Scottish Parliament Region: Glasgow

Case 200903956: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Maternity ward; clinical treatment

Overview

The complainants, Mr and Ms C, raised a number of concerns about the midwifery care and treatment provided to Ms C from 15 January 2009, prior to her admission to the Southern General Hospital (the Hospital) on 17 January 2009. Following admission later that day, their baby daughter (Baby C) was stillborn.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the ward based telephone assessment procedure was inadequate (*upheld*); and

(b) there was a failure to identify the changing presentation of Ms C prior to admission (*upheld*).

Redress and recommendations

The Ombudsman recommends that Greater Glasgow and Clyde NHS Board (the Board):	*Completion date*
(i) conduct an audit of the telephone triage system introduced in January 2010, to ensure its effectiveness;	18 August 2011
(ii) remind midwifery staff of the need to fully record and document all telephone contacts to ensure continuity of care when more than one telephone contact is made and more than one member of staff has been involved in handling the calls;	18 August 2011
(iii) conduct an audit to ensure appropriate midwifery staffing levels are being maintained;	18 August 2011
(iv) consider amending the Review to take into account the Adviser's comments at paragraph 24; and	18 August 2011

(v)	provide a full apology to Mr and Ms C for the failures identified in this report.	17 June 2011

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

Main Investigation Report

Introduction

1. Mr and Ms C were expecting their first child in January 2009. During the latter stages of Ms C's pregnancy, she began to experience some discomfort, abdominal pains and a vaginal discharge. On 15 January 2009, Mr and Ms C telephoned the Southern General Hospital (the Hospital)'s labour ward (the Ward). Ms C was provided with advice on managing the symptoms she was experiencing. She telephoned again later the same day indicating that she wished to attend the Ward. It was determined Ms C was not in established labour and she was sent home. Mr and Ms C subsequently contacted the Ward on 16 and 17 January 2009 by telephone and received advice. On 17 January 2009, Mr and Ms C decided to attend the Ward, at which time Ms C was admitted. Following admission, Ms C was assessed and she and Mr C were advised that their baby daughter had died. Ms C delivered her baby daughter (Baby C) later that day at 18:58, stillborn.

2. Mr and Ms C complained to Greater Glasgow and Clyde NHS Board (the Board) on 1 July 2009 about the care and treatment provided to them during Ms C's onset and establishment of labour. An investigation was carried out within the Board and subsequently an Obstetric Risk Management Review (the Review) and a Midwifery Report of Supervisory Investigation (the Investigation) were conducted which identified areas where the Board was lacking in care for Ms C and Baby C (see Annexes 5 to 9). Mr and Ms C received a response to their formal complaint on 16 October 2009.

3. Mr and Ms C remained unhappy with the response. They were particularly concerned that their deeply personal experience had been framed as a learning opportunity. Mr and Ms C acknowledged the Board's expression of regret but did not consider that they had received a formal apology.

4. Mr and Ms C brought their complaints to the Ombudsman on 9 January 2010, expressing their continued concerns about the quality of care Ms C had received prior to her admission to the Ward on 17 January 2009. Their key concern was that they had not been given appropriate advice or support when they contacted the Ward between 15 and 17 January 2009.

5. The complaints from Mr and Ms C which I have investigated are that:

(a) the ward based telephone assessment procedure was inadequate; and

(b) there was a failure to identify the changing presentation of Ms C prior to admission.

6. In conducting the investigation, my complaints reviewer reviewed all the information Mr and Ms C provided, Ms C's clinical records and the complaint file held by the Board. She interviewed both Mr and Ms C and the staff involved in Ms C's care. She also obtained advice from an independent adviser to the Ombudsman (the Adviser). I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr and Ms C and the Board were given an opportunity to comment on a draft of this report.

Investigation

Background

7. Ms C's overall pregnancy had progressed well with no complications. On 15 January 2009, Ms C began to experience abdominal pains and a vaginal discharge. It is recorded in the medical/midwifery records that at 12:40 on 15 January 2009, Ms C telephoned the Ward (phone call 1) for advice. She described cramping pains and a 'show'. Ms C was advised to bathe and take simple analgesia. It was recorded that she would call back if she had any concerns. On the same telephone enquiry sheet a further call was logged at 14:45 (phone call 2): Ms C advised that she could not sit down and she wished to come in. At 16:45 Ms C was assessed by a midwife (Midwife 1) at the Hospital. It was recorded that all observations were within normal limits and it was determined that Ms C was not in established labour. She was advised to go home but to telephone back with any further concerns. During the late morning of 16 January 2009, the pain and discomfort continued and paracetamol (mild pain relief medication) was ineffective in managing Ms C's pain. At 11:53, Ms C said she telephoned the Ward to ask if she could take co-codomol, a stronger pain relief medication. It was agreed by the staff member she spoke to that this would be fine. This call was not recorded by the Ward but was confirmed by a telephone bill (phone call 3).

