SCENARIO

Task Prioritisation

LEARNING OBJECTIVES

Labour Ward Task Prioritisation
Antenatal Booking Triage

Effective task delegation
Recognises staff skill sets
Clinical Prioritisation

EQUIPMENT LIST

Labour ward board supplied
Triage Vignettes

PERSONNEL	FACULTY
MINIMUM: 1	MINIMUM: 1

TIME REQUIRMENTS
TOTAL 30mins

Set up:	5 mins	Simulation:	15mins
Pre Brief:	5 mins	Debrief:	10mins

RCOG CURRICULUM MAPPING

Module 10 Manage Labour Ward
Prioritise labour ward problems, evaluate clinical risk, coordinate and run labour ward

INFORMATION TO CANDIDATE

TASK 1:

You are the ST5 on delivery suit.
Decide on the priorities for managing each patient and delegate tasks as appropriate (see Labour ward Board)

The staff that are available today are as follows:

An O&G ST1, in post for 6 months
A third year anaesthetic registrar (ST3)
The on call consultant has been asked to deal with a problem on Intensive Care Unit.
Six midwives.
SW is in charge.
SW, CK & MC can suture episiotomies;
DB, SW & PL can insert IV lines.
VM is newly qualified.
Community Midwife CMW is available to come in from the community for low risk

TASK 2:
Your consultant is away you have been asked to triage the referrals to the antenatal clinic. For each of the attached clinical scenarios select the most appropriate pattern of antenatal care.

A	Consultant led care with 4 weekly scans from 24 weeks gestation
B	Consultant led care with 2 weekly scans from 16 weeks gestation
C	Consultant led care in a tertiary unit
D	General Practitioner Care
E	Shared care between consultant obstetrician and consultant physician
F	Shared care between consultant and perinatal mental health team
G	Shared care between consultant and general practitioner
H	Shared care between midwife and consultant visits at 12 weeks and term
I	Shared care between midwife and consultant visits at 20 weeks and term
J	Shared care between midwife and perinatal mental health team
K	Midwifery led care throughout

TRIAGE REFERALS

1. Mrs Singh: She is 28 years old and is currently 10 weeks gestation in her third pregnancy. The first was a normal delivery and the second was an elective caesarean section for breech. She would like to discuss vaginal delivery.

2. Mrs Habon: She is in her first pregnancy and was seen last week in the early pregnancy unit with a threatened miscarriage. She had a scan that confirmed a viable monochorionic, diamniotic twin pregnancy of 10 weeks gestation.

3. Mrs Green: 32 years. Third Pregnancy. Both her children were born by normal vaginal delivery but after each pregnancy she suffered postnatal depression. She is no longer taking antidepressants and although a little anxious is coping well.

4. Mrs Dougle: This is her third pregnancy, her two children were born normally but this is a new relationship. She is a smoker and has a body mass index of 28.

INFORMATION TO FACILITATOR

TASK 1

Room 1
Review MEWS chart, urine and drain output, pain relief, blood loss, general condition post op. Check FBC. **Routine.** **ST1 & Anaesthetist**

Room 2
Assess progress. Why not delivered (3rd baby)? Check progress/ presentation & position / contractions. **Semi-urgent** **Senior midwife or ST5**

Room 3
Assess situation, fetus may be in vagina. May need manual delivery or further misoprostol, if cervix closed. If delivery imminent, starve / IVI
Semi-urgent **ST5**

Room 4
Grand multip (IV, G&S, check Hb) may be quick 2nd stage / active management 3rd stage **Routine** **Midwife**

Room 5
Needs assessment & diagnosis ?UTI (temperature/WCC/CRP dipstick/MSU result?). Needs speculum +/- fibronectin test, might need transfer to tertiary neonatal unit. Should consider Rx antibiotics.
Routine **ST1**

Room 6
IV, sliding scale, assessment, depend on whether ARM or prostaglandin induction
Routine **ST5**

Room 7
Slow progress. Needs ARM & fluids, check ketones. Check presentation, position, VE, will need syntocinon **Semi-urgent** **ST5**

Room 8
Needs suturing **Routine** **Midwife**

Room 9
Assessment, may require CS urgently or possibly VBAC if so check presentation
Semi-urgent **ST5**

Room 10
Needs IV, FBC/cross match/clotting studies. Fetal condition worrying. Likely abruption or praevia, discuss examination including VE if no praevia on scan, may need emergency CS, assess CTG
Top priority **ST5**

TASK 2:

Case 1.H Case 2.B Case 3.I Case 4. K

SCENARIO DEBRIEF

TOPICS TO DISCUSS

Need to understand the role of each team member in order to appropriately delegate

Understand competence level of ST5 to call for help appropriately

Structure of midwifery led and neonatal care

REFERENCES

NICE Guideline: *Antenatal and postnatal Mental Health, clinical management and service guidance* December 2014 CG192

NICE Guideline: *Antenatal care for uncomplicated Pregnancies,* March 2008 CG62

LABOUR WARD BOARD

RM	NAME	P	GEST	LIQUOR	EPID	SYNT	COMMENT	MW
1	MARSHALL	0	38	-	YES	YES	LSCS for Breech yesterday afternoon, taken back to theatre for bleeding at 2am. Angle over sewn and drain sited. Blood loss 2500mls	SW
2	FORD	2	41	Clear.	NO	NO	Spontaneous labour 6cm at 3am.	COM MW
3	OLDHAM	0	20	Membr Intact	NO	NO	Misoprostol TOP for Edwards Syndrome Stopped contracting at . R/V for oxytocin	CK
4	SCOTT	5	40	Clear	NO	NO	Contracting – Spontaneous labour 7cm at 8am? urge to push.	MC
5	GRANT	0	26	Membr Intact	NO	NO	Tightening, loin pain, abdominal discomfort CTG normal. Booked for ultrasound scan	CK
6	CHOPRA	1	40	-	NO	NO	Diabetic – insulin dependant For I.O.L.	MC
7	MURRAY	0	38	-	NO	NO	Contracting. 4cm at 0400h Repeat VE at 0700h still 4cm	VM
8	STOTT	0	39	-	-	-	Delivered at 6am Awaiting suturing	PL
9	BRYAN	3+1	41	-	NO	NO	For elective CS. Now contracting	VM
10	HUGHES	1	38	Blood Stained	NO	NO	APH, Contracting 2 in 10 & complaining of pain between contractions Early decelerations on CTG.	DB