How and When to call the Maternity Anaesthetic Consultant at University Wishaw Hospital

TARGET AUDIENCE	Secondary care, anaesthetists, obstetricians, midwives
PATIENT GROUP	Pregnant and birthing patients

Clinical Guidelines Summary

This guideline covers the methods of contacting consultant assistance in hours and out of hours. It provides a non-exhaustive list of when we should or could be contacted.

If in doubt we prefer to be contacted about problems that you may require our help with.

First port of call for clinical issues is the resident maternity anaesthetist on DECT 5757

Guideline Body

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1. Department Consultants and roles within maternity

Name	Role
Dr Gordon Peters	Clinical director
Dr Miriam Stephens	Clinical Lead Anaesthesia (deputy Clinical Director)
Dr Hamish McKay	Guidelines, ROTEM (Rotational Thromboelastometry)
Dr Yuvaraj Kummur	Training Lead, College Supervisor, Prompt
Dr Khaled Razouk	Audit and risk management
Dr Adam Livingston	Quality Improvement lead, risk management
Dr Ogechi Lubeigt	High Dependency Unit lead, ward watcher lead
Dr Maceij Dalidowski	Antental clinic lead
Dr Linzi Millar	Non Maternity trainee rota
Dr Sarah Smith	Consultant Rota
Dr Iain McKevitt	Risk management, trainee rota
Dr Barry Crockett	Risk management, guidelines, Initial Assessment of Competency in Obstetric Anaesthetia (IACOA), Clinical Lead Obstetric Anaesthesia
Dr Graeme Finnie	Initial Assessment of Competency in Obstetric Anaesthetia (IACOA)
Dr Colum Slorach	
Dr Gizzy Matthews	
Dr Clare Carson	

2. When and how to contact the consultant on call

University Hospital Wishaw is a busy maternity unit with many complex patients. Throughout the period of a shift it may be necessary to contact the consultant on call for;

1 - Advice regarding a complex or challenging case

2 - Unit acuity may be such that you have not been able to achieve a safe level of rest, there are too many cases at once (opening a second theatre) or multiple requests at once that could not be achieved within a reasonable of safe time frame (such as analgesia requests with back to back theatre cases booked)

3 - Anything you feel is out-with your skill or experience to handle.

4 – Needing additional support in theatre due to difficulty of case – including obstetric haemorrhage or airway complications

Your first port of call is the consultant on call for the labour ward from 8:15 to 17:00hrs. After this it is the consultant on call for maternity after 17:00hrs until 08:15. Both are designated by “MAT” next to their name on the consultant rota by Suzanne Lees. It would be anticipated that you would contact them via their mobile phone or switchboard if off-site, and via the maternity DECT 5758 when on site.

If for some reason you cannot get hold of the consultant on call, it would be advisable to contact the CEPOD consultant on call or the Intensive Care Unit (ICU) consultant on call and they can assist. It would be anticipated that all consultants are available for contact while on call and within 30 minutes of the site, thus being unable to contact the consultant oncall would be a rare event and likely something the other consultant (CEPOD/ICU) would wish to be aware of.

If the consultant on call is at home they will be within 30 minutes so if you are likely to need their help then you will need to account for this. For any assistance within the maternity unit the maternity consultant oncall is your first port of call. In extremis/extremely urgent situations you could call on anyone who is on site including the ICU trainee (while waiting for the maternity consultant to attend) - for instance, a difficult airway or massive haemorrhage that is beyond your skill to manage without help.

A non exhaustive list of when to contact the consultant on call for advice or assistance depending on your experience would be:

- Severe sepsis in a pregnant patient
- Viral Pneumonitis in a pregnant patient with O2 requirement or Respiratory Rate (RR) > 25
- Body Mass Index (BMI) > 45 going to theatre
- Major obstetric haemorrhage with on going bleeding at 1500ml.
- Patients admitted to the unit with anticipated difficult airway
- Any patient requiring transfer to Acute Critical Care Unit (ACCU)
- Medicolegally challenging cases
- Patients who will not achieve labour analgesia within 1hr from request
- Any critical incident that occurs due or in conjunction with anaesthesia
- Where there is an interprofessional difference of opinion with a senior member of staff from another speciality - Obstetric, Midwifery, Surgery etc.
- Unit acuity beyond your capacity to safely cope
- Unable to site neuraxial block for labour or theatre

- Triplets
- Very Pre term deliveries < 32weeks
- Any patient that you think may have a vertebral canal haematoma
- Patients with complex anaesthetic history (Malignant hyper pyrexia etc)
- Any other incidence that you feel is justified

We are a very supportive department, however if you encounter a problem and wish to discuss it after it has been resolved then contact Dr Crockett as Obstetric Anaeshtetic (OA) clinical lead or Dr Stephens as Anaesthesia Clinical lead/Deputy Clinical Director.

Appendices

1. Governance information for Guidance document

Lead Author(s):	Dr H McKay, Dr B Crockett
Endorsing Body:	Anaesthetic guideline group
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Responsible Person (if different from lead author)	

CONSULTATION AND DISTRIBUTION RECORD	
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CHANGE RECORD

Date	Lead Author	Change	Version No.
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			2
			3
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