

Departmental Compliance with the Royal College of Obstetrics and Gynaecology Standards for Roles and Responsibilities of a Consultant

Authors: Karen Parker, Lead Midwife for Risk, Safety & Quality, Gateshead Healthcare Foundation NHS Trust, karen.hooper6@nhs.net
Dr Hannah Bhopal/ Hannah.bhopal@northumbria-healthcare.nhs.uk/Year 5 specialty trainee in Obstetrics and Gynaecology

Abstract

Objective – audit of departmental compliance with the Royal College of Obstetrics and Gynaecology (RCOG) minimum attendance requirements for Consultant Obstetricians as detailed in the 2022 update of their “Roles and Responsibilities” guidance.

Design – retrospective clinical audit.

Setting – small (2000 delivery/annum) Consultant-led maternity unit in the North East of England.

Population or Sample – all eligible cases in Tables 1 and 2 of the RCOG guidance (Appendix 1) for the period April to September 2022.

Methods – quantitative case note review, qualitative review of cases linked to outcome/patient experience, triangulation of cases against patient safety incidents reported.

Main Outcome Measures –

- **Primary outcome** – Consultant presence (Table 1 cases), evidence of competency of most senior obstetrician present (Table 2 cases).
- **Secondary outcomes** – reason Consultant not present, impact on patient outcomes.

Results – there were 36 eligible cases for Table 1 indications with a compliance rate of 94%, and 57 eligible cases for Table 2 with a compliance rate of 84%. There were 7 post-partum haemorrhages when the Consultant was not in attendance. 1 non-compliant case correlated with a significant patient complaint. There were no reported occasions when a Consultant had refused to attend when requested.

Conclusions

- There were high levels of compliance with both RCOG tables.
- There was theme of non-attendance at post-partum haemorrhage events (both >2000ml and >1500ml). This was explored further and themes identified included the total blood loss not being calculated until the situation was under control thereby missing the opportunity to escalate, lack of awareness of trainee competency.
- Opportunities for further awareness work for PPH – earlier measurement/assessment/escalation, clarity of role of post-CCT clinicians when functioning as part of the trainee rota, psychological safety of who needs to be aware of individual competencies – rotating trainees and locum staff, explore the potential for regional/Deanery standardised process for recording competency and sharing records.
- **Funding** – this student is funded by the apprenticeship levy, Chartered Management Institute.
- **Keywords** – Consultant roles and responsibilities, Safety Action 4, Maternity Incentive Scheme, competency.
- **Tweetable abstract** – overall compliance with Obstetric Consultant attendance at RCOG specified clinical scenarios is good however transparency of trainee and locum competency levels and loss of situational awareness can lead to missed opportunities to escalate.

Introduction

Multiple maternity reports (Kirkup, 2015, Ockenden, 2020, Ockenden, 2022) have described workplace cultures with a reluctance to escalate, and delays and inaction once escalation has occurred resulting in lack of clinical experience and inadequate senior support (Ockenden, 2022).

The Royal College of Obstetrics and Gynaecology issued updated guidance detailing the roles & responsibilities of the Obstetric Consultant (2022) which has been used as evidence of a safe medical workforce in safety action four in the latest standards for the Maternity Incentive Scheme (NHSR, 2022). This recognises the pivotal role that Consultants play in providing not only clinical expertise, but also as role models, visible leaders and key players in improving maternity standards and creating a supportive, learning culture.

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g. a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ITU care is likely to become necessary
Caesarean birth for major placenta praevia/abnormally invasive placenta
Caesarean birth for woman with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g. septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
Gynaecology
Any laparotomy

Table 1 Situations in which the consultant MUST ATTEND.

Situations in which the consultant MUST ATTEND unless the most senior doctor present has documented evidence as being signed off as competent. In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.
GENERAL
Any patient in obstetrics OR gynaecology with an EBL >1.5 litres and ongoing bleeding
OBSTETRICS
Trial of instrumental birth
Vaginal twin birth
Caesarean birth at full dilation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Caesarean birth at <32/40
Vaginal breech birth
3rd degree perineal tear repair
Gynaecology
Diagnostic laparoscopy
Laparoscopic management of ectopic pregnancy

Table 2 Situations in which the consultant MUST ATTEND unless the most senior doctor present has documented evidence as being signed off as competent.

