STANDARD OPERATING PROCEDURE

Roles and Responsibilities of the Consultant providing acute care in Obstetrics and Gynaecology

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INTRODUCTION

The key roles of an O&G consultant encompass clinical skills and decision-making, team leadership, education and supervision, risk management, innovation and patient advocacy. Consultants have a responsibility to role-model personal values consistent with building trust – integrity, reliability, predictability and competence – as well demonstrate respect for colleagues and women. Such values are important in setting the culture of units; a factor repeatedly identified within maternity reports as fundamental to providing safe and compassionate patient care.

The guiding principle should be to ensure that, when required, consultant leadership is present and visible to ensure that there are adequate numbers of staff with appropriate competencies available at all times.

This SOP also includes recommended standards to define when consultants need to be involved in discussions about patient care and when they should attend in person.

Guidance is also provided on how ward rounds and safe handovers should be conducted.

LEVELS OF COVER

Labour Ward

In line with the Ockenden Report (Dec 2020) we have increased our Consultant presence and ward rounds on labour ward.

Labour Ward Monday-Friday 09.00-ward round after night handover

The Consultant covering labour ward is expected to be present on the labour ward from 09.00am until after the night handover (21.00) and for the night ward round Monday to Friday.

The roles of the Consultant on LW that are expected:

- Attend face to face the 09.00 and 21.00 multi-disciplinary handover
- Complete a bedside training ward round of all consultant led care women on LW after the morning and evening handover Monday to Friday
- On Saturday, Sunday, and bank holidays the ward round is after the morning handover and at 17.00 If the Consultant is busy, the expectation would be that a registrar ward round took place with Consultant input, with the expectation that the Cons would return to LW to review any complex patients before leaving
- Review patients in LW triage if junior doctor busy and can't attend in a timely manner or senior review is required
- Participate in the multidisciplinary safety huddle at 11.45
- Have oversight of the complex women on the antenatal/postnatal ward and review any of these patients if the COW Consultant is busy
- They will be expected to work in close liaison with the Obstetric Risk Management Team in performing a review of urgent risk cases
- Use the time on LW to teach CTG

- The LW Consultant will provide clinical leadership for any emergency, complex delivery and procedures in the rooms or Maternity Theatre and provide teaching, training and supervision of trainee doctors.

- Outside of COW hours the LW Cons would endeavour to allow the O&G Registrar to deal with emergencies in Gynae they were capable of handling.

- Should the emergency arise where the Cons covering Obs is no longer onsite and the LW Co-ordinator felt that the junior doctor (O&G Registrar) couldn't leave LW, the Cons covering Obs would triage LW to assess if they felt the junior doctor (O&G Registrar) could go to resolve the Gynae emergency and return.

- Should the O&G Registrar not be able to handle the Gynae emergency or the LW is unsafe for the O&G Registrar to leave for the time required; then the Cons covering Gynae will need to attend

- On a Saturday, Sunday and bank holidays, the LW Consultant is also responsible for seeing the antenatal patients, postnatal readmissions/complex postnatal patients, depending on the agreed rota they may also be undertaking a ward round to the gynaecology inpatients and provide advice/support/review emergency gynaecology patients

Saturday and Sunday 09.00-18.00

On Saturday and Sunday, the on call Consultant covering labour ward is expected to be on the site from 09.00 to 18.00.

The same roles and responsibilities apply as above.

After the evening ward round and overnight (Monday-Sunday) until 09.00

The consultant is on call from home during this time and can be contacted on their mobile phone (phone numbers by phone in LW office or contactable via switchboard).

They will be expected to attend the unit in line with the divisional maternity escalation policy, if the acuity is very high, asked by the shift leader for an appropriate reason, or for any of the trigger list situations.

