Multidisciplinary team working on the labour ward

SFOAI Svensk Förening för Obstetrisk Anestesi och Intensivvård

Rupert Gauntlett

Consultant in intensive care medicine and obstetric anaesthesia

The Newcastle upon Tyne Hospitals NHS

NHS Foundation Trust

Newcastle relegated: After years of poor decisions, what next for Magpies?

By Phil McNulty
Chief football writer

11 May 2016 | Football | 312

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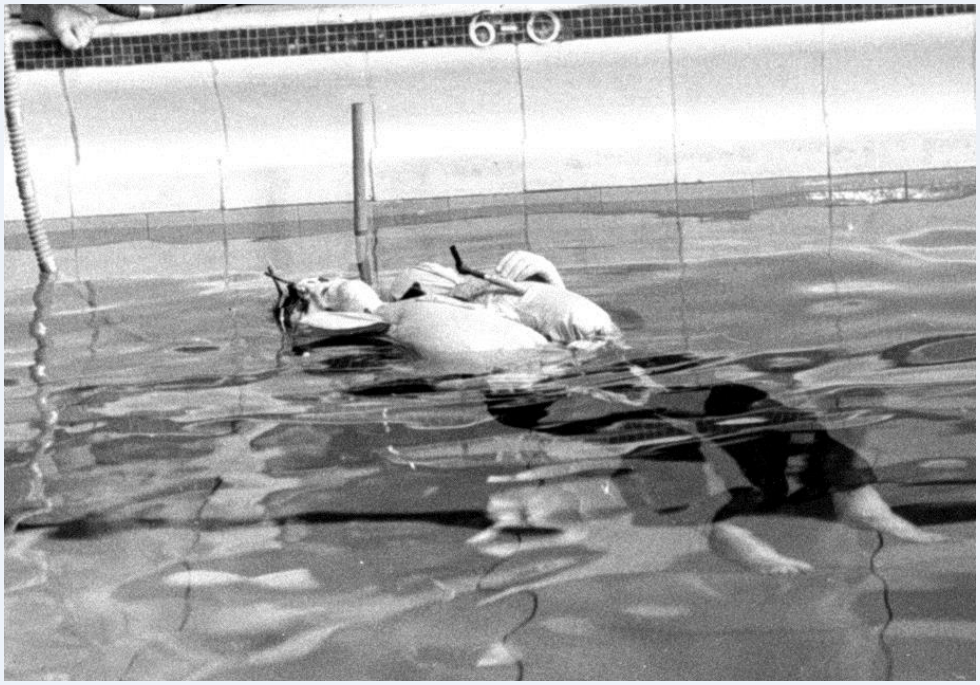
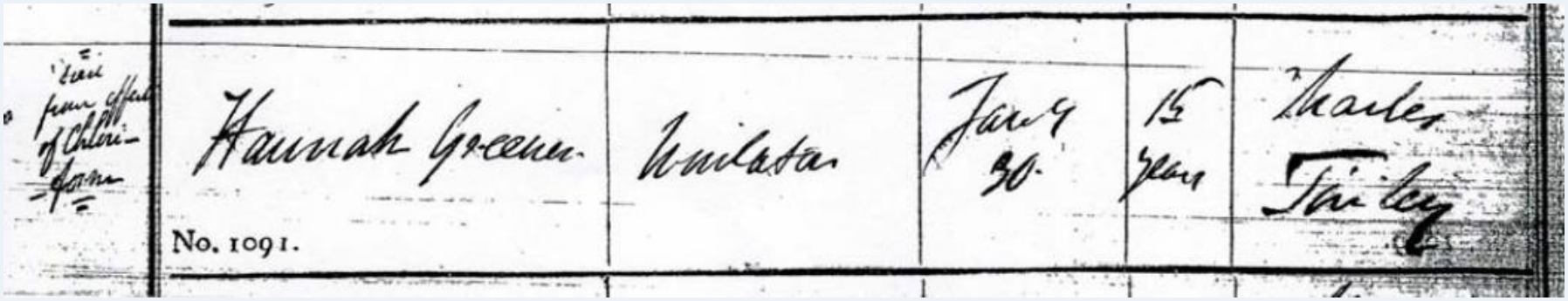
Newcastle fans will have to adapt to life in the Championship next season

Newcastle and the history of anaesthesia
T Phillip Ayre

Newcastle and the history of anaesthesia
Edgar Pask



Newcastle and the history of anaesthesia
Hannah Greener



First person in the world to die under chloroform anaesthesia - 28th January 1848

Newcastle and the history of anaesthesia
Hannah Greener

Mr. Meggison (surgeon)

I seated her in a chair, and put a teaspoon of chloroform into a tablecloth, and held it to her nose.

