Scottish Parliament Region: Mid Scotland and Fife

Case 200501360: Forth Valley NHS Board

Introduction

1. On 22 August 2005 the Ombudsman received a complaint from a woman (referred to in this report as Mrs C) that Forth Valley NHS Board (the Board) failed to provide her with adequate clinical care and treatment at the Stirling Royal Infirmary (the SRI) during her admission for the birth of her third child on 4 April 2005.

2. The complaints from Mrs C which I have investigated are that:

(a) Mrs C was not given an abdominal examination on 3 or 4 April 2005;

(b) the midwives did not arrange effective pain relief at an early stage, despite requests from Mrs C;

(c) the midwives did not arrange for Mrs C to receive the intravenous antibiotics she required at an early stage, despite requests from Mrs C;

(d) Mrs C was not given the information about her daughter's condition at birth for several days and the information she was given with regard to her daughter's antibiotic treatment was conflicting;

(e) staff who met with Mrs C to discuss her complaint were not prepared to apologise and would not discuss her specific issues. There was an excessive delay in providing Mrs C with a written response.

3. Following the investigation of all aspects of this complaint I came to the following conclusion(s):

(a) upheld, see paragraphs 11 to 18;

(b) partially upheld, see paragraphs 20 to 27;

(c) upheld, see paragraphs 29 to 34;

(d) upheld, see paragraph 36 to 41;

(e) not upheld, see paragraph 43 to 49. .

4. As the investigation progressed I identified issues concerning the availability of Mrs C's previous maternity records during this unplanned care episode. I have, therefore, additionally considered and commented on this matter at paragraphs 50 and 51. The Ombudsman's recommendation is at paragraph 52.

5. In summary my investigation found that there were clinical failures in the care provided, in both record keeping and communication. In light of these findings the Ombudsman has recommended that the Board apologise to Mrs C and ensure that staff are aware of certain protocols and standards of care.

6. Specific recommendations the Ombudsman is making resulting from this investigation are that the Board should:

i) apologise to Mrs C for the failure to perform any external examination;

ii) ensure that all maternity and labour ward staff are aware of the standards of external examination expected in the maternity and labour wards from admission onwards and provide this office with evidence of such knowledge on the part of staff;

iii) audit their standard of record keeping and provide this office with the results of this audit;

iv) apologise to Mrs C for the poor communication by midwives during her labour;

v) apologise to Mrs C that there was inadequate communication with her regarding the treatment for Strep B;

vi) consider the use of this complaint narrative at a multi-disciplinary team meeting to ensure that all staff are aware of both the protocols/procedures for treatment of Strep B;

vii) apologise to Mrs C that the appropriate information was not provided to her (not simply 'if' it was not provided);

viii) consider adopting the Scottish Woman Held Maternity Record (SWHMR) and advise me of the outcome of its consideration.

7. Following review of the draft report the Board have accepted the recommendations and will act on them accordingly.

Medical Background to the Complaint

8. Mrs C was 39 weeks into her third pregnancy at the time of these events. She was known to be Group B Strep positive and had been advised during her ante-natal care that she would need to receive intravenous antibiotics in labour. She planned to give birth at the St John's Hospital at Howden. Mrs C was admitted to Falkirk Royal Infirmary on 2 April 2005 with a history of chest pains and shortness of breath. A viral infection was diagnosed and antibiotics prescribed. Mrs C was transferred to the SRI later that day. On 3 April 2005 Mrs C's contractions began and several CTG traces were recorded. Mrs C remained on the maternity ward at this time. Early in the morning of 4 April 2005 there was a shift-change of midwife. A vaginal examination of Mrs C at 04:30 on 4 April 2005 noted a possible footling breech. The registrar was called to examine Mrs C and a breech position was confirmed. It was decided to opt for a caesarean delivery and Mrs C's baby was delivered by emergency caesarean section under general anaesthetic (it had not been possible to site local spinal anaesthesia).

Background to the Complaint

9. Mrs C complained to NHS Forth Valley on 3 June 2005. A response was drafted but before this was sent a meeting was arranged with Mrs C to discuss her issues on 28 July 2005. The meeting did not resolve matters and it was agreed that a written response would be sent out with further details. The written response was sent on 12 August 2005. This concluded the stage of the NHS Complaints Procedure referred to as local resolution.

Investigation and Findings of Fact

10. The investigation of this complaint involved reading all the documentation supplied by Mrs C; Mrs C's relevant medical records and the complaint files. I met with Mrs C. I also obtained the views of a midwifery adviser. I set out my findings of fact and my conclusions for each of the five heads of Mrs C's complaint. Where

appropriate the Ombudsman's recommendations are set out at the end of the sections dealing with individual heads of complaint. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. *Mrs C* and the Board have had the opportunity to comment on a draft of this report. A glossary of medical terms used appears at Annex 2.

