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Related Trust Policies (to be read in conjunction with)	04071 Policy for standard infection prevention precautions 04072 Hand hygiene policy 06036 Maternity record keeping including documentation in handheld records 07024 Emergency transport of blood and specimens in the event of major obstetric haemorrhage 10084 Maternity Services escalation policy 07074 Neonatal resuscitation 04234 Postpartum haemorrhage

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1.0 Purpose

1.1 The purpose is to provide medical and midwifery staff with guidance regarding their roles and responsibilities whilst working within Maternity Services at Mid Essex Hospitals Services NHS Trust.

1.2 All clinical decisions are to be taken within each medical or midwifery practitioner's scope of professional practice. They are responsible for seeking advice and referring patients and their babies appropriately when deviations from the normal are identified.

1.3 The guidance is referred to by each professional group with specific reference to communications and identified increased risk of split site working as maternity services are currently provided across three in-patient sites and in the community.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix A)

3.0 Background

3.1 The Consultant Obstetric Led Unit is located at Broomfield Hospital.

3.2 There are also two Midwife-Led Birthing Units based at Braintree Community Hospital and St Peters, Maldon providing midwifery care and low risk intrapartum care.

4.0 Roles and Responsibilities of Medical and Midwifery Staff

4.1. **Consultant Obstetrician and Gynaecologist**

4.1.1 The Trust provides **66 hours** of obstetric consultant presence on the Labour Ward complying with the standard proposed by Safer Childbirth (2007). The obstetric consultant should be present at or on the Delivery Suite for at least 10% of complicated deliveries as per the guidance proposed by Safer Childbirth (2007).

4.1.2 The obstetric consultant should be in attendance in the following clinical situations:

- Eclampsia;
- Maternal collapse;
- Caesarean section for major placenta praevia;
- PPH of more than 1500 ml where haemorrhage is continuing and a massive obstetric haemorrhage has been instigated;
- Return to theatre – laparotomy;
- Uterine rupture;
- When requested.

4.1.3 The obstetric consultant is available to provide junior medical and midwifery staff with professional advice and support. The obstetric consultant is responsible for the decisions and action of the medical staff.

4.1.4 'Hot Week': One consultant obstetrician is rostered to be purely available for The Consultant-led Unit and Gynaecology Services, Monday to Friday between 08:00 - 17:00 hours, with no other clinical commitments, to provide prospective cover. The consultant on call for Saturday and Sunday will be available between 09:00 to 13:00 hours. Outside of these hours an obstetric consultant should be on call for telephone consultations and in addition, must be available for physical presence for Labour Ward within 30 minutes.

4.1.5 The obstetric consultant on-call will conduct a telephone ward round with the obstetric registrar on duty at 22:00 hours providing an opportunity to identify any patient with high risk factors that could potentially present with complications during the remainder of the shift. This call will be initiated by the obstetric registrar.

4.1.6 This contact provides an opportunity to identify if there are any potential gynaecological problems that could impact on the availability of the senior medical team to the Labour Ward to allow for forward contingency planning.

4.1.7 In the event that a consultant is sick, he/she should inform the hot week consultant or the clinical lead. If the hot week consultant is sick, labour ward will be covered by the Caesarean section consultant and/or the consultant in the Antenatal Clinic.

4.2 Labour Ward rounds/ communication/ after hours and weekend consultant presence

4.2.1 Weekday ward rounds with consultant presence at **08:30** hours and **17:00** hours**.** The morning ward round should be attended by the consultant obstetrician, anaesthetist on for Labour Ward, the obstetric registrar and ST1-2/F2 doctor. The 13:00 hours ward round should be done by the consultant and Labour Ward coordinator +/- the obstetric registrar. The 17:00 hours ward round should be done by the oncoming obstetric consultant but may be delayed if he/she is in the outpatients department (OPD) or theatre. In this case, the oncoming obstetric consultant should telephone Labour Ward at 17:00 hours (approx.) and do the round when finished in these areas. Furthermore, a ward round attendance log should be completed.

4.2.2 Full ward rounds of patients should be conducted on Labour Ward (excluding the Co-located Birthing Unit), followed by rounds on the Day Assessment Unit (DAU), Postnatal Ward and Gosfield Ward.

4.2.3 If the obstetric registrar is called to A&E or to assess a patient on another ward, the obstetric consultant on for 'hot week' should look after Labour Ward patients.

4.2.4 The obstetric consultant 'hot week' bleep (#6400 836) should be carried by the hot week obstetric consultant from 08:00 hours until 17:00 hours Monday to Friday and handed over to the evening obstetric consultant during the week at 17:00 hours. The bleep should be left on Labour Ward at 20:00 hours by the evening consultant when he/she is then on call from home.

4.2.5 Weekends: ward rounds should be conducted on Saturday and Sunday at 09:00 hours on both days. The obstetric consultant should be on site until 13:00 hours on both days.

4.2.6 Elective caesarean sections: all clinically straight forward caesareans can be placed on any consultant's list. Those that are not clinically straightforward i.e. preterm/ early (< 38/40), maternal request, suspected macrosomia, failed induction need **direct** communication between the obstetric consultants to agree transfer of care and caesarean timing before informing the patient.

4.2.7 Consultant-led caesarean section lists should be performed by the consultant listed for that session and not delegated to the Labour Ward registrar unless cases 'spill' over to the afternoon (i.e. after 12:30).

4.2.8 If there is no obstetric consultant or registrar available to perform elective caesarean sections, then these should be done by the on call obstetric team.

4.2.9 At night-time and weekends, attendance at second stage trials and twin deliveries is at the discretion of the obstetric consultant on call but should be considered if Year 1-3 registrar is on duty or an obstetric junior doctor (FY1 & FY2) /registrar under additional 'supervision' due to concerns raised.

