Prioritisation on labour ward

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Abstract

Labour ward is a demanding and rewarding area of specialised work. It requires a specific skillset, of which one of the most important is knowing how to prioritise. The workload may include multiple simultaneous emergencies and women and their babies with complex needs. To prioritise safely, an obstetrician needs to act as a leader, communicate and delegate appropriately, work within the multi-disciplinary team, and all whilst maintaining situational awareness.

Keywords labour ward; obstetrics; prioritisation; triage

Introduction

The workload varies on each shift on the labour ward, both in the amount and complexity of elective and emergency cases. There can be a variation in the skill mix of the midwifery and medical staffing on each shift, with both permanent and locum staff.

It is thus vital to begin each shift with a structured handover followed by a ward round. This will facilitate individualised safe management plans for the women and their babies. Tasks can be prioritised, and completed in a timely manner by the most appropriate skilled professional.

Regular multidisciplinary board rounds will help staff to maintain an organised structure throughout the day, or the night, and help to re-prioritise when new cases arise and unexpected emergencies occur.

Staffing

There are numerous members of staff involved in running a safe labour ward. Knowing the staff's level of experience and expertise, and their familiarity with the unit, will aid with delegation of tasks and multi-disciplinary rewarding work for everyone.

The most visible members of the team are the medical teams, both obstetric and anaesthetic, and the midwives, including the co-ordinating midwife in charge. Doctors will include Foundation Year 2 doctors, GP specialty trainees, obstetrics and gynaecology specialty trainees year 1 and 2 (career 'SHOs'), specialty trainees years 3–7 ('registrars'), and consultants. Establishing levels of experience at the beginning of each shift will allow for appropriate delegation and support for the individual staff members. One must remember that a junior doctor, for example, may be a specialist trainee who has never done obstetrics before, or it may be a specialist trainee year 7 who is about to apply for consultant jobs. Ascertaining the skills and experience of each of the medical team members will also help in appropriately using training opportunities that present themselves over the course of the shift.

Important team members on labour ward include obstetric theatre nurses, operating department practitioners (ODPs), ward clerks, maternity healthcare assistants, medical and midwifery students, housekeepers and porters. Knowing theatre capacity and theatre team availability can help prioritise surgical cases.

Other departments and wards which work closely with labour ward include general theatres (other departments' theatre requirement would affect number of theatres available and theatre staff), adult intensive care, neonatal intensive care, the emergency department, and the antenatal and postnatal wards.

Handover

Handover was defined by Merten as 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or groups of patients, to another person ….. on a temporary or permanent basis'. This definition suggests that the professional can only take over care if they 'receive all relevant information to continue the treatment or care effectively and safely'.

A good handover does not just happen by chance, and it is not simply a tick box exercise. It benefits women and their babies by maintaining safety and decreasing the dangers of discontinuity of care. It improves patient's confidence in the team when they are knowledgeable and up-to-date (labours often cross handovers).

A good handover (see Box 1) can benefit the medical team too. It is an excellent opportunity for learning and reflection. It allows the medical staff to share difficult cases and leads to a decrease in stress levels. However, handover can be very challenging. Handovers can be complicated by high acuity and an

Example of an SBAR handover

Situation

Mrs Smith in bed 4 is an antenatal lady for induction of labour for reduced fetal movements.

Background

She is 32 years old, BMI 26, P0, currently 28/40. No other medical history, normal 36/40 ultrasound. Uncomplicated pregnancy.She was given 2 mg Prostin at midnight.

Assessment

Observations are stable and CTG is normal. Abdomen is soft. She is experiencing some tightenings but no contractions. On VE she is 2 cm dilated, favourable cervix.

Recommendation

She can be transferred to labour ward for an ARM.

Box 1

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unpredictable number of complex patients (some requiring multiple team inputs), the frequency of team changes, including senior cover, and the movement of patients between wards and rooms (see Box 2).

