RESPONSIBILITIES OF AN ON-CALL CONSULTANT

Obstetrics & Gynaecology

Cwm Taf Morgannwg University Health Board

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Summary

The purpose of this document is to support substantive staff and locum colleagues working within the department. This document outlines the requirements and procedures that need to take place when working on-calls within obstetrics and gynaecology.

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RESPONSIBILITY OF THE CONSULTANT ON-CALL

Introduction

The consultant's role starts with demonstrating leadership; ensuring safe and effective patient care while facilitating teaching and support of more junior doctors, midwives and nurses at all times. It encompasses providing direct clinical care for those patients who require senior medical assistance while at the same time undertaking simpler procedures when there is a need to do so. The consultant should therefore be present on the labour ward when they are job-planned to be there.

Resident consultant on-call

The consultant on-call is responsible for the care of all patients on the labour, antenatal, postnatal and gynaecology wards. They should maintain an overview of the workload in the unit by regularly checking with the on-call middle grade doctor and the LW coordinator.
Women in the Birth Centre will be the on call team's responsibility in case of emergency.

Occasionally, there will be a different resident consultant covering gynaecology. See below.

The consultant on-call is expected to carry their own individual bleep during the daytime with this number clearly identified on the delivery suite white board. For non-resident cover consultants are expected to provide their mobile contact number and be contactable at all times.

Handover

The on-call consultant leads the MDT handover including the obstetric and gynaecology on-call teams, the anaesthetic team, the neonatal team and the labour ward coordinator. Both the incoming and outgoing teams are involved and the handover takes place on labour ward. All patients on delivery suite are handed over along with any on-going concerns regarding women on the wards. Handover of gynaecology patients or any outliers should be ensured, and women booked on the CEPOD list should also be handed over.

All handovers should be documented in the SBAR proforma and should be signed by the individuals present for the handover. Handover sheets must be completed by the middle grade on duty and stored appropriately.

While resident

- Lead handover in the morning.

- Discuss clinical prioritisation and division of tasks with the incoming team, including ensuring all opportunities for teaching and training are utilised.

- Carry out a ward round on the labour ward, the antenatal ward, and of all gynaecology patients admitted as an emergency. Ensure review of all patients on the postnatal and gynaecology wards.

- Patients who had an operative delivery or a complicated vaginal delivery should be debriefed within 24 hours by the on-call team. Debriefing should be documented in the patient's notes.

- Collect cases for discussion at Reflections.

- Prioritise USC gynaecology referrals.

- Take part in rapid reviews of moderate and severe incidents (Datixes) in order to determine if they are Serious Incidents (SIs), and if any immediate make-safes are needed. Ideally this would NOT be the consultant involved in the incident.

- Provide immediate support for the wider team after unexpected adverse events or serious emergencies.

- Carry out an afternoon board round and review at around 1pm. The handover SBAR should be completed and filed.

- Carry out a handover and ward round at around 5pm. This must include all ongoing obstetric problems. The handover SBAR should be completed and filed.

Gynaecology

Occasionally, there will be a different resident consultant covering gynaecology.

In this case, they will be responsible for all gynaecology patients and issues, including in-patients, outliers, and CEPOD cases. They will carry out a ward round of all gynaecology patients that have been admitted as an emergency, ensure all gynaecology patients are reviewed daily, prioritise USC referrals and take responsibility for CEPOD cases.

At 5pm, any unresolved emergency gynaecology problems should be handed over to the non-resident gynaecology consultant oncall, if it is a different person.

While non-resident for obstetrics

A telephone ward round at around 22:00hrs is expected. The middle grade doctor on-call should normally make that call and document this on the handover SBAR.

Week-ends

Handover on labour ward takes place between the resident teams at the same time as week day handovers.
The consultant(s) on-call for obstetrics and gynaecology will undertake ward rounds on both Saturday and Sunday, reviewing all labour ward, antenatal and gynaecology patients with the on-call middle grade doctors as necessary.

Triage, antenatal day assessment and early pregnancy assessment units

These are nurse- or midwifery-led with medical input when required. Women suspected of having an ectopic pregnancy are admitted to the gynaecology ward and should be reviewed by the middle grade doctor on-call.

Medical input can usually safely be provided in the first instance by the middle grade doctor on-call, but when workload becomes heavy the consultant should expect to be asked to help out.

CEPOD list

Gynaecology emergencies are booked on the CEPOD or emergency lists and the consultant on-call for gynaecology should be informed. It is good practice to avoid operating after 22:00hrs unless the patient is hemodynamically compromised or otherwise critically unwell.