4.2.10 Situations where personal attendance of on call consultant is advised during daytime Delivery Suite 'hot week' sessions as follows:

- Pathological CTG should be reviewed by consultant before fetal blood sampling is performed;
- ECV (External Cephalic Version);
- Twin deliveries having vaginal birth;
- Breech deliveries;
- Second stage trials;
- High risk caesareans i.e. placenta praevia, more than 3 caesarean sections, previous visceral trauma, maternal BMI more than 40, transverse lie, gestation less than 28/40;
- Obstetric collapse (i.e. massive PPH, fulminating PET, eclamptic fit);
- Obstetric ultrasound assessments i.e. for fetal assessment/modified BPP;
- Returns to theatre (obstetric) for wound problems or bleeding;
- Registrar busy with operative delivery and another patient needing urgent assessment/delivery.

4.3. **The Obstetric Specialist Registrar (SPR)**

4.3.1 The SPR is rostered to cover the labour ward 24 hours per day on a 12 hour shift basis. The shift change times are 08:00 hours and 20:00 hours. Handover of care and the on-call bleep must be done on the labour ward during the shift handover.

4.3.2 The aims of the SPR handover are as follows:

- To physically handover the on-call bleep which must never be left unattended;
- To inform the incoming SPR of all the in-patients present under the care of the obstetric team on the labour ward, highlighting those at high risk to ensure a robust transfer and review of the on-going plans of care for these patients;
- To inform the incoming SPR of high risk cases, both antenatal and postnatal patients on admission to either the Day Assessment Unit or the Postnatal Ward;
- To inform the incoming SPR of any concerns that may have been raised during the shift, in relation to patients receiving intrapartum care at either of the birth centres or in the community;

- To inform the incoming SPR of any high risk gynaecological cases on Gosfield Ward;
- To inform the incoming SPR of any high risk cases either obstetric or gynaecological and of any patients who may require transfer to a tertiary centre.

4.3.3 The SPR is responsible for the Labour Ward when on duty, with reference to the obstetric consultant as and when necessary.

4.3.4 The SPR should liaise, in person or on the telephone, with the obstetric consultant on call at 22:00 hours to inform them of the current and expected activity in both the obstetric and gynaecological services during the out of hours period to allow for forward contingency planning to maintain a safe level of medical care.

4.3.5 The SPR must inform the obstetric consultant on call when called to attend the gynaecology theatre out of hours or if the work load on the Labour Ward becomes excessive effecting safe care to ensure safe cover at all times.

4.3.6 The on-call duty SPR should inform the on-call duty obstetric consultant of the following:

- In-utero transfer;
- Pre-term labour less than 34 weeks gestation;
- Breech deliveries;
- Trial of instrumental delivery;
- Lower segment caesarean sections (LSCS);
- Multiple births;
- Severe pre-eclampsia;
- Third/ fourth degree tears;
- ECV;
- Returns to theatre i.e. wound problems or bleeding;
- Obstetric ultrasound assessments i.e. for fetal assessment;
- Any serious maternal medical condition that may impact on antenatal, intrapartum or postnatal care to agree an appropriate care plan;
- Gynaecological procedures i.e. outside routine theatre list times.

4.3.7 **Postpartum** patients receiving high dependency care on the Labour Ward should be reviewed in person by the SPR every **4 hours** over the 24 hour period unless clinical activity delays the review, and the outcome of that review and the subsequent plan of care should be clearly documented in the healthcare records.

4.3.8 During weekdays Monday to Friday, there is usually a designated SPR to cover the elective LSCS list. On occasions where there is not any separate cover for the elective activity this must be highlighted in advance to the obstetric consultant responsible for the Labour Ward to make alternative arrangements ensuring safe medical cover is maintained for the. Labour Ward Clear lines of communication between midwifery and medical staff are essential on such occasions.

4.3.9 It is the SPR's responsibility, as the lead obstetrician present at an emergency LSCS to ensure there are clear lines of communication between the obstetric and anaesthetic team so that the plan of care for the operative delivery is the safest for the patient taking into consideration medical, obstetric and anaesthetic aspect of care.

4.3.10 The SPR should take the lead to initiate this professional discussion and ensure it is documented in the health care records. This responsibility can be transferred to the obstetric consultant if they are present and the identified lead obstetrician.

4.3.11 Emergency procedures will always take precedence over the elective LSCS list, the lead obstetrician is responsible in consultation with the anaesthetist to advise midwifery staff on the management and subsequent plan of care for those patients on the elective LSCS list whose surgery is delayed or cancelled. This subsequent plan of care should be documented in the health care records.

4.3.12 In the event that the obstetric registrar for Labour Ward is sick he/she should inform the medical secretary (Monday – Friday 09.00 – 17.00 hours only) and the obstetric consultant on call; for cover to be arranged.

4.4. Junior Doctors (FY1 & FY2)

4.4.1 There should be junior doctors (FY1 & FY2) cover for 24 hours within the consultant unit at Broomfield Hospital. The junior doctor should attend the Labour Ward for the shift handover at 08:00 hours and 20:00 hours and physically hand over the bleep to the incoming junior doctor.

4.4.2 The junior doctors (FY1 & FY2) is in a training capacity and they will be expected to perform obstetric tasks for which they have been judged as capable and competent as their experience increases. They should always be under the direct supervision of the obstetric SPR.

4.4.3 Junior doctors (FY1 & FY2) should not accept designated responsibility for taking consent for procedures they cannot perform personally, unless they have received appropriate training and been signed off as competent i.e. taking consent for an LSCS.

4.4.4 The junior doctors (FY1 & FY2) should refer to a senior member of the obstetric team when making a plan of care for an obstetric patient, the obstetric SPR or consultant should review the patient personally.

4.4.5 The junior doctor (FY1 & FY2) is expected to join the Labour Ward rounds as stated in point 4.2.1.

4.4.6 In the event that the junior doctors (FY1 & FY2) for Labour Ward is sick he/she should inform the medical secretary (Monday to Friday 09:00 hours - 17:00 hours) and the on call obstetric consultant, for cover to be arranged.

