Guidelines for Multi-Disciplinary Labour Ward Handover

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Guidelines Definition
Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments
If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
New Guideline for CTMUHB	Amalgamation of POW into CTMUHB	All	29/04/2020		Mohamed Elnasharty, Kathryn Greaves, Sharon Evans

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1. Introduction NHS Improvement March 2019

Caring for pregnant women and their babies requires all maternity staff to work effectively in multidisciplinary teams (MDTs) with agreed shared objectives. The Kirkup report recommended improvements in teamwork and communication in maternity services. Evidence shows that a structured, consistent approach adds value to frontline clinical services and improves safety.

Each baby counts (2017) highlighted the need to maintain situational awareness through effective communication using clinical handovers and huddles. However, a survey of obstetric and midwifery labour ward leaders for the ATAIN (Avoiding Term Admissions Into Neonatal units) programme found significant variation in structure, frequency, MDT representation and timings of clinical handovers and huddles. Some described the two processes as one and the same.
The evidence underpinning huddles and clinical handovers is at a relatively early stage and does not always originate in the NHS. We have highlighted where such evidence is available and signposted additional resources.

The terms 'huddle' and 'clinical handover' are sometimes used interchangeably, but in this document we describe their similarities and differences.

Handovers are distinct from huddles both in terms of purpose and information shared (see Table 1 below). The National Patient Safety Agency6 defined clinical handovers as involving a "transfer of professional responsibility and accountability for some or all aspects of care for a patient, or a group of patients, to another professional or professional group on a temporary or permanent basis". The most important point of handovers is the efficient transfer of clinical information during transfer of clinical responsibility. Effective handovers should include a succinct overview of:

- Current inpatients:
  - Their risk level
  - Their location
  - Status of their investigations and treatment
  - Any proposed clinical management plans to be implemented during the duty shift
- Patients expected from triage or home or transfers from other units.

Handovers often start with a brief huddle highlighting operational issues. Though this is not a clinical handover's main purpose, it is a good opportunity to make all team members aware of any safety issues.
Huddles in healthcare are short briefings where team leaders come together to share clinical information, review events and plan for the day ahead across disciplinary borders and services, while maintaining individual clinical responsibility. For example, managing the elective caesarean section lists and the induction-of-labour workload on a day when emergency activity has been high would be a topic for the huddle.

Huddles focus on:

- Sharing key general information to increase all team members' situational awareness (eg planned theatre work)
- Improving patient flow (eg available neonatal cots)
- Identifying patient safety concerns, including staffing.

Deciding the purpose

Be clear about the objective of a team meeting: this will help you decide if it is to be a clinical handover or a huddle which, in turn, will decide the audience. With a clear purpose, structure and outcome, individual 'buy-in' is much easier and the meeting can break down silo working across professional groups, encourage open communication and build trust. Neonatal consultant on the power of huddles

"Knowledge is power, and it helps us understand the pressure across our service rather than operating in silos where all we see is what we have got here. Over time it became apparent to people who engaged [in huddles], the actual benefits to their service, that if they were the most pressured service… through the huddle they were able to identify support. You may want someone from service management to be there. Their role would be looking at additional support in terms of service capacity, staffing."

Focusing on purpose can also help you define why you are holding the meeting. In handovers, the concise, structured communication of clinical details promotes the safe transfer of clinical responsibility. The reasons for holding huddles may be less tangible. Analyses of adverse incidents often cite lapses in non-technical skills as causes;8 these may be, for example, a fixation on a specific task resulting in failure to recognise a patient's clinical deterioration, or fear of speaking up within a strictly hierarchical team. It is this aspect of patient safety that huddles address. By seeking key team members' perspectives and promoting psychological safety to voice concerns, huddles can enhance the whole team's situational awareness.

Standardised approach

The core message is that each participant should follow the same procedure and deliver the same agreed content with all unnecessary steps removed. A planned handover process is often improved by using a structured communication tool. SBAR is a commonly used approach, in which the key domains of situation, background, assessment and recommendation ensure consistency of shared information.

Similarly, huddles need a standard template for both the information brought and the information gathered there, so all members are clear about what information they must share. Huddles are not just about staffing (although they should encompass staffing and clinical workload and the resulting impact on patient flow). Patient safety issues should also be raised in huddles to improve the team's situational awareness.

Standardised time and place

When: It is important to define a start time so staff attending understand their obligations. The most usual handover time is at the start of each shift of midwives/nurses, but this may not always coincide with medical handovers. Modifying start and finish times may enable a more multiprofessional approach if the case-mix demands a multidisciplinary review, as on labour wards. Time for handover must be included in contracted hours to ensure attendance and compliance with working-time directives and job plan timetables. It should usually be scheduled for at least 30 minutes, depending on the unit's workload and complexity. This reinforces the need for concise and consistent information sharing.

Highlighting learning and flexibility when implementing huddles can encourage commitment as teams realise they can mould the huddle to their needs. Huddles should take place seven days a week, 365 days a year.

