Scottish Parliament Region: Lothian

Case 200700720: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; Maternity

Overview

The complainant (Mrs C) raised concerns about the delays in being assessed when she attended the Reproductive Health Department of the Royal Infirmary of Edinburgh (the Department) on 28 May 2005.

Specific complaints and conclusions

The complaints which have been investigated are that there was a delay by staff in:

(a) examining Mrs C on arrival at the Department (*not upheld*); and

(b) checking for Mrs C's baby's fetal heart rate *(not upheld).*

Redress and recommendations

The Ombudsman recommends that Lothian NHS Board, as a matter of urgency, develop and implement:

(i) a written triage protocol for patients who attend the Department; and

(ii) a document which records the contents of telephone conversations between patients and the Department and is retained in their clinical records.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 11 June 2007 the Ombudsman received a complaint from Mrs C about the delays in being assessed when she attended the Reproductive Health Department of the Royal Infirmary of Edinburgh (the Department) on 28 May 2005. Mrs C complained to Lothian NHS Board (the Board) but remained dissatisfied with their response and subsequently complained to the Ombudsman.

2. The complaints from Mrs C which I have investigated are that there was a delay by staff in:

(a) examining Mrs C on arrival at the Department; and

(b) checking for Mrs C's baby's fetal heart rate.

Investigation

3. In writing this report I have had access to Mrs C's clinical records and those of her baby and the complaints correspondence from the Board. I obtained advice from two of the Ombudsman's professional advisers regarding the clinical aspects of the complaint. They are a Consultant in Obstetrics and Gynaecology (Adviser 1) and a midwifery adviser (Adviser 2). I also made enquiries with Mrs C and the Board.

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. An explanation of the abbreviations used in this report is contained in Annex 1. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) There was a delay by staff in examining Mrs C on arrival at the Department and (b) there was a delay by staff in checking for Mrs C's baby's fetal heart rate

5. Mrs C complained to the Board on 22 November 2006. She said she had telephoned the Department at 10:30 on 28 May 2005 to report that she was 38 weeks pregnant and had noticed a reduction in her baby's movement during the night and again at about 10:00. (Note: Mrs C told me that she could not recall the exact time that she noticed no fetal movements but thought it could have been while she was waiting to be assessed after attending the Department). Mrs C said she was advised to make her way to hospital. She arrived at the Department at 11:55 and registered at the reception. Mrs C

waited for 45 minutes and approached the reception desk to ask how much longer she would have to wait as she was concerned about her unborn child and had been led to believe in her telephone conversation that she would be seen quickly. Mrs C said she was finally examined by a midwife at about 13:45 and the midwife was unable to find a fetal heartbeat and told her she would obtain assistance from someone more senior. Mrs C said the midwife returned with another member of staff who said she could identify a heartbeat but was concerned. Observations were carried out on a monitor and it was noted that the baby's heartbeat was dropping and that a quick delivery was required.

6. Mrs C continued that her baby was delivered at 14:02 by emergency caesarean section. Her baby was not breathing at birth and required resuscitation. Mrs C's baby was then transferred to the Special Care Unit for treatment. Mrs C said she had been informed by a doctor that her baby was unwell and had suffered injury to his brain due to hypoxic ischaemia (lack of oxygen to the brain), which had occurred during a massive foeto-maternal haemorrhage (bleeding across the interface between the foetus and the mother) in the last couple of hours before delivery. Mrs C wanted to know why it took her so long to be examined on arrival at the Department and why the fetal heart rate was not checked sooner. Mrs C added that she had no complaints about the care her baby received once the decision had been taken to deliver.

7. The Acting Director of Operations (the Director) responded to Mrs C's complaint. She explained that it was noted, after a review of Mrs C's case notes, that she had had to wait nearly two hours before being assessed for symptoms of reduced fetal movement. The Director said that to wait for that length of time was regrettable and she understood that, in the absence of any pain or vaginal bleeding, the assessment of the fetal heart rate was not something which called for immediate attention. It was recorded that Mrs C was around 37/38 weeks gestation, having had an uneventful pregnancy, but had noted a reduction in fetal movements from the previous evening. The Director explained that in the Obstetric Triage Area patients are prioritised depending on their symptoms and if the unit is busy then women who present with symptoms suggestive of an urgent problem will be seen first.