A good handover requires shared responsibility and a co-ordinated approach by the entire MDT, and the organisation. Adequate time, a suitable place, and IT equipment (if necessary) should be set aside. Virtually all aspects of routine care can wait for 30 minutes to allow for handover to be uninterrupted, however in obstetrics this is sometimes not possible due to the urgency of care provided. Hence it is even more important to handover well in stressful times. Clear leadership of handovers is essential.

Handovers should start with a general introduction of all staff. This should include name, and position including level of experience, if any of the team is new, or a locum in the unit. This is essential in delegating routine tasks to the most appropriate professional, but also in case of an obstetric or medical emergency. Locum members of staff once identified should be familiarised with the unit, shown the location of emergency theatres, how to call for help in an emergency, and where emergency equipment is located.

A safety huddle, including the managerial staff, is also useful to update the team about any staffing issues and the elective work planned for that day. It is common in all units to expect and manage staffing shortages in specialities. It is important to bear this in mind when planning and prioritising the tasks for the shift.

When handing over an individual patient, it is vital that sufficient and relevant information, including management plans, should be included. The SBAR (Situation, Background, Assessment, Recommendation) format is one useful way to add structure to handover to reduce miscommunications and maintain safe care.

Handover omissions

Saturday night

Mrs Begum is dizzy on mobilising, can you please take bloods for her?

Sunday day

Mrs Begum's FBC was normal. Reporting abdominal pain and not yet mobilised. Plan is to optimise analgesia and continue with routine postnatal care.

Sunday night

Crash call to postnatal ward as Mrs Begum unresponsive and hypotensive. Taken to theatre and haemoperitoneum found.Mrs Begum, who had been handed over as needing a blood test, had undergone a difficult third caesarean section. However, it wasn't noted that there were, in fact, two Mrs Begums on the ward, so the wrong Mrs Begum was bled and her result had provided false reassurance. It is important to hand over name, bed number, and hospital number, as well as the clinical rationale for investigations so the incoming team have the full picture and can provide safe care.

Box 2

Ward round

At the start of any shift, day or night, there should be a multidisciplinary ward round with the obstetric team, co-ordinating midwife and anaesthetic team. This allows a further review of the relevant information about each patient, an opportunity for the woman and her birth partner(s) to meet the whole team when appropriate, and the agreement of a plan for further management, following discussion with the woman, her birth partner and the midwife looking after her. The multidisciplinary team can discuss potential concerns, such as increased risk of postpartum haemorrhage, and put plans in place to reduce the risk of harm. The complexity of a case should determine how often the woman is reviewed and by whom. At the end of the physical ward round it is useful to meet at the board to summarise the plan for each room and decide when the next MDT board round will be.

Elective work

Elective work is non-urgent obstetric work that needs to be completed, generally during the day shift. For the labour ward this includes elective caesarean sections, inductions of labour and elective cervical sutures. Due to staff shortages, or acuity, it may become necessary to re-prioritise the elective work, and clear communication with the patients is important.

Depending how units are set up, it may be important to assess the acuity of the labour ward, and consider the possible need for a second emergency theatre before proceeding with elective work.

Rates of operative delivery, including caesarean section, and induction of labour are both increasing, meaning that this is becoming a larger proportion of the workload, making it even more important to clinically assess cases and prioritise according to clinical need.

Skills to develop

Many of the crucial skills needed to successfully manage a labour ward are non-technical skills; social, cognitive and personal skills that complement clinical skills and directly affect patient safety. These improve with experience, exposure and guidance from senior colleagues of all specialities. Senior colleagues should be encouraged to give structured feedback on these non-technical skills using the NOTSS form on the e-portfolio.

Situational awareness

The Each Baby Counts report defines situational awareness as 'the perception of the elements in the environment within a volume of time and space, the comprehension of their meaning and the projection of their status in the near future' (2015).

Assessment of a situation, understanding it, and interpreting it with a 'helicopter' view, along with a predicted projection of how it will evolve, all help to inform decision making. Our memory is limited and when overloaded, clinical tasks can be forgotten or clinical signs and symptoms misunderstood which may create a chain of events leading to an unintentional poor outcome.

