University Hospitals Sussex
NHS Foundation Trust

# Standard Operating Procedure

# Consultant Led Ward Rounds and Presence in the Department (RSCH and PRH sites)

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Maternity Guidance SOP001

Date Agreed: September 2022

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| Guideline Reviewer: | **Katie Fraser** |
| Version: | **1** |
| Approval Committee: | **Women's Services Safety and Quality Committee** |
| Date agreed: | **September 2022** |
| Review date: | **September 2025** |

**1.0 Background**

The role of the on-call consultant is to support trainees and enhance the safety and quality of care for pregnant women / people and families.

Ward rounds are an important part of patient care allowing the whole team to share information and gain an oversight of the clinical condition, the social circumstances and the psychological impact and wellbeing of all pregnant women / people under their care. This enables staff to monitor, anticipate and respond in a timely way to emerging problems (HSIB 2020).
Ward rounds also offer pregnant women / people the opportunity to ask questions and be involved in their care planning.
Furthermore, ward rounds are an excellent opportunity for bedside teaching and clinical education.

The role of the consultant may be to lead the ward round or to support other team members in doing so. At all times, consultants should be mindful of the professional behaviours they role model during ward rounds, including respectful and courteous communication with pregnant women / people, families and all team members.

Typically for an obstetric ward round, the midwifery coordinator, obstetric consultant, junior tier and anaesthetic team should be present. However, it is not essential for all those present on the ward round to enter the room of each woman / person and the team should be mindful of patient dignity and preferences. This is particularly the case for birthing women / people in active labour, those separated from their babies immediately after birth and those who have suffered a pregnancy loss.

Where all team members do not see all pregnant women / people, it remains important that information is shared with all team members and everyone can input into the woman / person's care. This can be achieved during a board round before the ward round and updated again after the ward round.

Acute obstetric consultants should conduct twice daily ward rounds, one of which should be in the evening (RCOG 2016) and the Ockenden Immediate Essential Actions echo this.

There should also be a gynaecology ward round. Gynaecology consultants must ensure that they fulfil the standard that all pregnant women / people should be reviewed within 14 hours of admission. This will ensure that clear decisions in relation to diagnostics and theatre are made.

Regarding presence within the unit, and requirement for escalation; setting clear expectations for when the on-call consultant is to attend we reduce variation and confusion.

Providing defined requirements for attendance to the unit will break down barriers to escalation and promote better team working.

**2.0 PURPOSE**

- Meeting RCOG standards on the Role of the Consultant
- Implementing Ockenden Immediate Essential Actions

**3.0 SCOPE**

This SOP applies to the Consultant Obstetrician and Gynaecologist on call and the teams they work in.

**4.0 RESPONSIBILITIES**

It is the responsibility of the chief of service, obstetric lead and clinical director to

- Develop the SOP
- Ensure compliance with policies and procedures
- Update the SOP as the need arises

Compliance with this SOP applies to all medical and obstetric staff caring for pregnant women / people.

**5.0 PROCEDURE for Ward Rounds**

In the updated scope of consultant job plans, ward rounds should occur twice per day. This should be a full departmental ward round in the morning and in the evening at least a board round with targeted ward round.

Due to reduced consultant numbers and funding at PRH site, the evening weekday ward round will take place at 17.30 with a virtual round at 20.30.

Once recruitment is complete, this will be revised to be in-line with RSCH site.

On weekdays as a full departmental (labour ward, antenatal ward and where required, postnatal ward) round at:

- 08.30 at RSCH site
  (NB. There is a consultant led gynaecology ward round at 08.00-08.30)

- 09.00 at PRH site
- 17.30 board round / targeted ward round at PRH
- 20.30 board round / targeted ward round (pre- or post- board round) at RSCH site
- 20.30 telephonic board round with the night team at PRH

At weekends:

- Full departmental ward round at 08.30 on both sites.
- Evening consultant board round and targeted board round at 20.30 at both sites
- There should be flexibility within the scope of timing of a weekend ward round – eg. if the consultant has been present on the unit most of the day during a busy weekend, it would be reasonable to do an earlier evening review and not stay until 21:00.

