TYGERBERG HOSPITAL
Department of Obstetrics and Gynaecology: General Specialist Services

Standard operating procedure: **Continuity of care** and **Transfer of Accountability 2025**

Introduction

- At Tygerberg O&G multiple health professionals and teams contribute to the care of a single patient within a shift system. While patients value personal continuity, it does not necessarily ensure quality of treatment. It may also legitimise the idea that there are patients for whom an individual is not responsible and this threatens organisational responsibility.
- This shift system allows for the management of large numbers of patients in different areas (that is not always under the direct care of a registrar; e.g. elective Caesarean section lists done by medical officers); better patient flow, and more agreeable working conditions.
- Any shift system have challenges with continuity of information- namely large numbers of patients under the care of a single team; a doctor may have no day-to-day contact with the patients they are responsible for in the out-of-hours period; frequency with which the team changes, frequent movement of patients between wards and departments sometimes without the doctors' knowledge and the involvement of multiple specialist teams in the management of a single patient.
- To ensure continuity of care, the most important feature of the shift system is a safe handover system (Transfer of Accountability) during which sufficient and relevant information should be exchanged to ensure patient safety; and for which very specific criteria and responsibilities have been set within the department. Each area within the service has a dedicated team looking after the patients within that area.
- Continuity of care must involve some way of assuming personal responsibility for certain subsets of patients: ICU patients, complications from surgery, patient care involving morbidity or mortality reports; death certificates and medico-legal summaries and also following on the progress of complicated patients.

Implementation of the above principles is as follows:

1. Obstetrics:
   i) The obstetric team (led by the registrar) takes full responsibility for every patient in the acute labour ward, including any cases done in the two labour ward (C2A) theatres.
      - The theatre consultant is primarily responsible for the clinical governance and surgical assistance with complicated cases in the two obstetric theatres during office hours. The further care of any complicated cases done during this time belongs to the firm on call for that day and the labour ward consultant must be informed of the case directly after surgery.
      - The labour ward consultant (on call for 24 hours) assumes overall daytime (office hours) responsibility for the triage, antenatal and delivery rooms in labour ward, and after 16h00 also for the emergency labour ward theatre for the remainder of that 24 hour call. On weekends and public holidays and during de-escalation, there is only a labour ward consultant on call (no additional theatre consultant).
      - The further care of specific surgical complications managed by the consultant on call or the theatre consultant (e.g. post-partum hysterectomy) will remain with the group (group 1-4) that was on call when the complication was first managed, for further continuity.
   ii) If an obstetric patient is discharged from labour ward/hospital but re-admitted with an acute problem directly related to the delivery (e.g. primary postpartum haemorrhage) or the medical condition in pregnancy (e.g. pulmonary edema following pre-eclampsia; eclampsia etc) she will be admitted to the labour ward or OCCU and managed further by the emergency team on duty.

2. Gynaecology
   i) The registrar on call takes responsibility for all acute gynaecology emergencies admitted and evaluated during the 24 hour call period (08h00-08h00). The consultant on call in labour ward can be approached for advice and help with emergencies or ultrasound in the admissions area during office hours.
   ii) The consultant on 24 hour call for gynaecology for that firm takes overall responsibility for gynaecology admissions and must be aware of every admission, major theatre booking or complication; and be informed

of these patients on the 16h00 gynaecology/OCCU round as well as see them on the post-intake ward round the next morning.

iii) The consultant on call for gynaecology for the night takes day-time (office hours) responsibilities for cases done in the main hospital emergency theatre. These cases will either be originating from that day's call or be personally handed over from the previous day's call (see later). The consultant on duty for labour ward theatre can be asked to assist with these cases during office hours, but the further care remains with the original admitting firm.

iv) Any gynaecology patient in the ward remains the responsibility of the firm and registrar from that firm who were first involved in managing that patient and must remain involved in the further management of the patient, especially if there are re-look laparotomies etc.

v) If an obstetric patient is discharged and re-admitted with a new problem (e.g. wound sepsis, pneumonia, breakdown of episiotomy, breast abscess, wound dehiscence, etc.) she is now the responsibility of the gynaecology registrar who admits her with the complication; as she will be admitted into a gynaecology ward and operated (if needed) on the main theatre slate. Her further care is also now rendered by the firm who admitted her with this new complication.

vi) The gynaecology registrar who admits and books an emergency patient on the main theatre list remains responsible for the surgery and post-op care of that case; with the consultant who was on call with him/her, even on a post-call day; especially if it is a complicated/critically ill patient or difficult surgery is expected.

- If for some reason any one of them cannot do the case themselves after their call, they can hand it over to the next day's team, but it must be a documented (in the notes) registrar to registrar AND/OR consultant to consultant handover.
- The **admitting team** remains responsible for the further care of the patient when they return from their post-call day. If the patient was still not operated, **they** need to expedite the surgery and either operate themselves or hand over to the team on call for that day.
- When the team that operates on the patient is not the team that admitted the patient, and they experience surgical complications, it will be in the best interest of the patient if the operating team continue with the further care, especially if another re-look procedure will become necessary. There must be a clear (documented; consultant informed) decision on whether care will be continued or whether it is handed back to the initial admitting team.

vii) All gynaecology ICU patients, day 1 post routine gynaecology surgery and complicated/ill gynaecology patients must be managed/seen by the responsible registrar and not an intern (also over weekends; the registrar can designate this task to another registrar, who accepts this responsibility in documented notes).

viii) After discharge, a gynaecology patient should be referred to primary care for follow up. If she is re-admitted with the same problem within 6 weeks, she can be handed back the next day to the team that managed her problem initially. After 6 weeks, if she is seen as an emergency with any problem; the care will remain with the new group that manages her as an emergency case on that day (except if it is clearly related to her previous surgery, e.g. bladder/bowel/ureter injury etc).

3. OCCU

A patient in OCCU/ICU that needs surgery (and who is not already linked to a registrar/consultant group according to the points above) presents a specific challenge, as the OCCU team cannot take her to theatre; and she may have been there for several days without "belonging" to a specific person/group, and the complications she was admitted for (e.g. severe pre-eclampsia)- may not be the reason why she is going to theatre (e.g. acute abdomen/wound sepsis etc).

i) For this reason, the group (firm 1-4) on call for that day when the need for surgery becomes evident (and specifically the consultant on call for OCCU/gynaecology that evening) takes responsibility and the patient should be referred to the registrar on call for that day to discuss with his/her gynaecology consultant.

ii) If it is obstetric-related surgery (e.g. Caesarean section or postpartum bleeding); and it will be done in the labour ward theatre, the theatre consultant (office hours) and/or labour ward consultant with the OCCU registrar/MO takes responsibility.

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