When the semicircular incision was made, she gave a struggle or jerk

Her mouth was open, and her lips and face blanched…. I called for water when I saw her face blanched, and I dashed some of it in her face….I then gave her some brandy, a little of which she swallowed with difficulty

I then laid her on the floor and attempted to bleed her in the arm and jugular vein, but only obtained about a spoonful. She was dead, I believe

Multidisciplinary team working on the labour ward

Why does it go wrong?

You are all better than a F1 pit team

Even routine, uneventful antenatal care, an elective caesarean section and no post-partum complications represents a triumph of team working

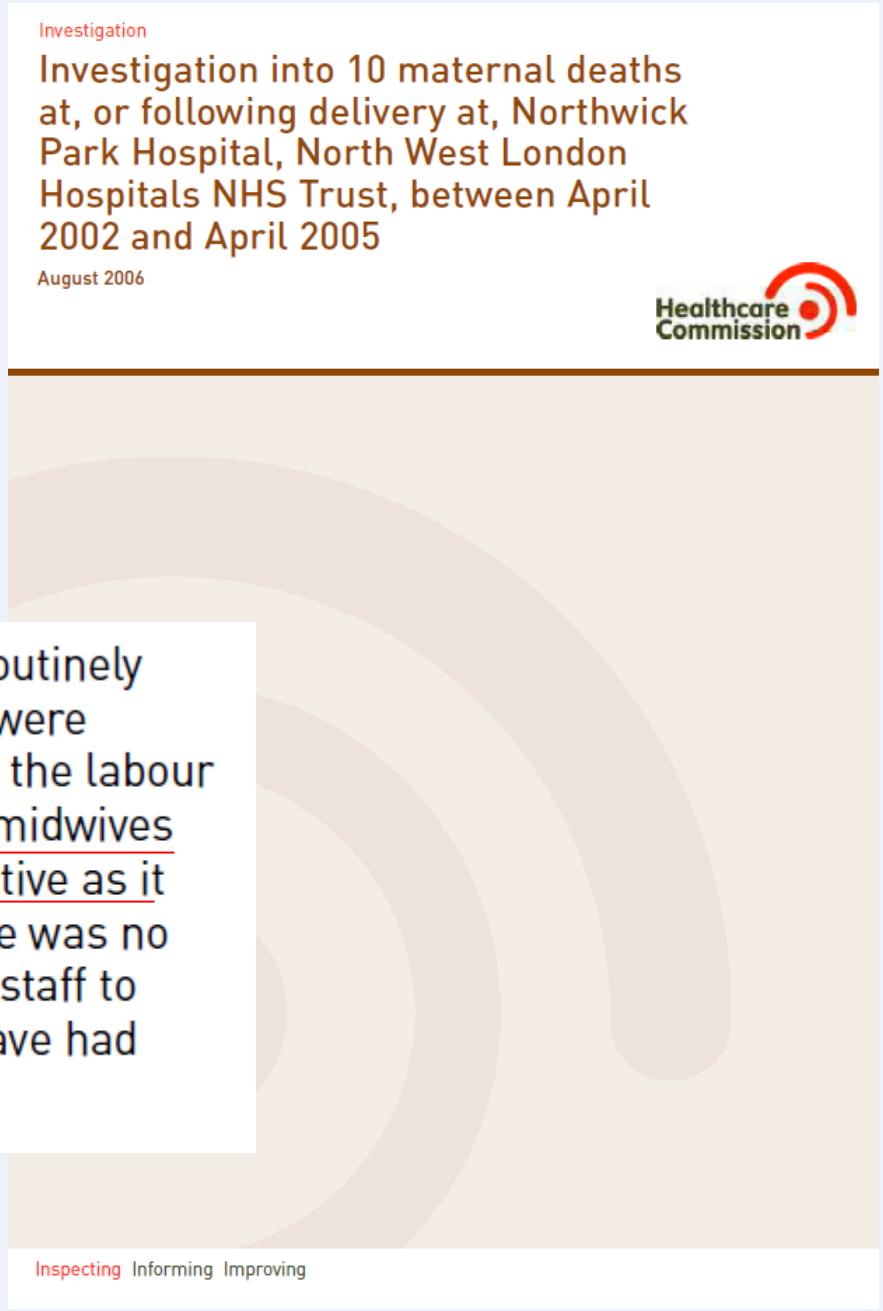
May 10, 2016 1:12 pm

Wales hospital uses F1 pit stop tactics for newborn resuscitation

Paul McClean

A hospital in Wales has drafted in the Williams Formula One team to help speed up its procedures for resuscitating newborn babies.