8. The Director continued that on the morning of 28 May 2005, 17 women attended the Obstetric Triage Area, 11 of whom needed to be seen by the medical staff. In addition, the Labour Suite had three urgent caesarean sections to be performed during that morning. The Director explained that such

a level of activity was unusual for a Saturday morning and would have accounted for some of the delay in patients being assessed. The Director said that, apart from Mrs C's history of reduced fetal movements since the previous day, there was nothing in her history that would have predicted the subsequent problems which occurred with her baby. The Director then addressed the issue of the fetal heart check and explained that when the first midwife listened to the fetal heart rate it was noted to be slow and she immediately asked for help from a colleague to confirm the slow heart rate. An emergency call was put out for obstetric staff and Mrs C was transferred immediately to the Labour Ward. Mrs C was then examined by a doctor, who confirmed by ultrasound scan that the fetal heart rate was very slow and an emergency caesarean section was carried out. Mrs C's baby was born in a poor condition and required intensive neonatal resuscitation. The baby was found to be anaemic and unfortunately subsequently developed changes in the brain in keeping with prolonged hypoxia (lack of oxygen).

9. In response to my enquiry, the Board provided details about what the expected level of activity would be for a normal Saturday. They explained that a typical workload would be between 25 and 30 women being seen during the day and between 18 and 25 at night. On the day in question, between 09:00 and 14:00, 11 women were seen who required medical review (see paragraph 8). The presenting conditions were reduced fetal movements; premature labour; bleeding; Deep Vein Thrombosis (DVT) review; abdominal pain; and blood pressure profile. However, information about the exact timings on arrival and length of time spent with each woman was not available. The Board said that, currently, there were no written protocols for triaging by presenting condition and that women contact obstetric triage and assessment in the first instance and the calls are prioritised according to need. They told me that since Mrs C's complaint, work has been ongoing with NHS 24 and the National Telehealth Project to develop and improve telephone triage, to help prioritise women prior to admission. The Board enclosed a copy of a Maternity Call Record which was part of a review. The Board were unable to provide me with information relating to Mrs C's telephone call to the Obstetric Triage Area as this was collected on a data collection sheet, however, the sheets for that period of time had been destroyed.

10. The Board added that the maternity service was currently under review in regard to workforce, protocols for triage and audit of time from admission to review. The Board also said that, since the complaint, all staff have been

reminded of the importance of seeing women for their initial assessment within 20 minutes of admission. It was accepted, however, that at times women would not be seen within that time. Women are now asked about fetal movements when they telephone the Unit and if no fetal movements are reported then they will be seen straight away although those with fetal movement, albeit reduced, may wait longer.

11. Adviser 1 reviewed Mrs C's clinical records and noted that it was recorded that the midwife listened for the fetal heart; noticed a fetal bradycardia (slowing of the fetal heart); rapidly informed the on-call medical team; and arranged for rapid transfer to the Labour Ward. Adviser 1 said that there was nothing else in Mrs C's history to suggest that she was at particularly high risk. Mrs C's baby was delivered at 14:03 and analysis of his blood revealed that he was hypoxic (subjected to low oxygen levels). The results of the analysis suggested to Adviser 1 that the baby had suffered a prolonged episode of reduced oxygen rather than a sudden, acute event, however, the exact timing of an episode of hypoxia cannot be assessed from the data. Adviser 1 continued that, subsequent to the detection of a fetal bradycardia, there was a commendably rapid ultrasound confirmation by medical staff moving to a rapid caesarean section.

12. Adviser 1 explained that reduced fetal movements are a very common presenting condition at maternity assessment units. The vast majority of patients with this presentation continue to have completely normal babies and the reduced fetal activity is simply due to fetal rest. He said that there is a tendency for fetal movements to naturally reduce as the pregnancy approaches term and Mrs C was 38 weeks pregnant by scan at the time of presentation to hospital.

13. Adviser 1 continued that there are occasions where reduced fetal movements are associated with underlying fetal compromise and there is an association with reduced fetal movements and foeto-maternal haemorrhage. Foeto-maternal haemorrhage can be secondary to placental abruption (large bleed behind the placenta), antererior placenta with trauma to the anterior abdominal wall or a spontaneous event without any underlying precipitating factor. Adviser 1 felt that the spontaneous event without any underlying precipitating factor applied in Mrs C's case.

