

A strategy proposal for obstetric emergencies



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REPORT: A STRATEGY PROPOSAL FOR MANDATORY SKILLS AND DRILLS SESSIONS FOR OBSTETRIC EMERGENCIES

1 Executive Summary

1. 1 This proposal was carried out following the need for drills as identified and recommended by the CEMACH report.

1. 2 The situation was reviewed in the light of current directives regarding inter-professional collaboration. This report will express the necessity to involve all obstetric and neonatal staff, ensuring competency and continuous professional development.

1. The report has identified mechanisms suggested for the introduction of obstetric drills in such a way that they are viewed by the potential participants as a non-threatening mechanism that is highlighting good areas of practice and areas for improvement.
2. The process will stand jointly with a programme of targeted education to address areas of weakness.
3. The process of drills and their feedback will be monitored and refinements made.
4. This system of risk management will feed into the process areas of concern suitable for drill evaluation.

2. Rationale for Choice of Topic

Maternity care has been identified as an area for improvement (Department of Health 2000 *An Organisation with a Memory*). This topic of drills was chosen because there are clear calls for its use by a number of bodies (these

include CEMACH, 1999, the Royal College of Obstetricians and Gynaecologists' " *Towards Safer Childbirth* " document and CNST) and it well illustrates the importance of multidisciplinary team working. These drills are a requirement of CNST level 2 which confers a 20% reduction in insurance premiums on trusts. Drills have been of proven benefit in improving performance in eclampsia simulations (Thompson, 2004). It is likely that drills in other areas of obstetrics will also lead to improved performance (Thompson, 2004). The midwifery statutory body, the Midwifery Committee of the Nursing and Midwifery Council, and formerly the UKCC are concerned with the regular updating of skills requiring at least five days of training every three years.

Humanistic approach

The very nature of improving patient care for its own sake should be sufficient impetus to create an environment receptive to this change.

The proposal is;

The introduction of mandatory skills and drills sessions for obstetric emergencies:

WHY:

To involve all staff and ensure competency and continuous professional development. To identify staff who need more training e. g. study days.

WHO:

Midwives and other clinical staff, to encourage professional development and capability to deal with emergency situations.

WHAT:

- Shoulder dystocia
- Antepartum and post partum haemorrhage
- Eclampsia
- Undiagnosed breech presentation
- Neonatal and Maternal resuscitation
- Placental abruption

CNST actually recommends the following drills annually;

- Cord Prolapse
- Vaginal Breech delivery
- Shoulder Dystocia
- Antepartum Haemorrhage / Severe postpartum Haemorrhage

HOW:

- Monthly skills and drills
- Change skill monthly
- Each drill twice a year
- Each midwife to attend a minimum of one of each skill per year

3. Critical Discussion

Background:

The drills will be a part of evidence-based training through practical skills, on emergency situations occurring in the antepartum, intrapartum and

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postpartum period to prevent maternal and neonatal mortality and morbidity (CEMACH). The latest report of the Confidential Enquiry into Maternal Deaths states that “ *emergency drills for maternal resuscitation should be regularly practised in clinical areas in all maternity units .*” The Clinical Negligence Scheme for Trusts (CEMACH) has Maternity Clinical Risk Management Standards. CNST (level 2, April, 2005) Criterion 5. 2. 1 states;

“ There is a system in place to ensure that all relevant staff participate in an annual skills drill .”

The CNST documentation advises that;

“ Collaborative, multidisciplinary practice sessions or “ drills”, for dealing with emergency situations, allow for all members of staff, especially new and junior staff, to know and understand their specific roles and responsibilities in an emergency. ”

The CNST also states;

“ Critical incident analysis is an effective educational and management tool, and its use should be incorporated into the philosophy and daily management of Labour Wards .”

For CNST satisfaction in this criterion there must be verification records of all those who attend each drill. The drills should be linked to a training programme. There should be at least 75% attendance and ideally 100% attendance.

Critical incidents in obstetrics are uncommon. Whilst the risk management already in place may highlight weaknesses in provision of care and remedial measures may subsequently be taken such as further training it is advantageous to simulate these uncommon but acutely life-threatening situations in order to feed the results into the risk management process.

Inter-Professional Team:

It is especially important that the drills involve the multidisciplinary team.