8. After a short period, just over one hour, Ms C telephoned the Ward again at 13:05 (phone call 4). This call was recorded. In the box marked 'membranes' on the telephone call form it was noted 'Trickling?'. It was also recorded 'FMF [fetal movements felt] although not so much today'. It was recorded that Ms C was advised to wear a pad to establish if her membranes had actually ruptured (rupture of the amniotic sac), take a bath, and call back

after one to two hours. Mr and Ms C remained at home and managed the symptoms, as far as they felt they were able to, until they made a further telephone call to the Ward at 05:45 on 17 January 2009 (phone call 5), when the contractions were recorded as 1:5 mins with no details relating to vaginal loss or fetal movement. No advice was recorded. Following this, Mr and Ms C made a decision to go to the Hospital.

9. On arrival at the Ward at 07:00, Mr and Ms C were asked to wait in a sitting room and were joined by a midwife (Midwife 2) at 07:45 who had begun her day duty at 07:30. Her assessment included questions about Ms C's discomfort, a recent history of what had been happening and, on accompanying Ms C into a toilet, she observed the vaginal discharge on a pad Ms C had in place. Midwife 2 asked about the length of time that the discharge had been occurring. Ms C reported that this had been present since 15 January 2009. Midwife 2 thought the discharge was a meconium stained liquor (green/brown staining which suggests the fetus has had a bowel movement and may indicate distress). Midwife 2 escorted Mr and Ms C to a bed and attempted to listen for the baby's heartbeat, without success. She called for medical assistance and an ultrasound was carried out, which confirmed Mr and Ms C's baby had died.

(a) The ward based telephone assessment procedure was inadequate

10. Mr and Ms C complained to the Board about the poor service they received when they had telephoned the Ward between 15 and 17 January 2009. They felt they had not been provided with the advice and support they required.

11. As documented above, Ms C made a total of five telephone calls during the period from 12:40 on 15 January 2009 to 05:45 on 17 January 2009. Additionally, Ms C visited the Ward on 15 January 2009 at 16:40. Further to this, Mr and Ms C presented at the Ward at 07:00 on 17 January 2009.

12. During this period the telephone calls were received by midwifery staff on duty with full responsibility for both ward based patients and a responsibility to respond to any telephone contacts made into the Ward for advice, care or information from expectant mothers and their families.

13. As stated at paragraph 2, the Board's consideration of the issues raised culminated in two separate reports produced in 2009, those being:

- Obstetric Risk Management Review, report dated February 2009 (the Review).
- A Report of Supervisory Investigation, report dated December 2009 (the Investigation).

14. The purpose of the Review was to 'identify issues surrounding care or process which may require a review of practice to reduce the risk of future incidents occurring'. The purpose of the Investigation was to consider the actions of the midwifery staff that provided care to Ms C prior to her coming into the Hospital on 17 January 2009. Annexes 5 to 9 of this report summarise the conclusions and recommendations from each.

15. In the complaint response provided to Mr and Ms C by the Board on 16 October 2009, the Board confirmed that the majority of points raised by Mr and Ms C had been covered within the Review, a copy of which had previously been provided to Mr and Ms C. They explained that the Review had identified deficiencies with the assessment sheet used to record the telephone calls Ms C had made, including the fact that there was no space for the name and signature of the person who had taken the call. As a result, the Board had introduced new data sheets that demonstrated more clearly the advice given and showed the frequency of telephone calls made. The Board also confirmed that they were in the process of implementing significant changes to the way in which telephone calls were handled and information shared on the Ward. This would offer the advantage of telephone calls and subsequent management of women in early labour being dealt with by a small dedicated team of staff who work separately from those in the labour suite.

16. In response to my complaints reviewer's enquiries the Board confirmed that, since January 2010, a dedicated Maternity Assessment Unit (the Unit) had been established to take calls with a smaller group of core staff. Women were offered a review in the Unit if a third call was made within 24 hours. The revised telephone call assessment form now required midwives to confirm with the caller that the advice/plan was acceptable. They confirmed that the new service had not been formally evaluated or audited as yet. The Review highlighted the need for changes in the service provided to expectant mothers prior to coming into the Hospital. As a result, improvements had been made since January 2010 and there was now a clear separation of the responsibilities for midwives in their care and treatment of the ward based patients and the

requirements of those calling the Ward from outside. An example of the revised telephone call sheet is available at Annex 4.

