Obstetric Anaesthesia
Annual Scientific Meeting 2021 goes virtual
10-11 June 2021

Enhancing multidisciplinary communication in emergency obstetric surgery during the COVID 19 pandemic

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Introduction

The COVID 19 pandemic has presented significant challenges to the delivery of safe, efficient care for emergency obstetric surgery. In particular donning airborne personal protective equipment (PPE) in a timely fashion and the associated barriers to communication in the operating theatre. Improvements to multi-disciplinary communication (MDT) has been identified in MBRRACE reports [1] as an area that is crucial in reducing maternal and fetal morbidity and mortality. We introduced a new **"Emergency Pre-Brief"** communication process for all obstetric surgical cases prior to transfer to theatre in May 2020 , performed 2 snap shot decision to delivery interval audits for Category 1 deliveries and evaluated feedback from an MDT staff survey about the impact of this change in practice on communication and patient care.

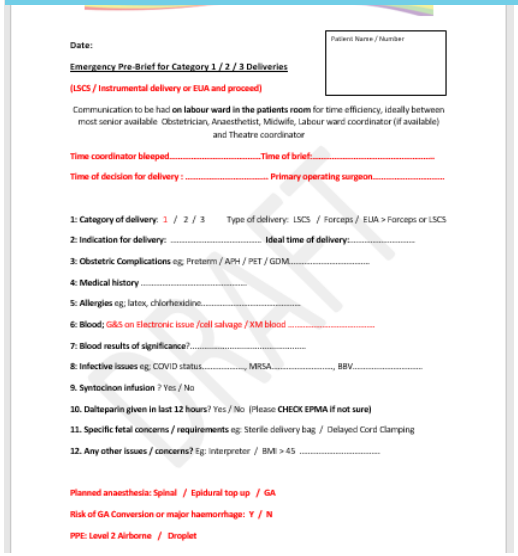
Methods

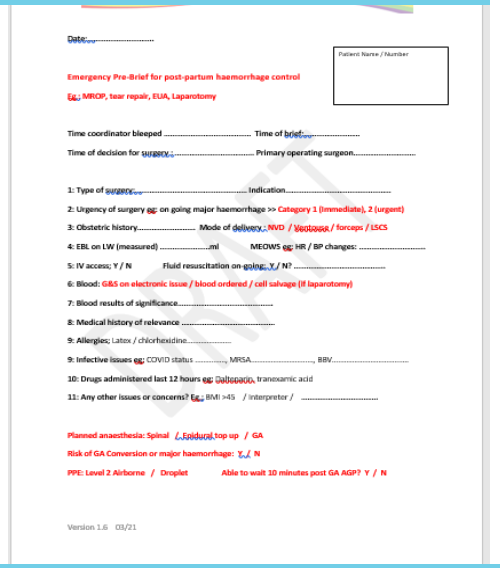
An **"Emergency Pre-Brief"** communication document was designed and introduced with MDT input through the labour ward forum. It included essential patient information: category of urgency, procedure type, indication for delivery/procedure, obstetric and medical complications, fetal concerns, allergies, abnormal blood results, G&S status, blood or cell salvage required, COVID swab result, type of anaesthetic, risk of GA conversion and PPE to be used. The Emergency Pre brief takes place on labour ward, led by the theatre coordinator with members of the MDT before transfer to theatre. The coordinator returns to theatre to communicate the details to the theatre team to ensure they are prepared for the correct anaesthesia and surgery, in the correct PPE, with the correct equipment and are aware of any concerns relating the case. In June 2020 and April 2021 snap shot audits were completed to look at decision to delivery times for Category 1 LSCS to ensure standards are being upheld post change in practice. We conducted an MDT staff survey sent to anaesthetic, obstetric, midwifery and theatre staff using Survey Monkey in January 2021 to assess the impact of this change in practice.