The following members will be regularly involved;

- Midwives
- Maternity assistants
- Obstetricians of all grades
- Anaesthetists
- Operating department assistants
- Porters
- Neonatal paediatricians and nurses
- Students

It is important that all the people involved in an actual emergency are considered when setting up a drill. In some scenarios the haematology team may be involved following consultation beforehand. The more realistic the drill the more valuable it will prove.

Strategy

The proposal consists of a number of aspects (Roberts, 1998) such as assembling a project team, planning the drills, implementation, evaluation,

modification then further implementation of the drills, further evaluation and so on.

With regard to strategy introducing drills does not fit so well into there being an agreed process in advance with the likely participants in the drill. This will make the drill less realistic and, especially if the subject matter is known in advance, it will enable participants to prepare. A fine balance will be sought between gaining the support of the individuals affected via effective interpersonal skills and leadership to enable an atmosphere of trust. This approach is of proven benefit (Kassean, 2005). This will involve informing the clinicians that drills will take place and the reasons why and that they should enable improvement in practice and team working with emphasis on this being in a non-threatening manner.

During initial drills the performance will depend on the abilities, clinical and team working of all the clinicians attending and will also depend on the drill itself. There are two things to evaluate; staff performance and the drill itself. The drill can be modified. The weak areas in the performance of staff can be evaluated and training issues made good. On repetition of the drills subsequent staff performance will reflect and can be used as a measure of the success or otherwise of the implementation of the drills. Discussion:

It will be important to pay particular attention to discussion and accurate planning of the drills. Meetings will be set up involving management and including the Professional Development Officer, Risk Management Officer, Head of Midwifery and Clinical Liaison Officer. Although it is proposed to cover the above lists the needs and timing and degree of repetition of

specific drills will be determined by incident reports. The risk management process will feed into the drill planning. The teaching elements will be modified in timing, content and repetition according to specific performance in the drills. Individual training can then be addressed where needed and appropriate and more general sessions also provided with the relevant attendance facilitated. The objective, which will be made transparent, is to maximise the combined motivation and effort of all those likely to be involved in the change.

Resources needed:

There are some resource implications although these are fairly minimal compared to the likely gains. Staff time is involved in setting up the drills. Rooms need to be available. However clinical rooms will be used for instance (but not confined to) the delivery suite when it is quiet. Standard equipment will be used and this will incur costs. It may be necessary to purchase models or these may already be available on the unit. Some handouts may be necessary and documentation will need to be kept of attendance registers and the progress and evaluation of the drills.

Management of change

There are many change theories. Particularly illustrative of the inertia to change is a major component of Lewin's (1951) theory of change. Here people are "frozen" in a particular manner of doing things. There are many reasons for this rigid position. Whilst some of the reasons relate to external factors the crucial resistance to change is at the level of the individual. In order for the individual to change, their way of thinking about the factor

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needs to be addressed. Too much pressure however can make an individual more resistant to change (Broome, 1998). Too many stressors will decrease the level of performance (Broome, 1998). An example of a successful change implementation emphasised the importance of communication at this stage in the change process (Kassean, 2005). Once the individual accepts the reasons for the change rather than just that change is necessary they can make the change, then further freezing in the new position effects the change.

Ethical and legal considerations

Midwives must be accountable for the actions and they have a duty of care to be up to date with their training. There are fitness to practice issues inherent here. Dimond (2006) describes the outcomes of some recent legal cases concerning interdisciplinary communication and management of obstetric emergencies. Evidence of team working and adherence to appropriate guidelines will help in the defence of such problems.

The process of drills and further training and repeat drills will help to create a learning culture (Garcarz, 2003). Burke (2003) compares their own study of the effectiveness and the subsequent changes in practice following drills to large awards where delivery was less timely than in their drills.

Evaluation

Feedback will be obtained in a variety of formats including questionnaires and in reflective practice interviews. This will enable qualitative data to be obtained and analysed. Quantitative data will be obtained and statistically

analysed. This evidence will be used to evaluate just how effective the drills and the associated training are in improving clinical practice and team working in the simulation environment. Informal feedback will be acquired from discussion in team meetings of those involved in the drills as trainers and trainees. Such feedback will be helpful in assessing problems not identified elsewhere and will also be illustrative of the real barriers to change and how these might be addressed.

4. Conclusion

The introduction of obstetric drills is mandatory for CNST level 2 and is also recommended practice from a number of other bodies. There is evidence in the literature that such drills can be introduced in a manner which is accepted by participants and which is effective in the subsequent improvement of performance criteria.

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