



Staffing of Obstetric Theatres – *A Consensus Statement*

May 2009

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In recent years, there has been an increase in the proportion of births by caesarean section and this puts additional pressure on hospital maternity services. Maternity Matters (DH, 2007) and Towards Better Births (Healthcare Commission, 2008) highlight the importance of adequate levels of appropriate staff to support women and provide choice throughout their maternity care. We believe that members of the perioperative team can make an important contribution to the care of those women where the delivery of their baby is assisted by caesarean section.

We commend this document to both providers and commissioners of maternity services, and anticipate that it will provide a framework for local action.



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– A Consensus Statement

Introduction

The United Kingdom national average for caesarean section, as a percentage of all deliveries, has increased over the past 10 years from approximately 18% to approximately 24% in 2006/07 (England). Safe staffing levels of obstetric theatres is an essential factor in ensuring the safety of mothers and the new born.

Background

A reported shortage of midwives (who in recent years have provided instrument/scrub assistance during obstetric cases), combined with the reduction in junior doctors hours because of the European Working Time Directive, prompted the College of Operating Department Practitioners (formally Association of Operating Department Practitioners) to conduct a survey in 2005 among their members to assess the impact of staff shortages on obstetric theatres (Kilvington, 2005). To quantify the situation, a larger survey was repeated later that year by the Royal College of Obstetricians and Gynaecologists among clinical directors of obstetric units throughout the United Kingdom.

The two surveys produced similar results. The response rate from the clinical directors of obstetric units was over 84%. The results showed that in nearly 80% of obstetric units, caesarean sections were performed in a dedicated obstetric theatre. A midwife took the role of the instrument/scrub assistant in 56% of cases during normal working hours (8am – 5pm) and in 60% of cases out of hours (5pm – 8am). The role of the first assistant to the surgeon was assumed by a doctor or a medical student in 90% of all cases.

Both surveys identified that in only 42% of cases was on-site dedicated anaesthetic assistance available out of hours. This is of significant concern. The 7th Annual Report of the Confidential Enquiry into Stillbirths and Deaths in Infancy, identified 11 anaesthetic-related deaths due to delays in getting appropriate staff, of which four were attributed to the absence of a skilled anaesthetic assistant (CESDI, 2000).

Context

The Perioperative Care Collaborative (PCC) (2007) agreed minimum standards of theatre staffing as follows:

- Surgeon
- Anaesthetist
- Surgical assistant – either a member of the medical team or a surgical care practitioner/advanced scrub practitioner
- Instrument / scrub practitioner – must be either an operating department practitioner or registered nurse with scrub competencies
- Where the scrub role is delegated by a registered practitioner to an assistant theatre practitioner (ATP) during an elective caesarean section, the registered practitioner and the organisation (in respect of corporate and clinical governance), must be assured that the ATP is qualified to S/NVQ Level 3 in Perioperative Care Surgical Support, with additional scrub competencies (Skills for Health PCS 13-18). Furthermore, and of significance, National Occupational Standards detail that the execution of the scrub role by an ATP must occur with reference to supervision by a registered practitioner competent in the scrub role at all times
- Circulating assistance – must be provided by either an operating department practitioner, registered nurse with circulating competence or trained perioperative support worker (qualified to S/NVQ Level 2 in Perioperative Practice)
- Anaesthetic assistance – must be provided by either an operating department practitioner or registered nurse (assessed as competent in providing anaesthesia assistance). This individual is dedicated to the anaesthetist and should have no other duties within the team (AAGBI 2005)
- Recovery Practitioner – must be provided by an Operating Department Practitioner or Registered Nurse (with a suitable recognised qualification in recovery practice) (AAGBI 2005).

Consensus agreements

To ensure safe and appropriate staffing of obstetric theatres, the following agreements were reached at a consensus meeting attended by the following organisations:

- The College of Operating Department Practitioners (incorporating The Association of Operating Department Practitioners)
- The Association for Perioperative Practice
- The National Association of Assistants in Surgical Practice
- The Royal College of Anaesthetists
- The Royal College of Midwives
- The Royal College of Nursing
- The Royal College of Obstetricians and Gynaecologists
- And through collaboration and full consultation with the Royal College of Paediatrics and Child Health.

It was agreed that the PCC Standard (2007) of operating theatre staffing is required for caesarean section, as for any other intra-abdominal surgical procedure, and that an essential and important distinction needs to be made between elective and emergency cases to contain and minimise actual and potential risks.

It was further agreed that within the context of the obstetric theatre, to ensure safe, quality patient care, additional staffing requirements must be as follows:

- A midwife must be present to attend to the holistic support and care needs of the mother
- A member of the team competent in basic neonatal resuscitation, with no conflicting duties within theatre must be present, to take responsibility for the care of the baby after delivery. If a paediatrician is not present then this duty is the responsibility of the attending midwife
- Where there are concerns about the baby, a member of the paediatric team with the level of competence appropriate to the expected problems must be present. This may be a junior doctor, an advanced neonatal nurse practitioner or a consultant

- It is important that the midwife's primary responsibility in the theatre setting is to the mother and her baby. The midwife should not be expected to provide instrument/scrub assistance or act as the assistant to the obstetrician if this detracts from her primary responsibility.
- Post-anaesthetic/recovery care – must be provided by an appropriately trained healthcare practitioner. This would normally be a registered nurse or an operating department practitioner, but could include a midwife who had formally demonstrated the appropriate competencies.

Recommendations

- The existing perioperative workforce is unlikely to be able to fully compensate for situations where midwives currently provide instrument/scrub assistance, without additional investment in training, recruitment and retention. Strategic Health Authorities and Health Boards are urged to assess workforce needs in relation to local delivery/service plans, and to commission sufficient education and training for perioperative personnel to have made significant progress in replacing midwifery staff in the scrub/instrument role by 2012, where appropriate
- Trusts and Health Boards should be planning their perioperative staffing establishments to meet this deadline. It is likely that in future, the management of obstetric theatres will become the responsibility of the operating department
- The obstetric unit must have a dedicated out of hours anaesthetic assistant, who is available on site. This recommendation should be implemented as a matter of urgency
- Given the risks and potential for complications, the instrument/scrub role for all emergency caesarean sections must be assumed from the outset by an operating department practitioner or a registered nurse (competent in the scrub role). Where it is necessary for this role to be assumed by a midwife, they should have formally demonstrated competence in the role and this must not conflict with her primary responsibility to the mother and baby. Similarly, organisations must ensure that elective caesarean sections are staffed at all times to facilitate a risk-contained and competent response to any presenting emergency
- Where a general anaesthetic is administered, care during the post anaesthetic recovery phase should be provided by an appropriately experienced operating department practitioner or registered nurse, with suitable, recognised recovery qualifications. Exceptionally, this could be a midwife who had formally demonstrated the appropriate competencies.

References

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**CESDI is now the Confidential Enquiry into Maternal and Child Health (CEMACH).*

Further reading

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