LM Learning Matters

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Special Maternity Edition

Introduction

Welcome to a special maternity edition of Learning Matters Newsletter. Investigation reports into maternity serious adverse incidents (SAIs) frequently identified regional learning which is usually disseminated through Safety and Quality learning letters and reminders of best practice letters (available to HSC staff at http://insight.hscb.hscni.net/safety/safety-and-quality-best-practice-reminder-letters/) and occasional articles in the Learning Matters Newsletter (also available at the above website). This special edition of Learning Matters Newsletter presents eight articles on topics which have bene recognised to be recurring themes in a number of maternity SAIs.'

Contents

The SAI Process: a Partnership between Regional Bodies and Trusts

In 2017 the BHSCT undertook a review of their governance structures in response to concerns raised about the implementation of learning from a series of similar SAIs. The engagement between PHA and the Trust was very constructive and provided assurance on the governance structures in place. Some key learning points arising from this process which may be of interest to other Trusts were:

The role of the DRO in SAIs can be useful in spotting trends in SAIs and prompting Trust action. DROs and the Trusts are partners in the process of improving the safety of services for patients.

Supporting staff who are involved in SAIs is an important area for improvement. The use of terminology can be helpful in that regard, such as asking staff for a 'recollection of events' rather than a 'statement'. The use of a staff liaison to keep staff updated with progress was also highlighted as good practice.

Issuing letters or certificates of good practice where this is identified through a review is conducive to supporting staff and rewarding good practice

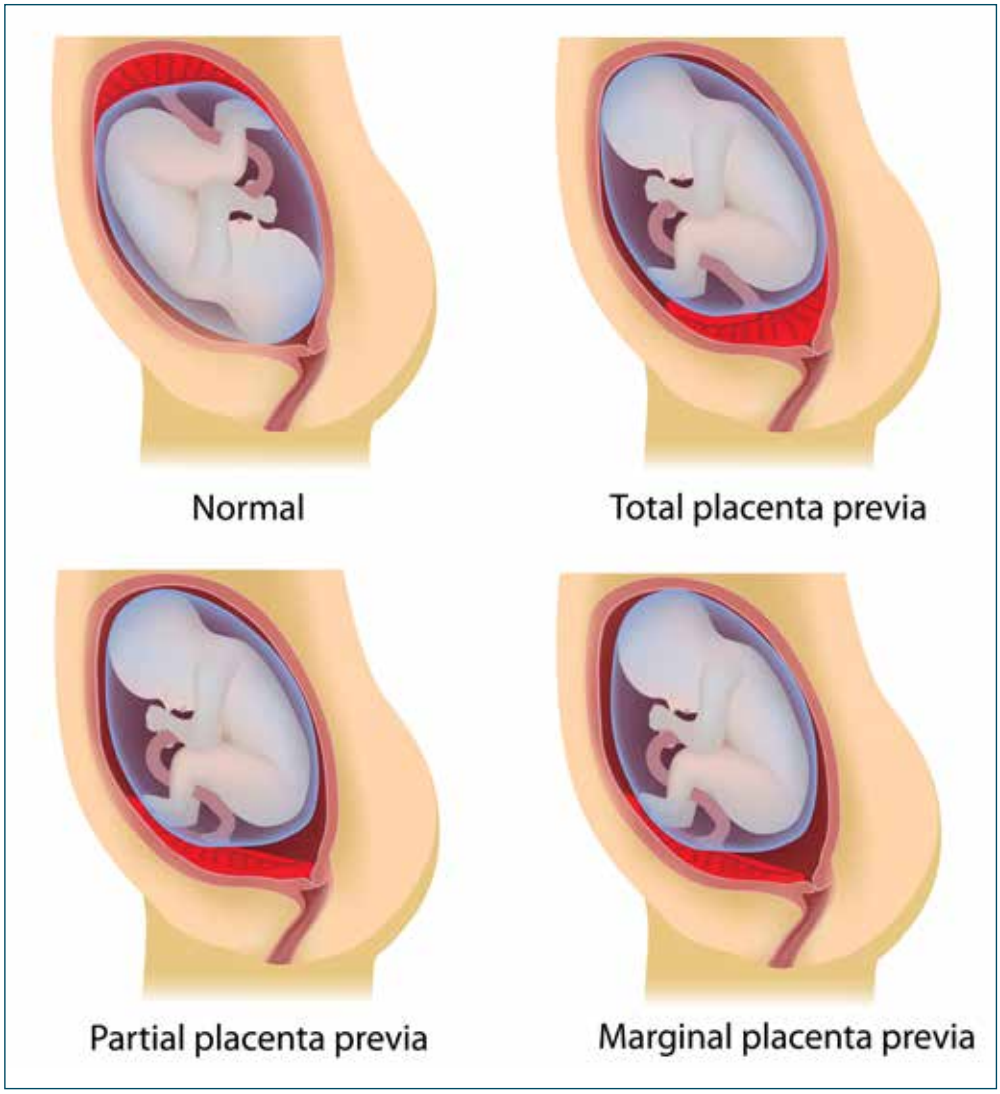
Considering how a measure of effectiveness of the recommended changes or actions made as part of an SAI report could be developed or included. This is a challenge across the system but in all areas however it should be a key part of consideration of review teams when making recommendations.

