

# Guideline for Multi-disciplinary Labour Ward Handover

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## Target Audience:

<b>People who need to know about this document in detail</b>	All Obstetric and midwifery staff including locum and bank staff.
<b>People who need to have a broad understanding of this document</b>	As above

## Integrated Impact Assessment:

<b>Equality Impact Assessment Date &amp; Outcome</b>	<b>Date:</b> July 2025 <b>Outcome:</b> No negative impact has been identified
<b>Welsh Language Standard</b>	Choose an item.
<b>Date of approval by Equality Team:</b>	(00/00/0000)
<b>Aligns to the following Wellbeing of Future Generation Act Objective</b>	Choose an item.



## Disclaimer:

If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or [CTM\\_Corporate\\_Governance@wales.nhs.uk](mailto:CTM_Corporate_Governance@wales.nhs.uk)

### **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
Updated in line with relevant guidance	3 yearly update		August 2025	1 to 2	Fran Hodge

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## 1. Introduction

The workload varies on each shift on the labour ward, both in the amount and complexity of elective and emergency cases. There can be a variation in the skill mix of the midwifery and medical staffing on each shift, with both permanent and locum staff<sup>1</sup>.

It is therefore vital to begin each shift with a structured handover followed by a ward round. This will facilitate individualised safe management plans for the women and their babies. Tasks can be prioritised, and completed in a timely manner by the most appropriate skilled professional<sup>1</sup>.

Regular multidisciplinary board rounds will help staff to maintain an organised structure throughout the day, or the night, and help to re-prioritise when new cases arise and unexpected emergencies occur. There are numerous members of staff involved in running a safe labour ward. Knowing the staff's level of experience and expertise, and their familiarity with the unit, will aid with delegation of tasks and multi-disciplinary rewarding work for everyone<sup>1</sup>.

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 and we have a safety brief attached to clinical handover for this purpose.

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 birth 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 team members' situational awareness (eg planned theatre work)
- Improving patient flow (eg available neonatal cots)
- Identifying patient safety concerns, including staffing.

It's so important we foster a culture of kindness and civility, not only because in doing so we support each other, but also because we know that incivility can be crucially linked to patient safety.

By promoting a positive culture, we enable psychological safety – making everyone feel valued, respecting and welcoming the input of every member of the team, and encouraging everyone to speak up without fear

of blame or retribution. This in turn has a big impact on patient safety, enabling everyone to speak up when they have concerns.

It's also so important to know your team for the day. Who are you going to escalate to? Who is going to escalate to you? Are you all ok? Does anyone need extra support? Or are there any learning or development needs to address?

Then handover structure is run as follows:

1. Set the expectations and the scene:  
Reduce distractions – *distractions can lead to error, with key information omitted*
  - Close door
  - Ensure privacy and confidentiality
  - Are there any immediate safety issues – delegate prior to Team of shift and Clinical handover.
  - The full MDT should be present (incoming and outgoing team) prior to starting this may include band 7 coordinator, Consultant Obstetrician and Anaesthetist, Registrar, obstetrician and anaesthetist, SHO's and neonatal team representation.

*Huddles and handovers can be the most dangerous time of the day as all the key team members are distracted. It's important to ensure time critical issues are dealt with prior to starting a huddle. However, it's also important as many of the incoming team are present as possible, in order to ensure everyone has the same shared mental model and key information isn't lost. Consider delegation – an example could be a consultant covering a different area, e.g., the elective caesarean birth list.*

2. Welcome incoming team
  - Ask how they are? (anyone hungry, angry, late, tired or distracted). *(We know that any or all of these things can affect our working memories and our situational awareness)*
  - Let people know who to talk to if they want to talk to someone privately *(e.g., if they need to debrief from a previous shift, or have personal concerns that may affect their performance at work).*
3. Introduce: 5-10mins for Team of the Shift then clinical handover. *(Huddles and handovers are a time when a large number of the team are away from clinical activity. It's therefore imperative that they start promptly, and take as short a time as possible whilst being as thorough as necessary, and giving everyone the opportunity to speak up. There should be no criticism or undermining, either of the outgoing team, or the choices of women / birthing people have made).*

#### 4. Team introductions and identification

- Name and role
- Shift duration e.g. early, late, long day etc
- Any support/skill development needs  
*(This is a crucial part of successful clinical escalation – everyone clearly knows who they are working with that day, and in what capacity. Introducing everyone by their first name flattens the hierarchy and encourages all staff to speak up and escalate. Addressing support and skill / development needs makes all members of the team feel valued).*

#### 5. Identify emergency team, their roles and any potential emergencies anticipated. *(This ensures everyone has the same shared mental model – and helps when emergency buzzers are pulled. A key part of maintaining situational awareness is preparation and planning).*

#### 6. Identify who to escalate to and any escalation buddies. *(Knowing who to escalate to and when is a crucial part of clinical escalation).*

#### 7. Clinical handover

#### 8. Thank outgoing team

- What went well?
- Is everyone ok?  
*(It's so important to check in with our colleagues, particularly at the end of a long shift. We need to remember what an amazing job we all do, every single day, saving many lives. As a team, learning from excellence and celebrating successes fosters a culture of joy at work)*

MDT proforma (appendix 1) to be discussed in full and saved digitally at each handover/huddle in appropriate file.