Advice received

17. The Adviser reviewed the records available and has seen the Review and the Investigation reports which were undertaken. She provided an initial view and, further to this, supported my complaints reviewer during the visit to the Board to undertake a series of interviews.

18. The Adviser was critical of the arrangements which were in place at the time of Ms C's labour and she highlighted a need for the separation of telephone triage and ward based activity. She said:

> 'Labour ward is a critical care area and when Midwives have to divert their attention from caring from labouring women and answering telephone enquiries the result can be twofold: 1. The women in the labour ward may be deprived of the full and concentrated care and attention of a midwife. The midwife may not spend sufficient time assessing, advising and reassuring the women on the telephone. Although many units still do not have a separate maternity triage, where this facility is provided, it is proving to be the best way to handle telephone enquiries and admissions of labouring women.'

19. She continued that midwives are required by their statutory body to keep accurate and contemporaneous records of all clinical observations made, care and treatment given and also of advice given. The telephone call assessment forms when completed by a midwife are part of the legal records and are, therefore, subject to the same scrutiny as other clinical records. She advised there are only four records of the five telephone calls made by Ms C and only the record of telephone call 1 was anywhere near adequate. The record of the second call was merely a jotting in the right hand corner of the first record; the third call was not recorded at all. With regard to telephone call 4, Midwife 3 noted 'trickling?' but did not apparently ascertain the type or colour of the fluid. She also recorded that fetal movements were reduced and the Adviser considered that Ms C should at this stage have been referred to the Ward. The Adviser commented that the record of the fifth call was appalling.

20. It was noted by the Adviser that the telephone call assessment form at that time was not a good pro-forma for recording and that the new paperwork in this regard was fit for purpose. Nevertheless she advised that, regardless of the

pro-forma, midwives should know the salient details that needed to be recorded when speaking to a woman in labour and in her view the record-keeping of the telephone calls was poor.

21. In addition, she commented that while to some extent clinical staff handling telephone calls are 'gatekeepers', Ms C on two occasions self-referred and in practice most midwives would say to a woman who telephones for advice that if she were worried she should just 'come in'.

22. She also noted that over the period 15 January to 17 January 2009 the midwifery staffing levels were suboptimal, in that the Ward was running seven midwives per shift rather than nine. This would have negatively influenced the level of care to labouring women. She advised that midwives working in such an environment have a responsibility to report to the Board when staffing levels are not safe and the Board have a responsibility to have a system in place to effectively manage such a situation.

23. The issue of staffing levels was addressed in the Investigation report which noted concern about staffing levels. It recommended that staffing levels should meet the optimal level required to meet the required practice standards and if not this should be escalated to senior managers.

24. The Adviser considered both the Review and Investigation were appropriately conducted, robust in their examination, open and honest in their reports with recommendations and actions which will minimise the risk of a reoccurrence. However, she commented:

> 'The Risk Management Review says that ... Ms [C]'s labour, although prolonged was managed appropriately as the circumstances dictated. [Ms C] was well advanced in labour when she self referred to the Hospital therefore (given the acknowledged failures in telephone advice) it would have been more accurate to precede that statement with: once in the labour ward.'

(a) Conclusion

25. The advice I have received is that, at the time Ms C was in telephone contact with the Ward, the system in place for receiving calls was poorly managed. Importantly, in relation to Ms C's needs, her frequency of calls was not picked up as a matter of concern. Additionally, the lack of detailed recorded information, taken by the midwives who spoke to Ms C and noted on the forms

provided, presented a challenge for staff to obtain a full picture of Ms C's changing and emerging needs.

26. Ms C has advised that she remained unhappy with the two reviews carried out. The advice I have received is that both reviews were conducted appropriately; were robust in their examination; were open and honest in their recommendations; with recommendations made which should minimise the risk of a recurrence. As a consequence of Mr and Ms C's complaint there have been improvements made within the procedures for the care and treatment of expectant mothers (see paragraphs 15 and 16). These will have a positive impact on the care for expectant mothers. Nevertheless, it is clear that the telephone advice system in place at the time Ms C required to access the service was inadequate and not fit for purpose and, in addition, staffing levels were below the optimal level. I therefore uphold this complaint and make the following recommendations.

