Obstetrics Service at St. Mary's Hospital

Revised June 2020

Basic Information

Overview: A team of three family medicine residents, two R1s and one "floating" R3, and one first year obstetric resident provide around-the-clock coverage of the low risk patients on St. Mary's OB floors (Labor and Delivery, Family Care Suites). Residents round as a team on all low-risk postpartum patients. They take turns covering the labor and delivery floor in 12-13 -hour shifts that change at 6 am and 7 pm.

Some notes on rotation scheduling: Clinic educational afternoons, In-Training exams, DO Workshops, critical care courses, and other unique events affect the schedule in atypical ways. Katy Bixby will try to arrange the schedule so that residents can attend such events. This may mean occasionally splitting a work shift between two residents. These situations are less than ideal and will be avoided when possible.

Key People

Who will I work with at St. Marys?

1. **Nurses and staff** (unit clerks, OR techs, and other occasional administration people)

2. **Attendings:**

--*Obstetricians*

- *Dean Obstetricians:* the majority of deliveries will be supervised by this group. One of their physicians is always in house 24 hours a day. The perinatologists are also Dean physicians but do not usually participate in the regular (low-risk) call schedule for Dean OBs.
- *Other Obstetricians:* There are no other obstetricians who routinely deliver at St Mary's after 1/1/2018. However there is also a UW OB group (Drs. Bills, Williams, Henry, Mackey, Ogden, Sandgren, etc) and Melius, Cardwell, and Schurr (an independent OB group) in the area that may deliver in rare circumstances.

--*Family Physicians:*

- Our Residency Family Physicians (includes patients managed by resident-only, resident and faculty co-managed, and faculty only): You will provide back-up for your resident colleagues if they are unable to be present (for duty hours, rotation, call or personal reasons) for the admission and management of their patients.
- Dean Family Physicians
- Wildwood Family Physicians (the one independent FM group in town; includes Hook, Lentfer, Lowery, Mallory, Midelfort, etc)

3. **Anesthesiologists:** Contact is limited to discussions about epidurals.

4. **OB residents**:

- First year OB residents functions as part of our team on the service. They should manage the low risk labors in the same manner as the family medicine residents.
- Senior OB residents run the high risk OB service at St. Mary's with the Dean OBs and Perinatologists. They always have a resident in-house and change shifts at 6AM and 6 PM. They are expected to have a collegial relationship with FM residents and are usually excellent teachers. You can ask them a lot of things, but do not ask them to make management decisions on patients that are not on their service. For the obvious medical -legal reasons, they cannot make treatment decisions on somebody else's patient. If you are unsure about the safety/treatment/management of a patient, you must communicate this directly to the patient's attending and s/he must come in to evaluate the patient. The Senior OB resident becomes involved directly only if an OB consult is made by the attending or the patient develops an acute high risk condition. So, please respect their

role on the floor. Again, they are generally a smart and wonderful group of people and can be very helpful.

Who won't I work with at St. Marys?

1. Neonatology team: A neonatologist, neonatal NP/PA, and NICU nurse will attend all caesarian sections and complicated births.

2. The baby: This rotation is modeled after the traditional OB residency model. You will catch many babies but otherwise not provide much if any care for the infant. Exceptions will include deliveries where resuscitations are unanticipated or those with a family medicine doctor where this is discussed prior to delivery.

Logistics

Overview of the Typical L&D Shift:

- Shifts last 12-13 hours and change over at 6:00 AM and 7:00 PM daily.
- At change of shift, residents should be changed into scrubs and ready to get sign out at 6 AM sharp.
- The resident coming off a labor and delivery shift signs out the board of actively laboring patients to the resident coming onto labor and delivery at the change of shift (6:00 AM and 7:00 PM).
- On weekday mornings, all four residents round on the low-risk postpartum patients on Family Care Suites, starting at 6:00 AM and finishing by 8:00 AM. The resident scheduled all day on the labor floor should prioritize deliveries during this time but should help with postpartum rounds if the floor is slow.
- Until 10/2/2017 All four residents will attend the scheduled 7:30 – 11:30 AM lecture block on Friday mornings. Residents will be excused from clinic for this lecture block.
- Other required lectures for residents on OB are listed below:
    - Gary Waters lecture, 7:30 – 8:30 AM – required for R1s, scheduled for the first Monday of the block (lecture will be held on the first Tuesday of the block if there is another required lecture scheduled for that Monday).
    - Susan Davidson/Brian Stafeil lecture, 7:30 – 8:30 AM – held the first Monday of the month. Attendance at lectures is mandatory; to facilitate attendance, clinics are not to schedule patients prior to 9:00 AM on these days.
- The resident covering labor and delivery overnight is finished when postpartum rounds, sign-out and the lecture are complete. In order to avoid routine duty hours violations, the resident shall not leave the service later than 9:00 am.* The other residents will be scheduled in clinic or occasionally as back-up on the labor and delivery floor. Residents on backup (LD2) for the morning are expected to remain on the floor until 12 noon to help with morning procedures (residents may scrub in for all scheduled caesarians if no OB resident is available), inductions, deliveries and triage.
- The weekend team (Saturday and Sunday) consists only of residents covering labor and delivery either overnight or daytime. The resident covering labor and delivery overnight is done when sign-out and postpartum rounds are complete. Postpartum rounds should begin as soon as sign-out is complete or may even start earlier (no earlier than 5 am) to facilitate the overnight resident getting out on time. Depending on the acuity of the L&D floor, it is possible that the resident covering labor and delivery overnight may need to complete most or all of the postpartum rounds independently.