You have a more complex job than a pilot



- Consultant obstetricians did not routinely carry out ward rounds when they were responsible for overseeing care in the labour ward and the teamwork between midwives and obstetricians was not as effective as it should have been. Therefore, there was no adequate mechanism in place for staff to discuss concerns that they may have had about the women.

Furness baby deaths inquiry: 'Lethal mix of failures'

By Nick Triggle
Health correspondent, BBC News

3 March 2015 | Health

Joshua Titcombe died nine days after being born at the Furness General Hospital maternity unit

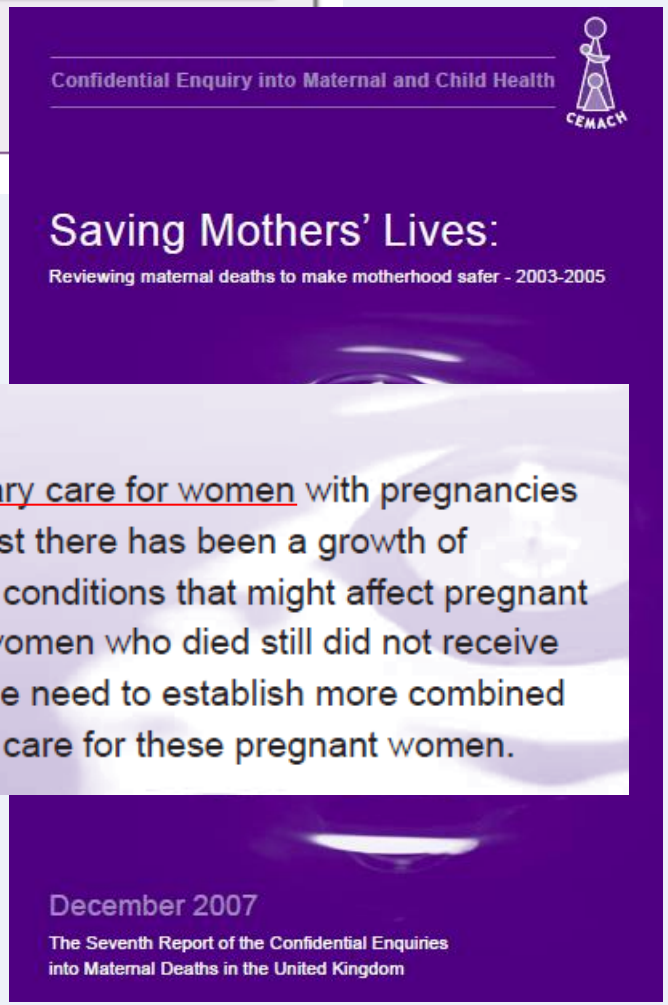
The Report of the Morecambe Bay Investigation

8. A cluster of five serious incidents occurred in 2008: a baby damaged by the effects of shortage of oxygen in labour; a mother who died following untreated high blood pressure; a mother and baby who died from an amniotic fluid embolism; a baby who died in labour due to shortage of oxygen; and a baby who died from unrecognised infection. All showed evidence of the same problems of poor clinical competence, insufficient recognition of risk, inappropriate pursuit of normal childbirth and failures of team-working, as seen previously. Initial investigation was again deficient and failed to identify manifest problems.

March 2015

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK



Poor management of higher risk women

Another recurrent feature of these Reports is the lack of multidisciplinary care for women with pregnancies complicated by existing, or new, medical or psychiatric problems. Whilst there has been a growth of multidisciplinary clinics for the management of the commoner medical conditions that might affect pregnant women such as epilepsy, diabetes and cardiac disease, some of the women who died still did not receive such care. The number of deaths from neurological causes, point to the need to establish more combined neurology or general medical / obstetric clinics in order to improve the care for these pregnant women.

PROMPT
Making Childbirth Safer, Together®

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PROMPT research contributes to Queen's Anniversary Prize 2014 for University of Bristol

1 2 3 4 5 6 7 8

PRactical Obstetric Multi-Professional Training

PROMPT (PRactical Obstetric Multi-Professional Training) is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.