4.5 Obstetric Anaesthetic Team

4.5.1 There is a 24 hour anaesthetic team cover for the Labour Ward. There is a designated anaesthetic consultant on Monday to Friday for the elective LSCS lists and also other Labour Ward sessions. Out of hours, weekends and bank holidays there is an anaesthetic consultant on call.

4.5.2 There is consultant anaesthetic cover from 08:00 to 18:00 hours Monday to Friday. Each morning the consultant anaesthetist is also running a caesarean section list. Monday and Thursday afternoon the consultant has sole labour ward duties, Tuesday, Wednesday and Friday the consultant runs an anaesthetic antenatal clinic as well as providing labour ward cover.

4.5.3 There is a designated junior doctor (FY1 & FY2) /SPR anaesthetist experienced in obstetrics providing 24 hour cover for the Labour Ward. The Labour Ward round is undertaken at 08:00 hours.

4.5.4 The anaesthetic consultant and/or the SPR should attend the Labour Ward round on Monday to Friday at 08:00 hours and 17:00 hours.

4.5.5 The on call duty anaesthetist SPR/consultant should be informed of the following to ensure an appropriate contribution to the care planning process.

- Patients with multiple pregnancies in suspected labour;
- Patients with a severe antepartum or postpartum haemorrhage;
  (Refer to guideline 'Emergency transport of blood and specimens in the event of major obstetric haemorrhage' (07024);
- Patients who may require or request an epidural for intrapartum pain relief;
- Patients with severe pre-eclampsia/ hypertension;
- Any patient who is identified with high risk factors for her on-going pregnancy who has not had an anaesthetic assessment;
- A planned LSCS;
- Patients with a retained placenta;
- Patients who may require patient controlled anaesthesia;
- A woman with a BMI more than 40.

4.5.6 The duty anaesthetist must attend immediately for the following:

- Maternal collapse;
- Emergency LSCS;
- Retained placenta with vaginal bleeding;
- Trial of instrumental delivery in the obstetric theatre;
- Repair of severe perineal body tears requiring suturing in theatre;
- Seizures;
- Patients with HELLP (H- haemolysis; EL- elevated liver enzymes; LP- low platelet count) Syndrome;
- Patients with disseminated intravascular coagulation (DIC);
- Patients who require transfer to ITU.

4.5.7 In the event that a consultant is sick, he/she should inform the on call consultant and cover will be arranged.

4.5.8 In the event that anaesthetic junior doctor (FY1 & FY2) /registrar is sick, he/she should inform the anaesthetic administration co-ordinator Monday to Friday 09:00 hours – 17:00 hours, and the on call anaesthetic consultant and cover will be arranged.

4.6 **Operating Department Practitioner** (ODP)

4.6.1 There is always an ODP providing 24 hour cover for the Maternity Consultant-led Unit. The ODP rostered carries a bleep and can be bleeped for any of the following:

- Any procedure that has to be carried out in theatre requiring a general or regional anaesthetic;
- Maternal collapse;
- Maternal seizures;
- Patients who require transfer to ITU.

4.6.2 In the event the ODP is sick, the ODP in charge for the day will cover Maternity Theatres as a priority.

4.7. Obstetric Theatre Nursing Team

4.7.1 Theatre and Recovery Nursing Services are provided by the Theatre and Anaesthetic Directorate. The management of the theatre is under their sphere of responsibility however it is imperative that there are robust lines of communication between the Maternity Medical and Midwifery teams to ensure a safe provision of care for patients and their babies in the obstetric theatre environment.

4.7.2 The senior nurse in charge of the obstetric theatre should liaise directly with the senior midwife co-ordinating the Labour Ward to agree schedules and plans for patients requiring transfer to the obstetric theatre.

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4.7.3 The midwife responsible for the intrapartum care of a patient transferred to the obstetric theatre for an emergency lower segment caesarean section (LSCS) continues her professional responsibility for the maternity care in partnership with the obstetric theatre and recovery nursing teams as well as the obstetricians and anaesthetic teams. The health care professional should ensure that the patient has been fully informed and that all care, conversations and decisions have been clearly documented in the patient's healthcare records

4.7.4 The recovery nurse is responsible for the immediate post anaesthetic recovery of the patient; they are not responsible for assessing the patient from an obstetric perspective.

4.7.5 The midwife responsible for patient's care is also responsible for the assessment and care of the newborn neonate. The recovery nurse would not be expected to assess the condition of the newborn neonate.

4.8. Paediatric Team

4.8.1 There is always a paediatric registrar (SPR) and junior doctor Advanced Neonatal Nurse practitioner rostered to provide 24 hour cover to neonates within the Maternity CLU.

4.8.2 The named consultant paediatrician is available Monday to Friday 08:30 hours -17:00 hours and on call out of hours, weekends and bank holidays.

4.8.3 In the event that a paediatric consultant is sick, he/she should inform the on call paediatric consultant and cover will be arranged.

4.8.4 In the event that a paediatric junior doctor (FY1 & FY2)/ registrar is sick, he/she should inform the on call paediatric consultant and cover will be arranged.

4.9 Labour Ward Co-ordinator

4.9.1 An experienced supernumerary midwife will be in charge of the Labour Ward on a shift to shift basis providing 24 hour cover. This will be the Labour Ward Manager or Band 7 midwife or an appropriately experienced senior Band 6 midwife in the absence of the Labour Ward Manager or Band 7 midwife.

4.9.2 The Labour Ward co-ordinator is responsible for the day to day running of the Labour Ward and co-ordinates the midwifery work load ensuring the communication board in the Labour Ward office is up to date and identifies the on call community midwife, obstetric, anaesthetic and paediatric teams.

4.9.3 The Labour Ward co-ordinator will allocate the midwife work load on each shift, taking into account their experience, the skill mix of the midwives on duty and complexities of each individual case.