(a) Recommendations

27.	I recommend that the Board:	*Completion date*
(i)	conduct an audit of the telephone triage system introduced in January 2010, to ensure its effectiveness;	18 August 2011
(ii)	remind midwifery staff of the need to fully record and document all telephone contacts to ensure continuity of care when more than one telephone contact is made and more than one member of staff has been involved in handling calls;	18 August 2011
(iii)	conduct an audit to ensure appropriate midwifery staffing levels are being maintained; and	18 August 2011
(iv)	consider amending the Review to take account of the Adviser's comment at paragraph 24.	18 August 2011

(b) There was a failure to identify the changing presentation of Ms C prior to admission

28. Mr and Ms C complained to the Ombudsman that they were not provided with appropriate care, support and advice, as the staff conducting the telephone assessments failed to register the concerns about Ms C's labour and how it was progressing.

29. During my complaints reviewer's meeting with Mr and Ms C, they spoke about the events as they unfolded. They said they had been unsure about making contact with the Ward, as they were concerned they were being over cautious. Mr and Ms C were clear about the details they provided to the midwives on the Ward when they made their telephone calls and also when they made a first visit to the Ward on 15 January 2009 at 16:40. Their recollection of the first telephone call was that Ms C was advised to take paracetamol. They phoned again and visited the Ward later that day, when Ms C was seen by Midwife 1. She had an internal examination and was advised that she was one centimetre dilated and was in early labour. Midwife 1 had said they had a 'happy wee baby' on examination. They were asked to look for contractions five minutes apart and lasting more than one minute.

30. Mr and Ms C told my complaints reviewer that by the evening of 15 January 2009 they timed the contractions and found them to be about 12 and 13 minutes apart. By lunchtime on 16 January 2009, Ms C recalled making a telephone call to the Ward and asking about medication for the pain. She let the member of staff know her vaginal discharge was a 'green/brown substance' and running down her leg. Mr and Ms C were concerned about the advice they received and the lack of enquiry made by the midwife (Midwife 3) on the telephone on that occasion. At that moment, as Ms C recalled, she could not remember the term meconium but felt that that was what she was trying to describe to the receiving midwife (Midwife 3). She said that she was advised to lie down on a towel and to call back in two hours if the pad was saturated. In the early hours of 17 January 2009, Ms C felt a strong desire to 'push' in respect of her advancing labour and felt that this was an indication to go to the Hospital. Mr and Ms C telephoned the Ward and then made their way to the Ward and were seen at 07:45 by a receiving midwife (Midwife 2), who subsequently examined Ms C and sought a medical opinion as she could not trace a fetal heart beat.

31. Mr and Ms C advised my complaints reviewer of their recall of later discussions they had with the Board about their loss and the likely causes, but they remained of the view that their concerns were not being picked up. They felt there had been missed opportunities to see and assess Ms C on a number of occasions during Ms C's labour, which may have resulted in a different outcome. In their letter dated 1 July 2009 to the Board Mr and Ms C wrote:

> 'In our opinion we feel that the care received, in particular on Friday 16 January 2009 and Saturday 17 January 2009, prior to us coming to the

hospital of our own volition, was not to a satisfactory standard and we feel this could also have contributed to [Baby C's] death. Five calls were made in total to labour ward and we feel it is unacceptable that the history of previous calls were not taken into account. We also feel that we were constantly being dissuaded from coming into hospital. It is our view that the staff on the telephone did not listen carefully to the information [Ms C] gave them and as result did not respond appropriately. Moreover, they did not ask relevant pertinent questions that would also have helped them assess that something was wrong.'

32. The Review summarised Ms C's care during her pregnancy and the contacts she made during the period between 15 January and 17 January 2009, prior to her admission to the Ward. It identified gaps in the care provided while Ms C was in labour at home. Importantly, it identified the specific opportunities which were missed, which should have led to a review of Ms C's progressing labour on the Ward. Other issues were also identified, as set out at Annexes 5 to 9.

33. The midwives involved provided verbal statements to my complaints reviewer regarding their involvement in Ms C's care. They recorded their interventions in line with their professional midwifery supervisory requirements (Nursing and Midwifery Council Midwives rules and standards), as well as making the entries in the clinical notes. The midwives also referred to their reflective statements during their interviews with my complaints reviewer.