Consultant of the Week

Monday to Friday 09.00-17.00

The COW Consultant responsibilities are:

- Provide an antenatal ward round to all antenatal patients including those women admitted for induction of labour
- Provide a review of any maternal postnatal readmissions within 14 hours of admission
- Provide a review of any complex postnatal patients
- Review any outlying maternity patients

- Review patients in maternity day unit if the trainee doctor is busy
- Oversight of the maternity COVID tracker
- Review the gynaecology inpatients
- Review any outlying Gynaecology patients
- Support the trainee doctors in the management of gynaecology patients
- Attend the multidisciplinary safety huddle on LW at 11.45 (if possible)
- Attend for emergency gynaecology theatre if called and for any gynaecology laparotomy
- Awareness of acuity in the unit
- Answer advice and guidance from our GP colleagues
- Supervise review of hot COW patients by trainee doctor
- They will be expected to work in close liaison with the Obstetric Risk Management Team in performing a review of urgent risk cases where needed

ROLES AND RESPONSIBILITIES OF THE CONSULTANT

The core roles and responsibilities of the Consultant can be broadly summarised in the figure below:

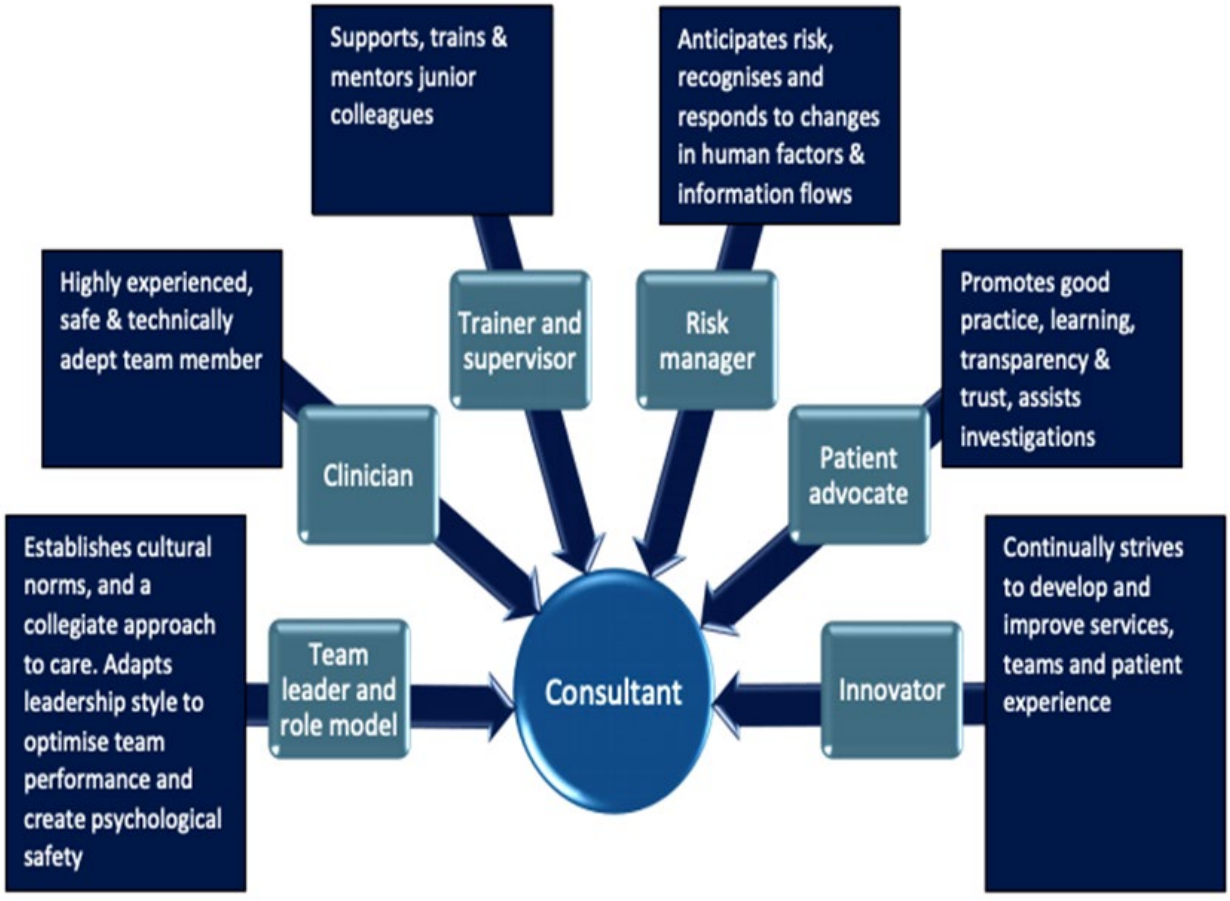

Figure 1. Roles and responsibilities of an O&G consultant

CONSULTANT ATTENDENCE IN PERSON

Situations in which the Consultant **MUST ATTEND**

General
In the event of high levels of acuity e.g. a second theatre being opened, unit closure due to high levels of activity requiring Obstetric input
Any return to theatre for Obstetrics or Gynaecology
An unexpected neonatal death at term
Team brief requested
If requested to do so *
Obstetric
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary
Caesarean birth for major placenta praevia/abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Vaginal breech birth at term
Unexpected Intrapartum still birth
Eclampsia
Maternal collapse e.g. septic shock, massive abruption/Maternal Death
PPH >2000mLs where the haemorrhage is continuing and massive obstetric haemorrhage protocol has been instigated
Gynaecology
Any laparotomy

*If there is high acuity in the unit without a specific obstetric clinical reason for Consultant attendance – the escalation policy is required to be followed and both Consultant and Senior Midwifery Leadership team (MOC) will be on site to support the clinical team and maternity unit

DISCUSSION WITH CONSULTANT ON CALL

Situations in which the Consultant must **ATTEND** unless the most senior doctor present has documented evidence as being signed off as competent. In these situations, the senior doctor and the Consultant should decide in advance if the Consultant should be **INFORMED** prior to the senior doctor undertaking the procedure.

