Scottish Parliament Region: Glasgow

Case 200801865: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Maternity

Overview

The complainant, an advocacy worker (Ms C), complained on behalf of the aggrieved (Miss A) in relation to the care and treatment she received at Paisley Maternity Hospital, in the area of Greater Glasgow and Clyde NHS Board (the Board). Ms C conveyed Miss A's dissatisfaction with the management of her pain during the birth of her daughter on 11 December 2007. Through the course of my investigation, I also identified concerns relating to the quality of the written records of Miss A's care.

Specific complaint and conclusion

The complaint which has been investigated is that the management of Miss A's pain was unreasonable (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Board:

(i) highlight the issues raised in this report to all staff in the maternity unit, particularly anaesthetic staff, emphasising the importance of keeping clear, detailed and consistent records;

(ii) offer Miss A an early appointment to be seen in an obstetric anaesthetic clinic, in line with the Adviser's comments at paragraph 23; and

(iii) apologise to Miss A for the failings identified in this report.

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

Main Investigation Report

Introduction

1. The aggrieved (Miss A) gave birth to her daughter by emergency caesarean section at Paisley Maternity Hospital (the Hospital) on 11 December 2007. Following this, an advocacy worker (Ms C) contacted Greater Glasgow and Clyde NHS Board (the Board) to express Miss A's unhappiness with the level of pain she had experienced during the delivery. She advised that Miss A felt that the staff had not listened to her when she made them aware of the pain she was in and that they had dismissed it as being pressure that she was feeling. Ms C stated it had later been revealed that there had been a problem with the catheter which was providing Miss A's pain relief and that it had, indeed, been pain she was experiencing. She requested a full explanation as to what went wrong during the delivery. Following a meeting with the Board on 2 April 2008 and receipt of a written response dated 14 August 2008, Miss A remained dissatisfied and Ms C contacted the Ombudsman on her behalf.

2. The complaint from Ms C which I have investigated is that the management of Miss A's pain was unreasonable.

Investigation

3. In writing this report my investigator has had access to Miss A's medical records and Ms C's complaints correspondence with the Board. In addition, my investigator obtained advice from one of the Ombudsman's advisers, a consultant anaesthetist (the Adviser).

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, a glossary of terms is at Annex 2 and a list of the guidance considered is at Annex 3. Ms C, Miss A and the Board were given an opportunity to comment on a draft of this report. A summary of the Board's comment and the Adviser's response to these is contained in Annex 4.

Chronology

5. The Adviser summarised the timing of events of 11 December 2007 from the 'Progress notes: Labour and birth' record. He indicated that Miss A's epidural was inserted at 09:30 and pain relief for labour pains was subsequently

described as effective. He advised that labour proceeded with increasing concerns for foetal well-being (as reflected by cardiotocograph) and it was decided at 14:10 to trial labour for two more hours with a view to caesarean if there was no further progress or evidence of foetal distress. At 14:10 it was also documented that Miss A was suffering increasing discomfort on her right side during contractions and the anaesthetist gave a top-up of the epidural. At 14:45, a prolonged period of slow foetal heart rate led to the decision to proceed to caesarean, the 'knife to skin' was documented at 15:14 and Miss A's baby girl was delivered at 15:21. Additional notes indicated that Miss A was aware of increased pain and discomfort at 15:15 and she was noted to have been 'sore' at 15:20 and a general anaesthetic (GA) was indicated for suturing of the wound. At 15:30 it was recorded that the GA was complete and Miss A was asleep.

Complaint: The management of Miss A's pain was unreasonable

6. Ms C complained to the Board, on behalf of Miss A, on 6 March 2008. She advised that Miss A had felt 'immense' pain during the birth of her daughter. She stated that Miss A had made staff aware of this, but they had not listened to her, and they told her it was pressure she was feeling and not pain. She said that it was subsequently explained to Miss A that the catheter which was supplying her with pain relief had slipped and that it was, indeed, pain she had felt during the procedure.

7. The Board called Ms C on 27 March 2008 and arranged a meeting with her and Miss A, which took place on 3 April 2008. Ms C subsequently made several requests of the Board for a formal written response/minutes from the meeting and the Board provided their written response some four months later, on 14 August 2008, along with a sincere apology for the lengthy delay in replying.

8. In their response, the Board confirmed that the consultant anaesthetist (the Consultant) in attendance at the meeting had expressed her extreme concern at hearing of Miss A's situation and she had profusely apologised for the pain and distress that Miss A suffered during her daughter's birth.

9. The Consultant explained that it was normal for patients to feel pushing and pressure during caesarean sections, but that it was not normal for patients to feel the degree of pain that Miss A had experienced. She advised that the

cut to the uterus was made within five minutes of the procedure beginning and that it was not until this point that they had decided Miss A required a GA.