34. The first midwifery contact was by Midwife 3, who took a telephone call from Ms C at 12:40 on 15 January 2009. Her statement to my complaints reviewer indicated that the initial information obtained from Ms C was recorded by the clerk on the Ward and then she spoke to Ms C. Midwife 3 recalled being told about the advanced stage of pregnancy and that pains were crampy but that Ms C was unsure if they were contractions. During the interview with my complaints reviewer, Midwife 3 did not recall being told about any vaginal discharge which would suggest meconium stained liquor. She recalled Ms C mentioning fetal movement and advised Ms C to relax in a bath and take paracetamol. She advised Ms C to call back if she had any concerns. The nursing notes recorded:

'FMF [fetal movement felt] Having abdo [abdominal] crampy Advised bath & simple analgesia Will call back if any concerns'

35. The second recorded midwifery contact was carried out by Midwife 4, who recalled having taken a call from Ms C at 14:45 on 15 January 2009. She said she had encouraged Ms C to come to the Ward, as she understood she was anxious. In her statement, she recorded that Ms C came to the Ward and was found not to be in active labour. Ms C went home, with the advice to telephone or return. Midwife 1 considered that this would have been usual. Within the interview with my complaints reviewer, Midwife 4 felt she had not recorded enough on the notes on this occasion. The nursing notes recorded:

'14:45 can't sit down wishes tci [to come in]'

36. The third recorded midwifery contact was a visit to the Ward, recorded by Midwife 1, who met Mr and Ms C on 15 January 2009. Ms C arrived on the Ward at 16:40 and Midwife 1 carried out an assessment of the recent events from Ms C. Midwife 1 recalled Ms C describing an experience of a 'show' to describe some vaginal discharge that day but did not recall any mention of a green or yellow vaginal discharge at this point. She carried out routine observations which she found to be within normal limits. She said Ms C requested a vaginal examination to determine labour, which Midwife 1 carried out, and at that point there was no evidence of a vaginal discharge. She recorded the baby's heartbeat as 132 beats per minute on examination. Mr and Ms C went home with an understanding that they were to call back if they had any further concerns.

37. Mr and Ms C provided details about a telephone call made to the Ward on 16 January 2009 at 11:53, as noted on their home telephone bill. This telephone call lasted 55 seconds. Ms C did not know who she spoke to but she took advice about pain relief during this call. There was no record of this call within the clinical notes (see paragraph 7).

38. The fourth recorded midwifery contact was a telephone call recorded by Midwife 3 (who had handled Ms C's first telephone call made to the Ward). Initially Ms C spoke to the clerk and then to Midwife 3. Ms C reported regular contractions and responded to Midwife 3's questions about the baby's movement with an agreement that she had felt the baby move, although not as much as normally. Midwife 3 recalled noting that Ms C was unsure about the vaginal discharge she was having at the time and she understood Ms C to say that she was unsure if her membranes had ruptured. She was unsure if her vaginal discharge was mucoussy or watery and Midwife 3 recalled that Ms C described the vaginal discharge as 'trickling', creamy coloured fluid, not yellow

or greenish. She recorded that she asked Ms C to wear a pad, observe the loss for one to two hours and call back if it was watery. The nursing notes recorded:

> 'FMF [fetal movement felt] although not as much today. Advised to wear pad & call back in 1-2 hours.'

39. The fifth recorded midwifery contact was when Midwife 5 took a telephone call from Ms C during a night shift starting in the evening of 16 January 2010. Midwife 5 started her shift at 19:30. She stated that she had no full recollection of the call made but noted that she indicated to Ms C that she should attend the Ward. She reviewed the information she gathered. During the interview with my complaints reviewer on 27 August 2010, she said she had reflected on the entries made by her at the time and there should have been a more full report. She agreed that her record was poor. As a result of this, some additional supervision has been undertaken to assist Midwife 5 in the improvement of her recording practice. The nursing notes recorded:

> '1:5 [indicating frequency of contractions]'

40. The sixth midwifery contact was when Midwife 2 met Ms C when she came on to the Ward in the early hours of 17 January 2009. She reported that she obtained a history from Ms C and invited her to provide a sample of urine for testing. During the time in the toilet area, Midwife 2 asked to see evidence of Ms C's vaginal discharge on the pad she had in place and Midwife 2 saw what she considered to be meconium stained liquor (see paragraph 36). She asked about the duration of the discharge and proceeded to conduct an examination to ascertain the health of Baby C. She recorded that, as a result of being unable to locate a heartbeat, she asked for the assistance of the Registrar on call on the Ward. Subsequently, it was confirmed that Baby C had died.

