Brighton and Sussex University Hospitals NHS Trust

Communication and Handover of Care between Professionals

Maternity Protocol: MP057

Date Agreed: August 2020

Guideline Reviewer:	Sarah Ward & Sonya Brear
Manager responsible:	Amanda Clifton
Version:	3
Approval Committee:	Women's Safety and Quality Committee
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Cross reference:	**MP023** Maternal and In Utero Transfers **MP056** High Dependency Care (HDU)

Contents

Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be use in the application of a protocol.

Scope

This protocol applies to:

- All midwifery and obstetric staff in all care settings

Responsibilities

Midwives & Obstetricians:

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this protocol

Management

- To ensure the protocol is reviewed as required in line with Trust and National recommendations
- To ensure the protocol is accessible to all relevant staff

1 Handover of care between professionals

A handover involves the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or groups of patients to another person , on a permanent or temporary basis

1.1 Handover of Care

1.1.1 Shift change hand-over is a critical time when information can be lost. Barriers which impede effective communication include: hierarchy, gender, ethnic background and differences in communication styles between midwives, nurses and doctors.

1.1.2 A structured hand-over tool should be used to improve communication on the labour ward and throughout ward areas.

1.1.3 Effective communication is recognised as central to promoting patient safety and reducing the number of serious clinical incidents

1.1.4 An effective working relationship between the multi-disciplinary team and a clear organisational structure for midwives and medical staff with explicit and transparent lines of communication is crucial to ensure optimum care for women and babies. For a consistent approach to communication and documentation of handover of care a locally agreed tool called SBAR is used:

- Situation
- Background
- Assessment
- Recommendation

2 PURPOSE

2.1 To give and receive information

2.2 To ensure all discussions, decisions, advice, actions, plans of care and management between healthcare professionals and parents are communicated effectively and documented contemporaneously, accurately and concisely.

2.3 Good documentation and communication will ensure decisions are transparent, that care planning is more effective, avoiding delays and that all who are involved with the mother and baby provide safe, consistent, quality care that ensures fetal, neonatal and maternal wellbeing.

2.4 It is important to optimise communication of critical information as an essential component of risk management and patient safety. (RCOG)

3 Documentation

3.1 All care, advice and medication given should be documented in the mother's handheld notes using the SBAR format where appropriate. If women are triaged by telephone all discussions should be documented on the triage documentation paperwork.

3.2 Once a mother is admitted a plan of care should be documented as soon as possible. This plan needs reviewing every 4 hours or sooner if indicated by a change in maternal or fetal condition. All plans and updates must be documented accordingly.

3.3 Handover communication at change of shift or any temporary handover of care should be documented using SBAR in the notes by staff handing over and staff taking over care

3.4 Handover communication when transferring between care settings should be documented in the maternal notes by staff handing over and staff taking over care (RCOG)

3.5 Midwives must ensure that their documentation is in accordance to the NMC guidelines on record keeping and maternity record keeping documentation for the Trust.

3.5.1 This must include;

- Correct date and time of entry
- Women's name, Hospital number and date of birth
- From whom care is being taken over and who is providing care
- The midwife's name must be printed clearly in the maternity record
- Black ink must be used
- All entries must be legible
- The plan of care must be clear
- Details and status of anyone involved in care and planning

4 Handover at the change of shift for each staff group:

4.1 Midwife to Midwife

4.1.1 At a change of shift the co-ordinator will give a brief synopsis of all patients using SBAR format highlighting important risk factors that may influence care.

4.1.2 The coordinator will refer to the white board/ communication diary to inform staff of any important notices.

4.1.3 Information will be given as to the bed state on the wards and availability of neonatal cots.

4.1.4 The coordinator will then allocate the available midwives to provide care for each woman.

4.1.5 There will be a personal handover of care between midwives at every change of shift or change of carer. This must be documented clearly each time a change has occurred in notes using SBAR sticker.

4.1.6 Handover to include Message of the week

5 Medical staff

5.1 There is a personal hand over of care on the labour ward when medical staff change between shifts.

5.2 There is a Consultant ward round which occurs every weekday morning on labour ward to be attended by the whole multidisciplinary team (both oncoming and finishing), including obstetric, anaesthetic (where possible) and input from the labour ward coordinator. At weekends the Consultant on call will be present for 4 hours.

