

From brief to birth: improving maternity theatre safety with the LABOUR team brief

Cecily Christopher & Fiona Pearson, Sunderland Royal Hospital

Fig. 1 LABOUR acronym for team brief

L	LISTED PROCEDURE
A	ANAESTHETIC PLAN ALLERGIES & ANTIBIOTICS
B	BLOOD RESULTS Hb, Plt, Blood group, Antibodies
O	OTHER MEDICAL PROBLEMS
U	UTEROTONICS
R	RESUSCITATION Resuscitaire checked, Need for neonates

Introduction

A well-conducted surgical team brief immediately before a case improves coordination, decision-making and reduces ambiguity that can lead to error [1]. Obstetric surgery presents distinct maternal and neonatal considerations compared with other specialties. Risk analysis of incidents in maternity theatres identified inadequate pre-operative communication as a contributing factor. We hypothesised that the introduction of a specialty-specific, structured obstetric team brief would improve the communication of key clinical information.

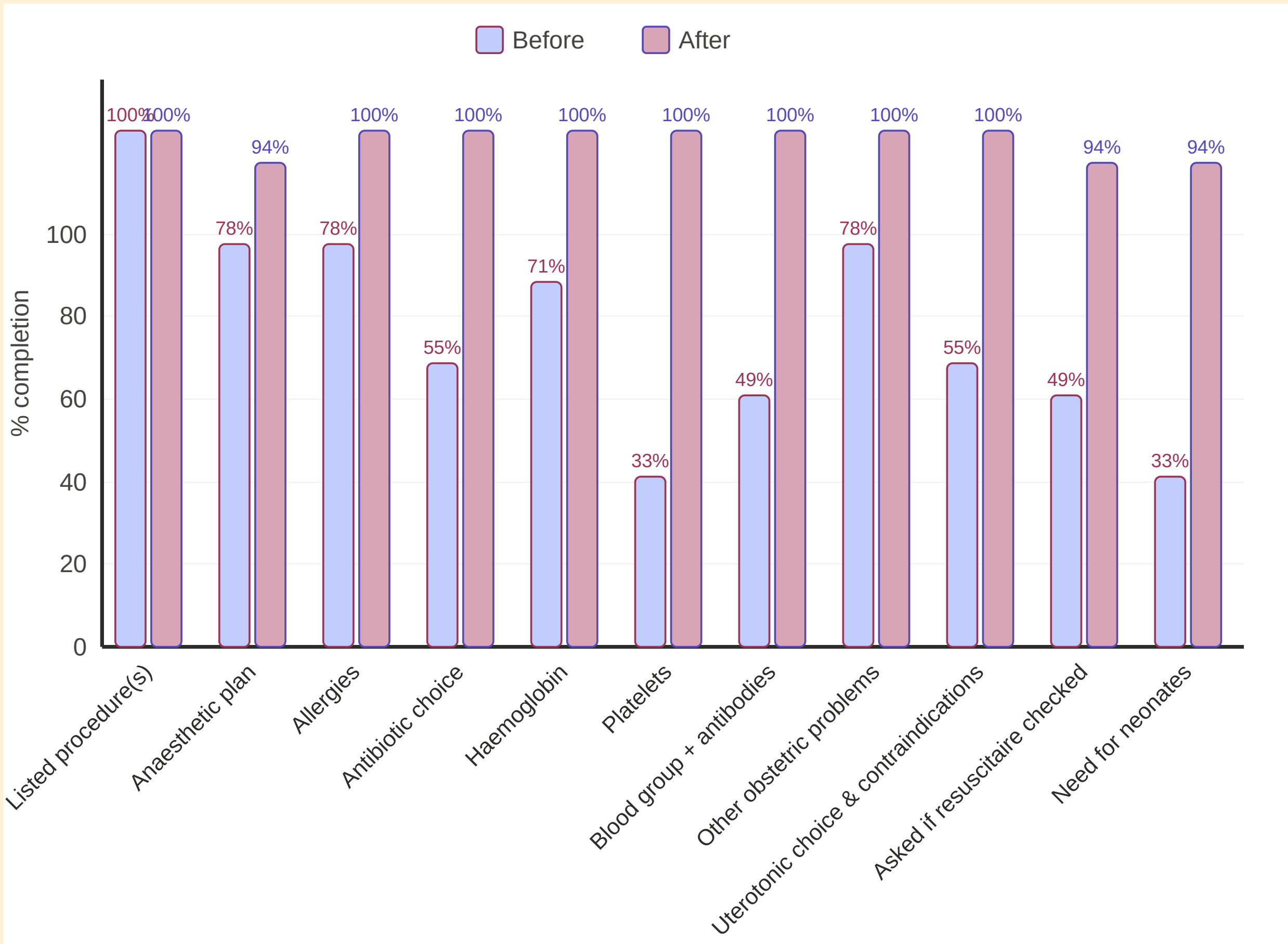
Methods

We developed an acronym-based aide-memoire (LABOUR) [Fig 1] outlining key information to be discussed at obstetric team briefs. This formed the basis of the data collection proforma. Following trust audit approval, baseline data of obstetric team briefs were prospectively collected over three weeks in December 2025. The LABOUR team brief was introduced as a quality improvement intervention through staff education and posters. Team brief practice was re-audited in January 2026.

Results

Data were collected from 18 theatre briefings before and 18 after intervention. Fig. 2 shows the proportion of team briefs that discussed each patient safety element from the aide memoire. Procedure details were discussed in all cases. Pre-implementation, uterotonic choice was discussed in 56% of cases, platelet count and need for neonates were discussed in 33%. Other elements were covered in 50–78% of team briefs. Following the introduction of the LABOUR team brief, only one case omitted discussion of anaesthetic plan and neonatal support. All other elements were discussed in all remaining cases.

Fig. 2 Pre- and post-survey results



Discussion

Introduction of a specialty-specific, structured team brief was associated with marked improvement in the consistency of information shared during obstetric theatre team briefs. Feedback from the theatre team was positive, especially by scrub staff who often know less about the patient and appreciate the clear structure and improved communication. Similar to the SAFER handover, this simple intervention improves multidisciplinary communication and patient safety. Further work is required to integrate it sustainably into practice and assess impact on safety incidents and drug error.

References

1.Russ, Stephanie et al. “Do safety checklists improve teamwork and communication in the operating room? A systematic review.” Annals of surgery vol. 258,6 (2013): 856-71.