(a) No abdominal examination was performed on 3 or 4 April 2005.

11. Mrs C complained that she was not given an abdominal examination on admission to the SRI or at any time subsequently. Mrs C considered this prevented staff recognising earlier that her baby was in a breech position. This led to a delay in administering intravenous antibiotics and compromised the ability of the anaesthetist to site a spinal anaesthesia (because labour was so advanced).

12. During local resolution the Board commented that the midwife responsible for Mrs C on the morning of 4 April 2005 advised that it was her normal practice to palpate the patient's abdomen prior to any examinations but that she was unable to recall if this was the case here. No further comment was made about the alleged lack of examinations by any other member of staff.

13. The adviser commented that none of the medical entries from the SRI indicate an abdominal examination was performed on 3 or 4 April 2005. The breech presentation was missed by four midwives who recorded care for Mrs C from 22:00 on 2 April 2005 to 04:30 on 4 April 2005. The adviser also commented that had Mrs C been examined then the breech presentation may have been identified earlier and the situation managed in a way more acceptable to Mrs C. The adviser said that it is not considered negligent to miss a breech and a high proportion are in fact only diagnosed in labour. She did consider it sub-standard practice not to carry out an abdominal palpation on admission or when undertaking a routine vaginal examination.

14. The adviser also commented that the record keeping was poor in that multiple abbreviations were used, one entry is not timed and the transfer to the labour ward is not documented.

15. The Nursing and Midwifery Council (NMC) is the body appointed by the UK Parliament to regulate the practice of nurses and midwives. The NMC regulations on record keeping state that patient records should (amongst other things):

- *be written as soon as possible after an event has happened to provide current (up to date) information about the care and condition of the patient or client*
- *be accurately dated, timed and signed, with the signature printed alongside the first entry*
- *not include abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements*
- *be written, wherever possible, with the involvement of the patient*
- *identify problems that have arisen and the action taken to rectify them*
- *provide clear evidence of the care planned, the decisions made, the care delivered and the information shared*

(Nursing and Midwifery Council 2002 Guidelines for records and record keeping. NMC, London.)

16. Following sight of the draft of this report the Board advised me that staff now have monthly study days, part of which covers documentation and that it is mandatory for all midwives to attend these days. The Board also advised me that the supervisors of midwives are undertaking to audit a set of case notes chosen at random for each midwife and discuss these with them at their annual supervisory meeting. This audit will become part of the supervisory record sheet. The supervisory meeting will also include discussion of NMC guidelines on record keeping. The Board already undertake an informal monthly audit of case notes which will now be formalised to ensure there are appropriate learning outcomes identified and carried out. The Board have also told me that they have undertaken additional action about documentation and ensured that the issues identified in this case are discussed by both midwifery and medical staff.

(a) No abdominal examination was performed on 3 or 4 April 2005
Conclusion

17. The medical records fail to meet the required standard in a number of instances. It is not clear (because of the inadequate standard of record keeping) whether Mrs C ever received an abdominal examination or whether one was performed but never recorded.

18. The medical record does not indicate any abdominal examination was performed on Mrs C by the SRI staff. This does not accord with standard practice. I accept that abdominal examination would not necessarily have detected the

breech position but it would have increased the possibility of this happening. Mrs C was not provided with an acceptable standard of clinical care and I uphold this aspect of the complaint.

19. In light of the conclusions reached in paragraphs 17 and 18, the Ombudsman recommends that the Board apologise to Mrs C for the failure by midwifery staff to perform any external examination. The Ombudsman also recommends that the Board ensure that all maternity and labour ward staff are aware of the standards of external examination expected in the maternity and labour wards from admission onwards and provide this office with evidence of such knowledge on the part of staff. The Ombudsman further recommends that the Board audit their standard of record keeping and provide this office with the results of this audit. The Ombudsman notes and commends the actions of the Board outlined in paragraph 16 and considers these would address the issues raised in this complaint. This office will review the action plan which the Board is developing in response to this complaint.

(b) Midwives did not arrange effective pain relief at an early stage, despite requests from Mrs C.

20. Mrs C complained that she requested pain relief (and in particular an epidural) on a number of occasions but the midwife did not take any action to provide this until Mrs C's labour was too far progressed for her to be able to maintain the position necessary for insertion of an epidural. Mrs C considers that accordingly her labour was more painful than was necessary and she was denied the opportunity to be conscious for the birth of her daughter.