Genetics, environment, health, fatigue and stress can all affect our individual memory. The acuity of a busy labour ward, with multiple simultaneous complex cases, provides a great challenge in maintaining situational awareness. It is important to involve

senior clinicians when there is a particularly busy shift, or a critically unwell patient, as the junior team unknowingly may lose situational awareness. Any member of the team can approach the consultant or midwifery manager in these situations to ensure patient safety is safeguarded. The latest MBBRACE report has emphasised that when complications arise, senior help is often called far too late. It is easy for a junior doctor to feel like they are managing a situation or a busy ward, but in reality they are only just coping.

Distractions can contribute to a lack of situational awareness. If undertaking a complex task, it is safer for the operator not to be interrupted. For example, prior to an operative delivery, the coordinator should be informed so that she can help delegate or approach other team members should routine queries arise.

Different team members may have valid concerns and the team should encourage them, sharing this regardless of their seniority. The labour ward board is a useful tool for this and should be frequently updated throughout the shift and referred to by the whole team.

Loss of situational awareness can also affect how we communicate with the patient and her birth partner(s). When dealing with life threatening emergencies, such as postpartum haemorrhage, the team can easily become so involved with providing direct clinical care, that no one is communicating with the patient and addressing her fears and concerns.

Decision making

This requires situational assessment and subsequent action(s). Women and their birth partners should be involved wherever possible. All options, and their associated benefits and risks, should be discussed to facilitate an informed choice.

All plans should be reviewed on a regular basis as they may need to be changed as the situation evolves. Being a good leader means being open to the views of other team members, the patient and her family. Fixation on a particular plan, or outcome, such as a vaginal delivery, can lead to unintended harm to a woman and her baby, as illustrated by examples from the Each Baby Counts study.

Time pressures, staffing shortages, fatigue, inexperience, equipment availability, and levels of support can all influence our decision making process, and we should always consider asking for help when we are struggling.

Communication

It is vital to communicate well with both colleagues, and women and their families. Labour and birth is often unpredictable and may be a frightening time for women and their birth partners. Good communication can reduce anxiety, improve confidence in caregivers, improve outcomes and patient experience, and reduce complaints.

Emergency care can be expedited by using the bleep system; emergency calls such as the massive obstetric haemorrhage call, or emergency neonatal and obstetric call, can ensure the necessary emergency team are all notified urgently. The MDT should communicate in a calm coherent manner and have a coordinated approach. At the outset, it is important to have verbalised the emergency (e.g. cord prolapse, shoulder dystocia etc) to ensure no time is wasted and appropriate help is sought. When teams arrive, the SBAR format should be used where possible to make communication as clear as possible.

Closed loop communication, whereby a direct instruction is given to a specific person and they feed back to the leader once they have completed the task, is advisable. Poor communication can lead to delay in appropriate help, incorrect diagnosis, unsafe management, frustration, complaints, and harm to the woman and/or her baby.

Teamwork

Prosser–Snelling provides the following description of what it is to be a team, and how a good team should function; 'a group of people working together in an organisation who are recognised as a team, who are committed to achieving team level objectives upon which they agree, who have to work closely and interdependently in order to achieve those objectives, whose members are clear about their specified roles within the team and have the necessary autonomy to decide how to carry out team tasks, and who communicate regularly as a team in order to regulate team processes'.

To optimise teamwork, first and foremost the team should be clear about their task. On labour ward this should be to provide a safe labour and delivery for both mother and baby and a good experience for her and her birth partner(s).

It should be clear what skills are needed in order to achieve this and the appropriate members of staff should be included in the team. It should be clear who everyone is in the team, which is why general introductions at handover are important. The labour ward teams may often be large, making it difficult to remember everyone's abilities and expertise. There should be no reluctance in asking a member of staff their role and seniority if unclear.

Teams function better in a positive, supportive, and appreciative atmosphere. Obstetrics and gynaecology trainees have reported the highest rates of bullying and undermining of all specialities. Rectifying this requires a cultural shift on behalf of trainees and trainers to assess their progress and reflect on the quality of care that they provide, in a transparent and kind manner. A debrief at the end of a shift or after a major emergency, is often helpful to allow members to reflect and feel supported.