4.9.4 The Labour Ward co-ordinator should assess the skill mix or level of activity, if either is compromised and the staffing levels or skill mix is not appropriate to meet the complexities of the individual cases, they have the authority to re-allocate staff from other areas of the service to maintain a safe environment for continued care.
(Refer to Appendix D - Obtaining back up for high work-load staff shortages and emergency situations)

4.9.5 The Labour Ward co-ordinator is responsible for answering their bleep (#6555 2017) to staff reporting sickness between the hours of 16:00 to 08:00 hours. In addition, switch board will fast bleep the Labour Ward Co-ordinator's bleep to communicate the incident and the location for a Code Blue/Red emergency.
(Refer to guidelines entitled 'Neonatal Resuscitation' (07074) and 'Management of postpartum haemorrhage' (04234)

4.9.6 The Labour Ward co-ordinator should escalate any concerns regarding the safety of the service to the to the Labour Ward manager or the maternity bleep holder during normal hours, and the on call midwifery manager and/or the Head of Midwifery for Maternity Services out of hours.
(Refer to guideline 'Maternity Services escalation policy (10084)

4.9.7 The Labour Ward Co-ordinator can access a Professional Midwifery Advocate (PMA) for professional advice and support when remedial management actions have not resolved the situation and the safety of the care provided remains compromised. PMA's are available from 08.00 –16.00 5 days a week and the rota for this is available via switchboard.

4.9.8 When activity allows the Labour Ward Co-ordinator should not be allocated to provide intrapartum care, antenatal or postnatal high dependency care as this will not enable them to co-ordinate the Labour Ward activity effectively.

4.9.9 If the Labour Ward co-ordinator is temporarily unable to co-ordinate the Labour Ward i.e. they are conducting midwifery care, involved in an emergency or called to another department, they should transfer responsibility to another Band 7 senior midwife or an appropriately experienced senior Band 6 midwife who will act as a shift co-ordinator on the labour ward; until they can resume the responsibility personally.

4.9.10 Out of hours the Labour Ward Co-ordinator is the most senior midwife on duty and has overall responsibility for the operational management of maternity services which includes both of the centres and community midwifery. The Labour Ward Co-ordinator will have access to the Manager on Call during this time for additional help and advice.

4.9.11 Labour Ward midwifery shift handover is the responsibility of the Labour Ward co-ordinator. It is carried out at 08:00 hours and 17:00 hours in the Labour Ward office and is multi-disciplinary. An additional handover will be undertaken if there are midwifery staff allocated to a late shift which will be at 12:30 hours.

4.9.12 In addition to the Labour Ward handover there is an additional personal face-to-face handover of care between the midwife assuming the care of the patient and the midwife relinquishing responsibility of care. This will usually be carried out in the presence of the patient enabling a clear understanding of her care and management. This face-to-face handover must be documented in the patient's health care records.

4.9.13 The Labour Ward Co-ordinator is responsible for providing the in-coming midwifery and medical staff with an up to date summary of the condition and progress of each patient present on the labour ward, highlighting those patients who are high risk.

4.9.14 Any serious, adverse or near miss incidents that have occurred during the Labour Ward co-ordinator's shift should be reported and handed over to the next in coming co-ordinator. This information should be escalated to the Labour Ward manager and Professional Midwifery Advocate in hours and to the on-call maternity manager and the on-call consultant obstetrician/anaesthetist if not already done so. The Labour Ward co-ordinator should also ensure that the patient's named consultant or midwife is informed of any incident.

4.9.15 The Maternity Bleep Holder during the hours of 08:00-16:00 hours and the Labour Ward Co-ordinator out of hours is responsible for maintaining an overview of the Maternity Services bed availability, activity and staffing; to identify and instigate contingency plans to ensure a safe service at all times. The bleep holder is responsible for maintaining the daily information for the bleep holder log and escalating concerns to the Lead Midwives during normal hours, and the on call Midwifery manager and /or Head of Midwifery out of hours. The communications in relation to the escalation of concerns to the Head of Midwifery; in the form of the daily information for the bleep holder log, emails, and transcriptions are logged and archived in the appropriate folder.
(Refer to guideline 'Maternity Services escalation policy (10084)

4.9.16 The handover should also include a summary of the on-going planned and elective activity such as inductions of labour, elective lower segment caesarean sections (LSCS) lists and any high risk antenatal. Postnatal patients receiving care elsewhere in Maternity Services or within the Trust.

4.9.17 The in-coming Labour Ward Co-ordinator must be informed if any members of staff have reported commencing sickness absence or return from sickness absence leave and the contingency plans instigated or outstanding management actions required.

4.9.18 Both the relinquishing and incoming Labour Ward co-ordinators are responsible for ensuring the controlled drug stock levels are checked by two qualified practitioners and that the theatre CD keys are confirmed and accounted for. This should be documented on completion and that a record of this activity has been undertaken.
(Refer to policy 'Administration of Medicines to Inpatients' (08103)

4.10 **Professional Midwifery Advocates**
(Refer to Appendix B)

4.10.1 The primary role of the PMA is concerned with the safety of patients and their babies and to provide professional advice and guidance on midwifery practice. The PMA can also act as an advocate for women.

4.11 **Midwives allocated to Practice on the Labour Ward**

4.11.1 A named midwife will be allocated to provide care to a patient on the Labour Ward. The midwife has full responsibility for providing intrapartum care of a patient in normal labour where no high risk factors have been identified. However, whilst working on the Labour Ward all midwives should ensure that the Labour Ward Co-ordinator is informed of the progress in labour for patients they are caring for. This does not distract from the individual midwife's responsibility and accountability but ensures good communication and an informed approach to co-ordinating the Labour Ward facilitating an overview of the current activity and the level of risk for that activity.

4.11.2 If a midwife is allocated to care for a patient with a high risk pregnancy, the obstetric medical staff must be involved in development and monitoring of the plan of care. The Labour Ward Co-ordinator should be kept informed of the progress and also advised if the midwife is uncertain about the plan of care ordered by the obstetric or anaesthetic team.