5.3 As part of the Consultant ward round all high risk cases are to be discussed with care/management planning whether on any maternity ward or any other inpatient ward in the hospital including outliers, surgical, IYU/HDU.

5.4 Handover to include 'message of the week'.

6 Locum Obstetric Registrar and/or SHO

6.1 Where a locum Registrar / SHO is employed a full handover should occur on their first shift. This will involve orientation to the unit, bleep systems, crash calls and channels of referral to the Consultant on call.

7 Handover for Transfer between Care Settings

7.1 Transfer to and Handover of Care to ITU/HDU

7.1.1 The decision to transfer a woman to HDU or ITU is made jointly by an

7.1.2 Obstetric Consultant and Anaesthetic Consultant in liaison with HDU/ITU *(please see Maternity Protocol MP056: High Dependency Care)*

7.1.3 Both teams should liaise with ITU/HDU and plan care that is appropriate to the individual patient.

7.1.4 This procedure must be followed even if no ITU beds are available, as alternative arrangements for ITU admissions may be required with input from the Outreach team

7.1.5 On transfer there must be full verbal handover of care to HDU/ITU staff from the Obstetric, Midwifery and Anaesthetic Teams using the SBAR systematic tool

7.1.6 Before transfer, the midwife in charge of the case must arrange care for the baby (on the postnatal ward, the neonatal unit or by a family member until the mother returns to the maternity unit.

7.1.7 The Labour Ward Co-ordinator must ensure mother's name and details will be entered on to the Labour Ward whiteboard with the medical team being updated daily (including the on-call Consultant) and ensure that the woman receives midwifery/obstetric input while on ITU/HDU.

7.2 Handover of Care when Transferring Women from the Antenatal Ward to the Labour Ward

7.2.1 The labour ward coordinator should be informed of the reason for transferring the woman and a room arranged (in advance of the physical transfer). If the reason for transfer is an emergency this must be clearly conveyed to the coordinator. If the emergency situation arises during a shift handover this must not delay the appropriate action being taken. The labour ward coordinators going off and coming on shift should agree which staffs are to be deployed to manage the emergency.

7.2.2 A personal handover of care must be given to the receiving Midwife. This should be undertaken using the SBAR system. The time of transfer and handover should be clearly documented in the labour notes and on the transfer form.

7.3 Handover of Care when Transferring Women from Labour Ward to the Postnatal Ward

7.3.1 Transfer should be documented in both the maternal and baby notes. A personal handover of care must be given from the midwife currently providing care to the receiving midwife and the relevant documentation completed in the postnatal maternity booklet.

7.3.2 **The midwife giving the handover** is responsible for ensuring the following is handed over verbally and is clearly documented in the maternal notes:

7.3.2.1 Relevant historical and current medical, social, psychological and obstetric factors from the antenatal, intrapartum and immediate postnatal period.

7.3.2.2 Details of the health care professionals involved in her care and that of the baby.

7.3.2.3 Method of infant feeding and feeding that has already occurred

7.3.3 **The receiving midwife** is responsible for:

7.3.3.1 Welcoming the woman / family onto the postnatal ward

7.3.3.2 Orientating the woman to the ward layout and ward processes (access to assistance, infant feeding areas, food, drinks, call bells and visiting times)

7.3.3.3 Ensuring a postnatal VTE assessment is completed and prescribed if required

7.3.3.4 Making an individual plan of care with the woman for the expected duration of her postnatal stay

7.3.3.5 Documenting all of the above in the postnatal notes

7.3.3.6 Checking the all documents are complete and no papers are loose

7.3.4 **The ward clerks or Midwife** are responsible for ensuring all transfers, admissions and discharges are logged as contemporaneously as possible on the Maternity IT system.

