Worcestershire Acute Hospitals NHS Trust

SBAR Handover in the antenatal, intrapartum and postnatal periods

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guideline is for use by the following staff groups:

Lead Clinician(s)

Fiona Ross	Consultant Obstetrician
Carol Rayers & Vicky Taylor	Digital Midwives
Daisy Bradley	Audit & Guidelines Midwife

Approved by *Maternity Governance Meeting* on:

Review Date:
This is the most current document and should be used until a revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
Nov 2023	Guideline Review and incorporation of RCOG escalation Toolkit.	

Details of Pathway
An effective working relationship between the multidisciplinary team and a clear organisational structure for midwives and medical staff with explicit and transparent lines of communication is crucial to ensure optimum care for women. There needs to be a structured handover at shift changes, and when individual women are being transferred between departments/healthcare professionals.

There also needs to be a standard clinical escalation process in order to minimise delay when raising clinical concerns. As part of 'Saving Babies Lives: Learning & Support', the RCOG have developed a Toolkit designed to flatten the hierarchy, create a supportive working environment and optimise clinical escalation.

Shift Handover
Daily, at 8am on Labour Ward, there should be a team handover (commonly referred to as the morning 'SBAR') which utilises a combination of the RCOG Toolkits and the SBAR format, in order for all the team to be informed of the current clinical situation on the unit. There should be representation from the following groups of healthcare professionals at the 8am handover: obstetric, anaesthetic, midwifery (delivery suite co-ordinator, '223' bleep holder, antenatal ward and postnatal ward), neonatal and obstetric theatre team.

As per the RCOG's Toolkit, at the beginning of every morning 'SBAR meeting' there should be an introduction of the 'Team of the Shift' (See appendix 1) – similar to a theatre team briefing, this is an opportunity for all staff members to introduce themselves and become familiar with who they are working with. The aim of this is to flatten the hierarchy and improve confidence when clinical escalation is required.

Every evening at 8pm, there should be a team handover, which includes the obstetric teams (both day and night), night gynaecology registrar, midwife-in-charge for the maternity unit and the anaesthetic registrar on call. Again, the team should introduce themselves at the beginning of the handover (Team of the Shift). The SBAR tool should be utilised when discussing patients/clinical care.

All obstetric on call staff should be wearing the appropriate 'red badge' with their role on, to allow all staff and patients to know the role of the person they are working with.

Individual Handover
When handing over individual patients between staff members, a beside handover should take place. An SBAR **MUST** be completed on badgernet for **every woman**, at **every handover** and/or **transfer**.

SBAR Tool:

S: **Situation**: Current clinical situation

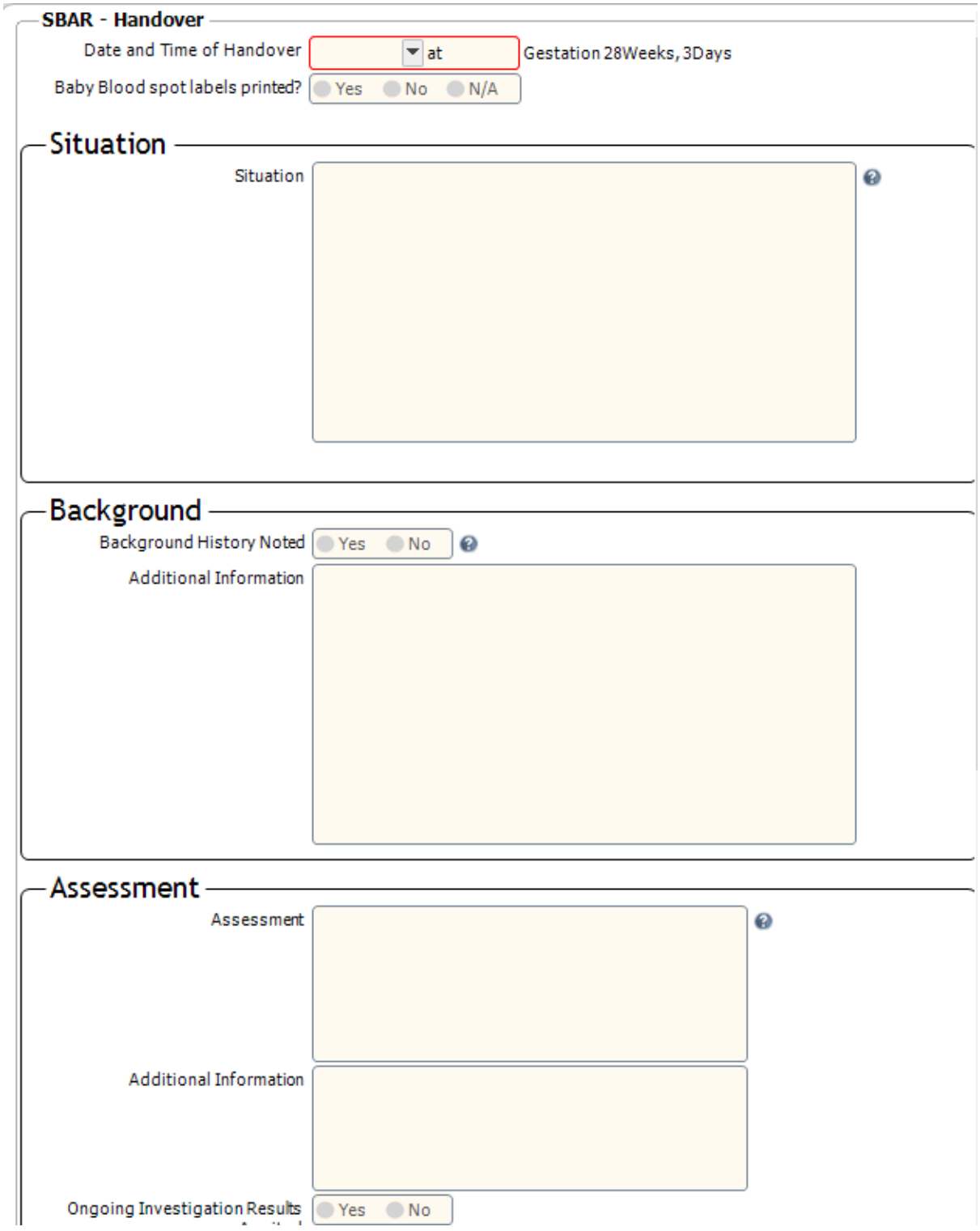
B: **Background**: Name and designation of members of staff involved in care. Risk factors