4.11.3 If a midwife caring for a patient with no risk factors who subsequently develops an abnormality, the obstetric team should be called to assess the situation and make a plan of care for that patient. The Labour Ward Co-ordinator or the midwife responsible for the patient may do this, but in the latter situation the Labour Ward Co-ordinator should be advised as soon as possible as to the plan of care. This ensures good communication and a co-ordinated approach to the clinical operational management of the Labour Ward. (Refer to Appendix A)

4.11.4 **Escalating concerns using SBAR** - Midwives are personally accountable for acts and omissions in their practice, and must always be able to justify their decisions. Concerns regarding patient care must be initially escalated to the relevant professional using the SBAR communication tool below:

Situation

Background

Assessment

Recommendation

4.11.5 The midwife responsible for the patient's care or the Labour Ward co-ordinator should at all times consider the appropriate level of obstetric or anaesthetic referral. The professional contacted must have the ability to deal with the concern identified. If a midwife is unhappy with the care provided or advice given by a member of the obstetric team they should contact a midwife with more experience i.e. the Labour Ward co-ordinator, midwifery manager on-call or PMA.

4.12 M**idwives allocated to Practice in Community, Midwife-led Birthing Units and the Co-located Birthing Unit**

4.12.1 In the community, Midwife led Birthing Units and the Co-located Birthing Unit there is a personal face-to-face handover of care between the midwife assuming the care of the patient and the midwife relinquishing responsibility of care. This will usually be carried out in the presence of the patient enabling a clear understanding of her care and management.

4.12.2 This face-to-face handover must be documented in the patient's health care records. When there are deviations from normal parameters, the named midwife will liaise with the Labour Ward co-ordinator and obstetric registrar to arrange timely transfer of the patient to the Consultant-led Unit.
(Refer to Transfer of Mothers and Babies to Different Care Settings; register number 06029)

5.0 Resolution for Professional Dispute

5.1 If issues are not addressed appropriately or to the satisfaction of the reporter then the situation needs to be re-evaluated using SBAR and escalated to the next level as indicated below
(Refer to Appendix A)

Situation,' professional disagreement of care plan '

Background, 'patient has … informed…'

Assessment, 'response from …, I feel that this response is not appropriate…'

Recommendation… 'revise care plan' or continuation of care plan'

6.0 Direct Access to a Consultant by a Midwife

6.1 Any midwife can refer a patient in her care directly to an obstetric consultant at any stage of antenatal, intrapartum or postpartum care in any event where they feel there are concerns for the welfare of the pregnant patient or her unborn baby. This means that midwives working in any part of maternity services in MEHT have direct access to a consultant. Ensure that the Labour Ward Co-ordinator is informed of this referral occurs on Labour Ward.
(Appendix A and B)

6.2 A midwife should refer a patient direct to a consultant:
(this is not a prescriptive list)

- When the midwife has concerns regarding the pregnant patient or fetus' condition and is unable to obtain a timely response from the obstetric registrar (SPR) i.e. the SPR is dealing with an emergency and the midwife identifies that to wait would be detrimental to the patient or her unborn baby;
- When the midwife has concerns that the performance of a junior medical staff is jeopardising the health and safety of a pregnant patient and her unborn baby i.e. there

is a disagreement with the patient's plan of care, junior staff fail to provide a plan of care or the plan of care provided is inadequate;
- When the skills and experience required are beyond the scope of the junior medical staffs' professional practice and experience.

6.3 In a situation where the woman is a patient on the, Labour Ward referral is usually via the Labour Ward co-ordinator. However, any midwife can refer directly to the consultant. The midwife may wish to refer directly, if the Labour Ward co-ordinator is not immediately available or the Labour Ward Co-ordinator and the junior medical staff fail to respond appropriately to the developing emergency.

6.4 A good working relationship is necessary to foster a culture of effective team working. If a midwife refers directly to an obstetric consultant, the Labour Ward Co-ordinator should be informed as soon as possible.

6.5 If the referral is in relation to challenging a junior medical staff decision, an explanation should be presented to the junior medical team member highlighting the rationale and the professional accountability and responsibility of the midwife to the patient and her unborn baby. Any decisions between professionals should be open and honest and all actions taken should be for the welfare and safety of the patient and her unborn baby.

6.6 Each midwife caring for a patient in labour is responsible for updating the progress of labour to the Labour Ward Co-ordinator.

7.0 Locum Doctors or Agency Midwives

Refer to the guideline 'Mandatory training policy for Maternity Services (incorporating training needs analysis)'(09062)

7.1 As a minimum all locum and agency staff should receive a copy of this guideline on appointment. Depending on the role they are employed to cover their practise will be within the roles and responsibilities as described within this guideline.

7.2 For medical staff, the Obstetric Registrar or Obstetric Consultant responsible for the Labour Ward at the commencement of the first shift; or the Labour Ward Co-ordinator for midwives should ensure completion of the agency and locum local induction checklists.

7.3 The completed Induction Programme Checklist for Bank/Agency midwives should be filed in the appropriate folder kept in the Labour Ward Handover Room.
(Refer to Appendix E)

7.4 The completed proforma entitled 'Essential information for Locum Doctors' should be returned by the Locum Doctor at the end of the shift to Medical Resources (B244) or Clinical Operations Centre (A202).

7.5 The locum or agency staff should be orientated to all the relevant clinical areas.

7.6 Where there is a locum, he or she will receive a personal handover from the obstetric registrar or junior doctor (FY1 & FY2) as appropriate as for point 5.0.

7.7 The locum or agency staff must be orientated to all the relevant clinical areas highlighting the following:

- Fire procedures including, the fire alert number evacuation collection points;
- Location of the cardiac arrest trolley and defibrillator;
- Awareness highlighted to medical staff that the obstetric medical team are part of the cardiac arrest team for adults at Broomfield Hospital;
- Bleep system;
- Crash call signs and expected responses;
- Location of hard copies of the policies and guidelines;
- The split site considerations relating to transport of blood specimens and blood products;
- The potential for admissions via Accident and Emergency Department at Broomfield Hospital;
- The location of the birth centres and potential referral.