Results

The Emergency Pre-Brief has been fully adopted in our clinical practice since May 2020 during the pandemic. The decision to delivery snap shot audits for Category 1 LSCS ranged from 9-33 min in June 2020 and 20 – 47 minutes (Average 30 minutes) April 2021 (1 x 47 minute case 2' to difficult spinal). The MDT staff survey reported 87% of respondents agreed the pre brief had improved MDT communication, 80% reported a positive change to efficiency of theatre preparations and safe delivery of care, 74% reported improved postpartum surgical theatre efficiency. 84% reported improved mutual understanding of multi-speciality concerns.

Emergency Pre-Brief Documents


Date:
Patient Name / Number
Emergency Pre-Brief for Category 1 / 2 / 3 Deliveries
(LSCS / Instrumental delivery or EUA and proceed)
Communication to be had on labour ward in the patients room for time efficiency, ideally between most senior available Obstetrician, Anaesthetist, Midwife, Labour ward coordinator (if available) and Theatre coordinator
Time coordinator bleeped.....Time of brief:.....
Time of decision for delivery : ..... Primary operating surgeon.....
1: Category of delivery: 1 / 2 / 3 Type of delivery: LSCS / Forceps / EUA > Forceps or LSCS
2: Indication for delivery: ..... Ideal time of delivery:.....
3: Obstetric Complications eg; Preterm / APH / PET / GDM.....
4: Medical history .....
5: Allergies eg; latex, chlorhexidine.....
6: Blood; G&S on Electronic issue /cell salvage / XM blood .....
7: Blood results of significance?.....
8: Infective issues eg; COVID status....., MRSA....., BBV.....
9. Syntocinon infusion ? Yes / No
10. Dalteparin given in last 12 hours? Yes / No (Please CHECK EPMA if not sure)
11. Specific fetal concerns / requirements eg: Sterile delivery bag / Delayed Cord Clamping
12. Any other issues / concerns? Eg: Interpreter / BMI > 45 .....
Planned anaesthesia: Spinal / Epidural top up / GA
Risk of GA Conversion or major haemorrhage: Y / N
PPE: Level 2 Airborne / Droplet


Date:.....
Patient Name / Number
Emergency Pre-Brief for post-partum haemorrhage control
Eg.; MROP, tear repair, EUA, Laparotomy
Time coordinator bleeped ..... Time of brief:.....
Time of decision for surgery : ..... Primary operating surgeon.....
1: Type of surgery:..... Indication.....
2: Urgency of surgery eg: on going major haemorrhage >> Category 1 (immediate), 2 (urgent)
3: Obstetric history..... Mode of delivery : NVD / Ventouse / forceps / LSCS
4: EBL on LW (measured) .....ml MEOWS eg: HR / BP changes: .....
5: IV access; Y / N Fluid resuscitation on going; Y / N? .....
6: Blood: G&S on electronic issue / blood ordered / cell salvage (if laparotomy)
7: Blood results of significance.....
8: Medical history of relevance .....
9: Allergies; Latex / chlorhexidine.....
9: Infective issues eg: COVID status ....., MRSA....., BBV.....
10: Drugs administered last 12 hours eg: Dalteparin, tranexamic acid
11: Any other issues or concerns? Eg.; BMI >45 / interpreter / .....
Planned anaesthesia: Spinal / Epidural top up / GA
Risk of GA Conversion or major haemorrhage: Y / N
PPE: Level 2 Airborne / Droplet Able to wait 10 minutes post GA AGP? Y / N
Version 1.6 03/21
DRAFT

Discussion

The COVID -19 pandemic has presented many challenges for obstetric services. We have shown the Emergency Pre-Brief process has improved communication and ensured timely preparations for surgery. It is an example of effective MDT working and is something that can be used by other obstetric units, particularly in light of essential actions in the Ockenden report [2] of staff working together in partnership. During this process we have importantly improved the communication of urgency of surgery for instrumental deliveries and post partum surgery.

References

1. Knight M, Bunch K, Tufnell D et al on behalf of MBRRACE-UK Saving Lives, improving mothers care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths & Morbidity 2016-2018. Oxford: National Perinatal Epidemiology Unit . University of Oxford 2020
2. Ockenden D. Independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. 2020.https://www.ockendenmaternityreview.org.uk