Prioritisation on the labour suite

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Abstract

The ability to successfully prioritise the workload on a labour suite is an essential skill for a trainee obstetrician to develop. It requires a trainee to develop effective leadership skills which encompass the ability to work and communicate well in a multidisciplinary team of obstetricians, anaesthetists and midwives who are all vital members of the labour suite team. In addition, the trainee needs to be organised, able to delegate work appropriately, and have a high level of situational awareness to anticipate issues arising on the labour suite.

Keywords labour suite; obstetrics; pregnancy; prioritisation; triage

General principles

The workload on a labour suite varies little over the course of 24 hours with the exception of elective work such as planned caesarean sections and inductions of labour. The work carried out is varied in nature and may include caring for women requiring high dependency care through to supporting natural birth. Similarly the experience levels of healthcare professionals involved in intrapartum care will vary from newly qualified midwives and foundation trainees through to Band 7 midwives and consultant obstetricians. The working day is structured around formal handovers and regular ward and board rounds which should enable current and potential future problems to be identified.

Handover

It is recommended that a period of time is allowed for a formal handover between staff at the shift change over. The handover should be multidisciplinary and involve the midwife co-ordinating the labour suite, the incoming and outgoing obstetric and anaesthetic teams and, where possible, the senior obstetrician and anaesthetist covering the labour suite. A handover that is supported by written documentation has been shown to improve the retention of information minimising the risk of important patient information becoming lost.

Structuring the handover using the SBAR (situation, background, assessment and recommendation) tool keeps the process of giving information efficient and succinct and allows all members of the team to contribute to handover in an organised way. All consultant led cases should be discussed along with new referrals to the unit and midwifery led cases as required. The handover for each patient should include the current management plan and detail any outstanding investigations or jobs that need to be completed. Any woman who is pregnant on a non-obstetric ward should also be discussed so that care can be co-ordinated.

Ward rounds

At the start of each shift there should be a ward round involving the obstetric team, the co-ordinating midwife and, where possible, the anaesthetist covering the labour suite. The safer childbirth report recommends that when there is no consultant presence on the labour ward there should be two ward rounds in the day with a further round in the evening.

The complexity of individual cases and the workload on the labour suite should determine the frequency of additional board or ward rounds. Women receiving high dependency care on the labour suite should be reviewed at least four-hourly. The ward round is the time to identify any current problems and develop a management plan. It is also an opportunity to identify potential future problems and put in place plans to reduce the risk of complications arising.

Balancing planned and emergency work

A large proportion of the workload on a labour suite is emergency cases and the degree to which they are predictable will vary. The planned work on a labour suite takes place on most days and includes elective caesarean sections and inductions of labour. In most units the planned workload will need to be fitted in amongst the emergency work. In recent years, a gradual rise in elective caesarean section and inductions of labour had increased the workload on labour suite. Therefore, as part of the skill of prioritisation, it is vital that a trainee develops an understanding of balancing an increase workload of elective and emergency work.

Non-technical skills

Originally adapted from the aviation industry, non-technical skills are the cognitive, social and personal resource skills that complement clinical and technical skills. Non-technical skills such as effective leadership, high levels of situational awareness, good decision making, workload management and communication can improve patient safety. Such skills are of particular relevance in our specialty, where multiple tasks are often required simultaneously.

The link between poor teamwork, communication and poor maternity care has been highlighted in previous CMACE reports and the Kings Fund safer birth enquiry with the outcomes being increased maternal mortality and also significant morbidity and economic losses, with obstetrics and gynaecology malpractice claims representing half of the UK NHS litigation bill over the last 10 years. Therefore, there had been a more recent emphasis on developing non-technical skills in medicine through leadership and patient safety initiatives. The non-technical skills for surgeons (NOTSS) tool is a behavioural marker system initially developed by the royal college of surgeons of Edinburgh to aid

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trainers in providing feedback to trainees on non-technical aspects of their management. This has been adapted for use on labour ward and gynaecological theatres and is gradually being introduced into the curriculum.

