Scottish Parliament Region: Lothian

Case 201201084: Lothian NHS Board - University Hospitals Division

Summary of Investigation

Category

Health Hospital; Gynaecology and Obstetrics Maternity; clinical treatment; diagnosis

Overview

The complainant (Mrs C) alleged that the care and treatment given to her at St John's Hospital at Howden (the Hospital) during her admission of 18 to 21 November 2011 were below a reasonable standard.

Specific complaint and conclusion

The complaint which has been investigated is that the care and treatment given to Mrs C at the Hospital during her admission of 18 to 21 November 2011 were below a reasonable standard (*upheld*).

Redress and recommendations

The Ombudsman recommends that Lothian NHS Board (the Board):	*Completion date*
(i) formally apologise to Mrs C for all their failures in the provision of care and treatment to her during the period between 18 and 21 November 2011;	27 May 2013
(ii) satisfy themselves that proper reflection (see paragraph 20) is carried out by the staff concerned;	27 May 2013
(iii) review their process of written and electronic note taking to ensure that the 'story' of an untoward, unusual or exceptional event is clearly recorded and that steps taken to mitigate the situation are highlighted; and	25 June 2013
(iv) take steps to ensure that missed vital signs observations and missed medication administration are alerted appropriately.	25 June 2013

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

Main Investigation Report

Introduction

1. Mrs C said she attended a routine appointment with her community midwife on 18 November 2011 and because of the size of her 'bump' and because she had been leaking fluid for a number of days, she was sent to triage at the Royal Infirmary of Edinburgh. When she was there, she was told that her waters had broken earlier and she would need to be admitted to hospital. She was admitted to St John's Hospital at Howden (the Hospital), where she was booked to deliver, at 19:00.

2. Mrs C's complaint concerns what she said happened to her at the Hospital during her admission in November 2011. She alleged that: although she was considered to have a high risk of infection, her temperature was not monitored; she advised the midwife that her waters had broken at 12:20 and her contractions were approximately three minutes apart but she received no vaginal examination and the baby was not checked; when contractions reduced to being 90 seconds apart she asked for 'gas and air' but was refused; her transfer to the labour suite was rushed and staff failed to monitor her labour properly; she suffered a three to four degree tear and required a surgical repair which, she said, could have been avoided or its severity reduced if her labour had been monitored and managed properly; she was left overnight with a sanitary towel which required to be replaced and consequently left in a wet bed. Despite asking, the pad was not changed; her medical notes incorrectly recorded that she had been given an injection of dalteparin on 19 November 2011 but this was not changed; an injection given on 20 November 2011 was incorrectly administered; and, despite her anti-natal notes highlighting a psychological disorder of 'chronic hyperventilation', recording that her pregnancy was high risk for Downs Syndrome and that her psychological needs should be addressed, they were not.

3. After Mrs C formally complained to Lothian NHS Board - University Hospitals Division (the Board), the Board conceded that not all the care and treatment given to Mrs C was appropriate. They apologised. They have since spoken to those midwives concerned who have been asked to 'reflect on their practice'. Mrs C did not consider that this was specific or sufficient, nor did she feel that all of her complaints had been addressed appropriately.

4. The complaint from Mrs C which I have investigated is that the care and treatment given to Mrs C at the Hospital during her admission of 18 to 21 November 2011 were below a reasonable standard.

Investigation

5. As part of the investigation, all the information provided by Mrs C and the Board has been given careful consideration. This included all complaint correspondence, Mrs C's relevant clinical records, together with the Board's relevant guidelines (including guidelines for Assessing Neonatal Unit Admissions Status, Pre-labour rupture of membranes at term, Induction of labour, and guidelines for Assessing the Safe Management of Peak Activity). Independent specialist midwifery advice has also been obtained. This too has been taken into account.

6. While this report does not include every detail investigated, I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Complaint: The care and treatment given to Mrs C at the Hospital during her admission of 18 to 21 November 2011 were below a reasonable standard

7. Mrs C was admitted to the Hospital on 18 November 2011 at 19:00 for induction of labour, as she presented with a history of ruptured membranes without labour for four to five days. She said that she was, therefore, at risk of infection and on admission she and her baby were monitored initially. At approximately 21:00 Mrs C said she was given a drug to induce the birth and she was monitored throughout the night.

8. The next day, Mrs C said that at approximately 10:00 she received her first vaginal examination and was three centimetres dilated. She was told that an induction would normally be allowed to progress for 24 hours but, given the length of time her waters had been leaking and the risk of infection, she would need to be transferred to the labour ward to begin induction intravenously. However, she was told that the labour ward was full and it was unclear when a bed would become available.