Methodology

In order to demonstrate compliance with safety action four (medical workforce); Trusts should monitor their compliance with the RCOG standards on a monthly basis. Episodes where a Consultant has not been in attendance when indicated should be reviewed as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance (NHS, 2022).

This study is a retrospective clinical audit with a clearly defined set of standards, set inclusion criteria and information that is easily available by reviewing the electronic clinical patient records. The limitations are a small unit with <2000 annual births; small numbers of eligible cases making trend analysis difficult. Because of the rare and differing nature of the non-compliant cases, a qualitative case note review of these incidents was completed to identify potential learning.

The study population includes all eligible obstetric cases captured over a 6 month period; April – September 2022.

Research Ethics Committee clearance was required and Caldicott Guardian consent was sought for the use of non-identifiable data, both permissions were granted before commencing the audit.

Results

During Quarters 1 and 2 of 2022/23, there were 36 eligible cases from Table 1 and 57 eligible cases from Table 2.

Primary outcomes

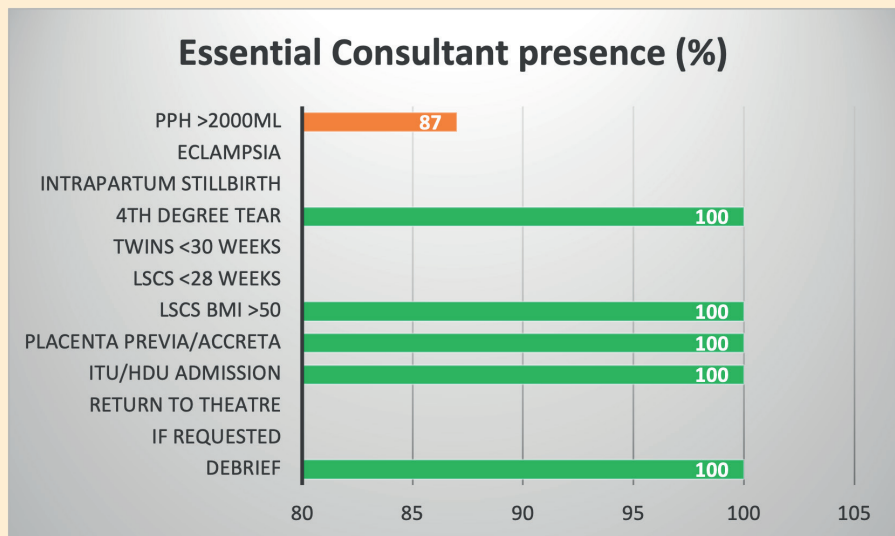


Table 3

Compliance with Table 1 of the RCOG Consultant attendance requirements – situations when a Consultant **must** be in attendance