10. In response to Miss A questioning why the procedure could not have been stopped at this point to allow a top-up to the epidural or a GA, the Consultant explained that this would have been dangerous for the baby. She advised that once the uterus was opened, the oxygen supply to the baby could be at risk and that delivery was imminent.

11. The Consultant said that they had decided to anaesthetise Miss A as soon as her baby was delivered and that this had been explained to her and her partner. She explained that, as the epidural top-up given before the procedure was not providing adequate pain relief, a further top-up was not deemed appropriate as it may not have worked. She stated that, even if such a top-up had worked, it would have taken longer than a GA to provide relief. The Consultant apologised that Miss A had been so distressed she had felt that the procedure was 'never going to end' but she explained that Miss A had, in fact, been anaesthetised within seven minutes of the start of the section.

12. In response to Miss A raising her concerns that a similar problem would occur if she were to have another baby, the Consultant reassured her that her previous history would be taken into account by the attending anaesthetist and obstetrician when planning the management of future deliveries. She stated that, whilst she could not provide a guarantee that Miss A would not encounter similar problems with a future epidural or spinal anaesthetic, she could provide assurance that everything possible would be done by staff to support her through her next delivery.

13. The Ombudsman received a complaint from Ms C on 9 October 2008. She explained that Miss A was unhappy with the Board's response to her complaint and with the length of time she had to wait for their written response. She advised that Miss A felt she should have received a clearer explanation of what when wrong during the delivery of her baby. In addition, she advised that Miss A felt that, although she was told she would be given a GA after the baby had been delivered, staff had 'continued to work on her for quite a while despite her screams before she was put to sleep'. Ms C also reiterated Miss A's concerns that staff had dismissed the pain she was experiencing as pressure.

Adviser's view

14. My investigator asked the Adviser to review the records of Miss A's care and treatment. He informed me that the 'Progress notes: Labour and birth' record were legible, signed and dated and clearly documented the progress to caesarean (as outlined in paragraph 5). He advised that the 'Labour and birth summary' record was generally complete and referred to 'attached anaesthetic records for further details'. He observed that the 'Details of caesarean section birth' record was completed fully and the 'Operation notes' record was complete and detailed but not timed. Finally, he advised that the anaesthetic notes recorded the process and drug dosages but he stated that they were a poor record of specific timings.

15. In reviewing the records, the Adviser observed that Miss A appeared to have made a successful post-operative recovery and her baby appeared to be well. However, he acknowledged that Miss A had experienced excessive pain during the operation. He explained that this pain and distress had required Miss A to receive a GA in order to complete the procedure after the delivery. He stated that there was no doubt from the records from clinical attendants, and from Miss A's statement, that she became extremely uncomfortable at some point during the delivery. He advised that Miss A was given an epidural to assist labour pains and that the only record of this suggested a block up to the umbilicus on both sides. He indicated that this would have been adequate for the control of labour pains. He advised that one of the benefits of labour epidural analgesia was that the catheter could be used to initiate a surgical block should the need for caesarean delivery arise and he stated that this was a very standard practice.

16. The Adviser informed me that the emphasis in modern obstetric anaesthesia is to deliver the baby using every method available to avoid the use of GA. He advised, however, that it is sometimes not possible to obtain adequate surgical anaesthesia via a previously placed labour epidural catheter and that the cause of this failure is unknown. He indicated that there is a failure rate even in the most expert hands and he advised that studies variously quote a failure rate of two percent (while The Royal College of Anaesthetists expect a failure rate of less than three percent). He said that a failure to establish a block was, therefore, not necessarily one of poor technique, however, he advised that assessment and recognition of such a failure was essential.

17. The Adviser stated that, whilst the anaesthetic notes showed the 'epidural top up' level at T4 (see Annex 2) at 12:10, he advised that it was impossible to identify, from this record, the timing and how the level of the epidural was checked prior to skin incision. He noted that, at 15:45, the anaesthetic chart suggested that thiopentone and suxamethonium (agents used for inducing GA) were given. However, he indicated that this was at variance to the midwife note (which, as stated in paragraph 5, recorded GA as being complete at 15:30). He advised that free text on the chart explained that Miss A was very uncomfortable 'though the level was very high'. He noted that the 'Epidural Prescription' noted that infusion started at 10:00 but the only record on this chart suggested a level of T10 at 14:00.

18. The Adviser informed me that the level of T4 recorded at 12:10 would have been adequate for caesarean section, however, he said the level of T10 recorded at 14:00 would not have been adequate. He stated that there was inadequate documentation to gauge whether the epidural was effective in the relatively short period prior to surgery and he stated the block height and the efficiency of the block at the lower end (between the legs and the perineum) should have been assessed and recorded. The Adviser said that without these recordings it was impossible to verify if an adequate assessment of the extent and density of nerve block was performed. He also noted that fentanyl and lignocaine were provided but that the indications for, and timing of, this was not recorded. He suggested that this could either have been to augment the aforementioned T4 block or as an additional dose given in first response to Miss A's distress.