The PROMPT Maternity Foundation (PMF) is a multi-professional group of obstetricians, midwives and anaesthetists based in the UK. PMF strives to make childbirth safer through training, education and research. Our aim has always been to make evidence based multi-professional obstetric emergencies training available to all

SaFE study (2002)
(Simulation and Fire drill Evaluation)

- Is local scenario based training as good as a high fidelty simulation centre?
- Does teamwork training actually improve clinical performance?

- 50% reduction in neonatal hypoxic injuries
- 70% reduction in injury after shoulder dystocia
- Improvements in the performance of emergency caesarean sections

IMPROVING SAFETY IN MATERNITY SERVICES

A toolkit for teams

Vinice Thomas
Anna Dixon

The King's Fund

Teamworking

Introduction

The Safe Births inquiry concluded that the overwhelming majority of births in England are safe (The King's Fund 2008); however, where some births are less safe, safe teams are the key to improving the outcome for mother and baby. It highlighted the link between poor teamwork and risk to women. It also noted the difficulties staff said they had encountered in working relationships. The inquiry stressed the need for staff to work more closely together and appreciate each other's roles.

The organisational culture within which staff operate can also affect teamwork; it can either enable or hinder learning, innovation and change and, ultimately, safety.

Safer Births projects to improve teamwork

The maternity team at Derby Hospitals NHS Foundation Trust developed their open labour ward forum, providing an opportunity for all members of the labour ward team to share ideas and opinions. The forum also created a safe environment for medical staff, midwives, health care assistants (HCAs) and receptionists to share their experiences. Staff reported feeling valued by this opportunity. Of equal importance was the opportunity to improve interactions with other staff and to challenge interprofessional and departmental barriers.

> *The project gave us the opportunity to spend time with each other and look at different aspects through different viewpoints. So we had a multidisciplinary team where different viewpoints and aspects were aired and discussed. This helped to build a cohesive and productive team...*
>
> Consultant obstetrician

Northampton General Hospital's project included improving multidisciplinary teamworking. Following a Manchester Patient Safety Framework (MaPSaF) workshop to assess the department's safety culture, the staff identified the need to clarify the roles of other team members. As a result they listed all staff and their roles and responsibilities in a document available on the labour ward which is also given to all new staff. Building on this the maternity team then worked to formalise medical labour handovers and multidisciplinary ward rounds so that staff not only know their roles and responsibilities but also the care/tasks required for mothers.

Among the interventions adopted by the maternity team at Medway NHS Foundation Trust (MFT) was strengthening the labour ward team by developing and delivering a team awayday with the support of external facilitators. These facilitators provided a fresh perspective to how the team interacted. In addition, the involvement of staff known to be influential as 'champions' was vital to the change process at MFT.

Key points for improving teamworking

- Consider creative ways to increase staff interaction and team-building, eg, forums, awaydays.
- Use recognised tools to identify the preferences, strengths, weaknesses, traits within the team, eg, Myers-Briggs Type Indicator, Belbin.
- Consider the organisational culture within your maternity unit; is it open to change, innovative, or are there pockets of resistance to change?
- Work with staff to address some of the organisational culture issues that can hamper success.
- Consider applying an organisational or safety culture analysis tool to help determine areas for further development such as MaPSaF.

5 rules for effective teamwork

by ADMINISTRATIVE PROFESSIONAL TODAY on MAY 5, 2015 7:00AM
in CENTERPIECE,LEADERS & MANAGERS,TEAM BUILDING

Print PDF

When you're collaborating with great people, it's important to make sure you gather everyone's best ideas and use their time and energy efficiently, says UpdateZen founder and CEO Paul Ruderman. Here are some of his "golden rules" for collaboration.