Leadership

Being a leader on labour ward involves organising, directing and motivating the medical and midwifery teams and delegating tasks whilst constantly reassessing the environment. A good leader creates a positive work environment in which team members feel well supported and unified to achieve a common goal. It is the leader's responsibility to be decisive on labour ward, whilst being open to other points of views, including the patient and her family.

Prioritising

Prioritising is the process of deciding the urgency of a case, or action, in the context of other concurrent clinical demands. This triaging is crucial in providing the right care to the right patient at the right time. This is key on labour ward where there are often

multiple events occurring simultaneously. Cases can either require action immediately (straight away), urgently (within the next 30 minutes), or may be delayed (requires treatment but there is no time frame). In obstetrics, threats to maternal or fetal wellbeing influence the urgency of a case. In immediate threats to maternal life, the woman should be assessed using the ABCDE approach and management started as necessary during assessment. This can then be followed by an assessment of fetal condition, but the mother's wellbeing taking priority.

Time management

This requires that decisions and management plans are carried out in a timely fashion. It is important not to defer making decisions, as this can lead to a relatively straight forward situation becoming much harder to manage and complex with the passage of time.

Senior team members should be involved at the earliest opportunity if any doubt exists regarding the correct course of action. Being prepared for possible complications means having clear contingency plans in place and avoiding unnecessary panic. It is useful to try and manage complex elective cases during the day, when there are more staff available in the hospital.

Teaching/simulation

The labour ward provides a good opportunity for teaching junior members of staff, whether they be doctors, midwives, or medical students. The senior members of staff should use their experience to teach these more junior members, when time and acuity allows. Teaching allows junior staff members to improve their skills and therefore become more independent and empowered. For example, teaching a midwife to cannulate or suture means they can function more independently. This is especially useful in an emergency or as acuity increases.

Supervision should be done by sufficiently trained senior staff. When supervising, it is important to create time for constructive feedback, allowing consolidation of learning points. Where possible, the senior teacher should be encouraged to complete written work-based assessments.

Simulation training for obstetric emergencies can be carried out by the MDT in the simulation lab or 'in-situ' on labour ward. The advantages of performing in-situ simulation are that it familiarises staff about emergency pathways and equipment in a true working environment and allows embedding of leadership skills.

Challenges

Simultaneous emergencies/theatre occupied

It is important that surgical cases are prioritised. In most units, elective work is ongoing alongside the emergency work. Opening a second or third theatre may be necessary as emergencies arise whilst theatre is occupied and good communication with theatre staff is vital to receive their necessary support. Having a helicopter view and learning to prioritise and predict surgical cases minimises the need for opening second obstetric theatres which can divert staff from other theatre departments, or necessitate staff coming in from home.

At these times of high acuity calling for senior midwifery and medical staff and using available resources and methods to maintain safety is crucial. This can mean using main theatres, giving tocolysis, discontinuing the oxytocin infusion, stopping pushing in second stage when delivery is not imminent awaiting a trial in theatre, and filling up the bladder in a cord prolapse. In rare circumstance the unit may need to be closed and emergency cases diverted. This requires senior MDT discussions within the unit and with neighbouring units, and should only be performed when all avenues of help have been exhausted.

Stress and fatigue

Labour ward can, at times, be stressful, no matter the level of seniority and experience. The stress itself can make us revert back to familiar courses of action, even if they are unwise and inappropriate. This is why it is important to be approachable and open to constructive discussions and different perspectives from different personnel. The reluctance to change our approach can have devastating consequences and we need to be aware of this.

Fatigue may be caused by high levels of activity or complexity and it reduces both cognitive and manual dexterity. If unsure of a decision because of case complexity, or simply because of exhaustion, there is no shame in asking someone else's advice, as patient safety is paramount. Again, if a doctor is unsure whether they are safe to perform a procedure, or they feel it will be a difficult case, it is their duty to discuss this with another doctor who is able to assist them or safely perform the procedure instead.