7.8 Locum and agency staff should refer to the Trust policies and guidelines, seeking advice from senior midwifery and medical staff if they are unclear.

7.9 Locum and agency staff should only practice within the scope and sphere of their practices acknowledging their limitations.

7.10 Agency midwives should complete or provide an intention to practice form and present this evidence to a SOM prior to commencing duty to enable a professional registration check to be undertaken.

8.0 Communication Systems- Maternity Services

8.1 There is a designated consultant obstetrician with the professional responsibility for Labour Ward matters.

8.2 The Labour Ward Manager is responsible for the clinical operational management of the Labour Ward.

8.3 How to contact Staff as follows:

- The Labour Ward office has a communication board with the names and bleep numbers of the on call medical teams: obstetric, anaesthetic and paediatric. All medical rotas and bleep numbers are retained in a folder kept in the Labour Ward office;
- All medical staff bleep numbers are available displayed by each of the phones in the Obstetric Theatres;
- The names of the Labour Ward Co-ordinators for each shift, Midwifery Manager and PMA’s are displayed on the communications board;
- The community midwifery rota is in a folder kept in the Labour Ward office;
- Each of the medical team will have a personal bleep but when they are rostered to cover the Labour Ward they will carry an additional bleep which has a constant bleep number retained on the labour ward.

8.4 The 24 hour Labour Ward Bleeps numbers are:

Obstetric Team	
SPR	#6500 3500
junior doctor (FY1 & FY2)	#6500 3501
Paediatric Team	
SPR	#6500 3522
junior doctor (FY1 & FY2)	#6500 3521
Anaesthetic Team	
SPR/ junior doctor (FY1 & FY2)	#6500 3021
ODP	#6500 3020

8.5 Staff to be contacted by switchboard or mobile phone. The Labour Ward Co-ordinator has access to the consultant obstetricians home and mobile phone numbers:

- On call consultant obstetrician;
- On call consultant anaesthetist;
- On call consultant paediatrician;
- On call midwifery manager;
- On call Trust general manager;
- On call Trust executive (contact via general manager);
- PMA's (available Monday to Friday from 08.00 – 16.00; 5 days a week).

9.0 Staffing and Training

9.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

9.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are Up-to-date in order to complete their portfolio of professional development for their appraisal.

10.0 Audit and Monitoring

10.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy and the Maternity annual audit work plan. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

10.2 The maternity service has approved documentation that describes the duties and requirements of key individuals on the Labour Ward, which as a minimum must include:

- Requirement for consultant obstetrician attendance in person in the following clinical situations:
  - i. Eclampsia;
  - ii. Maternal collapse (such as massive abruption, septic shock);

iii. Caesarean section for major placenta praevia;

iv. Postpartum haemorrhage of more than 1.5 litres, where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated;

v. Return to theatre – laparotomy;

vi. Uterine rupture.

- Requirement to have an experienced midwife who acts as a shift coordinator on the labour ward;
- Arrangements for ensuring availability of a duty anaesthetist on the labour ward 24 hours a day, 7 days a week ;
- Process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans.

10.3 A review of a suitable sample of health records of patients and pertinent evidence to include the minimum requirements as highlighted in point 10.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

10.4 The findings of the audit will be reported to and approved by the Women's and Children's Clinical Audit Group and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by the Women's and Children's Clinical Audit Group at subsequent meetings.

10.5 The Women's and Children's Clinical Audit report will be reported to the monthly Maternity Directorate Governance Meeting and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

10.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

10.7 Key findings and learning points will be disseminated to relevant staff.

11.0 Guideline Management

11.1 As an integral part of the knowledge and skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

11.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

11.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

11.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

12.0 Communication

12.1 A quarterly ‘maternity newsletter’ is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or ‘bank’ staff have letters sent to their home address to update them on current clinical changes.

12.2 Approved guidelines are published monthly in the Trust’s Staff Focus that is sent via email to all staff.

12.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

12.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

13.0 References

Nursing and Midwifery Council (2018) Raising concerns: Guidance for nurses, midwives and nursing associates.

Professional duty to act to protect people in our care who you consider may be at risk.

General Medical Council (2012) Raising and acting on concerns about patient safety.

RCOG, RCM, RCOA, RCPCG (2007) Safer Childbirth: Minimum standards for the organisation and delivery of care in labour.

Nursing Midwifery Council (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Appendix A: Preliminary Equality Analysis

This assessment relates to: (please tick all that apply)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	**Answers**
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