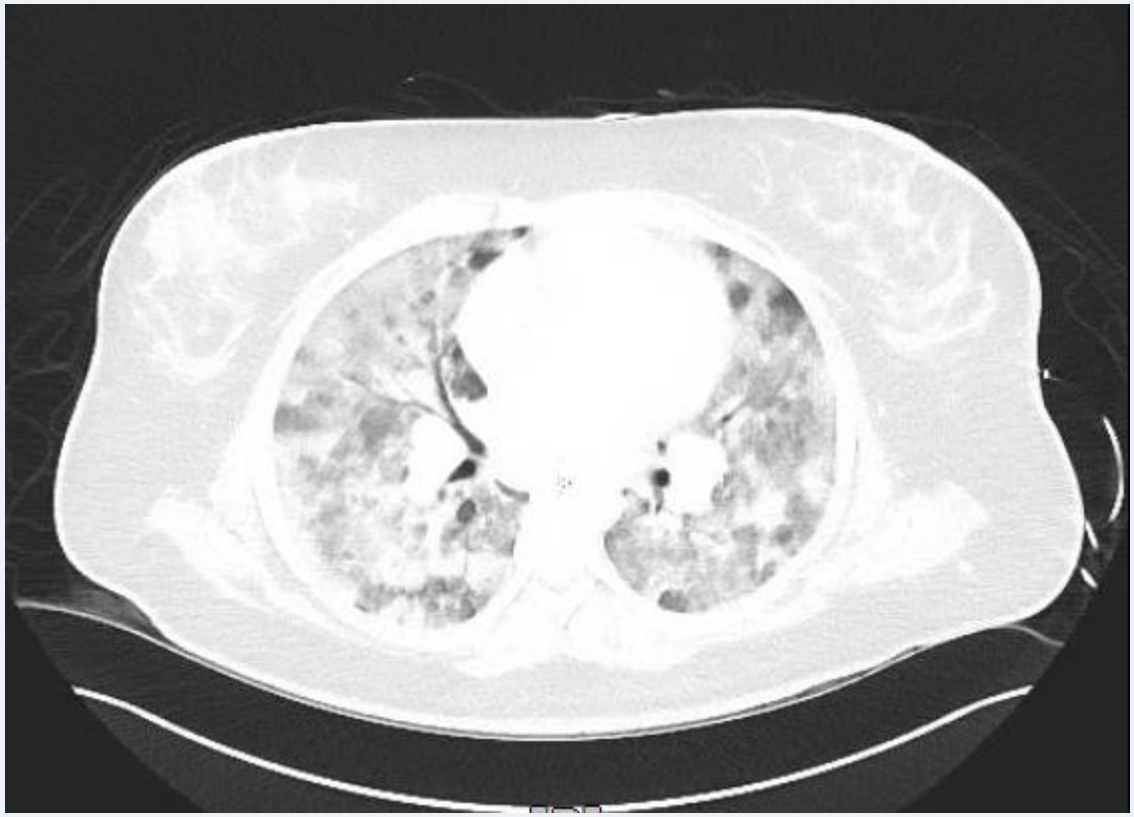
1. Show everyone respect. This should go without saying, but it's necessary to remind people sometimes.

- Show everyone respect
- Champion polite disagreement
- Always explain
- Communicate in brief
- Get rid of toxic people

Case 1 Influenza A, severe ARDS

- 27 year old, previously fit
- Presents at 23/40 with shortness of breath

- Rapid deterioration despite support
- Severe respiratory failure, discussed with ECMO centre

