WOMEN'S HEALTH & PAEDIATRICS

MATERNITY UNIT

General Duties of the Obstetric Anaesthetist

Amendments			
Version	**Date**	**Comments**	**Approved By**
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General Duties of the Obstetric Anaesthetist

1.0 Labour Ward Duties

a) Provision and management of effective pain relief in labour

b) Provision of effective/safe anaesthesia for theatre

c) Review and management of HDU patients

d) Close communication with obstetricians, midwives and theatre team

e) Attend obstetric emergencies

f) Assistance with vascular access

g) Support the antenatal high risk anaesthetic service

h) Support Anaesthetic/ICU team in managing surgical pain issues

2.0 At Change of Shift

a) Ensure the names of the anaesthetists covering the unit are up to date on the Staffing white board, and enter the name of the Duty/On call consultant anaesthetist.

b) Ensure that the bleep is working properly (replace batteries if indicated).

c) A comprehensive handover from outgoing anaesthetist covering maternity must occur. This should consist of the "SAFER" (**S**ick patients, **A**t risk Patients, **F**ollow ups, **E**pidurals, **R**emote Patients) format, and should be documented in the "Handover and Feedback" book.

d) Check anaesthetic machines, emergency drugs and epidural trolley. Confirm the checks have been completed by signing the sheet on the Theatre 2 fridge door.

e) Review all women on delivery suite with ongoing epidural analgesia, and any women on the wards with antenatal or postnatal problems. (e.g. post-dural puncture headache).

f) A post-anaesthetic follow up round should be completed daily. The follow up should be documented on the Badgernet.

g) If requested, assess women with specific antenatal problems/risk factors for anaesthesia. If there are any problems/uncertainties regarding the proposed anaesthetic management of any woman contact a consultant obstetric anaesthetist.

3.0 Be aware of what is happening on the unit

a) The duty anaesthetist should be an active part of a multi-disciplinary team, working closely with obstetricians, midwives and paediatricians. They should take an active role in clinical management decisions and ward rounds.

b) The duty anaesthetic team must participate in the Maternity Safety Huddle, which occurs

daily at 11:45. This should be prioritised to ensure attendance of the most senior anaesthetist on Labour ward.

c) Co-ordinate with the midwife shift leader to identify any high risk women who are already in hospital or expected soon. Ask if there are any women for whom an operative delivery is becoming increasingly likely, and with whom a discussion about anaesthetic options might be appropriate. Promote the use of the epidural information sheet.

d) Join the obstetricians on the delivery suite handover at 9am. Prioritise attendance of the White board reviews at 1pm, 5pm and 8pm if workload allows. Discuss potential problems with the obstetricians at the round.

e) If you leave the unit it is of paramount importance that you ensure the midwife shift leader is aware of where you are going and has a means of contacting you. Inform her/him on your return.

4.0 Act professionally

a) Introduce yourself to the midwives/obstetricians if you, or they, are new. Familiarise yourself with the locations/access to the ante/postnatal wards in case you're called there in a hurry.

b) Always knock and wait for an answer before entering a delivery room. Always treat peripartum women and their birth partners with consideration.

c) Be mindful of how you communicate with patients, their family and staff. Do not be afraid to apologise if you think someone may have taken offence, even if this wasn't intended.

d) Check all epidural and spinal drugs with another member of staff before administration.

e) Be aware of the infective status of every patient, and ensure that you taking appropriate infection control and PPE precautions.

5.0 Antenatal anaesthetic assessment

a) The duty anaesthetist may occasionally be asked to assess antenatal women who may be a risk. This is most likely where women are unable to attend the formal Anaesthetic Antenatal Clinic, which runs every Tuesday (e.g. due to urgency).

b) Documentation should take place in BadgerNet ("Specialist Review – Anaesthetics"), and the patient details should be emailed to the referral email address (asp-tr.labour.wardreferrals@nhs.net).

6.0 Labour Ward Consultant Notification Triggers

a) There is always a consultant anaesthetist responsible for labour ward. This will be either a named Duty Anaesthetic Consultant or an On Call Anaesthetic Consultant.

b) The Consultant Anaesthetist on call should be informed and should be expected to attend in the following situations:

- **i.** Maternal collapse
- **ii.** Maternal death
- **iii.** Massive obstetric haemorrhage (>2L) with on-going, uncontrolled bleeding
- **iv.** Eclamptic fit

v. Suspected uterine rupture
vi. Failed intubation or anticipated difficult intubation
vii. A second emergency maternity case requiring a 2nd theatre to be opened
viii. Consultant Obstetrician request for Anaesthetic Consultant attendance

c) The Consultant Anaesthetist on call should be informed in the following situations and may attend depending on their clinical discretion:

i. ASA 3 patient factors
ii. BMI >50
iii. Massive obstetric haemorrhage (>2L) with haemostasis secured
iv. Severe PET (for example, patients requiring iv antihypertensives, coagulopathic, severely symptomatic etc)
v. Problems with consent or patient refusal to undergo recommended treatment (e.g. Inform consultant if Jehovah's Witness patient with significant bleeding risk)
vi. Potential conflict between Obstetrician/Labour Ward Team Leader and Duty Anaesthetist regarding patient management
vii. Admission of Patient to ICU
viii. Patient has waited more than 30 minutes for labour analgesia (epidural or CSE)
ix. Failed insertion of epidural anaesthesia or instigation of opioid Patient-Controlled Analgesia (PCA)

7.0 Elective caesarean deliveries

a) The labour ward consultant anaesthetist may be requested to support colleagues covering elective caesarean section lists (The emergency theatre anaesthetist is also able to support depending upon theatre activity).

b) The elective caesarean section list will run Monday – Thursday, 8am – 1pm.

c) Where the elective caesarean section list is taking place away from the labour ward by a separate team, the labour ward anaesthetist's duty is to maintain overview of labour ward and must be immediately available.

d) A clear handover must be conducted between the anaesthetists responsible for the elective caesarean section list and labour ward, regardless of the post-operative destination of the woman.

e) In exceptional circumstances, elective caesarean sections may need to occur between 1pm – 6pm, or on Fridays, on labour ward. This will be the responsibility of the duty labour ward anaesthetic team. No elective caesarean sections should occur outside the times stated.

8.0 Other Duties

a) Covering labour ward is the labour ward anaesthetic team's primary responsibility.

b) The labour ward anaesthetist may leave the labour ward to assist the Anaesthetic/ICU team in other areas of the hospital if work load allows, but must be able to attend labour ward immediately.

c) The labour ward anaesthetic team should be prepared to assist the theatre and ICU teams with surgical pain issues. This is dependent on skills/experience mix and work load in maternity.

9.0 References

Guidelines for the Practice of Obstetric Anaesthesia in Nottingham

ASPH Anaesthetic Services Out of Hours

Royal College of Obstetricians & Gynaecologists and The Royal College of Anaesthetists. Good Practice No. 11 – Classification of urgency of caesarean section – A continuum of risk. (https://www.rcog.org.uk/globalassets/documents/guidelines/goodpractice11classificationofurgency.pdf - last accessed July 2020)

Antenatal anaesthetic clinic guidelines – ASPH

Elective caesarean delivery list SOP - ASPH