*ACGME clinical and educational work hour requirements and residency standards dictate that residents may not be scheduled to see clinic patients following an overnight inpatient shift. Work hour requirements recognize and support the collective responsibility of residents and faculty for the safety and welfare of patients. It is the responsibility of each resident, therefore, to proofread carefully her/his clinic and

inpatient schedules early and often to make sure that s/he is
not scheduled in clinic following an overnight shift. To protect both yourself and your clinic patients from a post-shift scheduling problem, it is imperative that you check your schedules with great care. In the event of an immediate

scheduling issue, contact your clinic manager and the family medicine faculty staffer for the day ASAP; for les s immediate scheduling problems contact the acting chief.

Shift Responsibilities Summary:

1. Evaluate and manage all low-risk obstetrical patients from presentation/admission until discharge.

2. Assess patients in triage and determine an appropriate treatment plan -- admission, further observation or discharge -- in consultation with the attending. Residents will complete progress notes, orders and communicate with patients, nurses, and attendings in a timely fashion. Residents will perform the delivery and repair and round on all postpartum patients.

3. ALL low risk patients are admitted to the "teaching service" regardless of the attending's clinic/call group. (This is true for rare admissions from the Melius, Cardwell and Schurr OB group who primarily deliver at Meriter Hospital). This includes all scheduled admissions for cervical ripening or admission for low-to moderate risk reasons like post-dates and other conditions at the discretion of the attending (like IUGR at 37 weeks, gestational hypertension, diet-controlled gestational diabetes, etc).
   Note: The rare exception where the FM resident is not involved with a low-risk patient, is usually when the patient is a member of or married into the Family Medicine Department and expresses discomfort with the association. Pregnant people in the department are encouraged to discuss their feelings early in the pregnancy with their individual attending, as most attendings expect that a resident will always be involved with a delivery.

4. Evaluate and manage all family *medicine* patients (including high risk patients) from admission until discharge or the point where OB consultation and transfer to the OB high-risk service is indicated.

5. Involvement with other high-risk obstetrical patients will be at the discretion of the OB attending.

6. Give thorough sign-out on all patients on L&D and any postpartum patients with complications requiring active management.

7. May assist in caesarian sections when coverage of the labor floor allows at the discretion of the attending.

8. Observe or participate in other obstetrical procedures when possible and at the discretion of the attending. This includes external cephalic versions, high-level obstetrical ultrasounds with perinatology, and dilation and curettage for management of spontaneous abortion or postpartum hemorrhage.

9. Attend all scheduled didactic sessions.

10. Maintain accurate notes for procedure logs and complete rotation evaluations.

11. Be courteous, attentive, collegial/respectful and efficient in your interactions with patients, nursing staff and physicians.

12. Assure there has been a change name/pager number on L&D and Family Care suites call boards at the change of shift and carry the resident phone.

13. On rare occasions, you may be contacted by an attending to follow a patient admitted to Family Care Suites for late postpartum complications. These are rare but important learning opportunities. You should follow all of these patients unless they are re-admitted for social reasons (ie: readmitting a breastfeeding mother because her infant is in the IICU or on pediatrics).

14. Stay clean. Be fastidious with sharps. Wear protective eye, shoe, and hair gear. Always. Wear scrubs at all times (if you're not in scrubs you're not working on the L&D floor). Change scrubs as needed to prevent spread of contamination through exposure to bodily fluids. Should you be exposed to bodily fluids or a needle stick and are treated in the ER, please report this incident as soon as possible to Jenny White, the Residency Education Coordinator, to file a worker's compensation report.