21. Mrs C said she did not require an epidural in either of her two previous labours but that on this occasion she felt the pain was far more intense. She also pointed out that she was labouring in an unknown hospital, without her partner present and suffering from a prolonged chest infection which had affected her overall wellbeing. She believes the midwives did not give sufficient thought to her overall condition and were not listening to her requests.

22. The midwifery adviser said that epidurals are not sited until labour is established and that strong opiates would not be administered in early labour. She further commented that CTG traces and internal examination performed at or before 01:00 on 4 April 2005 indicated that Mrs C was not in established labour at this time. It was, therefore, not appropriate to provide stronger pain relief before

this time. The adviser considered the pain relief offered to be appropriate at that stage. Mrs C was given a mild oral analgesic at 01:30 on 4 April 2005 and entenox at 02:30 on 4 April 2005, and the adviser considers both of these to be appropriate for that stage. She notes that the time of transfer to the labour ward was 04:30 on 4 April 2005 (approximately) and that this was appropriate. She further notes that Mrs C's labour progressed rather rapidly from then on.

23. The medical record indicates that Mrs C requested a transfer to the labour ward at 01:30 on 4 April 2005 and to use entenox, but was advised to give 30 minutes for the oral analgesia to take effect. The entry at 02:30 on 4 April 2005 indicates Mrs C requested an epidural 'when in established labour'.

24. There is no record of any discussion with Mrs C regarding the progress of her labour and the impact of this on her pain relief options.

25. There is no record of any discussion with Mrs C about her previous labours or possible differences on this occasion. Mrs C's medical notes from her previous births were not available to staff at the SRI.

(b) Midwives did not arrange effective pain relief at an early stage, despite requests from Mrs C

Conclusion

26. The midwife's records indicate that she was aware of Mrs C's wish for pain relief and in particular for an epidural. The difference in view appears to arise from the different views of the progress of Mrs C's labour. Mrs C considers she was in labour from the very early hours of the morning and because of her added difficulties on this occasion she required stronger pain relief than for previous births. Medical diagnosis of established labour is not an exact science and relies on a number of variable factors including length and strength of contractions and physical examination. This may not accord with the views of the expectant mother.

27. The adviser considers that an appropriate level of pain relief was given at the appropriate time. I do not, therefore, find any clinical failure in this aspect of the complaint. I am concerned that the difficulties experienced by Mrs C were caused by very poor communication between the midwife and Mrs C on the morning of 4 April 2005. Such communication should include actively listening to the views of the patient and discussion of the options available – there is no evidence of this in

the midwifery record. I partially uphold this complaint.

28. In light of the conclusions reached in paragraphs 26 and 27 the Ombudsman recommends that that the Board apologise to Mrs C for the poor communication by midwives during her labour. The Ombudsman's comments in paragraph 19 with respect to the actions already taken by the Board in paragraph 16 are relevant here.

(c) Midwives did not arrange for Mrs C to receive the intravenous antibiotics she required at an early stage, despite requests from Mrs C.

29. Mrs C previously tested positive for a Strep B infection. Because of this she was aware that it would be important for her to receive intravenous antibiotics in labour at least four hours before her baby was born. She advised staff of this on admission and the records indicate repeated requests on 3 and 4 April 2005. Mrs C was given antibiotics at 03:45 on 4 April 2005. In the event this was less than four hours before the birth. Mrs C complained that her earlier requests were ignored and this resulted in an unnecessary risk to her new-born child.

30. Mrs C told me that it was her understanding (from conversations with her consultant in the St John's Hospital) that the oral antibiotics she was receiving for her chest infection did not provide cover for her unborn baby. The midwifery notes for 3 April 2005 record that Mrs C 'will need IV in labour if more than 4 hrs since oral dose'.

31. During local resolution the Board commented that while it would be hoped that the initial dose of antibiotics would be fully administered prior to delivery, labour and its progress are not predictable and this cannot always be achieved.

32. The adviser commented that in her view the antibiotics were given at 03:45 on 4 April 2005 because of Mrs C's repeated requests and Mrs C's labour progressed very rapidly from the time of transfer to the labour ward at approximately 04:30 on 4 April 2005. She also noted that the midwifery sister who admitted Mrs C on 3 April 2005 did not make any note of Mrs C's Strep B status and the need for antibiotics in labour. This may have been recorded in Mrs C's ante-natal notes but because this was not the hospital providing Mrs C's ante-natal care these were not available at this time. The adviser regards this omission (combined with the failure to examine the abdomen referred to in complaint (a)) as sub-standard care.