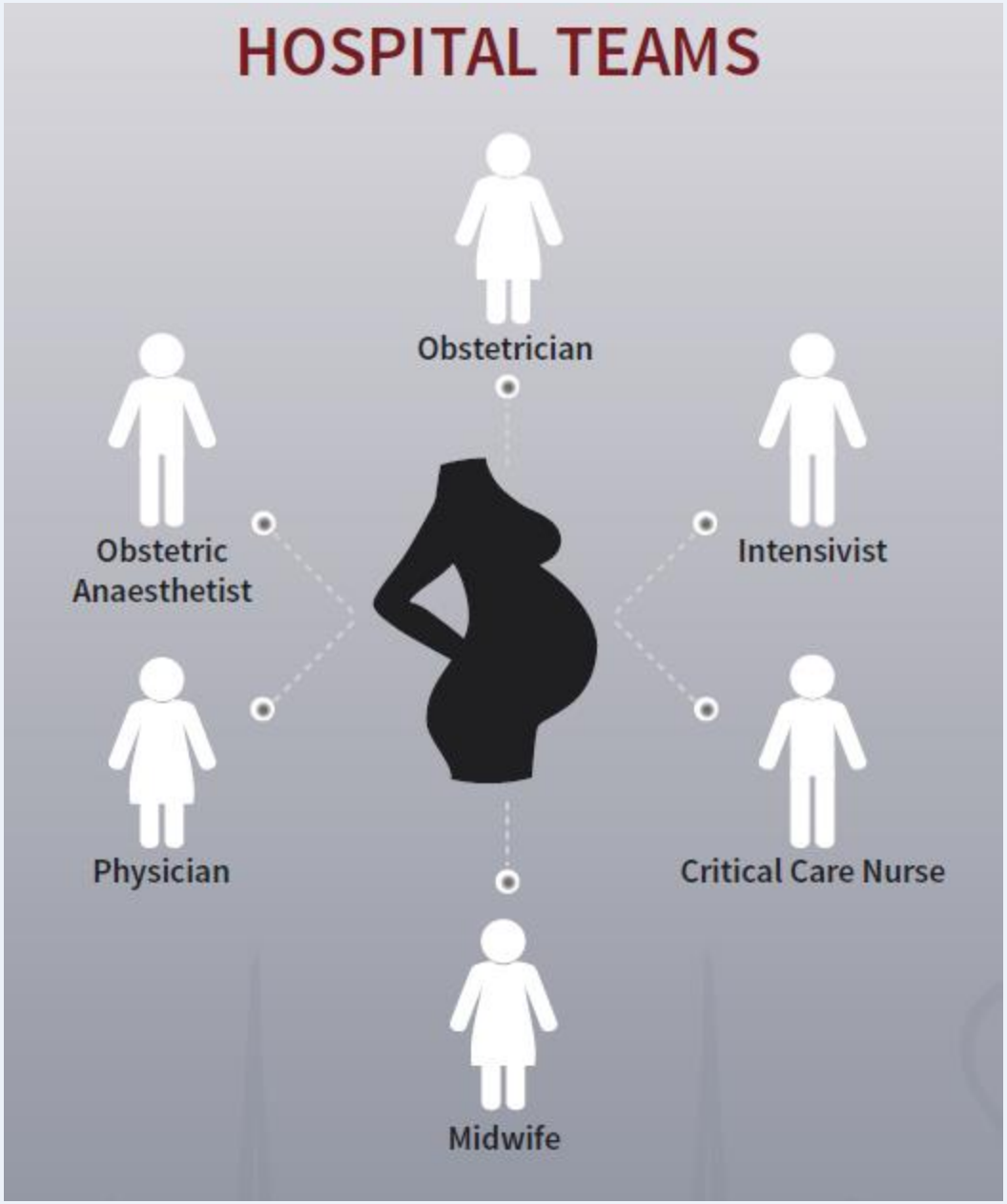


Case 1 Progress

- ‘Non-viable fetus’
- Turned prone to improve ventilation
- Multi-organ failure including renal failure requiring replacement therapy
- Critical care nurses anxious about baby/delivery
- Day 11, show followed by PV bleed, delivered into critical care bed (24+4)

How did MDT working fail?

- Show everyone respect
  - The critical care nurses views were not given sufficient consideration
- Champion polite disagreement
  - Obstetricians reluctant to review/revise their position
- Always explain
- Communicate in brief
- Get rid of toxic people


HOSPITAL TEAMS
Obstetrician
Obstetric Anaesthetist
Intensivist
Physician
Critical Care Nurse
Midwife

Case 2 Pre-eclampsia and PPH

- 35/40 twins, pre-eclampsia
- In-patient for 4 weeks for BP control
- Grd 2 CS (poor Dopplers)
- Spinal

Case 2 Progress

- Rapid PPH (atony)
- GA, balanced transfusion including 8 units PRBC
- Admitted to ICU post bleed