Overall compliance for all eligible cases = 94%

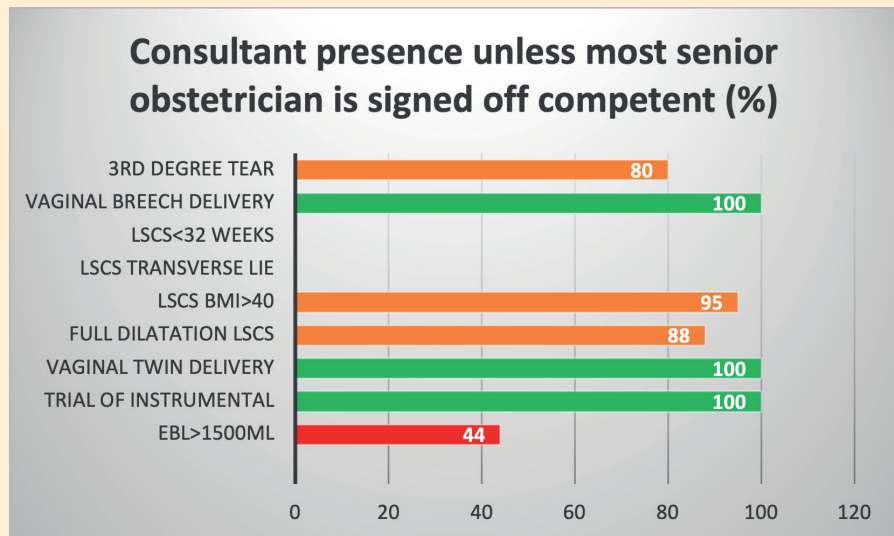


Table 4

Compliance with Table 2 of the RCOG Consultant attendance requirements – situations when a Consultant **must** be in attendance unless the most senior obstetrician is signed off as competent

Overall compliance for all eligible cases = 84%

Discussion

The primary aim of this audit was to review unit compliance with Consultant attendance at specific clinical situations as identified by the RCOG (2022). The secondary learning was to understand reasons why the Consultant was not present and whether there was thought to be any impact of this on the patient outcome.

Overall compliance with the RCOG requirements was met in 94% of Table 1 and 84% of Table 2 clinical indications. This reflects the positive culture of the department; obstetric trainees and senior midwives can request Consultant attendance and escalate concerns with the anticipation of a positive response.

Twice daily Consultant-led ward rounds and team safety huddles enhance the safety of the unit as many of the cases indicated may present an opportunity for anticipation, joint discussion and planning before the incident occurs. It is the responsibility of the Consultant on-call to know the team working that day and to have an agreement around what situations they would want to be notified and/or in attendance for.

There was a slight reduction in compliance observed with the Table 2 list at the start of Quarter 2 – this coincided with the changeover of trainee placements. There could be different explanations for this; individual knowledge of trainees of the requirements, previous negative experiences of trainees or an ineffective induction process.

There is a theme of non-compliance with post-partum haemorrhage (PPH) cases with an overall total of 71%, falling to 44% in the second list. Qualitative analysis of these cases suggest that total blood loss is often not calculated until the completion of the clinical care and is often underestimated. Therefore by the time the blood loss is known, the situation has been controlled and the opportunity for escalation has been missed.

Review of individual cases suggests some confusion when post-CCT clinicians work as part of the trainee rota – at these times, for Table 1 – Consultant attendance remains mandatory. Consultant attendance enhances safety in these most hazardous clinical situations for several reasons; an additional pair of hands, second opinion, support for staff and families involved in serious incidents, helicopter view – if staff are busy in a serious clinical situation, the Consultant can support with triage, clinical care, escalation for the rest of the labour ward, clinical skills and expertise.

A second case resulted in no actual patient harm; however, it resulted in a formal complaint to the Trust from the patient involved. The senior support which could have been offered by a Consultant in attendance on this occasion, may have reassured this family and alleviated the need to raise a complaint.

Conclusions

For any member of staff to be able to request appropriate Consultant attendance, a culture of psychological safety must exist – staff must feel confident and able to escalate when the situation dictates.

The awareness of all members of the team of the standards required, the shared communication between Consultant, trainee and coordinator on a regular basis and a psychologically safe culture will provide a safe and learning culture with a collective competence to drive forward standards in maternity safety.

The RCOG standards are included in the induction programme for junior doctors joining the Trust and a competency assessment record has been designed for completion with individual educational supervisor at commencement of employment. The form allows for updating of competencies on an on-going basis as clinical experience is gained.

Further work is suggested to align with the newly released guidance to support locum clinicians (RCOG, 2022) accompanied by a “Certificate of Eligibility” passport (RCOG, 2022) to ensure that key members of the team have oversight of the experience and educational needs of all members of the team on any clinical shift.

Work is on-going within the department to review and update the post-partum haemorrhage guidance to include a move towards measured rather than estimated blood loss and supporting implementation of this into practice with education, resources and audit.

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