Advice received

41. On reviewing the care offered to Ms C, the Adviser noted that Ms C was pregnant for the second time, having had a previous miscarriage; she was assessed as low risk and booked to deliver in hospital. The expected delivery date was recorded as 11 January 2009. There were no additional risk factors and a low risk care pathway was followed. Throughout Ms C's pregnancy all observations and investigations were within normal limits. The Adviser reviewed the care Ms C received from 15 January 2009 onwards and considered that, from admission to the Ward on 17 January 2009 to discharge the next day, the midwifery care was good and sensitive, taking into account the

circumstances. However she found the midwifery care from 15 January 2009 up to admission on 17 January 2009 to have been less than optimal (see paragraph 19). She noted:

> 'In my opinion it would have been appropriate at both the fourth and fifth telephone calls to invite [Ms C] to attend the labour ward for assessment. I am fairly sure that if the Midwives taking the calls had been aware of the frequency of the calls over a 2 day period they would have invited [Ms C] to attend for assessment even if it was just to put her mind at rest. In this regard I would say there was a systems failure.'

42. The Adviser continued that one can never say with certainty that if Ms C had been admitted earlier Baby C would have survived, but there was every indication that at the time of the fourth telephone call (13:05 on 16 January 2009) Baby C was moving, even though fetal movements were reduced and, therefore, alive. By the time Ms C went into the Ward she was well advanced in labour and Baby C was not alive. Had Ms C been admitted on 16 January 2009, any signs of fetal distress should have been notified, a responding attempt to deliver Baby C quickly and perhaps Baby C would have survived.

43. The Adviser concluded that where failings had arisen this had resulted in a delay and, although it cannot be said with certainty that if Ms C had been admitted earlier Baby C would have survived, the Adviser was clear that by the fourth telephone call to the Ward, Ms C was still feeling her baby move and, therefore, Baby C was most probably still alive.

(b) Conclusion

44. Both the Board's investigation and my investigation have identified considerable failings in the care provided to Ms C prior to her admission to the Ward on 17 January 2009. The advice I have received is that by the fourth telephone call made by Ms C she should have been advised to attend the Ward and at that time Baby C was still alive. The impact of those failings on Mr and Ms C cannot be underestimated. As a result of this complaint there has been a considerable review of practice undertaken to improve the service provided to women in labour. There were conflicting recollections about the information given by Ms C and the midwives. The Board have since followed an action plan and implemented a series of improvements to the telephone contact procedures for gathering and accessing of information about women in labour who are making contact with the Ward. They have introduced a dedicated triage team of

qualified midwives to take responsibility for the telephone calls made from the community into the Ward. The triage team are separated from the day to day running of the Ward and no longer have to divide their time between in-patient care and the provision care and support to those who call in or visit the Ward. These improvements were introduced in January 2010 but have yet to be subject to audit and evaluation. I look forward to receiving feedback from the evaluation that will be carried out in due course. I uphold this complaint, as Mr and Ms C were not provided with appropriate responses to the contacts they made during Ms C's labour. The recommendations made under complaint head (a) are also relevant for this head of complaint. In addition, I recommend that the Board provide a full apology to Mr and Ms C for the failures identified in this report.

(b) Recommendation

45.	I recommend that the Board:	*Completion date*
(i)	provide a full apology to Mr and Ms C for the failures identified in this report.	17 June 2011

46. 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.

Annex 1

Explanation of abbreviations used

Mr and Ms C	The complainants
The Hospital	Southern General Hospital
The Ward	Labour ward
Baby C	Mr and Ms C's daughter
The Board	NHS Greater Glasgow and Clyde
The Review	Obstetric Risk Management Review
The Investigation	Supervisory investigation
The Adviser	Independent Midwifery Adviser to the Ombudsman
Midwife 1	Midwife involved in Ms C's care
Midwife 2	Midwife involved in Ms C's care
The Unit	A dedicated Maternity Assessment Unit
Midwife 3	Midwife involved in Ms C's care
Midwife 4	Midwife involved in Ms C's care
Midwife 5	Midwife involved in Ms C's care

Annex 2

Glossary of terms

Paracetamol	An over the counter analgesia
Meconium	Early stools of an infant
Triage	A process of determining the priority of patient treatment based on the severity of their condition

Annex 3

List of legislation and policies considered

NHS Complaints Procedure

Nursing and Midwifery Council Code of Professional Conduct

Nursing and Midwifery Council Midwives Rules and Standards

Nursing and Midwifery Council Guidelines for records and record keeping (2004, superseded 2009)

Annex 4

Telephone Contact Sheet

Maternity Call Record GGC: Please complete clearly in black ink and in **BLOCK** capitals