Safety huddles are an emerging strategy for maximising patient care. These are short, well led, structured meetings of key professionals to discuss patient care. They improve communication in complex cases. These meetings improve awareness of safety and also communication between members of staff.

Example of running a labour ward

Labour ward board at 08:00

1. 30 year old lady. BMI 37, P0, 27 + 4/40, in-utero transfer. Known placenta praevia grade 4. Admitted with SROM 2 days ago. EFW 983 g.
2. 29 year old, BMI 22, P1 (SVD), 36/40, MCDA twin pregnancy. Admitted with SROM 03:00, clear liquor, twin I cephalic and contracting over the past 2 hours.
3. 37 year old, BMI 21, P1 (SVD 16 years ago), 39 + 2/40, anterior lip on examination, transferred from birth centre with deceleration heard on intermittent auscultation.
4. 31 year old, BMI 48, P0, 38/40, IOL for persistent reduced fetal movements. VE 3 cm dilated at 07:30 with ARM. CTG normal. Requesting an epidural
5. 35 year old, BMI 30, P6 (normal births), 38 + 5/40, 8 cm dilated at last examination. Previous atonic PPH.
6. 32 year old, BMI 24, P1 (CS for FTP at 4 cm and PPH), 40/40, admitted in spontaneous labour and 3 cm dilated.
7. 39 year old, BMI 29, P0, 38/40, IOL for pregnancy induced hypertension and growth restriction. Has had two Prostin pessaries, and has been transferred to LW for artificial rupture of membranes at 2 cm dilatation. Blood Pressure 145/98.
8. 24 years old, BMI 23, P0, 37/40, admitted for an ECV to labour ward.

9. 33 year old, now P1, having recently given birth normally. The umbilical cord snapped during cord traction in third stage. She is not currently bleeding.
10. 36 year old, BMI 30, P1 (normal birth), 39/40, 5 cm dilated at last examination. Recent spike in maternal temperature (38 °C).

At handover there is a consultant obstetrician and a consultant anaesthetist, a midwifery co-ordinator, an obstetric registrar (ST3), an anaesthetic registrar (ST4) and an ST1 in obstetrics and Gynaecology. Each patient has one to one midwifery care.

Patient 1*:* this patient is an in-utero transfer and it is important that a full booking history is available. She would require a group and save and a full blood count and CRP taken on admission in case of a further bleed, or concerns regarding infection. The midwife in the room could undertake these tasks. She should be prescribed steroids for lung maturation and thromboprophylaxis, both of which the STI could undertake. If her observations are normal, and she is not bleeding, she could be transferred to the ward after being counselled with regards to indications for preterm delivery by caesarean section and magnesium sulphate for neuroprotection. The neonatal team can be contacted by her midwife to counsel her. It is important that the patient is aware of the increased risk of postpartum haemorrhage and discussions had with regards to anaesthesia by the obstetric consultant and consultant anaesthetist. Blood should be available in case of emergency delivery

Patient 2*:* this is a planned vaginal twin delivery. It is important that the twins are being monitored continuously. She should have a vaginal examination by her midwife to assess progress and a fetal scalp electrode applied if her cervix is dilated. She should have good intravenous access and a FBC and Group and Save sent as there is an increased risk of postpartum haemorrhage. The portable scan should be located and easily accessible should there be any doubt about presentation or fetal heart localisation. The instrumental trolley should also be easily accessible as assisted vaginal birth may become necessary during the course of the delivery. The midwifery coordinator should confirm availability of uterotonics and two neonatal resuscitators. The patient should be offered an epidural, which the ST4 in anaesthetics could provide. The ST3 should be supervised leading the delivery by the consultant obstetrician

Patient 3*:* continuous fetal heart monitoring should commence immediately and if the CTG is pathological she should be reassessed by the obstetric registrar regarding the feasibility of assisted delivery should normal birth not be imminent. The midwifery co-ordinator should contact the neonatal team urgently to be present at delivery. This room requires urgent attention