In-utero transfers

All Wales In-utero Transfer Guideline

Accepting or requesting in-utero transfers may be done by the middle grade doctor on-call, but should only be done after discussion with the obstetric consultant on-call. When women need to be transferred it is usually the labour ward coordinator's responsibility to identify and liaise with the relevant labour ward and SCBU. The obstetric middle grade doctor on-call should discuss the case with the obstetric middle grade doctor on-call in the other unit. The all Wales transfer document should be completed in all cases, including those within the same trust.

Education and training

Obstetrics and gynaecology is an apprenticeship-based specialty and the consultant must be present to ensure that the trainee is taught and supervised properly; ultimately, the consultant is responsible for their trainees. There comes a time when trainees need to learn to work alone but this should never be at the expense of their confidence or, importantly, the safety of patients. The consultant must be nearby at all times until the trainee has been assessed as fit for independent practice.

Escalation

Doctors at every level have a duty to call for help if they feel that a clinical situation outside the list below requires the direct input of a consultant. The request should be documented in the notes. Midwifery, nursing or other medical staff should contact the consultant or senior middle grade doctor directly if it is considered that the clinical situation requires senior medical input (known as 'jump call'). Consultants should be aware that there are some situations where they must attend in person. Patient safety is the priority.

Attendance in person at all times

In the following situations, the consultant should attend in person, whatever the level of the middle grade doctor:

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- Caesarean section for major placenta praevia
- Postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated.
- Return to theatre – obstetrics or gynaecology
- Critically unwell patient – obstetrics or gynaecology
- Laparotomy for ruptured ectopic pregnancy
- Whenever requested

Attendance in person while resident

In the following situations, the consultant should attend in person, when a trainee at ST5 or below is involved, in order to provide training and direct supervision. For specialty doctors and more senior trainees, the level of supervision can be determined by their known competencies:

Obstetrics

- Vaginal breech delivery
- Trial of instrumental delivery in theatre
- Repair of a third or fourth degree tear
- PPH > 1000mls
- Shoulder Dystocia
- Twin delivery
- Caesarean section at full dilatation
- Caesarean section in women with body mass index greater than 40
- Caesarean section for transverse lie
- Caesarean section at less than 32 weeks of gestation

Gynaecology

- Diagnostic laparoscopy
- Laparoscopic management of ectopic pregnancy or any laparotomy

Both

- Any deviation from the usual clinical pathway, with unexpected or unexplained symptoms.

Attendance in person or immediately available when non-resident

The consultant should attend in person or should be immediately available if the middle grade doctor on duty has not been assessed and signed-off, by OSATS where these are available, as competent for the procedure in question:

Obstetrics

- Vaginal breech delivery
- Trial of instrumental delivery in theatre
- Repair of a third or fourth degree tear
- Twin delivery
- Caesarean section at full dilatation
- Caesarean section in women with body mass index greater than 40
- Caesarean section for transverse lie
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Gynaecology

- Diagnostic laparoscopy
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Both

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Consultant's decision to attend

When a senior trainee (ST6/7) is on call with a more junior doctor or when the labour ward and emergency gynaecology clinics are being covered directly by a senior trainee, it is the consultant's decision whether to attend.

Doctors in non-training grades

Doctors in the non-training grades should have their capabilities and experience assessed by their individual units and a clear decision should be made as to the level at which they should be working. The doctor should then be provided the same level of supervision as a trainee with the same competencies.

Appendix 1

Consultant duty hours by site and speciality

PoW

All consultants cover both obstetrics and gynaecology.

Most consultants are resident Monday – Friday 9am – 8pm, Saturday and Sunday 9am – 11.30am. It should be clear from the weekly rota when there is a resident consultant.

The consultant is non-resident but within 30 minutes travel time at all other times.

PCH/RGH

Consultants cover obstetrics, gynaecology or both depending on the time of day, the site, and the individual concerned. It should be clear from the weekly rota who is covering which elements of the service at all times.

PCH obstetric cover resident Monday – Friday 8.30am – 8.30pm.

PCH obstetric cover non-resident but within 30 minutes travel time at all other times.

Resident gynaecology cover for PCH, Monday – Friday 8.30am – 5pm. In PCH, this is mostly provided by the same consultant as the obstetric cover.

Resident gynaecology cover in RGH by consultant, or resident middle grade with consultant cover from PCH, Monday – Friday 8.30am – 5pm.

Gynaecology cover non-resident by one consultant for both PCH and RGH at all other times. This is provided by a different consultant than the obstetric cover.