9. At 11:00, Mrs C and her husband decided to go for a walk and, while walking, at 12:10 her waters broke. She said that she and her husband then returned to the ward and told the midwife. She also told the midwife that her

contractions were increasing. However, Mrs C was advised again that there were still no beds available in the labour ward. At 13:40, Mrs C said that her labour was progressing and, as she was in pain, she requested 'gas and air' but was informed that because she was not in the labour ward this was not available. By 14.45 Mrs C said that her contractions were 30 seconds apart and her husband told the midwife that she needed to push. At this point, Mrs C said that she received a vaginal examination and was rushed to the labour suite at 15:00. She gave birth to her son at 15:40 although she suffered a three to four degree tear which required a surgical repair. Mrs C was discharged from the Hospital with her son on 21 November 2011.

10. Because she was unhappy with the care and treatment she received, Mrs C formally complained to the Board on 13 February 2012. She outlined the concerns she had (see paragraphs 2 and 3) and she met with staff to discuss these on 5 April 2012. On 10 May 2012, the Board's Clinical Midwifery Manager (the Manager) replied on their behalf.

11. The Manager confirmed that Mrs C's temperature had not been monitored as it should have been. She apologised for this and for the fact that it would appear that staff had not listened to the baby's heartbeat or performed a speculum examination. She added that, despite the fact that Mrs C's contractions had increased in frequency and strength, pain relief options had not been discussed with her. The Manager said that this level of care had fallen below the standard of care the Board would expect. Apologies were also given that because Mrs C had not been examined it had not been known that she needed to be transferred to the labour suite; and that she required to stay in a four bedded room when she was distressed and in pain; further, she had been left in a bed which was blood stained and the sheets had not been changed. The Manager concluded by saying that matters had been taken up with the staff concerned and that they had been asked to reflect on their practice.

12. Mrs C was unhappy with this response. She considered it to be inadequate, failed to respond to all her concerns and did not tell her what was going to happen to make sure that the situation would not occur again. She complained to me.

13. Independent midwifery advice was obtained on the care and treatment given to Mrs C during the time concerned and about the response that the Board had made (see paragraphs 10 and 11). The midwifery adviser (the

Adviser) was of the view that if the midwife had examined Mrs C when she returned from her walk, when she reported increasing contractions and a spontaneous rupture of membranes, the stage of labour would have been known and a more timely transfer to the delivery suite could have been scheduled. Mrs C believed that the rushed nature of the delivery led to her suffering a three to four degree tear, however, the Adviser was of the opinion that, essentially, nothing could be done to prevent a third degree tear and that they were slightly more common in first vaginal deliveries. The Adviser added that although an episiotomy (surgical cut) made more room for a baby to be born, it did not prevent third or fourth degree tears from occurring. Furthermore, she said that Mrs C had been in a very good position (all fours) to ensure that her baby had as much room as possible to emerge from the birth canal. The Adviser noted that three to four degree tears which were well repaired and healed did not necessitate a caesarean section for future births as Mrs C feared.

14. Mrs C said that her medical records incorrectly noted that she had an injection of dalteparin on 19 November 2011. The Adviser explained that dalteparin was a drug used to prevent deep vein thrombosis which in turn could lead to blood clots in the lungs. The drug is administered by a deep subcutaneous injection (under the skin) usually over the abdomen in u-shaped distribution around the navel, or in the upper outer quadrant of the buttock or upper outer part of the thigh. The Adviser added that, in her experience, most women remember this uncomfortable injection clearly, unless they were in a state of altered consciousness.

15. The Adviser reviewed Mrs C's clinical records which showed the drug being prescribed in two places: in the Repeat Medications section where there was an 'x' for 22:00 on 19 November 2011 and two initials for 22:00 on 20 November 2011; and in the Once Only area of the drug chart where it was prescribed to be given at 23:39 on 19 November 2011 where it was initialled for administration. The Adviser pointed out that the Manager, in her letter of 10 May 2012, said the drug had been administered on a site higher than usual. However, she said she did not address Mrs C's concern that the drug had not been given to her on 19 November 2011 (at a time when she had been feeding her son). The Adviser said that the Manager had explained that in her view the records showed that the drug had been checked but not given but, the Adviser commented, there was no explanation why this should have happened. In the Adviser's opinion, the Board should have explained clearly why the drug was

checked (or prepared) but not given. The drug was administered the next day but in an inappropriate site. The Adviser went on to say that both these events were medication errors which should have been treated with 'the utmost seriousness'. She explained that in each case, it would have been usual for the midwife concerned's own supervisor to meet with him/her, together with the ward manager, to discuss a plan to ensure that the midwife was safe and competent to administer medication. If any lack of competence was assessed, the Adviser said, the midwife would require to complete a period of assessed supervised practice and complete an update in the administration of medications.

16. With regard to Mrs C's concerns that insufficient regard was taken of her psychological state and that her pregnancy was high risk, the Adviser said that there was only one reference in Mrs C's notes about this, where it stated: '... chronic hyperventilation - stress related, recognises triggers - coping mechanisms in place'. She said that this was insufficient for her to formulate an opinion as to how serious the condition was or how the midwife had planned to offer care and support in pregnancy. Although she added that there did not appear to have been a requirement for a referral to specialist antenatal psychological support services.

