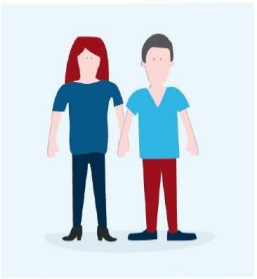
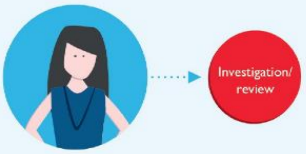
Royal College of Obstetricians & Gynaecologists

Each Baby Counts: Key Recommendations Summary

each baby COUNTS

Each Baby Counts: Key messages from 2015

Messages from the brief report from the Each Baby Counts programme released early in June 2016 as clear messages for improvement were identifiable within the interim data.

Ensure that the care of every baby eligible for Each Baby Counts gets a comprehensive and robust **review** by a **multidisciplinary team** that has **time set aside** for doing this work.	
Make parents aware that a local review is taking place and **invite them to participate** in accordance with their wishes.	
Recognise the additional perspective an **external panel member** will bring to local reviews	
Focus on finding **systemic** rather than individual-level actions and recommendations to improve future care.	
Engage with the **new standardised perinatal mortality review tool** once it is available.	

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2015 Key recommendations for reporting and reviewing

The recommendations below have been identified through detailed thematic analysis of the 2015 reviews. They address critical factors in the care of many of the Each Baby Counts babies that may have prevented their death or brain injury.

All eligible babies should be reported to Each Baby Counts within 5 working days.	
All local reviews of Each Baby Counts babies should contain sufficient information to determine the quality of the care provided.	
All trusts and health boards should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.	
All local reviews must have the involvement of an external panel member.	
All reviews of liveborn Each Baby Counts babies must involve neonatologists/neonatal nurses.	

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2015 Key recommendations for clinical care

Intermittent auscultation

Women who are apparently at low risk should have a formal fetal risk assessment on admission in labour irrespective of the place of birth to determine the most appropriate fetal monitoring method. The development of IT tools that bring together data from across a trust's systems to support accurate, easily accessible risk assessment should be prioritised.	
NICE guidance on when to switch from intermittent auscultation to continuous cardiotogography (CTG) monitoring should be followed. This requires regular reassessment of risk during labour.	

Continuous cardiotocography (CTG)

Staff tasked with CTG interpretation must have documented evidence of annual training.	
Key management decisions should not be based on CTG interpretation alone. Healthcare professionals must take into account the full picture, including the mother's history, stage and progress in labour, any antenatal risk factors and any other signs the baby may not be coping with labour.	

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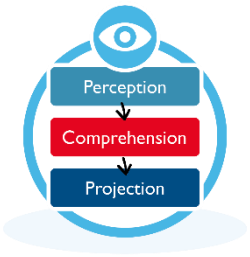
Human Factors

'Human factors' are the ways in which people interact with each other and their surroundings. One element of this is 'situational awareness', which involves understanding all the things that are happening around you and anticipating their potential consequences. Other elements are staff stress and fatigue, including how they influence decision making.

All members of the clinical team working on the delivery suite need to understand the key principles (perception, comprehension, projection) of maintaining situational awareness to ensure the safe management of complex clinical situations.	
A senior member of staff must maintain oversight of the activity on the delivery suite, especially when others are engaged in complex technical tasks. Ensuring someone takes this 'helicopter view' will prevent important details or new information from being overlooked and allow problems to be anticipated earlier.	

Stress and fatigue

Decision making is more difficult when staff feel stressed and/or tired. A different perspective improves the chances of making a safe decision. Clinical staff should be empowered to seek out advice from a colleague not involved in the situation who can give an unbiased perspective (either in person or over the phone).	
When managing a complex or unusual situation involving the transfer of care or multiple specialities, conduct a 'safety huddle' – a structured briefing for the leaders of key clinical teams. This will ensure everyone understands their roles and responsibilities and shares key clinical information relevant to patient safety.	

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Neonatal care

If therapeutic hypothermia is being considered, continuous monitoring of core temperature must be undertaken. Early efforts to passively cool the baby should also be considered (turn off the heater, take off the hat).	
The paediatric/neonatal team must be informed of pertinent risk factors for a compromised baby in a timely and consistent manner.	

Each Baby Counts: Anaesthetic care key recommendations

Reviews in which critical anaesthetic contributory factors had been identified by Each Baby Counts reviewers or which had been referred for review by an Each Baby Counts anaesthetic assessor were included in this analysis.