Invasive Placentation – increase in SAIs reported

Summary of Events

In recent years there have been three SAIs reported which have involved invasive placentation i.e. placenta accreta, percreta or increta. None of the cases were diagnosed antenatally. All three cases resulted in hysterectomy to control the bleeding. In one of the cases there were no risk factors identified antenatally for invasive placentation.

The incidence of these conditions has increased due in part to the increased rates of caesarean section in recent decades. These conditions may therefore be seen more commonly in future and clinical teams should be aware of risk factors and ensure they are prepared to deal with such cases which may become emergencies. The RCOG published updated guidance on this area in 2018 which outlines the risk factors and recommended management of these conditions.



Key Learning

- SAI review teams noted that prompt recognition of the degree of haemorrhage and initiation of the massive obstetric haemorrhage and massive transfusion protocols were points of good practice
- Antenatal diagnosis of placenta accreta spectrum is crucial in planning its management and has been shown to reduce maternal morbidity and mortality. [RCOG Green-top Guideline No 27a]Controlled Cord traction as part of the active management of third stage of labour should only proceed after signs of separation of the placenta (NICE Clinical Guideline 190)
- Postpartum haemorrhage due to placenta accreta can occur even in the absence of apparent risk factors.

Undertaking and Documenting Important Discussions on Mode of Delivery and Interventions

Summary of Event

Common findings from a number of SAIs involving cases of shoulder dystocia and Vaginal Birth After Caesarean (VBAC) have highlighted the importance of having and appropriately documenting discussions with women which centre on the risks versus benefits of a mode of delivery or of an intervention.

Across five SAIs involving different clinical scenarios there was a consistent finding of a lack of documentation of and therefore a query over the adequacy of counselling women and their partners about the risks and benefits of different modes of delivery or interventions. Specifically these centred on:

- babies who experienced shoulder dystocia at delivery and antenatal counselling about mode of delivery
- counselling on the risks and benefits of VBAC when antenatal risk factors were not favourable for a vaginal birth or when the presence of other risk factors meant complications such as bladder injury is more likely
- the risks and benefits of delivering a baby before term when there was a suspicion of chorioamnionitis

Key Learning

- Inadequate discussion and documentation of discussions on the risks and benefits of planned mode of delivery and interventions has been a common finding across a number of SAIs
- These discussions should explore the risks and benefits of mode of delivery and be presented to women utilising appropriate supporting literature as required. An appropriate summary of the discussion should be documented in the Maternity Hand Held Record.

Pregnant women presenting at Emergency Departments (ED)

Summary of Events

There have been a number of complaints received recently regarding care pregnant women have received when attending emergency departments with pregnancy related issues.