14. Adviser 1 told me that in Mrs C's case the reduction in fetal movements started on 27 May 2005 (unspecified time) and, therefore, that this was in this case a true sign of fetal compromise the condition must have started prior to this. Adviser 1 said that the advice which Mrs C said a paediatrician gave her that the event occurred a few hours before delivery was, therefore, incorrect. Adviser 1 said that as Mrs C had told staff on the telephone that the movements had simply been reduced then assessment of the fetal heart would still have been important but perhaps with less urgency. Adviser 1 told me that, as it appeared the Department was busier than expected, the delay was regrettable but perhaps understandable.

15. Adviser 1 was concerned that there were no written protocols for triaging patients by presenting condition and, despite the gap of some two years since the incident, there are no protocols currently in place although it is noted that there is ongoing work between the Board, NHS 24 and the National Maternity Telehealth Project. Adviser 1 believed that it would not be unreasonable for the Ombudsman to insist that such protocols be put in place urgently.

16. Adviser 1 also commented about the lack of a written record of the telephone conversation which Mrs C made to the Department. Such information should routinely form part of the patient healthcare records and should not be destroyed, despite the Board's explanation that this was the case. Adviser 1 noted that the Board had provided me with a pro-forma for Maternity Calls Record and thought that this should be in use now as part of the patient healthcare record.

17. Adviser 2 told me that, due to the lack of recorded information, she found it difficult to form an opinion. However, as Mrs C had told staff on the telephone that, as her baby's movements were reduced, although a delay was not ideal, in the absence of pain or bleeding, it was not unreasonable given that the unit was busy. Adviser 2 said that maternity units should, as a matter of good practice, keep a record of every telephone call made by women who request advice. The record should be filed in the medical/maternity records and available should there be any discussion about what date and time the call was made and what advice was provided.

18. Adviser 2 recommended that, as a matter of urgency, the Department should develop a simple paper pro-forma Telephone Call Record, to be completed and signed by the midwife/doctor taking the telephone call for

advice. The basic documentation should include the patient's name, address, date of birth, time of call, nature of concern and advice provided. This completed form should be filed as a permanent record in the medical/midwifery records. In addition, a maternity triage protocol should be developed and in place as a matter of urgency.

(a) Conclusion

19. Mrs C arrived at hospital at 11:55 on 28 May 2005 after reporting reduced fetal movements but was not seen by a midwife until nearly two hours later, at 13:45. The Board have explained that the presenting condition of reduced fetal movements, in the absence of other symptoms such as pain or vaginal bleeding, would not warrant immediate attention. The Board have apologised for the delay in being reviewed by a midwife, which was caused in part by the department being extremely busy at that time. The advice which I have received and accept is that there were no grounds to suggest that Mrs C should have been treated immediately on arrival at hospital and that normal triage assessment should take place. Although there was a delay in being reviewed, I feel the explanations provided by the Board are reasonable and, accordingly, I do not uphold this aspect of the complaint. I do, though, share the Advisers' concerns about the lack of written triage protocols.

(a) Recommendation

20. The Ombudsman recommends that, as a matter of urgency, the Board develop and implement a written triage protocol for patients who attend the Department.

(b) Conclusion

21. Mrs C had also complained about the time taken for staff to check her baby's fetal heart rate. It has already been mentioned in this report that Mrs C's reported symptoms of reduced fetal movement, without any additional symptoms, would not have been an indication that immediate attention was required. Mrs C has confirmed that she told staff about the reduced fetal movements in her telephone call but was unable, after such a length of time, to recall when she could not feel movement. Again, in view of the advice which I have received, I do not uphold this complaint. This investigation has been somewhat restricted due to the lack of documentation. The Advisers have noted great concern that there is no record of Mrs C's telephone call to the Department. This is compounded by the fact that this type of information used to be recorded on data collection sheets but they have since been destroyed.

This information is very important and best practice dictates that, as such, it should be recorded and permanently retained in patient records.

(b) Recommendation

22. The Ombudsman recommends, as a matter of urgency, that the Board develop and implement a document which records the contents of telephone conversations between patients and the Department and is retained in their clinical records.

23. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Department	The Reproductive Health Department at the Royal Infirmary of Edinburgh
The Board	Lothian NHS Board
Adviser 1	The Ombudsman's professional medical adviser – Obstetrics and Gynaecology
Adviser 2	The Ombudsman's professional medical adviser – Midwifery
The Director	The Acting Director of Operations