**RSCH Site**

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| **Weekdays** | **08.00-08.30**<br>**Gynae Ward Round**<br><br>**0830-0900**<br>**Full obstetric ward round** | **20.30-21.00**<br>**Board Round + targeted ward round** |
| | Consultant obstetrician<br>Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Consultant Anaesthetist | Consultant obstetrician<br>Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Night anaesthetist |
| **Weekends/BH** | **08.30-09.00**<br>**Full departmental ward round** | **20.30-21.00**<br>**Board Round + targeted ward round** |
| | Consultant obstetrician<br>Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Labour ward anaesthetist | Consultant obstetrician<br>Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Night anaesthetist |

**PRH site**

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| **Weekdays** | **09.00-09.30**<br><br>**Full departmental ward round** | **17.30-18.00**<br><br>**Board Round + targeted ward round** | **20.30-21.00**<br><br>**Virtual attendance to Board Round** |
| | Consultant obstetrician<br>Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Consultant Anaesthetist | Consultant obstetrician<br>Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator | Consultant obstetrician<br>Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Night anaesthetist |
| **Weekends / BH** | **08.30-09.00**<br><br>**Full departmental ward round** | | **20.30-21.00**<br><br>**Board Round + targeted ward round** |
| | Consultant obstetrician | | Consultant obstetrician |

| | | |
|---|---|---|
| | Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Labour ward anaesthetist | Obstetric SpR<br>Obstetric SHO<br>Labour ward coordinator<br>Night anaesthetist |

Acute obstetric admissions should be reviewed within 14 hours – including all antenatal, intra-partum and postnatal admissions.

There should also be a daily gynaecology ward round.
Gynaecology consultants must ensure that they fulfil the standard that all patients should be reviewed within 14 hours of admission.

**6.0 Procedure for escalation to the On-call Consultant**

Consultant presence on the labour ward is expected as follows:

- At RSCH the consultant presence on LW will be from 08.30-21.00 Monday to Friday with consultant on-call from home from 21.00-08.30
- At PRH the consultant presence on LW will be from 08.30-18.00 Monday to Friday with consultant on-call from home from 18.00-08.00
- At both sites there is consultant presence from 08.30-12.30 Saturday, Sunday and Bank holidays, with on-call from home thereafter (and presence on labour ward for evening board and ward round as highlighted above)
- Where the consultant is on-call from home, escalation should occur as highlighted below

As per the RCOG Good Practice, 'Responsibility of Consultant On-call' the following guidance is given with regards to consultant awareness and responsibility when on-call

Where the registrar is unable to escalate due to clinical need, other members of the MDT should do so.

All consultant contact details should be readily available on the ward and via switchboard.

| **Present** | **On Site (attendance in person / immediately available)** | **Aware** |
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| **Eclampsia** | Vaginal | All cases |

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| | breech | going to theatre |
| **Maternal collapse** | Vaginal twins | COVID positive cases on LW |
| **CS for placenta praevia** | LSCS BMI >40 | Pre-term labour <34 |
| **MOH with on-going bleeding** | LSCS <32 weeks* | Admission with severe sepsis |
| **LSCS <28 Weeks** | | Admission with PE |
| **Return to theatre** | | TPTL / Transfer from another Trust (TBC according to BAPM framework) |
| **Trial of instrumental *** | | |
| **Gynae cases going to theatre** | | |
| **Unwell COVID + patient requiring theatre** | | |
| **When requested due to heavy workload** | | |

*There may be flexibility in these requirements based upon level of skill of the onsite on-call registrar and clear expectations made about this is advance.

Where a consultant has been in overnight, and has clinical duties the following day, the consultant should make the management team aware that these may need to be covered / cancelled.

Upon recruitment of a full complement of consultant staff, there should be provisions in the job plan to account for this.

**REFERENCES**

Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology
roles-and-responsibilities-of-the-consultant-workforce-report-june-2021.pdf (rcog.org.uk)

Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (donnaockenden.com)