A: **Assessment**: (Recent observations of vital signs/examination findings/CTG review)

R: **Recommendation:** Management care plan

NOTE: Modified early warning obstetric charts (MEOWS) is used in all obstetric inpatient settings, this is available on the 'observation' note on badgernet.

Screenshot of SBAR:



This should be updated at each handover – removing any previous information that is no longer relevant to the clinical situation i.e. labour care information in the postnatal period.

When handing over care to another professional:

It should be documented at every handover of care that it was based on SBAR. By documenting SBAR handover of care the staff involved take responsibility that the care has been handed over and received in the manner described above.

During medical ward rounds SBAR note should be completed to provide assurance that a full and accurate review of the history, clinical picture, risk assessment and management plan has taken place. All antenatal, intrapartum, and postnatal care should be documented on Badgernet.

Escalation of Clinical Concerns

Whenever the staff caring for a patient has a clinical concern about their patient, this should be escalated appropriately. This can be to the midwife-in-charge or a member of the medical team (obstetric/anaesthetic/neonatal).

As per the RCOG Clinical Escalation Toolkits, the person escalating should initiate the conversation with the use of '**AID**' (see below and Appendix 2). This ensures the person being escalated to understands what is required from them at the beginning of the conversation. It should be used by all clinical staff when escalating (for example, when ringing the consultant on call).

A: **Advice** (I am contacting you for advice….)

I: **Inform** (I am contacting you to let you know….)