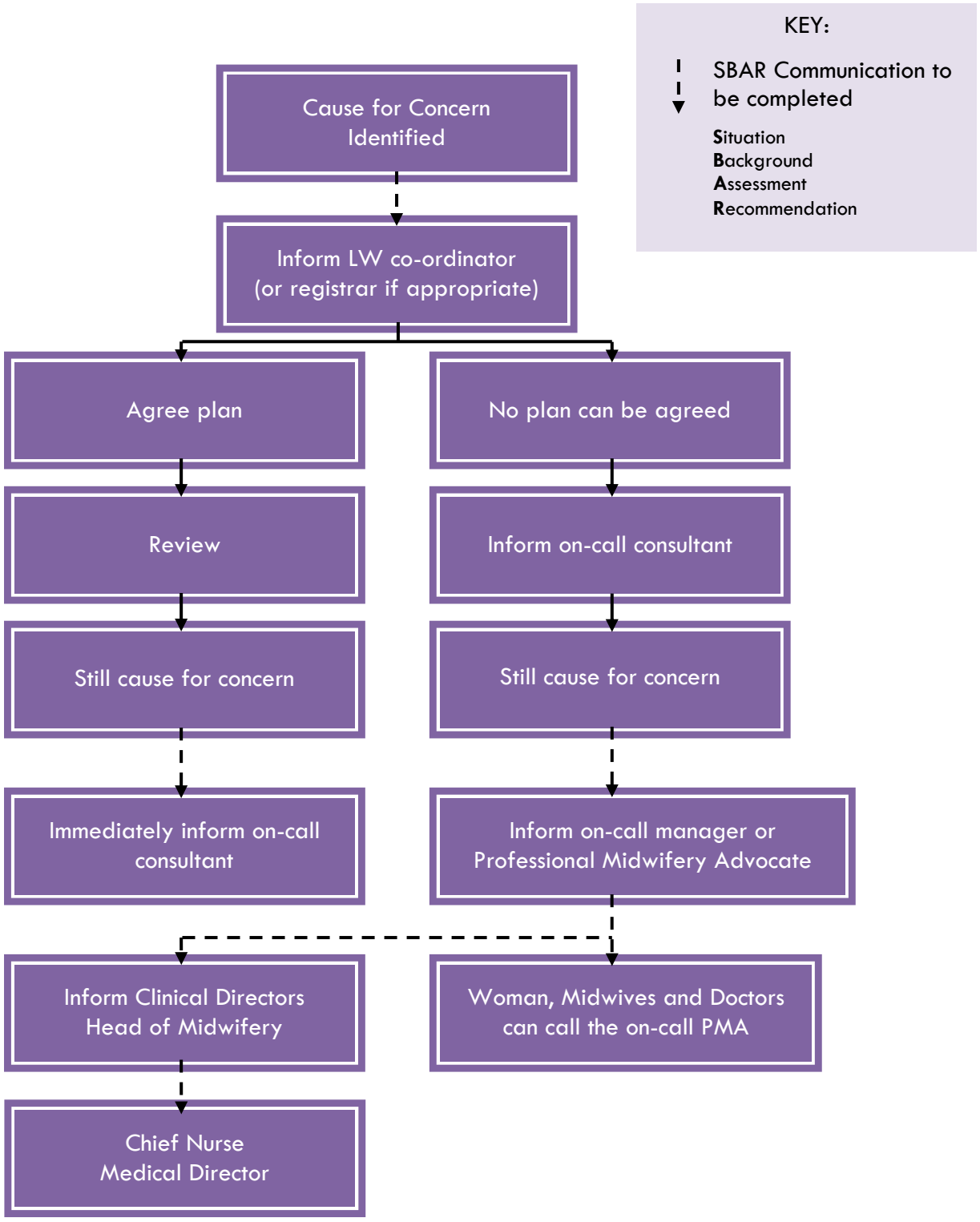
Preliminary analysis completed by:

Name	Amanda Dixon	**Job Title**	Lead Midwife Acute In-patient Services	**Date**	January 2019

Appendix B

Escalating Concerns

If your concerns are not initially addressed then initiate the following procedure:-



Please refer to guideline entitled 'Roles and responsibilities of Medical and Midwifery staff working within the Maternity Services'; register number 04227

Revised 01/2019

Appendix C

Maternity Services
Bleep Holder's Assessment Documentation

Staffing Escalation Flowchart to Ensure Maintenance of safe staffing levels

Midwives Staffing	*Early*	*Late*	*Night*
Unit minimum staffing levels	15	15	13
Unit standard staffing levels	16	16	14

*All staffing under review; awaiting Birthrate Plus final report (due Oct-18)

Bleepholder

- Books Bank / Agency Midwife
- Identifies Unsafe Levels
- Following re-deployment extended

Reviews

- Activity
- Action
- Projected Activity
- Bank / Agency deficit (book upto a maximum of 3 agency Midwives)
- Review Skill mix

Report to 8a

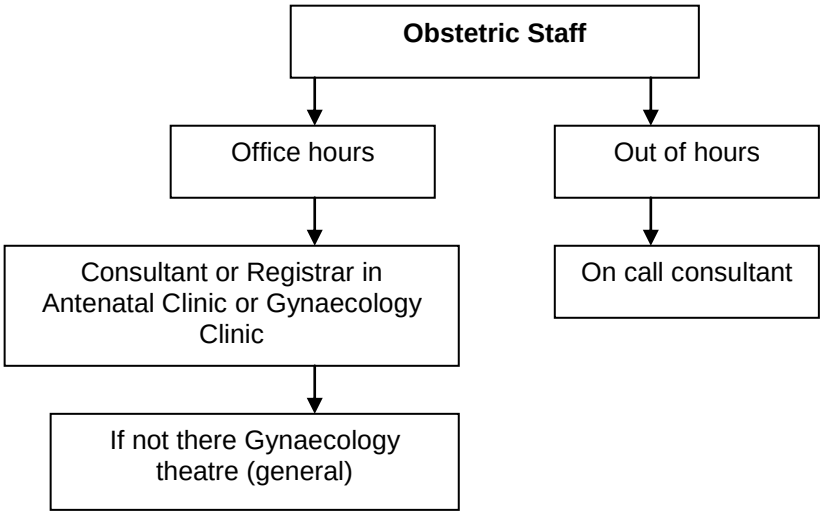
- 8a reviews options
  - Consider 4th Agency Midwife
  - Consider closure of MLU(s)