17. Overall, the Adviser commented, the Board's response to Mrs C's complaint given by the Manager detailed many aspects of care and treatment which were below the usual standard accepted. She said that certainly, as described, midwives omitting basic hygiene, basic observations and vital signs recording and basic communication with Mrs C and her husband during the time she was admitted to be induced, through her labour and delivery and after the delivery of her baby, fell well below acceptable standards of care.

18. The Adviser said that, in her view, the Board's response was not sufficient. It had confirmed that many of Mrs C's complaints had been upheld and that staff members were to be asked to reflect upon their practice but it did not explain to Mrs C what this would involve. The Adviser explained that reflection could mean that the member of staff was interviewed by senior staff, the situation explained and then the midwife asked to review her involvement. Alternatively, the midwife could have been required to perform a structured professional reflection on their involvement and practice, aimed at improving the standard of care they provided. The Adviser added that reflection was a professional tool which could be employed to review an incident or event. She said that in the

situation covered by this complaint, reflection should have involved a written statement and assessment by the midwife, which would then have been reviewed by the manager who had requested the exercise, as well as the midwife's own supervisor of midwives. The Adviser said that to state simply that a midwife or midwives were to be asked to reflect was insufficient.

19. The Adviser said that overall, she was 'taken aback by the apparent low key approach' adopted by the Board to address the acknowledged shortcomings of the midwives concerned. She said that although she noted that it was a very busy shift at the time Mrs C gave birth and that her care spanned a number of days, there was very little in the continuation or midwifery notes about how it was planned to mitigate this and ensure that, at the very least, basic care was given. She said that, while the Board's letter to Mrs C mentioned an escalation plan being used, she had not seen a record of this and that without full details recorded in the clinical notes, the only conclusion she could draw was that no action had been taken and no escalation plan had been put in place. In this connection, she said that the clinical records should have been clear in describing the exceptions as to why care and events were not progressing in accordance with the Board's own clinical guidelines.

Conclusion

20. The Manager's letter written on behalf of the Board to Mrs C (dated 10 May 2012) acknowledged many, but not all, of their shortcomings with regard to her care and treatment. They offered their apologies and said that the midwives concerned had been asked to reflect on their behaviour. This was satisfactory as far as it went but the advice received was that there were further, other, failures which were not addressed. For instance, if a midwife had examined Mrs C when she returned to the ward at 12:20 on 19 November 2011, she would have established the progress of her labour and a more timely transfer could have been made to the labour suite. What actually happened was rushed and very concerning for Mrs C and her husband. The Adviser also maintained that Mrs C's medical records were confused about the administration of dalteparin and, when it was given to Mrs C, it was done incorrectly. The Adviser said the Board did not deal properly with these two medical failures. And finally, the Board's response to the failures they identified (to offer apology and say that the midwives had been asked to reflect) was insufficient. No explanation was given to Mrs C about what this meant and there was no evidence to show that a structured approach had since been taken to improve the skills of the staff concerned.

21. I accept the advice of the Adviser and, therefore, uphold the complaint. The Board should now formally apologise to Mrs C for all their failures in the provision of care and treatment to her during the period between 18 and 21 November 2011. They should satisfy themselves that proper reflection (see paragraph 20) is carried out by the midwives concerned. The Board's Maternity Care/ Governance department should also review their process of written and electronic note taking to ensure that the 'story' of an untoward, unusual or exceptional event is clearly recorded and that steps taken to mitigate the situation are highlighted. Finally, the Board should take steps to ensure that missed vital signs observations and missed medication administration are alerted appropriately.

Recommendations

22. I recommend that the Board:	*Completion date*
(i) formally apologise to Mrs C for all their failures in the provision of care and treatment to her during the period between 18 and 21 November 2011;	27 May 2013
(ii) satisfy themselves that proper reflection (see paragraph 20) is carried out by the staff concerned;	27 May 2013
(iii) review their process of written and electronic note taking to ensure that the 'story' of an untoward, unusual or exceptional event is clearly recorded and that steps taken to mitigate the situation are highlighted; and	25 June 2013
(iv) take steps to ensure that missed vital signs observations and missed medication administration are alerted appropriately.	25 June 2013

23. 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

Mrs C	The complainant
The Hospital	The Royal Infirmary of Edinburgh
The Board	Lothian NHS Board – University Hospitals Division
The Manager	The Board's Clinical Midwifery Manager
The Adviser	The independent midwifery adviser

Annex 2

Glossary of terms

Episiotomy	A surgically planned incision to assist in childbirth
Hyperventilation	Breathing faster or deeper than normal
Subcutaneous	Beneath or under all of the layers of the skin