MDT Professional Handover etiquette

1. AM Handover starts at 08:30 PCH / 09:00 POW
   PM consultant Handover starts at 17:00 PCH
   Night MDT Handover starts at 20:30 PCH / 21:00 POW
2. Hand over runs through the following structure:
   - Introduction (Who is who and doing what)
   - Labour Ward Acuity
   - Staff Rosters
   - LW board handover (to be led by the outgoing)
   - IOL handover – new admissions and ongoing IOL
   - Elective case load
   - Triage cases

- AN handover
- PN Hand over
- Gynaecology Handover

3. MDT proforma (appendix 1) to be signed at each handover, proformas to be scanned on weekly basis by the ward Clerk and saved electronically

To be observed at each handover:

- It is the responsibility of every person to check the roster before attending the shift to understand their role and place of clinical care (work)
- Everyone should observe closed loop communication during the handover so please do not conduct individual discussions during this
- Minimise disturbance during the handover – ensure the team are aware that the Handover is taking place
- Monitor the level of noise – do not conduct other conversations with the team during the handover. If there is key information pertaining to the case in discussion then please indicate you wish to add to the clinical discussions
- The Consultant is the most senior person in the MDT handover which means they should be responsible for etiquette during the hand over
- Handover proformas should be treated as any other clinical documentation and the security of these records should be maintained in the same way. These are confidential legal documents.
- A minimum standard of professional behaviour will be observed, please listen to your colleague giving the handover. Any concern needing addressing must maintain a professional approach during the hand over. If you concerned with the management of the women's care, there is a professional way in which these discussions must be conducted. These should be conducted with the Consultant.
- The staff area is visible to our internal and external colleagues, please be courteous in the way we use our shared spaces. It is our second home. Please observe the health and safety of our colleges and ensure the space is clear and tidy.

Expectations of the Multi-Disciplinary Team Professional Hand Over on Labour Ward.

- At the start of the handover, all the team should introduce themselves and clarify their roles for the shift. All medical staff are to write their name and number on the contact board.
- Commence Hand over promptly.

- Ensure no interruptions or that they are kept to a minimum like in the case of an emergency.
- Handover in progress signs to be displayed.
- Door to be shut to avoid unnecessary distractions.
- Coordinator to hand keys to another midwifery staff member during the handover.
- Keep handover succinct.
- Nurture an open environment where all professionals' comments are welcomed.
- No food to be consumed during handover. This is a clinical handover of care.
- The handover should be led by both the Coordinator leading the shift and the Obstetric Registrar going off shift.
- Encourage SBAR style communication. (Situation, Background, Assessment and Recommendation).
- Handover should include all women that require review on the labour ward, triage and the antenatal and postnatal ward (Please refer to Appendix 1 for the handover information discussion and acuity/activity capture). For information the team should be made aware of the elective list. Representation from the NNU should be present and their acuity should be discussed.
- At the end of the handover, a plan for a huddle should be made and a formulated action plans and allocation of tasks made in order of priority;-
  ACTION - task
  PERSON - who
  PRIORITY - order
- The labour ward team should then review all women on labour ward and a documented plan of care is made in their maternity notes. A review of the women on the antenatal and postnatal ward (High Risk cases requiring review) should follow. Please prioritise any calls in the case of an emergency.
- The team should work together to ensure that actions are completed/followed up in a timely manner and that the labour ward runs efficiently and effectively.

N.B. when activity increases please remember that a safety huddle can be called for by any member of the team and this should be encouraged to provide assurance of situational awareness, safety of the women and staff and to prioritise any actions required.

1. Appendix 1

OBSTETRIC TEAM	**IN PRINT**	**SIGN**	**OUT PRINT**	**SIGN**
Consultant				
Registrar				
SHO				
GMP/SCM				
GYNAE TEAM				
Consultant				
Registrar				
SHO				
ANAESTHETIC TEAM				
Consultant				
Registrar				
ODP				
MIDWIFERY TEAM				
LW Coordinator			N/A	
Scrub Team			N/A	
AN Ward Manager/Midwife			N/A	
Current Acuity Status				
Current Acuity Delays				
Midwifery Staffing Roster – any staffing issues which may affect service provision				
Medical Staffing Roster – any staffing issues which may affect service provision				

MDT HANDOVER DATE …… Time (use 24hr clock**)**

New IOL To Be admitted to Antenatal Ward			
Initials	**G/P & Gestation**	**Indication for IOL**	**Risk factors?**
Ongoing IOL from Antenatal Ward Awaiting Transfer to LW			
Initials	**G/P & Gestation**	**Indication for IOL**	**Risk factors?**

ELCS LIST *Order of priority to be decided by MDT at handover (PCH EL LSCS recorded on separate worksheet – must be filed with MDT Handover)*								
Initials	**G/P & Gestation**	**Indication for ELCS**	**BMI**	**Hb**	**Plt**	**EI?**	**All?**	**Order**
		Placental site:						
		Placental site:						
		Placental site:						

Outliers

TRIAGE Cases on site				
Initials	**G/P & Gestation**	**Indication for Referral**	**CON/MLU**	**BMI**

TRIAGE Cases expected				
Initials	**G/P & Gestation**	**Indication for Referral**	**CON/MLU**	**BMI**

Labour Ward Occupied Room MDT Case Discussions

Room No.	**Initials & Hospital Number**	**Situation**	**Background**			**Assessment / Progress / Results**	**Recommendation**
		Date & Reason for admission	**Obstetric Hx**		**Medical Hx**		
			BMI	VTE	Anaest ?		
			BMI	VTE	Anaest ?		
			BMI	VTE	Anaest ?		
			BMI	VTE	Anaest ?		
			BMI	VTE	Anaest ?		
			BMI	VTE	Anaest ?		
Blue-Bell/ Primrose							
			BMI	VTE	Anaest ?		
Th1							

			BMI	VTE	Anaest ?		
Th2							
			BMI	VTE	Anaest ?		

LUNCH TIME HUDDLE PLANNED AT: LUNCH TIME HUDDLE DONE ☐ SAFETY BRIEFS DISCUSSED DATED:	SCBU STATUS: POW/PCH STATUS TIRION BIRTH CENTRE:	Antenatal Handover patients discussed Yes/No Postnatal High Risk Patients discussed Yes/No Gynae Patients discussed Yes/No

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