19. The Adviser explained that a factor associated with a failure of the epidural block was an increased requirement for supplemental local anaesthetic boluses during labour in order to provide adequate analgesia. He stated that most epidural catheters placed for labour could be used to induce a surgical block. However, he informed me that, when significantly more local anaesthetic than usual is required to maintain analgesia during labour, the epidural catheter may not be functioning properly and consideration should be given to replacing it. However, he advised that there was inadequate documentation to gauge whether the epidural was effective in the relatively short period prior to delivery.

20. The Adviser indicated that factors which are associated with pre-operative failure of regional anaesthesia included body mass index, no previous caesareans, acute foetal distress and maternal medical conditions. However,

whilst Miss A fulfilled some of these criteria, he advised that this should not have altered the anaesthetist's management and he said that none of these risk factors should dissuade an anaesthetist from continuing to use the epidural for operative delivery, as well as labour.

21. The Adviser stated that the point at which Miss A had become extremely distressed, and the relief offered with GA, were of crucial importance, however, he advised that the timing of these events was also poorly recorded. He stated that the operative note indicated that the baby was delivered before the GA was instituted, however, he noted that the records were not clear as to when Miss A's pain became intolerable. He advised that, had this been as soon as her skin was cut, then staff would have had the opportunity to immediately desist and perhaps convert to GA at that point. However, he stated that it appeared as though the discomfort developed when delivery was imminent and, if this was the case, he believed that staff took justifiable action in trying to alleviate Miss A's pain whilst the baby was delivered and preparations for GA were made. He advised that they would not have been able to interrupt the procedure to deliver the baby at that stage. However, the Adviser said that, from the records, it was impossible to definitely state the course of events.

22. The Adviser summarised that the midwife notes and obstetrician records were complete and documented the progress in labour and operative delivery. He advised, however, that the anaesthetic record was incomplete, as was the chart recording the epidural in labour, with timings being at variance with those recorded in the labour notes. He said that there were no entries which gave an assurance that the block had been adequately assessed and no record of the timing and effect of a top-up. He stated his view that it was extremely likely that the pain was not apparent until deeper dissection of the womb when delivery was imminent and he suggested that it was, therefore, reasonable to have tried treatments to alleviate Miss A's pain until GA was possible after delivery. However, he confirmed that this cannot be definitely supported because of the inadequate documentation. In addition, the Adviser noted that there was no record of an anaesthetic follow-up in visiting Miss A to explain events, apologise and provide reassurance.

23. The Adviser recommended that Miss A be seen in an obstetric anaesthetic clinic in order to be assured that epidurals remain a safe option for her should any subsequent pregnancies require an operative delivery.

24. When Ms C brought the complaint to this office, she stated that Miss A wanted an explanation of what went wrong during the birth of her daughter. Whilst the inadequacy of the record-keeping has made it difficult to definitely state the exact course of events, I hope that this report, based on the independent clinical advice I have received, has gone some way towards clarifying matters and providing Miss A with the explanation she was seeking.

Conclusion

25. Due to the inadequacy of the documentary records, the Adviser has been unable to identify the exact course of events. The timing of many significant events, such as when Miss A began to experience pain, is incomplete and there are inconsistencies in the records regarding the time the GA was administered. The earliest recorded GA time was 15:30 (midwife notes) and the 'knife to skin' was recorded at 15:14. There is, therefore, nothing in the notes to support the Consultant's view that Miss A was anaesthetised within seven minutes of the start of the procedure. The Adviser has also been unable to confirm whether or not the effectiveness of the nerve block had been adequately assessed prior to surgery. In addition, the anaesthetic staff did not follow-up and offer Miss A any explanation, reassurance or apology. In light of this, I uphold this complaint.

Recommendations

26. I recommend that the Board:

(i) highlight the issues raised in this report to all staff in the maternity unit, particularly anaesthetic staff, emphasising the importance of keeping clear, detailed and consistent records;

(ii) offer Miss A an early appointment to be seen in an obstetric anaesthetic clinic, in line with the Adviser's comments at paragraph 23; and

(iii) apologise to Miss A for the failings identified in this report.

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

28. In commenting on the proposed report, the Board provided some medical records which had not previously been made available to my investigator, or the Adviser. In light of this, my investigator asked the Adviser to review this new documentation, along with the Board's comments. Following this, my conclusions and recommendations remain unaltered, however, both the Board's

comments and the Adviser's additional remarks have been summarised in Annex 4.