Triage:

The resident covering labor and delivery is responsible for evaluating all low-risk OB patients who present to triage. Most patients present for evaluation of labor, rupture of membranes, fetal well-being and other complaints like vaginal bleeding or cystitis. The resident will examine and develop an appropriate treatment plan for all triage patients in consultation with the triage nurse and attending physician. The L&D floor has a policy of contacting the attending physician within 30 minutes of the patient's arrival to triage. Ideally, the resident will complete their initial assessment in that window of time. If the resident is occupied by other duties on the floor (like a delivery), he/she will work closely with the triage nurse to delegate this initial phone call. When appropriate, the resident will coordinate the discharge of triage patients, discussing the case with the attending prior to discharge and thoroughly documenting the evaluation and treatment plan in a triage note. The resident will admit and manage the labor of all low-risk obstetrical patients. Residents will complete admission orders and a concise history and physical in a timely fashion. Residents will continue to monitor patients throughout their labor, completing exams and documenting their assessments in progress notes.

Communication with Attendings:

Residents will work with the nursing staff to ensure that attendings receive timely updates and are in house at the appropriate time (when primigravidas start to push, when multiparous patients are 6 to 8 cm, or when any patient develops a complication or for whom the general standard of care assumes that an attending should be present, such as a patient on an epidural or trial of labor after caesarian section.)

Delivery and Postpartum:

Residents will perform the delivery and immediate postpartum management (including repair of perineal lacerations and management of postpartum hemorrhage) under the direct supervision of an attending.

Following the delivery, residents will help clean up the patient. The resident will dispose of all delivery tabl
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sharps however an OB tech will clean the rest of the delivery table and perform a count of sponges with the patient's nurse.

Residents write a delivery note and write postpartum orders. A computerized nursing record will be available shortly after the delivery that will provide many of the details needed for the traditional delivery note (like time of delivery, birth weight and APGARS).

Patients will be transferred to the postpartum floor (Family Care Suites) about 2 hours after a routine delivery. Residents are responsible for daily rounding on these patients and should place a high priority on seeing patients they delivered. The resident covering labor and delivery (LD) will also take phone calls from the floor and manage postpartum complications.

High Risk:

The LD resident is also responsible for the initial assessment of high-risk pregnant patients who are under the care of a family physician. The resident will do an appropriate history and exam, and discuss his/her assessment with the patient's attending physician. The FM resident will remain involved with the patient's care as long as deemed appropriate by the patient's FM attending and any consultant obstetrician.

All scheduled admissions and procedures are recorded in a book on L&D. The LD resident is responsible for checking this schedule at the beginning of his/her morning shift and being available for all scheduled procedures (like inductions and scheduled caesarians, external cephalic versions if OB resident not available) and completing admissions for inductions/cervical ripening in a timely fashion. This work can be done in advance of the patient arrival if time allows.

Documentation:

It is worth noting that concise, accurate and timely notes and orders are a crucial part of providing obstetrical care. Guidelines for documentation including sample notes will be posted on New Innovations for you to review and download. It is essential that you document your discussions with attendings and patients accurately.

Evaluation:

During the rotation you should ask attendings you work with to complete a “card” which is available on the LD floor to facilitate evaluation. At the end of the rotation you will receive an evaluation form from the L&D Nursing Council and collated feedback from the attendings who you asked to complete cards. You will be asked to evaluate lectures and the rotation as a whole. At any point during the rotation, please contact Lee Dresang if you have feedback or want to discuss a problem with the rotation. Other members of the faculty, chief residents, and your senior residents are also good people to talk with about the rotation.

Continuity OB Patients:

Residents should arrange coverage for their continuity or personal OB patients as they would for any other inpatient rotation. Due to duty-hours restrictions and fatigue, it is usually impossible to attend your own continuity OB patient after completion of a 12-hour shift. Residents may not leave the hospital while covering labor and delivery in order to cover their own laboring patients at Meriter Hospital. The designated backup for all resident patients laboring at Meriter is the resident on the Maternal Child Service. If you are unavailable (due to work or duty hour restrictions or personal reasons), the designated back-up resident and the faculty member on OB call for the day will manage the patient. At St. Marys, the resident working on L&D is the designated backup for all resident patients laboring there and, as above, the resident on L&D at Meriter is the backup there. If you admit one of your own continuity patients to St. Mary’s during your L&D shift, you will follow her (as you would other residency clinic patients) with help and supervision of the residency faculty member on OB call.