Print Form

Version 1 17.12.09 Approved by GONEC Review 6.12

Surname: [ ]

First Name: [ ]

DOB (or age): [ ]

CHI No. or Hosp. no. if CHI n/a: [ ]

Phone No.: [ ]

Location: [ ]

Post code: [ ]

Date: [ ] Time: [ ] Call No. [ ]

Caller name if different: [ ]

Delivery Unit [ ]

Consultant/Named Midwife [ ]

Type of Call

Antenatal ☐ EDD: [ ]

Prelabour/ Intrapartum ☐ Parity: [ ]

Gestation: [ ]

Obstetric History: SVD ☐ Forceps/Ventouse ☐ CS ☐

CALL REASON (record relevent details only)

	Yes	No	
Contractions	☐	☐	Frequency 1 in [ ]
S.R.O.M	☐	☐	
Colour of liquor [ ]			
Group B Strep	☐	☐	
Fetal Movements	☐	☐	
Headache	☐	☐	
Visual disturbances	☐	☐	
Oedema	☐	☐	

	Yes	No
Bleeding:	☐	☐

Minor ☐ Mod ☐ Major ☐

Rh Pos. ☐ Rh Neg. ☐ Rh unknown ☐

	None	Mild	Mod	Severe
Anxiety/distress:	☐	☐	☐	☐
Abdominal pain (not contractions)	☐	☐	☐	☐

	Yes	No
Vag discharge	☐	☐

Colour [ ]

	Yes	NO
Urinary symptoms	☐	☐

CLINICAL SUMMARY (including PMH/problems with pregnancy/medications)

ADVICE GIVEN

[ ]

DECISION SUPPORT

Discuss with senior MW/obst ☐

Name: [ ]

Call back advice given ☐

Woman agrees with plan ☐

CALL OUTCOME

	Yes	No
Requested to attend unit	☐	☐
Ambulance required	☐	☐

Time if arranged: [ ]

Routine ☐ Urgent ☐ 999 ☐

Self care ☐ Routine appoint ☐

GP ☐ Day care ☐

EPAS ☐ Gynae REG ☐

Signature: [ ] Type Name: [ ]

Designation: [ ]

FINAL OUTCOME IF WOMAN ATTENDS

Time in [ ] Time out [ ]

Ref to: AN ward ☐ DCU ☐ L/S ☐

Routine care ☐

Annex 5

Obstetric Risk Management Review (the Review), issues identified regarding care (prior to admission on Saturday 17 January 2009)

- Documentation within the Maternity Record is at times incomplete.
- Signatures are missing from the signature identification sheet.
- Transfer of details from the Maternity record to Maternity Summary Record (hospital held document) is at times inconsistent.
- The clerical officer in labour ward completed the initial enquiry slip prior to giving the call over to the Sister to reconfirm details of the call and offer advice.
- This requires the patient to re-tell her presenting history to the midwife.
- The first telephone enquiry slip was not fully completed.
- The answer as documented in the telephone enquiry sheet around the question of status of membranes is unclear.
- The 2nd telephone call was documented on the first telephone sheet but no additional details were recorded. This made it difficult for the RM review group to ascertain whether any of the preceding documentation details had changed.
- The 2nd telephone call taken was unsigned for, although midwife has subsequently been identified.
- No documentation for the first call.
- The clerical officer in the labour ward completed the initial enquiry sheet prior to giving the call over to the Sister Midwife to reconfirm the details of the call and offer advice.
- There is contradictory evidence presented; [Ms C] has intimated she mentioned green discharge during her telephone conversation to Labour ward. None of the Midwives involved in the telephone calls detail this in their documentation or recall this on interview.
- Four calls to the Labour ward in twenty four hours.
- Onus placed on patient to confirm if membranes have ruptured and fetal movements have returned to pattern within time frame stimulated [stipulated].
- Onus on patient to report if fetal movement pattern does not return to normal within time period stipulated.
- Incomplete documentation.