All pregnant women who present at ED with a pregnancy related issue should be referred to the maternity admissions unit or early pregnancy assessment unit for assessment and not seen in the emergency department unless it is an emergency situation or confirmed non pregnancy related as per the direct referral to Early Pregnancy Assessment Service (EPAS) pathway.

This was reminded to staff in previous correspondence with a reminder of best practice letter issued May 2015 regarding pregnant women and domestic violence presenting to emergency departments and the issue of an early pregnancy pathway in June 2016.

All maternity units have a 24 hour assessment unit where pregnant women with any pregnancy related issues can be seen and assessed by initially a midwife and if required an obstetrician and these are the safest and most practical areas for pregnant women to be assessed.

Therefore if any woman presents to an emergency department with any pregnancy related complaint she should be referred immediately to either early pregnancy (as per pathway) or maternity assessment.

Key Learning

- Ensure all pregnant women who present to an emergency department with a pregnancy related condition are referred to maternity admissions or early pregnancy assessment unit as required.

Group B Streptococcal Disease, Early-onset - Green top guideline 36

Summary of Events

In September 2017 the Royal College of Obstetricians and Gynaecologists published new guidance for obstetricians, midwives and neonatologists on the prevention of early-onset (less than 7 days of age) neonatal group B streptococcal (EOGBS) disease and the information to be provided to women, their partners and families.

This was an update to previous guidance and contained some new risk assessments. At present there continues to be no screening programme for Group B Strep across the United Kingdom.
The main change to affect maternity services is that if a woman was positive for GBS in a previous pregnancy she should be offered a high vaginal swab at 35 weeks. If this swab is positive or if she declines testing then the woman should be treated with intrapartum antibiotic (IAP) prophylactis..

Main points of guidance:

- No benefit to routine screening for GBS, but if a positive swab in previous pregnancy testing after 35 weeks for low risk women should be offered (high risk 32-34)
- If GBS Positive in incidental urine sample in current pregnancy (growth of greater than 105 cfu/ml)– treat at time plus offer IAP
- If GBS Positive vaginal swab in current pregnancy - do not treat during pregnancy unless symptomatic BUT do offer IAP
- IAP for GBS = Benzyl Penicillin (clindamycin if allergic)should be commenced as soon as possible after the onset of Labour
- NICE CG 132 recommends that routine antibiotic prophylaxis be given to all women undergoing C/S
- IAP is recommended for women in confirmed preterm labour. [New 2016] IAP is not recommended for women not in labour and having a preterm planned caesarean section with intact membranes.

Key Learning

- Please ensure all staff are familiar with the new matrix for group B streptococcus
- Ensure all women who are deemed as at risk receive the appropriate intrapartum antibiotics
- Women who have been positive for GBS in a previous pregnancy should be offered testing at 35 weeks and if positive treated appropriately. If testing is declined treat with IAP

Clinicians should also take into account:

- NICE Antibiotics for early-onset neonatal infection: Antibiotics for the prevention and treatment of early onset neonatal infection. Clinical Guideline no.149 (2012)
- NICE Induction of Labour. Clinical Guideline no. 70 (2008)
- RCOG Preterm Pre-labour Rupture of Membranes. Green-top Guideline No. 44 (2006, Minor amendment October 2010)

Use of syntocinon for induction of labour

Summary of Event

A number of Serious Adverse Incidents (SAI) within maternity have highlighted issues with syntocinon use in induction of labour.

Syntocinon can be used either to start labour following artificial rupture of membranes or to stimulate labour in those women whose contractions are not strong enough. However it is a drug that requires cautious use in line with protocols and with knowledge of the woman's and the fetus's clinical condition, and continuous monitoring of the fetal heart is required. Women should be given a full explanation of the reason why syntocinon is being used and the potential side effects.