Patient 4*:* due to her obesity, this lady requires special care to keep her and the baby safe during labour. She should have IV access with a FBC and a group and save sent as she is more likely to require intervention. Fetal monitoring may be challenging and an FSE should be considered should there be loss of contact with the cardiotocograph whilst the regional analgesia she has requested is being sited. The siting of the epidural may take more time than normal and consultant anaesthetic input may become necessary. She should be reviewed by the obstetric ST3 to ensure progress is made

Patient 5*:* this patient is a grand multip and so preparations should be made to avoid a postpartum haemorrhage. The midwifery coordinator/obstetric ST1 should confirm that the patient has IV access and a FBC and group and save is sent. Uterotonics should be readily available and senior midwifery support present for delivery which may be soon

Patient 6*:* this patient is in spontaneous labour at 3 cm dilatation. She needs to have continuous monitoring and have IV access. She should have pre-medications and also have a haemoglobin and group and save sent. As she is in spontaneous labour, hopefully she is contracting well enough. Syntocinon should be used with caution and only when contractions are thought to be infrequent and inadequate. This decision should only be made by a consultant or senior trainee. The risk of scar rupture increases with the use of Syntocinon. Uterine rupture should be considered if there is a sudden change in fetal monitoring or maternal compromise. If this were to occur, an urgent grade 1 caesarean should be carried out if vaginal delivery not amenable

Patient 7*:* this patient's blood pressure needs to be treated prior to continuing with her induction of labour. A full review of this patient and her fetus is required including maternal symptoms and observations, clinical examination, blood results and urine output, recent fetal scans and fetal heart monitoring. She should have oral anti hypertensives to treat her hypertension. An MDT review is required to discuss the ongoing induction, including analgesia options

Patient 8*:* this is an elective case. She needs to have an ultrasound at the onset to check for presentation as the baby may have spontaneously become cephalic. She should be counselled by the ST3 or the consultant with regards to the ECV, the process, the success rates, and the small chance of requiring emergency caesarean section. This is an ideal teaching case, and should be carried out once the consultant obstetrician and the ST3 are both able to attend

Patient 9*:* this lady should have her observations checked, as well as her blood loss. She requires intravenous access, a full blood count and group and save. She requires a vaginal examination as the placenta may have already separated and able to be removed in the room

Patient 10*:* this lady needs a full set of observations and a review to ensure the Sepsis Six bundle has been actioned. She requires an examination to ensure progress and antibiotics

Prioritising: patient 3 requires urgent review and if not deliverable in the room an urgent transfer to the operating theatre. Patient 9, with the retained placenta, should also be reviewed

and if the placenta is not deliverable then preparations made for manual removal in theatre. The obstetric ST3 and the consultant could each see a patient separately, depending on the level of experience of the ST3. The anaesthetic specialist trainee and consultant could also do the same

The ST1 should attend to room 7 and review the patient whilst ensuring anti-hypertensives are prescribed and then attend room 10 to ensure antibiotics are prescribed.

The midwifery coordinator could oversee the preparations for the twin delivery in room 2 and birth in room 5 where the greater risk of postpartum haemorrhage has been recognised.

There should be a huddle by the board once these tasks are carried out. If no urgent issues have arisen then elective work can commence if any pending potential complex cases have resolved themselves, or there is deemed to be time before they might require medical involvement. ◆

Practice points

- It is important that all team members know who each member of the team is, and their level of experience.
- Quality handover is vital for high levels of patient care and continuity.
- Lack or loss of situational awareness is a major threat to patient safety and all staff should recognise what threatens it, and when they are losing it, and what to do if this is the case.
- Decisions should be made collectively with women, their birth partners and other staff members.
- Team leaders on labour ward should have a 'helicopter' view which sees each of the individual cases as part of the whole, and predicts how the situation will evolve. They must have well developed skills of prioritisation and time management.
- The SBAR communication tool and safety huddles are examples of strategies employed to improve the process of information transfer.

FURTHER READING

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