## **Handover Timings**

- 9. AM Midwifery handover 07.00  
AM MDT Handover starts at 08:30 PCH / 09:00 POW  
Lunchtime Huddle 13.00 PCH/POW  
PM consultant Handover starts at 17:00 PCH and POW  
PM Midwifery handover 19.00  
Night MDT Handover starts at 20:30 PCH / 21:00 POW

# Team of the Shift Checklist to be used for all MDT handovers as below



## TEAM OF THE SHIFT

### Checklist

#### Incoming team- Start of the Shift

- ✓ Is everyone ok?
- ✓ Discuss who to contact if need to discuss anything in private.
- Introductions**
  - Name and role
  - Shift duration
  - Any learning/educational needs for the day ie assessment request, procedures required
- Identify any anticipated emergencies**
  - Discuss potential roles
- Identify who to escalate to:**
- Clinical handover**
  - Anyone unwell/priority for review
  - Labour ward
  - AN ward
  - PN ward
  - Planned IOL
  - Planned LSCS
  - Gynae

#### EXCELLING AT CLINICAL ESCALATION TOGETHER AS A TEAM

At the start of each shift, ask yourself...

- Do I know everyone on shift today?
- Do I know who I'm going to escalate concerns to?
- Have I said thank you to a colleague?
- Have we celebrated our successes together?
- Have I checked if my colleagues are okay?

#### Outgoing team- End of the Shift

- Any problems not already discussed?
- Are the **team** ok?
- Any debriefs needed?
- Any women taken to theatre
- What went well?

- ✓ Let's make clinical escalation easy
- ✓ Let's give every team member a voice so they can raise concerns without fear
- ✓ Let's pledge to respond with kindness and compassion to all our colleagues

- The labour ward team should then review all women on labour ward and a documented plan of care made in their maternity notes. A review of all women on the antenatal and high risk women on the postnatal ward 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.
- Prior to discharge from LW please ensure the obstetric team have completed the postnatal section of the Individualised Obstetric Care Plan to ensure quality of ongoing handover to the postnatal team.

**N.B. when activity increases, please remember that a safety huddle can be called at any time 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.**

**Information adapted from RCOG Escalation Toolkit.**

#### References

1. Garner, Murray & Parisaei (2022) Prioritisation on the labour ward  
Obstetrics, Gynaecology and Reproductive Medicine, 32 (3) P 38-43
2. RCOG Escalation Toolkit. Available from [Escalation toolkit | RCOG](#)

## 2. Appendix 1

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

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

<b>New IOL To Be admitted to Antenatal Ward</b>			
<b>Initials</b>	<b>G/P &amp; Gestation</b>	<b>Indication for IOL</b>	<b>Risk factors?</b>

<b>Ongoing IOL from Antenatal Ward Awaiting Transfer to LW</b>			
<b>Initials</b>	<b>G/P &amp; Gestation</b>	<b>Indication for IOL</b>	<b>Risk factors?</b>

**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)*

<b>Initials</b>	<b>G/P &amp; Gestation</b>	<b>Indication for ELCS</b>	<b>BMI</b>	<b>Hb</b>	<b>Plt</b>	<b>EI?</b>	<b>All?</b>	<b>Order</b>
		<b>Placental site:</b>						
		<b>Placental site:</b>						
		<b>Placental site:</b>						

**Outliers**

<b>TRIAGE Cases on site</b>				
<b>Initials</b>	<b>G/P &amp; Gestation</b>	<b>Indication for Referral</b>	<b>CON/MLU</b>	<b>BMI</b>

<b>TRIAGE Cases expected</b>				
<b>Initials</b>	<b>G/P &amp; Gestation</b>	<b>Indication for Referral</b>	<b>CON/MLU</b>	<b>BMI</b>

### Labour Ward Occupied Room MDT Case Discussions

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

			BMI	VTE	Anaest ?	
<b>Th2</b>						
			BMI	VTE	Anaest ?	
LUNCH TIME HUDDLE PLANNED AT:	SCBU STATUS:		Antenatal Handover patients discussed		Yes/No	
LUNCH TIME HUDDLE DONE	POW/PCH STATUS		Postnatal High Risk Patients discussed		Yes/No	
SAFETY BRIEFS DISCUSSED DATED:	TIRION	BIRTH	Gynae Patients discussed		Yes/No	
	CENTRE:					

**Filed By:**  
**date:**

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