Introduction

OB is quite a bit different that other MSD rotations you may have completed. There is a slightly different culture within the division, which can take some adjustment. Overall, the OB Division prioritizes the following:

- **Timeliness**: arrive for shifts, MDR's (multi-disciplinary rounds), and educational events on time. If you are two minutes late, you will be late. Be efficient and do not let your to-do list grow by more than a few items, as the volume is quite unpredictable.
- **Professionalism**: The diversity of patients here requires a flexible and understanding mindset, and respecting each patient will look different. Do your best to meet their needs and show your respect for them as much as you can.
- **Protocols**: The division has done extensive research and/or literature reviews for almost every part of OB anesthesia. Given the homogeneity in cases, protocols have been developed for almost every aspect of the job; this allows additional research to be conducted easily. For the most part, unless you have a strong reason to stray from the protocol, you are expected to follow it.
- **Follow-up**: Every patient who receives an anesthetic is expected to have a follow-up (ideally in-person) documented in their chart. Complications should be followed to resolution.
- **Proactive management of pain**: Effective treatment of labor pain is a hallmark of the division, and inadequate treatment of pain is seen as a urgent problem requiring immediate attention.
- **Triage**: Since the residents are often the first point of contact for nursing and OB, it is important to stay in close communication with your team and delegate tasks. See below.

Triage and Roles

The OB anesthesia team is quite different from other services you may have rotated on, which can cause some confusion for the first few days. Residents hold the primary phones used to contact the team. The vast majority of requests will come from nursing. Unlike other services, the OB fellows are not to be seen as your supervisors and/or seniors—their participation in day-to-day clinical care is

minimal and for the most part relegated to high-risk OB cases. The attending should be your first call, even for tasks that do not require their supervision; they expect to be called to offload your to-do list for any time-sensitive requests. For example–if you are called to see two patients for consult, then get another call for help with an IV, call or text your attending to help with the IV, or direct the caller to them. Having more than a few to-do's lined up is problematic when a more urgent task (ie, stat CS) suddenly removes you from the floor.

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Preparation

- When you first arrive for your shift and complete signout, you should check the status of the Ors and ensure that the ORs are set up to your liking.
- Whenever a case finishes, circle back to set up the appropriate ORs.
- Resources can be limited, especially on the weekends and nights. It is best to become comfortable with the environment during the day so that you can respond quickly. This includes knowing where emergency drugs are kept (interlipid, code drugs, nitro spray), how the carts are organized, where OmniCells are.

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Clinical Responsibilities

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Epidurals/Labor Analgesia

- Encounter: You will be called by the nurse to either perform a "consult" or place an epidural. A consult is a blank anesthetic record that is made to generate a preop note; these are done to document history/physical for patients even if they are not interested in an epidural. If they require anesthesia, you will be their anesthesiologists so it is important to identify any major problems

beforehand. If the patient wants an epidural immediately, the consult encounter is not needed and your can just open a "labor analgesia" encounter, and use the preop note within that encounter.
- Based on their history, decide whether a plain epidural, dural-puncture epidural, or combined spinal-epidural would be best for them.
- Discuss the procedure, as well as the risks and benefits with the patient and any family members present.
- Obtain your medication and epidural cart, set up the kit and call your attending. If you are sterile, the nurses are happy to call your attending for you.
- Target pain score is three or less (five or less during pushing), and tolerable for the patient.
- After placing an epidural or CSE, do not leave until the patient has started to feel some relief. If their pain score is above 3 during labor or is intolerable, continue to check in and treat as needed. Round on patients frequently (q2-3 hours) and document in Epic as "epidural check."
- Apart from bedside rounding, pain scores are documented in epic in the "Pain summary" as well as a "sparkline report" on the OB home page.
- You need to complete a minimum of 5 blocks under ultrasound-guidance and 5 blocks in the lateral position (second rotation only).
- Please keep track of your lateral and ultrasound blocks on the Google Sheet Document. Find your tab at the bottom and track your blocks for the month. Your evaluations will be submitted after Gill Abir sees you have completed your sheet. In the logbook please be sensitive to HIPPA when recording patient details - i.e. just name initials will be fine.

Other clinical tasks

- **Quality Improvement**: Be diligent about recording QI events in Epic and modifying QI notes if issues arise later. This will need to be done with every procedure and notable event. This is an essential part of our practice and your learning.
- Follow up: Do post-op checks and fill in the Epic 'Follow-Up' note.

If the post-op checks are delayed due to a busy L+D floor, call the fellows to advise and make a team plan for getting these done.

- Charting: Ensure your Epic charting is kept up-to-date, ready and available for your Attending to sign and attest. Be especially careful to enter "Anesthesia Stop Times" after deliveries (preferably 15 minutes afterwards), and ensure that all essential components of a procedure or follow-up note are completed.

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