Syntocinon should be titrated against contractions until an optimum of 4 contractions in 10 minutes is achieved ensuring the strength and duration of the contractions are also being monitored and recorded on the Cardio Toco Graph (CTG) and the partograph.
Syntocinon should be stopped immediately if there is any evidence of hyperstimulation or fetal distress.

Case 1:
In this case Syntocinon continued to be used in the presence of both an abnormal CTG and hyperstimulation of the uterus with sustained and frequent uterine contractions.

Case 2:
While it was noted that there was "little resting tone between the contractions" the syntocinon was reduced but not discontinued as would have been advisable.

Key Learning

- Syntocinon should be administered in line with agreed protocols. A regional syntocinon protocol has been developed by the NI Maternity Quality Improvement Collaborative
- A decision to continue with or increase the dosage of syntocinon should be considered in the context of the clinical picture; any concern over fetal wellbeing should prompt a review including a senior review where appropriate, before progressing with further syntocinon use

- Women with previous uterine scar
- Women with intact membranes
- Grand Multiparous women
- Women in second stage labour
- Within six hours of administration of vaginal prostaglandins
- With high risk women i.e. cardiac or severe eclampsia
- Multiple pregnancies

In these circumstances, senior medical review [ST 3 or above] of the patient must be completed and documented

Importance of all staff documenting care in the Maternity Hand Held Record

Summary of Event

All women in Northern Ireland carry a maternity hand held record during their pregnancy in order to document any care they receive through their pregnancy birth and postnatal period.

While it will be largely maternity staff who document in this record it is important that any other clinicians that a woman sees during this time also document any care, particularly if it is relevant to her pregnancy. Therefore her Maternity Hand Held record (MHHR) should be taken to appointments attended across other specialties.

For example a woman who attended a surgeon during her pregnancy and advice as to care in labour was given to her. However this was not documented in her MHHR.

Key Learning

- Women should be advised by maternity services to ensure they take their maternity hand held record to all appointments during pregnancy even if they are not pregnancy related
- All clinicians who see women during pregnancy should ensure they document any care or advice in the woman's maternity hand held record.

Cold Chain Failures Affecting Antenatal Anti-D Immunoglobulin

Summary of Event

SAIs notified from two different Trusts have reported that cold chain failures resulted in 127 antenatal women receiving anti-D immunoglobulin that had not been stored at the correct temperature.
If a woman is Rhesus negative but her baby is rhesus positive the mother's body can develop antibodies which can cause significant problems in future pregnancies. Anti-D immunoglobulin is given to rhesus negative mothers antenatally to prevent the development of Rhesus disease in future pregnancies.

The affected immunoglobulin could not be guaranteed to be efficacious, and so all women who received anti-D during the timeframe in question were followed up. Those who had not yet delivered received an additional dose of anti-D and women were followed up at 6 months to check for the development of antibodies.

Thankfully, in these 127 Rhesus negative pregnancies, no known cases of Rhesus disease or development of maternal antibodies have been detected.

On analysis contributing factors in these SAIs were; a faulty fridge, lack of training and awareness of how to use the fridge and temperature checking equipment, lack of awareness of the need to treat fridges as medical devices, lack of robust procedures including temperature recording paperwork and what to do when a temperature reading was outside the target range, and lack of clarity on roles and responsibilities with regard to maintaining and checking fridge temperature.

Key Learning

- Fridges must be managed as medical devices and monitored properly.
- Protocols outlining roles and responsibilities for maintaining the cold chain for Anti-D immunoglobulin should be available
- Training in how to use different types of fridges and temperature checking equipment should be provided to all staff responsible for managing a fridge containing Anti-D immunoglobulin
- Checks should ensure that minimum and maximum fridge temperatures are not exceeded and both temperatures should be recorded.
- As a blood product, consideration could be given to anti-D being stored in the blood bank and requested as needed.

Contact us

HSC Health and Social Care

If you have any comments or questions on the articles in the newsletter please get in contact by email at learningmatters@hscni.net or by telephone on **0300 555 0114 ext: 1695**

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