General
Any patient in Obstetrics or Gynaecology with an EBL of 1.5litres and ongoing bleeding *
Obstetric
Trial of instrumental birth
Vaginal twin birth
In utero transfers
Caesarean birth at full dilatation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Caesarean birth at <32/40
Vaginal breech birth
3rd degree perineal tear repair
Gynaecology
Diagnostic laparoscopy
Laparoscopic management of ectopic pregnancy

*This includes women in early pregnancy. Consultants should be informed earlier than 1.5 litres if the woman is haemodynamically unstable, has a low body weight, has a low starting haemoglobin, if there is a rapid rate of bleeding or if there are other complexities regarding her care. Should the Consultant chose not to attend in person, there should be a full discussion regarding resuscitation of the patient and ongoing bleeding management. This should be documented along with the reasons why the Consultant has not attended.

The above list is not exhaustive and therefore it is recommended that prior to any shift, there should be a discussion between the Consultant and the on-call team regarding any scenarios where the Consultant would wish to be informed, even if their attendance may not be immediately required. These scenarios may vary according to the level of experience of the most senior doctor present.

Role of co-ordinating midwife or nurse

Senior midwifery, nursing and other medical staff should contact the consultant or senior trainee directly if it is considered that the clinical situation requires senior medical input. If the team are unable to agree on a plan or there is a conflict of clinical opinion this is an indication to involve the Consultant on call. Any team member will be supported in contacting the Consultant directly.

Patient safety is the priority and consultants and senior trainees should respond positively to requests for assistance from all staff.

WARD ROUNDS/HUDDLES/HANDOVER

Ward rounds are an important part of patient care because they are a way for the whole team to share information and gain an oversight of the clinical condition of all women under their care. This enables staff to monitor, anticipate and respond in a timely way to emerging problems (HSIB 2020).

The LW Consultant will need to undertake a face to face Obstetric ward round twice daily on LW– in the morning after handover every day, and again after the night handover (Monday-Friday) and at 17.00 (Weekends and bank Holidays) of all patients on the labour (unless they are there as the birth centre is closed and everything is low risk).

On Saturday/Sunday the on call Consultant will also provide the LW ward round, antenatal and complex postnatal ward round and Gynaecology ward round.