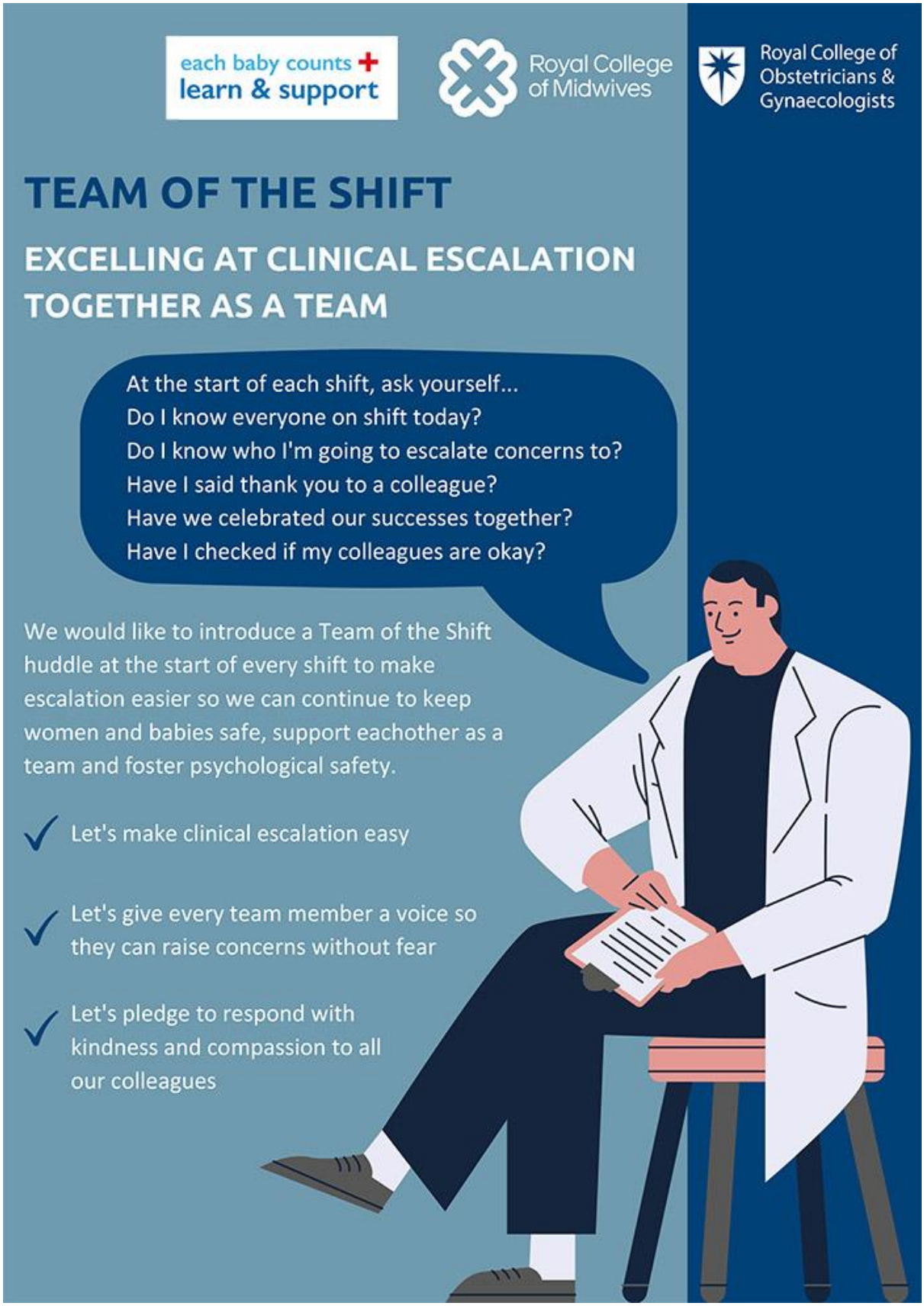
D: **Do** (I need you to do….)

Following the opening explanation of what is required from the person being escalated to, the SBAR tool should then be used to handover the clinical situation.

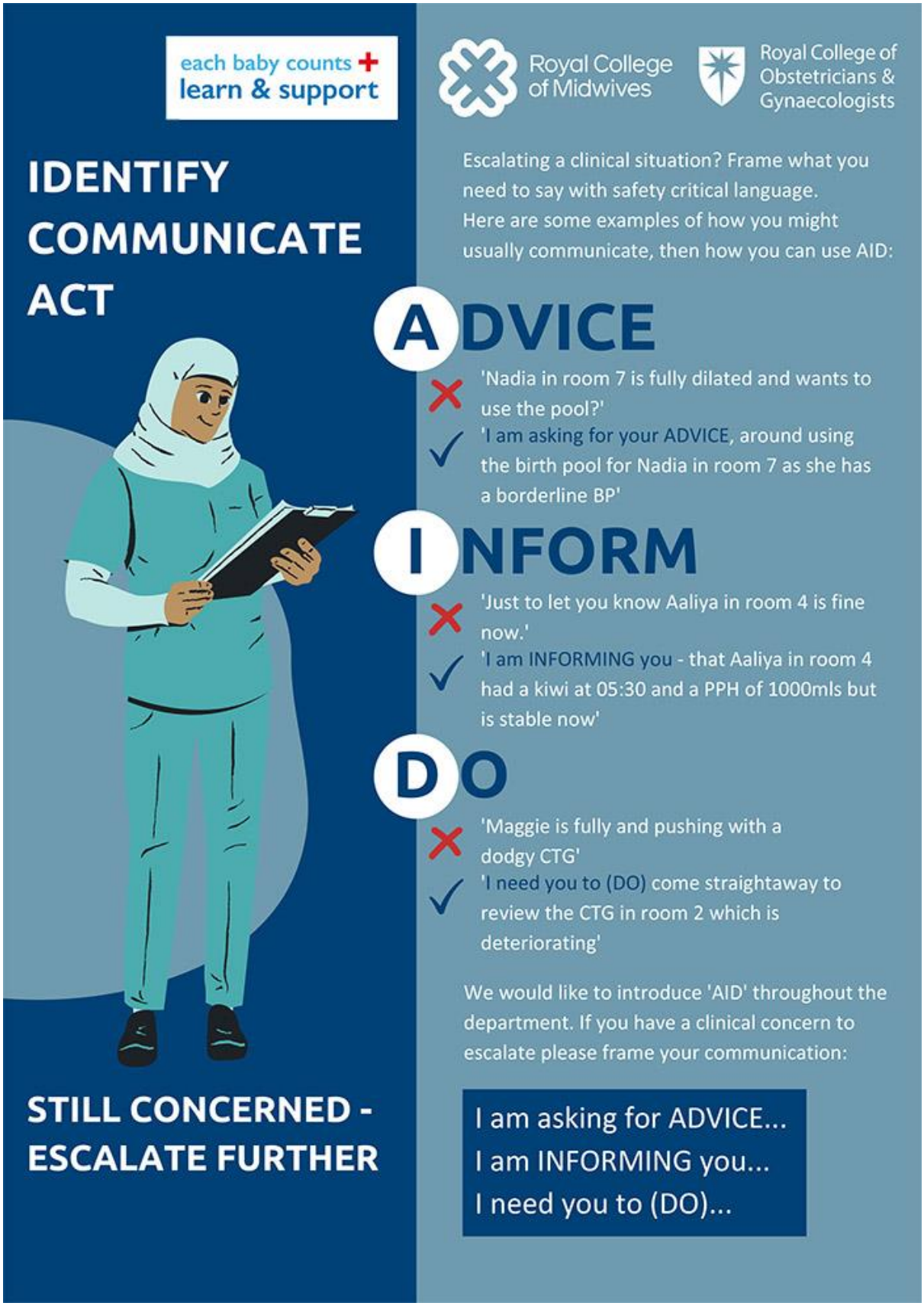
When reviewing a patient clinically, staff should use the RCOG Toolkit '**Teach or Treat**' (see appendix 3). The aim of this is to ensure that staff and patients are aware of why no action is required (Teach) or intervention is needed (Treat). This should be used whenever performing a 'Fresh Eyes' review, or when a clinical concern has been raised.