33. The Board provided me with a copy of the labour protocol for Group B patients - dated January 2005. I have reviewed this and confirmed that the actions taken by staff following the initial IV dose comply with this protocol. The protocol does not make any mention of oral antibiotics as an alternative to IV antibiotics and the adviser has told me that oral antibiotics are not considered to be effective in labour. Following sight of the draft report the Board advised me that the feedback from this report will be discussed at a teaching session with junior doctors and a consultants' meeting as well as a multidisciplinary labour ward forum.

(c) Midwives did not arrange for Mrs C to receive the intravenous antibiotics she required at any *early stage, despite requests from Mrs C*

Conclusion

34. Once again the different view of when active labour commenced meant staff and Mrs C had different views of when the intravenous antibiotics should be given. The IV antibiotics as administered were given in accordance with the protocol. The evidence I have seen in the medical records suggests that not all staff understood that the protocol did not include oral antibiotics. Accordingly I uphold this aspect of the complaint. I also consider that once again there was poor communication between staff and Mrs C regarding the progress of her labour and the implications of this for treatment of Strep B.

35. The Ombudsman recommends that the Board apologise to Mrs C that there was inadequate communication with her regarding the treatment for Strep B and that the Board consider the use of this complaint narrative at a multi-disciplinary team meeting to ensure that all staff are aware of both the protocols and procedures for treatment of Strep B. The Ombudsman notes and commends the action proposed by the Board in paragraph 33.

(d) Mrs C was not given information about her daughter's condition at birth until several days later. The information she was given with regard to her daughter's antibiotic treatment was conflicting.

36. Mrs C complained that as the caesarean was performed under a general anaesthetic neither she nor her husband were able to witness the birth of their daughter. It was not until three days after the birth that she was advised by a paediatrician, during a routine check, that her daughter had been floppy at birth

with an apgar of 3/10. It was only when she raised questions about her daughter's IV antibiotic treatment as part of her complaint that Mrs C was told that her daughter was receiving intravenous antibiotics because the baby had passed meconium before birth. Prior to this Mrs C was under the impression that her daughter required IV antibiotics because Mrs C had not received full intravenous antibiotic cover for Strep B prior to the birth (see complaint (c)).

37. The adviser commented that there is no record of anyone, doctor or midwife, explaining to Mrs C about her daughter's condition at birth or the reasons for her antibiotic treatment. She noted that the reasons for the administration of the antibiotics (the presence of meconium at birth) are documented in the records.

38. An entry at 11:00 on 5 April 2005 notes that Mrs C was advised that her daughter did not require any further antibiotics as the baby had received three doses and Mrs C had one dose in labour. There is no record of any explanation about her daughter's IV antibiotics being given to Mrs C.

39. During local resolution the Board stated that all women who have a caesarean birth are reviewed on the ward round by doctors who will offer information regarding the birth. The Board apologised if this was not Mrs C's experience.

(d) Mrs C was not given information about her daughter's condition at birth until several days later. The information she was given with regard to her daughter's antibiotic treatment was conflicting

Conclusion

40. There is no written record of Mrs C receiving any information about her daughter's condition at birth or the reason for her daughter's antibiotics. It is not clear that the reason for the intravenous antibiotics was always understood by staff (see complaint (c)).

41. Explanations to parents are clearly very important in preventing the type of anxiety and concern felt by Mrs C in this case. I accept that it is the usual practice for doctors to give these explanations but cannot find evidence that this happened in this case. I would expect staff to be proactive in providing this information and not rely on the patient/parent to be sufficiently informed to know there were questions they needed to ask. I uphold this aspect of the complaint.

42. The Ombudsman recommends that the Board apologise that the appropriate

information was not provided to Mrs C (not simply 'if' it was not provided). The Ombudsman's recommendation in paragraph 35 is also relevant to this aspect of the complaint.

(e) Staff who met with Mrs C to discuss her complaint were not prepared to apologise and would not discuss her specific issues. There was an excessive delay in providing her with a written response.

43. Mrs C complained that when she met with staff to discuss her complaint they did not appear to know her medical history. Staff would not comment on the specifics of her case and often gave irrelevant general information, for example, that some women have a spinal defect which can make it difficult to site an epidural – a fact that has no bearing on Mrs C's complaint. Mrs C also complained that she was promised a written response within 4 weeks of her complaint but it was 8 weeks before she received this.

44. In response to my enquires the Board told me that the staff at the meeting were aware of Mrs C's medical history. The file note in the complaints file for this meeting is very brief and does not detail the responses given by staff.