Annex 6

Conclusion of the Review's areas of concern:

- The use of the National Scottish Women's Hand Held Maternity Record is still new to practice. There are still multi-disciplinary failures to document signatures in the signature recognition sheet. There are failures to document recordings within the appropriate spaces available.
- The clarity and completeness of documentation around telephone enquiry in this case is at times poor and in one episode, completely absent.
- The lack of clarity around the then telephone enquiry documentation at times failed to give a clear record of the advice given to [Ms C] by phone to help future communication episodes.
- That, on occasions the labour ward clerk first documented information from the caller on the telephone enquiry sheet, she then passed the caller onto the Midwife who then went through the same process again. This resulted in the patient requiring to give information and resulted in two different people documenting on the same telephone enquiry sheet (although the Midwives give advice). This occurred twice in this case.
- That, on the occasion of [Ms C]'s first in-patient review, routine urinalysis was not performed. It was confirmed later that [Ms C] could not provide a specimen at that time and all other observations were deemed satisfactory. This detail should have been documented within the case notes at the time.
- The current [at the time] lack of a dedicated 'maternity admissions suite', where telephone enquiries could be directed to a small team of professionals means that all calls current [at the time] are received through the main labour ward. This results in a large number of calls being received by this area by a large number of different staff.
- The conflicting information provided around telephone information received.

Annex 7

Recommendations from the Review

- Continue ongoing review of the use of the Scottish Women's Hand-Held Maternity Record allowing feedback to the national steering group.
- The current on going audit of the quality of Midwifery documentation to be accompanied by a regular audit of medical staff documentation. Staff should be appraised of results at regular intervals and any individual issues highlighted are taken forward appropriately.
- The importance of good communication and documentation is taught as part of each ongoing teaching session within the unit.
- A review of the current system of telephone enquiry within the labour ward is undertaken - this should include guidance on the management of recurrent calls from individual patients.
- Interim measures are put in place to improve the system of telephone enquiry until a full review has concluded.
- In recognition of some of the Midwifery issues identified a Supervisory review should be undertaken separately. This will include a review of the quality of Midwifery record-keeping in this case.
- All staff are reminded of the current interim measures in place to support families with fetal loss in the unit whilst recognising an integrated fetal loss suite will form part of the new Labour Ward building when it opens.
- The lessons learned from this case to be shared at the Greater Glasgow and Clyde wide Gynaecology, Obstetric, Neonatology Effectiveness Group meeting and thereafter within the bounds of confidentiality at local teaching sessions.

Annex 8

Report of Supervisory Investigation (the Investigation)'s key issues of concern:

- There was no guidance in place when to admit women to labour ward when following a series of contacts when in early labour.
- Method of taking and logging telephone calls. There is no clear pathway for taking the past history of contacts into consideration and follow up contacts with women if a plan of care is made.
- Clear verbal communication.
- Record keeping was not of the standard set out in the NMC guidelines for records and record keeping (NMC 2009, [updated from 2004]).
- Midwifery staffing levels in labour ward.

Annex 9

Recommendations from the Investigation

- Following this event as an interim measure Midwives in the labour ward were advised to routinely review on site any women who have made 3 consecutive calls to labour ward for advice. This should be reviewed further locally and a policy developed based on best available evidence to ensure clear guidance for staff and women.
- The number of Midwives responsible for telephone enquiries should be minimised to facilitate greater continuity of information giving. In January 2010 a maternity assessment unit is being established within the unit and this will facilitate continuity of care.
- There should be a review of the method for recording calls to the labour ward. This should include a comprehensive tick chart and a facility to continue recording each call on the same record for women making contact in early labour. During the course of the investigation the reviewers are aware that an interim change has taken place and that further change is planned. The interim change includes a carbonised call log book to replace the single sheet system. This includes a prompt to allow recording of whether the liquor is clear or meconium stained. The format for logging calls is still under review. It is aimed to have standardised documentation in relation to call taking city wide. This will be implemented fully by January 2010 with the establishment in Glasgow, of a maternity assessment suite within both maternity units. This will also have the benefit of increasing continuity of care given for the purpose of call taking. The maternity assessment unit will be staffed by a small number of experienced Midwives who will triage calls that would previously have been received in the labour ward.
- The contents of NMC Guidelines for record and record keeping (NMC 2009) along with Midwives rules and Standards (NMC 2004) must be adhered to by all Midwives. This is audited through the ongoing supervisory record keeping audits within the unit.
- Midwifery staffing levels should meet the optimal level required to meet optimum practice standards if not this should be escalated to senior managers.
- Three Midwives failed to meet the standards laid down by NMC in Midwives Rules and Standards (2004) Rule 9 Records point 1 as they did

not make detailed contemporaneous records. They also did not take account of the full clinical picture. It is recommended that they undertake a formal reflection. This will be organised jointly with the Midwives, the investigating supervisor of Midwives and the named supervisors of Midwives. The named supervisors of Midwives should ensure that the reflection has been completed to a satisfactory level.

- Two Midwives standard of practice of care was acceptable.