Clinical staff should perform their clinical review face-to-face unless not possible (for example, patients who have been seen in other hospitals, or when there is a more urgent clinical need elsewhere) to ensure that both the staff and the patient understand what decisions have been made, along with ensuring the whole clinical picture has been taken into consideration.

Appendix 1



Appendix 2


each baby counts
learn & support
Royal College of Midwives
Royal College of Obstetricians & Gynaecologists
IDENTIFY
COMMUNICATE
ACT
Escalating a clinical situation? Frame what you need to say with safety critical language.
Here are some examples of how you might usually communicate, then how you can use AID:
ADVICE
'Nadia in room 7 is fully dilated and wants to use the pool?'
'I am asking for your ADVICE, around using the birth pool for Nadia in room 7 as she has a borderline BP'
INFORM
'Just to let you know Aaliya in room 4 is fine now.'
'I am INFORMING you - that Aaliya in room 4 had a kiwi at 05:30 and a PPH of 1000mls but is stable now'
DO
'Maggie is fully and pushing with a dodgy CTG'
'I need you to (DO) come straightaway to review the CTG in room 2 which is deteriorating'
We would like to introduce 'AID' throughout the department. If you have a clinical concern to escalate please frame your communication:
I am asking for ADVICE...
I am INFORMING you...
I need you to (DO)...
STILL CONCERNED -
ESCALATE FURTHER

Appendix 3


each baby counts + learn & support
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TEACH OR TREAT
IDENTIFY COMMUNICATE ACT
As a department, we are promoting learning conversations. If clinical concerns are escalated to you, please use TEACH or TREAT to frame your response.
TEACH
Reassuringly explain to colleagues and women why you think there is no need for clinical concern and action to be taken.
TREAT
Take action, provide the appropriate response in the appropriate time frame.
STILL CONCERNED? ESCALATE FURTHER
You as a clinician are worried that a mother or baby are deteriorating and have escalated. Your colleague does not seem concerned. What do you do?
Have you ever felt uncomfortable and still worried with another clinician's decision in response to an escalation?
What do you do?
A) Worry about the baby, but feel unable to do anything?
B) Wait until your colleague comes back despite still being worried about the baby?
C) Ask your colleague to explain to the woman and you why they think the CTG is OK and make a plan together taking into account the woman's birth preferences?
Have you considered the impact on others of how you respond to clinical escalations?
What do you do?
A) Say everything is ok, sign the CTG and leave the room?
B) Say everything is ok for now and you will come back to review after 30mins?
C) Explain to your colleague and woman why you think the CTG is OK and make a plan together taking into account the woman's birth preferences?

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	SBAR Handover completed correctly on Badger	Local Audit	Quarterly	Digital Midwives	Maternity Governance	Quarterly

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
All Maternity Staff – Newsletter and Guidelines Forum

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Maternity Quality Governance Meeting Maternity Guidelines Forum Meeting