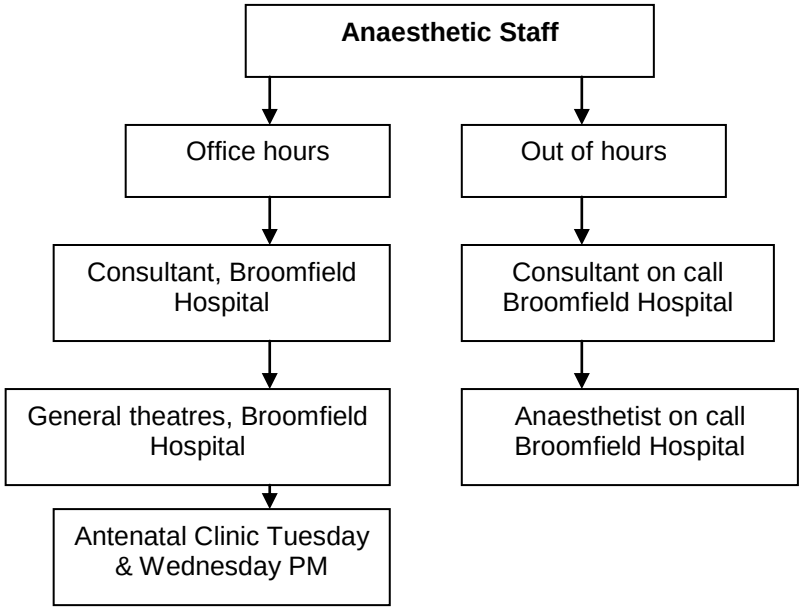
8a Escalates to HoM

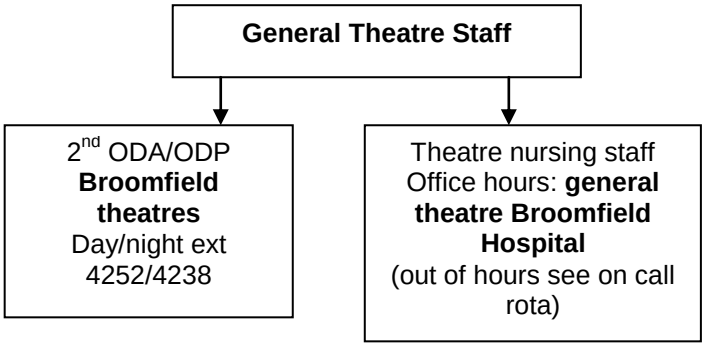
- HoM Decides
  - If 4th Agency Midwife is a safe option
  - If Unit closure is required
- Duration of Closure
- Escalates to Executive & OMS & Bed Management

Appendix D

Obtaining Backup for High Work-load / Staff Shortages / Emergency Situations







Appendix E

Induction Programme Checklist

Agency / Bank and Locum Staff

Name	DOB	Status
AODP / NMC No.	**Identity Check**	

Agency Reference	*For Agency Midwives – complete intention to practice form*
Agency Name	**Date(s) Worked**
Area(s) Worked	

Description	Competent	Date
Introduction to maternity department *Layout: including location of NNU, reception, maternity admin, day assessment unit, postnatal ward, Labour ward, obstetric theatre, offices for Head of Midwifery/ directorate manager, matron and maternity secretaries, antenatal clinic and ultrasound department, aware of location of midwife led units*	**Yes** ☐ **No** ☐	
Location of; *- Fire exits -* *- Fire alarms -* *- Fire extinguishers -*	**Yes** ☐ **No** ☐	
Alarm systems & evacuation protocols: *- Assembly point -*	**Yes** ☐ **No** ☐	
Cardiac arrest	**Yes** ☐ **No** ☐	
Location of trolley: **Arrest team bleep & phone:**	**Yes** ☐ **No** ☐	
Using the pager system: **Availability of duty, on call staff and bleep numbers** **Security system:** *Procedure for arranging transport for blood samples to the laboratory (pneumatic tube system)*	**Yes** ☐ **No** ☐	
Location of: **Policies & procedures folders:** **Drug policy** **Risk event forms** **Patient information board :**	**Yes** ☐ **No** ☐	
location of staff facilities including changing rooms, and lockers, toilets, coffee room and the canteen	**Yes** ☐ **No** ☐	
Roles and responsibilities of medical and midwifery staff working within Maternity Services (04227) **guideline given to staff**	**Yes** ☐ **No** ☐	

Labour Ward	Competent	Date
Ward layout including location of obstetric theatres, staff changing rooms & toilets. blood gas analyser, drug fridge and cupboard, store rooms, sluice, linen room	**Yes** ☐ **No** ☐	
Location of patients records	**Yes** ☐ **No** ☐	
Recordkeeping: hand held notes, hospital based records, and CDC	**Yes** ☐ **No** ☐	
Location of delivery register & theatre register	**Yes** ☐ **No** ☐	
Location of the following equipment: fetal heart monitor, resuscitaire, portable incubator, IVAC, infusion pump, FBS and epidural trolley	**Yes** ☐ **No** ☐	
Equipment in delivery rooms, including delivery bed/leg rests, delivery trolley, entonox, suction and oxygen (mother and baby) location of emergency guideline folders	**Yes** ☐ **No** ☐	
Receiving and documenting patient telephone enquiries	**Yes** ☐ **No** ☐	
Location of emergency rhesus negative blood and cross-matched blood bank	**Yes** ☐ **No** ☐	
Doctors on call rooms, code access numbers for relevant staff to on call rooms	**Yes** ☐ **No** ☐	

Postnatal Ward	Competent	Date
Ward layout including location of emergency equipment, resuscitaire, storerooms, drug and treatment room, patient areas and kitchen.	**Yes** ☐ **No** ☐	

Day Assessment Unit	Competent	Date
Layout, including patient areas, store room, sluice, use of security phone, and kitchen	**Yes** ☐ **No** ☐	
How to book ultrasound scans	**Yes** ☐ **No** ☐	

Midwife Led Units	Competent	Date
William Julien Courtauld – Braintree	**Yes** ☐ **No** ☐	
St. Peter's – Maldon	**Yes** ☐ **No** ☐	
Midwife-led Units providing low-risk midwifery antenatal, intrapartum and postnatal care	**Yes** ☐ **No** ☐	
Any woman with **high-risk pregnancy** factors will be referred directly to the consultant unit	**Yes** ☐ **No** ☐	

Staff Sign off		
Name	**Sign**	**Date**

Supervisor Sign off		
Name	**Sign**	**Date**