All reviews should involve an obstetric anaesthetist and should include review of the detailed anaesthetic record.	

Communication

Anaesthetists should always be informed of the degree of urgency of delivery. As an aid to communication, the classification of urgency of caesarean section should be used for all operative deliveries, vaginal as well as abdominal.	
A decision about the purpose of transfer to theatre and urgency of any birth should be made together with the anaesthetist before transfer to theatre. The degree of urgency should be reviewed on entering theatre prior to the WHO check, and the obstetrician should confirm the degree of urgency directly to the anaesthetist.	

Each Baby Counts: Key Recommendations Summary

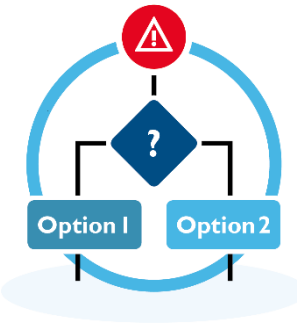
Anaesthetists should use a structured and validated anaesthetic handover tool between shifts and, if possible, participate in the routine labour ward handover/review of the delivery suite board. This will help maintain situational awareness and enable early anticipation of anaesthetic difficulties.

Regional anaesthesia

All women who receive epidural analgesia should be reviewed to ensure the effectiveness of the epidural and to minimise delays should the need for operative delivery arise. The functioning of an in-labour epidural should be taken into consideration when deciding on the most appropriate and timely means of anaesthesia for operative delivery.

Difficult intubation

The safety of the mother must be the primary concern at all times. Women should not be put at risk of airway problems through inadequate preparation/positioning due to haste to achieve rapid delivery. The required equipment for the management of difficult and failed tracheal intubation in obstetrics detailed in the OAA/DAS guidelines should always be available and all anaesthetists should undergo specific difficult airway training.



Implementation

There is a need for the development of a structured communication tool to include the three-fold elements of the delivery plan: mode of delivery, location of birth and category of urgency. This will form a key Each Baby Counts implementation output from this report, and the RCOG is committed to collaborating with the relevant organisations to produce this at the earliest opportunity.

Each Baby Counts: Key Recommendations Summary

2018 Progress Report

Key Recommendations for Clinical Care

This report presents key findings and recommendations based on the analysis of data from 2016 relating to the care given to mothers and babies throughout the UK, to ensure each baby receives the safest possible care during labour.

Guidelines

Workload The labour ward coordinator must remain supernumerary at all times and should not be caring for women during the antenatal, intrapartum or postnatal period.	
Escalating high activity There must be a clear escalation policy in place and a culture that empowers staff to escalate when the workload is becoming difficult to manage. All members of staff, irrespective of their role or grade, should feel empowered to inform senior midwives, managers and consultants when concerns arise both within their own specialty but also on behalf of another specialty. The consultant obstetrician should always be informed when labour ward activity is high.	
Cross-site communication Women receiving care from multiple units must have an individualised management plan for antenatal, labour and postnatal care that outlines the roles and responsibilities of each site to avoid any confusion. All sites should be able to readily access a woman's notes whether they be hand-held or electronic.	

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Local guidelines There must be a clear policy to ensure that local guidelines are updated in line with national guidance. Appropriate resources and staff time must be allocated to facilitate this. Where units decide to deviate from national guidance, this should be clearly documented and units should undertake regular review of local deviations from national guidance. All guidelines should be reviewed in light of incidents to ensure that they improve care as intended.	
Migration of boundaries Teams should protect against migration of boundaries by ensuring that real practice reflects practice as described in guidelines. Audit identifies where migrations from safe practice are occurring, but it is only through a process of quality improvement or changing unworkable guidelines that these migrations can be corrected.	

Recommendations for future reviews

This full analysis of the 2016 data underlines the recommendations for reviews highlighted previously. Improving the quality of local reviews will improve the lessons learned and, ultimately, improve care.

Barriers to reporting to Each Baby Counts

Neonatal input Assess your local processes for involving neonatal team members in the review of Each Baby Counts babies to see whether this needs to be improved to ensure a collaborative multidisciplinary approach. This could include identifying an Each Baby Counts neonatal lead for each unit.	

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Local reviews

All trusts and health boards should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.	
All Each Baby Counts eligible babies who are stillborn or who die within the first 7 days of life should be reviewed using the Perinatal Mortality Review Tool (PMRT).	
There is an urgent need for a PMRT-style tool that includes morbidity to be commissioned by the UK healthcare system.