Annex 1

Explanation of abbreviations used

Miss A	The aggrieved
The Hospital	Paisley Maternity Hospital
Ms C	The complainant, an advocacy worker representing the aggrieved
The Board	Greater Glasgow and Clyde NHS Board
The Adviser	One of the Ombudsman's anaesthetist advisers
GA	General anaesthetic
The Consultant	The consultant anaesthetist who met with Miss A and Ms C on 3 April 2008

Annex 2

Glossary of terms

Block (or nerve block)	The term used for the resulting effect of focussing regional anaesthesia on specific nerves
Block height (or level T4/T10)	The effects of epidural anaesthesia are noted below a specific level on the body. This is given a specific identifier dependent on the area of the body, for example, a level of T10 refers to a block up to the level of the umbilicus/navel and a level of T4 refers to a block up to nipple level
Bolus	A concentrated mass given as a single dose
Cardiotocograph	A method of recording the foetal heartbeat and uterine contractions during pregnancy
Epidural	Form of regional anaesthesia involving the injection of drugs through a catheter placed into the epidural space (situated within the spinal canal)
Fentanyl	A strong pain-killing drug (opioid)
Lignocaine	A drug used for local anaesthesia
Suxamethonium	A drug used in anaesthesia to induce short term muscle relaxation
Thiopentone	A drug used for general anaesthesia

Annex 3

List of guidance considered

Acta Anaesthesiologica Scandinavica, Volume 50, Issue 8, Pages 1014-1018

Anesth Analg 2009; 108:252-254 Shuying Lee et al

Annex 4

The Board's comments on the proposed report and the Adviser's remarks

In commenting on the proposed report, the Board advised that the anaesthetic notes contained an A3 sized double-sided chart and they attached a full copy of this chart. It appears as though my investigator was only provided with a partial copy of the chart in the first instance and the Adviser, therefore, did not have full records at his disposal.

The Board commented on the Adviser's observation that the only record of the epidural suggested a block up to the umbilicus on both sides (paragraph 15). However, from the additional documentation now provided, they advised that the inside of the chart (the Continuous Epidural Analgesia Record) recorded hourly block heights from 10:30 until 14:00 and noted the provision of a top up at 14:20. In the 'Progress notes: Labour and birth' record, it was noted that the block had risen to T8/T9 at 14:32, indicating that the top up had been effective.

My investigator provided the Adviser with the previously missing documentation and asked him to comment on this and the Board's comments. He noted that the new documents were a well completed record of the epidural infusion and blood pressure data from the time of insertion through to 13:00. He confirmed that this showed the level of block to T4 and T6, which would have kept a labouring mother comfortable, however, the block was down to T10 at 14:00, which would have been inadequate for a caesarean section. He noted that the timing of the Fentanyl top up (as referred to in paragraph 18) was now evident as 14:20 and this would have been in accordance with the inadequate block at 14:00.

The Board also noted the Adviser's observation that the anaesthetic notes showed the 'epidural top up' level at T4 at 12:10 (paragraph 17). They stated that this was incorrect and that a level to T4 was achieved at 15:10. The Adviser has reviewed this and noted that he may have misinterpreted the handwriting, as the time had been overwritten on the chart, and it could be interpreted as 15:10. However, that did not change his overall opinion.

With regards to the Adviser having noted that no anaesthetic follow-up was evident from the records, the Board provided a copy of Obstetric Anaesthetic Audit and Patient Satisfaction forms which showed that Miss A was seen the

following day. The Adviser reviewed these new documents and noted that the section on satisfaction of the epidural in caesarean section was not complete. He also noted that there were instructions on the form to complete free text to account for any complications in surgery, however, there was no record of this having been done.

Finally, as a general comment regarding the criticism of the anaesthetic record-keeping, the Board noted that this was an emergency caesarean performed for foetal bradycardia (a foetal heart rate of less than 100 beats per minute). They stated that, in a clinical emergency, the priority was to treat patients first and write notes later and any inaccuracies in the notes may have been as a result of this retrospective recording of events. They accepted that the GA record did not precisely record exact timings of events but concluded that it was a true record of Miss A's anaesthetic.

The Adviser commented that Miss A was clearly uncomfortable to the extent that GA was necessary to complete the procedure. This distress was due to the ineffectiveness of the epidural and, whilst there are reasons why epidurals are less effective in certain patients, the Adviser noted that the failure here was in assessing the intensity of a block sufficient for a pain free caesarean section. Due to the inconsistencies in the documentation, he reiterated that it had not been possible to be assured that an adequate assessment occurred and that the pain arose despite all measures having been taken before the operation to prevent distress.

In relation to recommendation (ii), the Board noted that the Consultant met with Miss A on 3 April 2008 and gave an unqualified apology and a full explanation of the anaesthetic management of her delivery. They also noted that the anaesthetic management of future deliveries was discussed with Miss A to try to reassure her as much as possible. However, they confirmed that, in line with the recommendation, they would be happy to organise a further meeting with a Consultant Obstetric Anaesthetist if this would be beneficial to Miss A.