standard for the decision to delivery interval is less than thirty minutes. In this study, only 1.49% of the clients had a decision to delivery Interval of less than thirty minutes. The major cause of delay was lack of theatre space followed by anesthetic delays and delays in the labor ward. There is urgent need to find space in

existing operating theatres to expedite surgeries. Anesthetic and labor ward staff must be encouraged to improve on the preparation of patients before they are taken to theatre. This will reduce on the decision to delivery interval and improve maternal and fetal outcomes.