45. The draft written response was prepared in advance of Mrs C's meeting with staff on 28 July 2005. There was a short delay after the meeting to update the response to include information requested from the meeting. The response was sent on 12 August 2005 (received on 17 August 2005). The response detailed the views of the midwife who attended Mrs C on the morning of 4 April 2005 but makes no reference to the lack of examination by other midwives. The response repeats the view that the oral antibiotics were providing relevant cover for the Strep B.

46. The NHS complaints procedure expects that all complaints should be responded to within 20 working days or, if not, that the complainant be advised of the delay and the reasons for this delay.

(e) Staff who met with Mrs C to discuss her complaint were not prepared to apologise and would not discuss her specific issues. There was an excessive delay in providing her with a written response

Conclusion

47. Meetings with staff are very often of great value in resolving complaints at a local level. Unfortunately there are occasions when such meetings are not

productive and this happened in this case. The written response did not address all the points raised by Mrs C and did not address the question raised by Mrs C regarding the efficacy of oral antibiotics in the treatment of Strep B.

48. The response time from the Board did exceed the time limits set out by the NHS complaints procedure and no written explanation for this was given to Mrs C. I am satisfied that there was good reason for the delay and that staff were in telephone contact with Mrs C.

49. On balance I do not uphold this aspect of the complaint. I acknowledge the added distress caused to complainants by unexplained delays. I would also emphasis the importance of managing a complainant's expectations of what response will be given and when, and of ensuring that all the points raised by a complainant are directly addressed.

Further Comment and Recommendation

50. In the course of investigating this complaint I have become concerned about the difficulties resulting from Mrs C's care being provided in an unplanned location. Mrs C did not have her antenatal notes with her at this admission and there was no record of any decisions that had been taken previously or advice given previously with regard to the management of her labour. I consider that the expectations of Mrs C would have been better addressed had these records been available for staff at the SRI to review and discuss with Mrs C prior to her labour.

51. NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board by the Scottish Executive in 2003, in order to act as the lead organisation in improving the quality of healthcare delivered by NHS Scotland. NHS QIS have developed the SWHMR as a standard document for use throughout Scotland. They have also produced Guidance for Maternity Professionals on the use of this document. This office has noted in a previous report (ref TS0135_03) that this document would have been beneficial in avoiding some issues of a complaint but recognised the need for it to be universally adopted by Health Boards in Scotland. I have reached a similar conclusion in this complaint.

52. NHS Forth Valley already has a system of physical and electronic women held maternity records for women who plan to have their babies at the SRI. The difficulties in this case were caused because Mrs C had not planned to have her

baby at the SRI and perfectly illustrates the need for a Scottish-wide record such as the SWHMR. The Board is currently reviewing the SWMHR and considering its implementation and will notify this office of the outcome of its considerations. The Ombudsman commends this action to other NHS Boards in Scotland who provide Maternity Services and will draw this matter to their attention.

Further Action

53. The Board have accepted all the recommendations and will provide this office with written evidence of the action taken to fulfil all recommendations.

28 March 2006

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
NMC	Nursing and Midwifery Council
SWMHR	Scottish Woman Held Maternity Record
The Board	Forth Valley NHS Board

Annex 2

Glossary of medical terms

Term	Definition
Apgar	The muscle tone, appearance, reflex, pulse and respiration of a newborn baby are reviewed at birth. A score from 0 to 2 is given for each sign at one minute and five minutes after the birth. If there are problems with the baby an additional score is given at 10 minutes. A total score of 7-10 is considered normal, while 4-7 might require some resuscitative measures, and a baby with an apgar of 3 and below requires immediate resuscitation.
Cervix	Neck of the womb.
CTG	Cardiotocography. CTG is a technical means of recording the fetal heartbeat and the uterine contractions during childbirth. CTG can be used to identify signs of fetal distress.
Entenox	A pain-relieving gas - an equal mixture of nitrous oxide and oxygen. It can be self-administered.
Epidural	A local anaesthetic sited through the spine.
Established labour	When the cervix is about 4cm dilated and there are strong regular contractions.
Footling breech	A complication of birth where the baby's foot or feet enter the birth canal before the bottom.
	Group B Streptococcus. GBS. Bacteria found in the 10-35% of all healthy adults. Normally,

Group B Strep	the presence of GBS does not cause problems but it can be harmful to new-born babies.
Intravenous (IV)	Giving medications or solutions (fluids) through a needle or tube inserted into a vein, which allows immediate access to the blood supply.
Meconium	Newborn infant's first stools.