The team members expected to be present for this ward round are the Obstetric Consultant, LW co-ordinator, Obstetric Reg/SHO and Anaesthetic staff.

The COW Consultant will be expected to undertake a face to face review of all antenatal patients on Joan Booker ward including those women admitted for induction of labour and a ward round of any gynaecological inpatients. If the Consultant is busy, the expectation would be that a registrar ward round took place with Consultant input, with the expectation that the Cons would return to review any complex patients before leaving.

All acute gynaecological admissions should be seen within 14 hours of admission. This also applies to acute antenatal, intrapartum and postnatal admissions.

The COW Consultant will also review any outlying Obstetric or Gynaecology patients.

The ward round should be seen as an opportunity for bedside teaching and clinical education.

Huddles

Huddles are team based meetings which occur part way through a shift to review activity and care plans.

We have a multidisciplinary safety huddle at 11.45am. The expected people to attend this are: - LW Consultant, COW Consultant (if able), LW team leader, Anaesthetic Consultant, Neonatal Consultant, Neonatal nurse in charge.

This opportunity to meet should also be considered a means to plan workload for the unit.

Safe Handovers

Multidisciplinary handovers improve communication and reduce errors and omissions.

It is important that information is accurate and succinct so that it is understood and actioned by the incoming team. Good handovers also facilitate clinical decision making and planning of future management to ensure that care is progressive across shifts.

Consultants must ensure that plans are clearly explained and documented for teams providing care out-of-hours or during a weekend. Consultants should support a standardised handover model that promotes information flows across the multidisciplinary team. RCOG Good Practice Paper 12 'Improving Patient Handover', and the NHS Improvement paper 'Implementing handovers and huddles: a framework for practice in maternity units' introduce tools that standardise information flow across variable levels of activity (RCOG 2010, NHSi 2019). This will help junior doctors prioritise women across both obstetrics and gynaecology out-of-hours and reduce uncertainty regarding care plans.

Particular attention should be given to women / patients who have prolonged admissions, recurrent attendances or those in whom there is not a clearly established diagnosis. This can make discussion difficult, with such women often overlooked until serious difficulties emerge. Creating psychological safety so that all members of the multi-professional team feel able to escalate concerns and taking a collegiate approach between consultants around unresolved issues will optimise care for a woman with complex needs.

Using a structured approach to handover will ensure that all the correct information is conveyed in an appropriate manner to the incoming team from the outgoing team.

The handover should include:

- Staffing for the day – any issues should be discussed and a plan made for this
- A verbal handover of all patients on the board using SBAR
- Any critical incidents from the previous shift
- In-utero transfers accepted/declined
- Patients waiting for theatre

- Sick patients
- Those mothers at risk
- Follow up for sick patients
- Inductions
- Anaesthetic issues
- Gynaecology handover

Key messages

- Consultants providing on-call cover in Obstetrics and Gynaecology must ensure that they maintain their skill set post-CCT, particularly for more complex obstetric scenarios.
- When on-call, consultants must not be engaged in other activities such as theatre, clinics or off-site work which could delay attendance*.
- Ward rounds and huddles are important to ensure situational awareness is maintained by the whole multidisciplinary team, appropriate plans and decisions are made regarding patient care and that women have the opportunity to receive information and ask questions.
- Ward rounds should be conducted by consultants twice daily on labour ward, with one of these occurring in the evening.
- Consultant-led gynaecology ward rounds should also take place. Units should ensure that they meet the standard that all patients are reviewed by a consultant within 14 hours of admission.
- Developing a standardised handover model helps improve communication and reduce omissions and errors.
- Consultants must be involved in the care given to women who have prolonged admissions, recurrent attendances or those in whom there is not a clearly established diagnosis

RESPONSIBILITES
All clinical staff are responsible for complying with this policy.
AUDIT
Ongoing audit of Consultant attendance in response to the trigger list

REFERENCES: -

1. RCOG: Roles and Responsibilities of a Consultant providing acute care in Obstetrics and Gynaecology. June 2021