Situational (or situation) awareness: situational awareness is the ability to understand the workload and the resources available to you and how you can best use this information to prioritise tasks, anticipate future problems and take effective actions. This concept is crucial to prioritising the workload on a labour suite, where multiple tasks may present themselves simultaneously, task interruption is common, and delegation is often required. Situational awareness can occur at three levels, namely the procedure, the patient and the relationship between the team and environment. For example, whilst performing a procedure such as a complex caesarean section, surgical complications such as haemorrhage and injury to internal organs need to be anticipated. Situational awareness whilst communicating to patients involves being aware of their concerns and how our position as doctors and the way we communicate can influence the dynamic with the patient. Situational awareness of the workload on labour suite can be aided by regular board rounds with the labour suite co-ordinator, anaesthetist and junior colleagues in order to maintain a shared mental model and in doing so any future events can be anticipated and workload delegated appropriately and in a timely manner.

Decision making: decision making requires an assessment of the situation and choosing a course of action. The woman should be involved in the decision making process with the benefit of clear, accurate information so that she can make an informed choice. It is also necessary to review the result of a chosen plan of action, check that the desired outcome has been achieved and default to a 'Plan B' if necessary. Decision making may be influenced by fatigue, time pressures, the feasibility of available options, task demands, experience and the levels of support available to you.

Communication: effective communication with the multidisciplinary team and the women is crucial to ensure optimal birth outcomes. The ability to communicate effectively with the mother and her partner is essential in order to gain their confidence, provide reassurance in a stressful situation and to avoid complaints. In emergency situations, once a crisis has been recognised, verbalise the crisis clearly and use close loop communication (task clearly and loudly delegated to specific individuals and task accepted, performed and completion of task acknowledged by the individuals) to ensure clear communication which will produce efficient team working. Staff should be encouraged to use the SBAR format (situation, background, assessment and response) in transmitting critical information during handovers, advice telephone calls and referrals. Although poor communication does not always lead to harm, it may lead to an increase in frustration, complaints and litigations, and delay in treatment.

Dissemination of information and mobilising the necessary staff can be streamlined by making certain that the bleep numbers of all relevant medical staff including on-call consultants and a list of the extension numbers that may be required (ward, laboratories, porters) are clearly displayed and up to date.

Leadership: good leadership skills are essential to the smooth running of the labour suite. This involves motivating, directing and organising the medical and midwifery team, encouraging individuals to work together, appropriately triaging and delegating the workload, assessing performance and generating a positive environment. One of the keys to good leadership is to make decisions at the appropriate times so that clear plans exist for all women, meaning that both patients and staff understand what is happening and what will happen going forward.

Teaching

Labour suite is an excellent place for learning opportunity and senior trainees are expected to engage with teaching medical students and supervising more junior doctors and midwives when labour suite activity allows. By supervising midwives with suturing and cannulation, this will help empower the midwives to be able to cannulate their own patients when access is required prior to commencing Syntocinon or in a post-partum haemorrhage. This in turn will provide greater flexibility to delegate tasks during busy periods and help reduce any unnecessary delays. However, supervision of trainees should be balanced against the trainee's own educational needs and they should only be supervising procedures to a level that is appropriate for their stage of training and competency level. Quiet periods on the labour suite can be used to complete workplace based assessments such as mini CEX, OSATS, NOTTS and to provide constructive feedback.

Consultant presence on labour suite

Currently most maternity units in the UK have consultant presence on the labour suite during daytime working hours. Larger units may have a consultant presence out of hours as well. The aim of this is to improve patient care and safety and also to provide support and supervision to trainees to maximise their learning opportunities. Trainees should be encouraged to take this opportunity to complete workplace base assessments requiring direct observation of a patient encounter or clinical skill such as mini CEX, OSATS and labour ward assessment tools. Situational awareness on labour ward can also be assessed using the non-technical skills for surgeons (NOTTS).

Simulation training

With the implementation of the European Working Time Directive, specialty trainees are spending fewer hours on the labour suite leading to a reduction in their experience of managing obstetric emergencies. Successive confidential enquiries have consistently identified problems such as poor communication and poor or non-existent team-working as obstacles to the provision of care. Simulation based training provides an opportunity to develop and practice the technical and non-technical skills necessary to successfully manage obstetric emergencies.

Senior specialty trainees should aim to become involved in the running of these drills as this will help to fulfil the