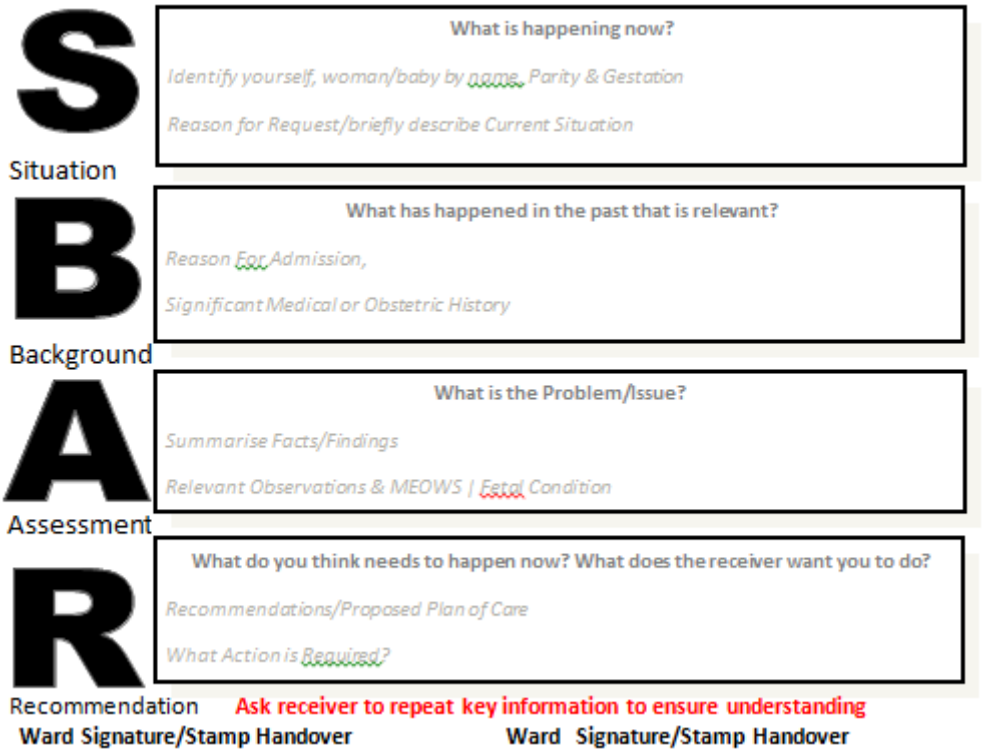
8 References

Ottewill M, Urben J, Elson D .Safe handover: Safe care. Midwives RCM December 2007 Volume 10 No 11

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*. London: RCOG Press. Available at: www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists (2010) *Improving Patient Handover.* RCOG. https://www.rcpch.ac.uk/sites/default/files/2018-02/bma_handover_college_tutors.pdf

Appendix A: SBAR stickers for handover of care between health care professionals:

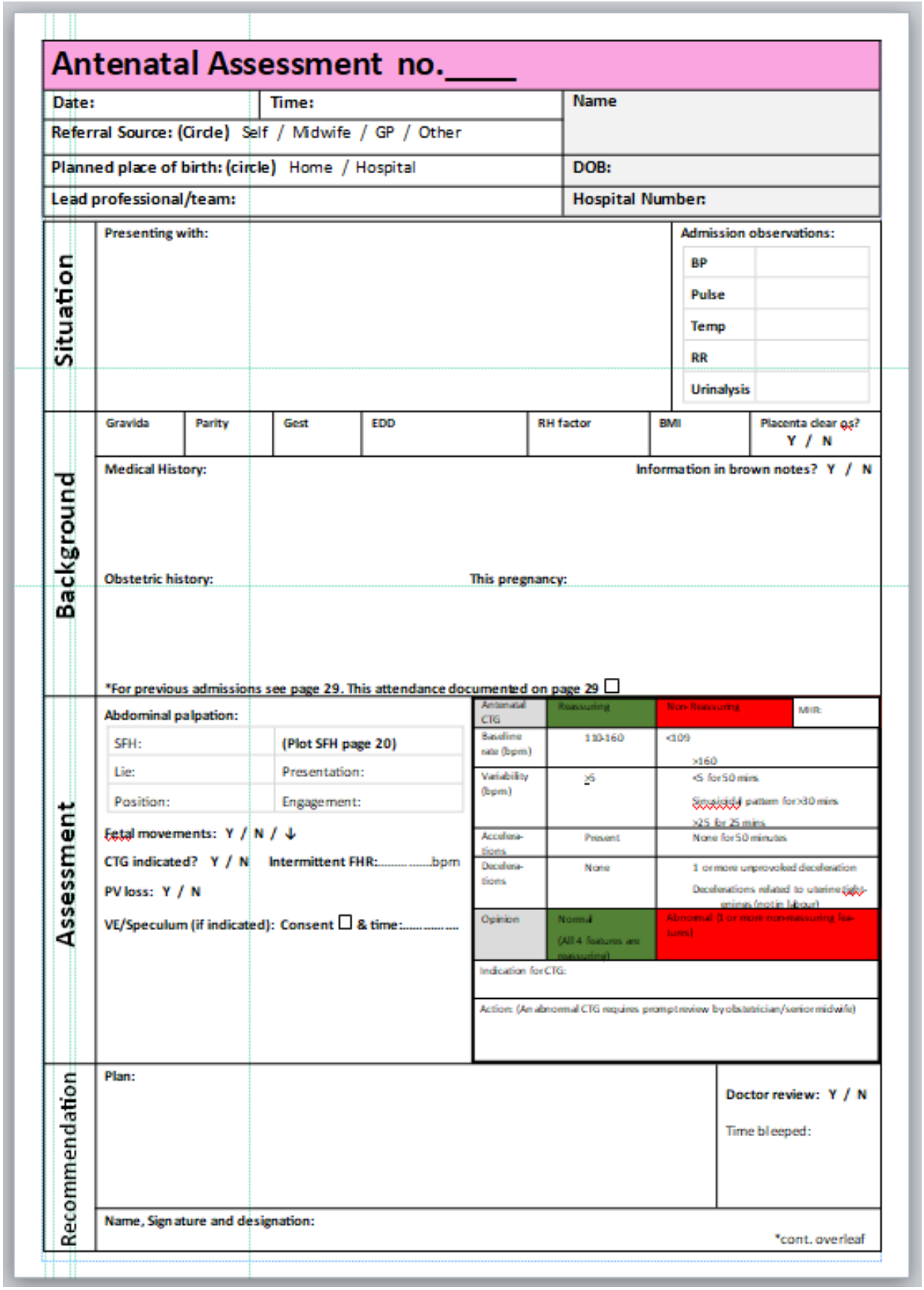


9 Apppendix B: SBAR Escalation

SBAR report to escalate to clinician about a clinical situation	
S	I am calling about ..... On ..... The problem I am calling about is: On assessment the observation are: Resps: Sats: BP: / P: T: Meows / Eobs Score:
	I am concerned about: **Blood Pressure** because it is: Systolic > 160 Dystolic >100 Systolic <90 **Pulse** because it is: Over 120bpm Less than 40bpm **Respirations** because they are: Less than 10 Over 30 Oxygen requirements are _____ **Temperature** because it is _____°C **Urine output** because it is: Less than 100mls over the last 4 hours Significant proteinuria _____ **Haemorrhage**: Antepartum Postpartum **Fetal Wellbeing**: Non reassuring trace Abnormal trace **Serum Lactate** because it is _____mmol/l **Blood results** because:_____ _____ **Blood Sugar**_____gl
B	**The women or Person who births is:** Primparous Multiparous Grand Multiparous Gestation_____ wks Singleton/Multiple Pregnancy Previous LSCS or uterine surgery **Fetal assessment:** SFH____cms Presentation:_____ Fifths palpable:_____ FH rate: _____bpm CTG: Normal Non-Reassuring Abnormal **Antenatal History:**_____ **Labour:** Spontaneous Induced IUGR Pre-eclampsia <FM Diabetes: GDM/GIDM/DM APH Oxytocin Augmentation VE at _____ Findings: _____CM's, Presenting part at_____ , Position_____ SROM: Date _____ Time: _____ PV Loss: Meconium, Fresh red, clear or Intact Third stage: complete or retained placenta **Postnatal:** is _____ days postnatal following a _____ delivery the EBL was _____ Fundus is: Normal Atonic High Uterus is: Non-tender / tender Abdominal/perineal wound is oozing / Offensive **Current treatment** is:_____
A	I think the problem is:_____ I am not sure what the problem is.
R	**Request:** Please can you come and review immediately ☐ I think delivery needs to be expedited ☐ I think a transfer to delivery suite / HDU is required ☐ I would like your advice please ☐ **Reported to:** _____Bleep Number/Extension Number_____ **Response:** _____ _____

Person Completing (name)_____ Date_____ Time_____

Apppendix C: Antenatal Assessment Form



Antenatal Assessment no.____

Date: Time:	Name
Referral Source: (Circle) Self / Midwife / GP / Other	
Planned place of birth: (circle) Home / Hospital	DOB:
Lead professional/team:	Hospital Number:

Situation

Presenting with:

Admission observations:

BP	
Pulse	
Temp	
RR	
Urinalysis	

Background

Gravida	Parity	Gest	EDD	RH factor	BMI	Placenta clear o/s? Y / N

Medical History: Information in brown notes? Y / N

Obstetric history: This pregnancy:

*For previous admissions see page 29. This attendance documented on page 29 ☐

Assessment

Abdominal palpation:

SFH:	(Plot SFH page 20)
Lie:	Presentation:
Position:	Engagement:

Fetal movements: Y / N / ↓

CTG indicated? Y / N Intermittent FHR:.....bpm

PV loss: Y / N

VE/Speculum (if indicated): Consent ☐ & time:.....

Antenatal CTG	Reassuring	Non-Reassuring	MHR:
Baseline rate (bpm)	110-160	<109 >160	
Variability (bpm)	≥5	<5 for 50 mins Sinusoidal pattern for >30 mins >25 for 25 mins	
Accelerations	Present	None for 50 minutes	
Decelerations	None	1 or more unprovoked deceleration Decelerations related to uterine contractions (not in labour)	
Opinion	Normal (All 4 features are reassuring)	Abnormal (1 or more non-reassuring features)	

Indication for CTG:

Action: (An abnormal CTG requires prompt review by obstetrician/senior midwife)

Recommendation

Plan:

Doctor review: Y / N

Time bleeped:

Name, Signature and designation:

*cont. overleaf

Allergies and Adverse Drug Reactions		
No Known Allergies ☐	Unable to determine ☐	Red wrist band ☐
Drug/Food/Other	Reaction & Severity	Safe to administer?
		Y / N Initial:
		Y / N Initial:
		Y / N Initial:
		Y / N Initial:
Completed by (name & signature):		Date:

Once only drug prescription and administration- for Maternity Assessment Unit use only.

Date	Drug Approved Name (BLOCK LETTERS)	Dose	Route	Time	Prescribers signature	Given by	Time given	For pharmacy use

Continuation of documentation from previous page:

Date/time	
	Name, Signature and designation:

Recommendations:	Home	Labour ward	Antenatal ward	GP	Other
Advice given re:	FMs	Labour	SROM	PVB	Other (specify below)

Apppendix D: Postnatal Assessment Form

Postnatal Assessment no.____

Date: Time:	Name
Referral Source: (Circle) Self / Midwife / GP / Other	
Planned place of birth: (circle) Home / Hospital	DOB:
Lead professional:	Hospital Number:

Situation

Presenting with:

Admission observations:
Charted on MEOWS: Y / N

BP	
Pulse	
Temp	
RR	
Urinalysis	

Background

Gra/Par	Covid swab	Day PN	Date of del	Type del	EBL	RH factor Anti D given ☐

Medical History:

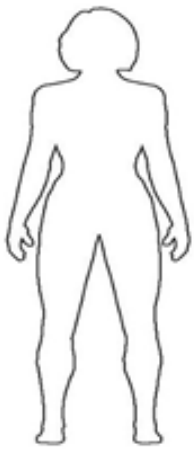
This pregnancy, delivery, postnatal period:

Assessment

MH		
Chest		
Breasts		
Uterus		
Wound/ trauma		
Lochia		
Bladder		
Bowel		
Legs		
PN VTE Assessment		
Medication		
Other		

Any signs of sepsis? Y / N

Golden hour commenced at: .....



Recommendation

Plan:

Doctor review: Y / N

Time bleeped:

Name, Signature and designation:

* Cont. overleaf

Allergies and Adverse Drug Reactions		
No Known Allergies ☐	Unable to determine ☐	Red wrist band ☐
Drug/Food/Other	Reaction & Severity	Safe to administer?
		Y / N Initial:
		Y / N Initial:
		Y / N Initial:
		Y / N Initial:
Completed by (name & signature):		Date:

Once only drug prescription and administration- for Maternity Assessment Unit use only.

Date	Drug Approved Name (BLOCK LETTERS)	Dose	Route	Time	Prescribers signature	Given by	Time given	For pharmacy use

Continuation of documentation from previous page:

Date/time	
	Name, Signature and designation:

Recommendations:	Home	Labour ward	Antenatal ward	GP	Other
Advice given re:	FMs	Labour	SROM	PVB	Other (specify below)