Best Practice & Research Clinical Obstetrics and Gynaecology 29 (2015) 1044–1057

Contents lists available at ScienceDirect

Best Practice & Research Clinical Obstetrics and Gynaecology

journal homepage: www.elsevier.com/locate/bpobgyn

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Team training for safer birth

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Keywords:
teamwork
training
multi-professional
situational awareness
emergency
communication

Effective and coordinated teamworking is key to achieving safe birth for mothers and babies. Confidential enquiries have repeatedly identified deficiencies in teamwork as factors contributing to poor maternal and neonatal outcomes. The ingredients of a successful multi-professional team are varied, but research has identified some fundamental teamwork behaviours, with good communication, proficient leadership and situational awareness at the heart. Simple, evidence-based methods in teamwork training can be seamlessly integrated into a core, mandatory obstetric emergency training. Training should be an enjoyable, inclusive and beneficial experience for members of staff. Training in teamwork can lead to improved clinical outcomes and better birth experience for women.

Background

Birth is usually very safe in the developed world; however, it is not without risk [1]. One in six women in the UK faces a potentially life-threatening intrapartum emergency, with one in 12 labours resulting in poor maternal or neonatal outcome [2]. Obstetric emergencies can develop rapidly and unexpectedly, requiring an efficient and coordinated response from the multi-professional team.

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http://dx.doi.org/10.1016/j.bpobgyn.2015.03.020
1521-6934/

Fortunately, many of these emergencies are rare. Accordingly, combined with the mandatory reduction in working hours, it can be difficult for maternity staff to learn by experience alone. Training should provide an opportunity for members of staff to learn, refine and practise the necessary skills required to manage both the common and uncommon high-risk situations effectively.

We should empower clinicians to feel confident, leading the management of obstetric emergencies; yet, evidence from research suggests otherwise. In a multicentre survey of 614 multi-professional staff in the USA, less than two-thirds of the participants replied that there was clear leadership in these situations [3]. In an Israeli study, in which 60 obstetric trainees and 84 midwives were video-recorded managing obstetric emergencies (eclampsia, shoulder dystocia, breech extraction and post-partum haemorrhage (PPH)), feedback indicated that 68% were not trained to take independent action in any of the four selected scenarios. Furthermore, 64% had never been required to lead the management of these emergencies in real life [4].

National confidential enquiries and medico-legal cases highlight the devastating consequences of suboptimal care resulting from inadequate experience, repeatedly citing poor teamwork as a factor contributing to poor outcomes [5,6].

Consequently, there has been a drive to promote effective teamwork training. In maternity, the 2004 King's Fund report 'Safe Births: Everybody's business' advocated teamwork training for all maternity staff, highlighting the key issues of leadership and communication [7]. More recently, the Royal College of Obstetricians and Gynaecologists (RCOG) published 'Becoming Tomorrow's Specialist', which actively promotes teamworking and discourages clinicians from 'working in isolation'. The report emphasises the need for effective teaching in multi-professional teamworking from the outset of training [8].

The primary recommendation in the most recent confidential enquiry, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), is to tackle the ongoing problems with communication, clinical leadership and teamwork in maternity care. The report recognises that reduced hours and shift patterns present difficulties regarding training and continuity of care. It underlines the need for seniors to take responsibility for coordinating care, and it emphasises the importance of joint communication and agreement between midwives, obstetricians and anaesthetists when managing critically ill women [9].

The importance of teamwork training has been emphasised throughout the National Health Service (NHS). In 2008, a Patient Safety report from the House of Commons recommended that 'those that work together should train together', underlining skills such as teamwork, leadership and situational awareness [10]. This was echoed in the recent Keogh report, which highlighted the need for customised training in teamwork for all NHS staff [11].

This chapter summarises the most up-to-date research on how best to prepare maternity staff to deal with these high-stake emergencies, focussing on the risks involved, the core characteristics of an effective team and evidence-based training methods.

Risks of poor teamwork

The consequences of deficient communication and a lack of leadership are far reaching, and the stakes are high. Poor teamwork can result in huge physical, psychological and financial costs to those involved.

Maternal risks

Recognition of serious illness can be challenging in the obstetric population. Not only are pregnant women generally younger and fitter than the general medical population, but also the physiological adaptations of pregnancy can mask deterioration and conceal complications. Consequently, an awareness of the early warning signs is essential to improve detection of the critically ill pregnant patient and to avoid unwanted delays in effective management. Good teamwork and communication are vital.

Maternal mortality

Half of maternal deaths are avoidable [6]. Maternal cardiac arrest is a time-critical and rare event. Any delay in the recognition of a woman who is peri-arrest is perilous. Management requires all