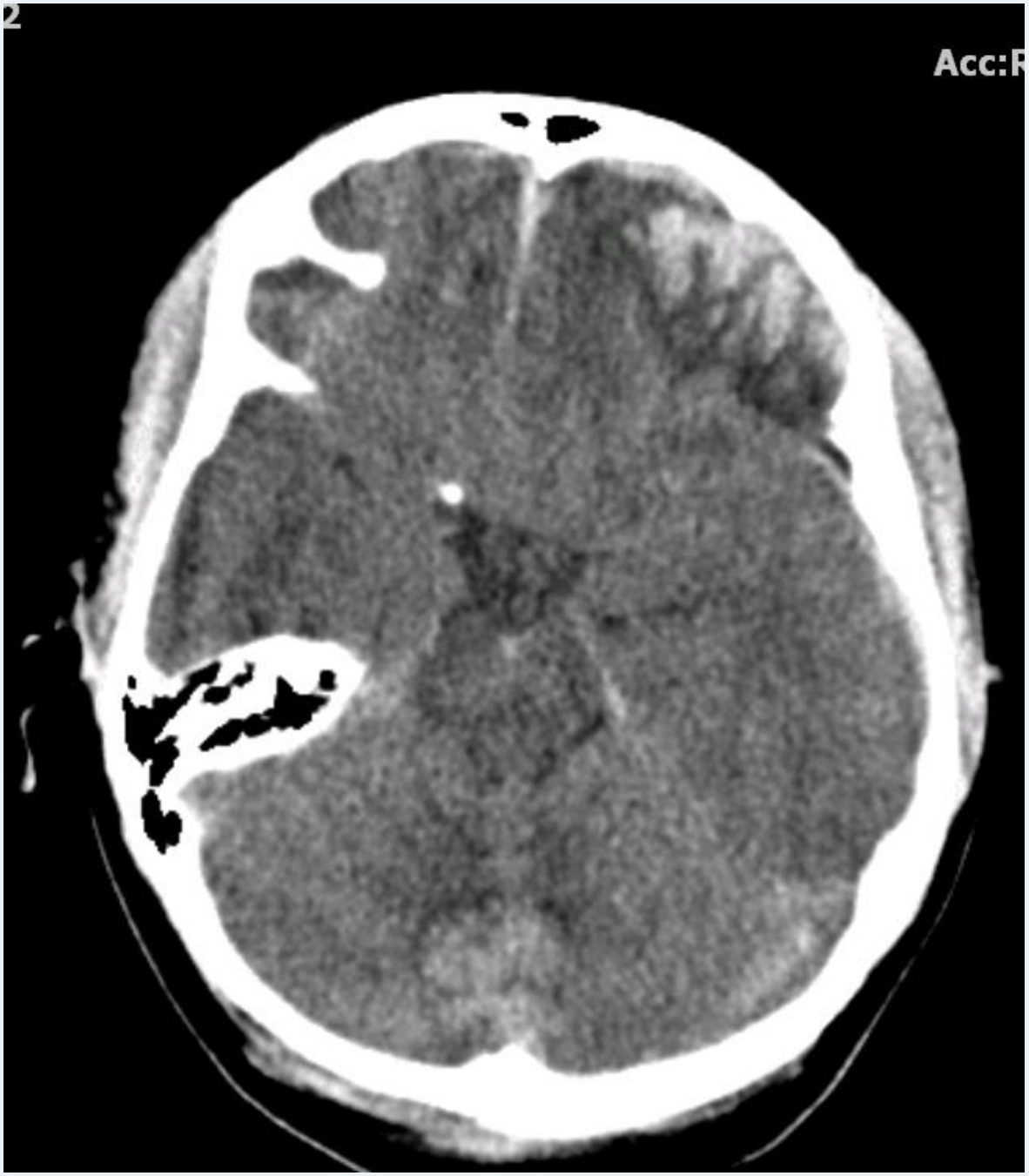
- Stabilised, woken and extubated
- Gaps in BP record, inappropriate thresholds for intervention

How did MDT working fail?

- Show everyone respect
  - Not giving sufficient priority to the opinion of the attending obstetrician
- Champion polite disagreement
  - The haemorrhage was over the focus should have returned to the high blood pressure
- Always explain
- Communicate in brief
- Get rid of toxic people

Case 3 Major trauma

- 17 year old, 40/40
- Unconscious at scene (GCS 5, improved to 14)
- Rapid deterioration in ED, intubated and ventilated for trauma CT scans
- CVS stable, obstetrician confirms FH, no sign of abruption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Acc:R

Case 3 Progress

- Needs urgent transfer to neurosurgical unit
- Multi-disciplinary discussions
- Obstetrician, emergency medicine, neuro-intensivist

Case 3 Progress

- Arrived at neuro centre, rapid transfer to CT and then on to theatre
- Emergency caesarean section, ICP bolt inserted (pressure 15)
- ICP remained stable overnight, waking appropriately, extubated
- Deteriorated, reintubated, stormy course as brain injury developed. EVD, decompressive craniotomy & clot evacuation

How did MDT working fail?

- Show everyone respect
  - Include all specialities who may be able to contribute something
- Champion polite disagreement
- Always explain
- Communicate in brief
- Get rid of toxic people
  - Appreciate a viewpoint from outside your speciality

- Adrian Plunkett, Birmingham Children's Hospital, UK
- Safety 2
- Active excellence reporting