Mid Essex Hospital Services NHS
NHS Trust

LEARNING FROM INCIDENTS, COMPLAINTS AND CLAIMS IN MATERNITY AND GYNAECOLOGY SERVICES	**CORPORATE/STRATEGIC** **Registration No: 12021** **Status: Public**

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Document History

Review No	**Reviewed by**	**Review Date**
1.0	Meredith Deane	October 2012
1.1	Meredith Deane – clarification to 3.0	November 2012
2.0	Chris Berner, Lead Midwife for Clinical Governance	10 May 2016

INDEX

1.0 Purpose

1.1 The purpose of this guideline is to set out and demonstrate how the Maternity and Gynaecology Services will ensure that learning occurs from all kinds of incidents, serious incidents, near misses, complaints and claims. This will include all of those investigated in relation to patients, staff or visitors and will ensure that all sources of learning are identified and utilised and that these are shared across the Maternity Service and where appropriate the organisation as a whole.

1.2 The Maternity and Gynaecology Services will promote a fair blame culture and the findings of investigations are not intended to blame individuals but to identify the casual factors and prevent recurrence. This guideline is therefore designed to support a learning culture and to ensure that changes in practice or system design occur where required.

1.3 Refer to:

- Women's and Children's Clinical Governance Structure; register number 05098
- Trust Risk Management Strategy and Policy; register number 04061
- Trust Serious Incident Requiring Investigation Policy; register number 11025
- Trust Learning from Experience; register number 10088
- Complaints Handling Policy; register number 04082
- Trust Incident Reporting Policy; registration number 09100; being Open, Duty of Candour policy
- Trust Claims Handling Policy and Procedure; registration number 04081

2.0 Objectives

2.1 The key objectives of this guideline are:

- To ensure that every incident, serious incident, complaint or claim is investigated within the set timescales.

- To initiate a systematic process for aggregating analysis of incidents, complaints and claims.

- To ensure that all serious incidents undergo a root cause analysis investigation, involving, as appropriate unbiased input as set out in the Trust Serious Incident (SI) Reporting Policy; register number 11025

- To communicate lessons learned from all incident investigations to all staff across the service and that action plans are monitored and reported via the monthly Directorate Governance Meeting

- Action Plans will be centralised on a database and monitored at least monthly, non-compliance will be escalated to the Head of Midwifery/Nursing. The database will be the responsibility of the Lead Midwife for Clinical Governance. Actions are monitored through Datix, and all evidence of actions are attached to the Datix.

- To discuss learning from analyses, trends and themes at Directorate Governance Meetings, multidisciplinary perinatal mortality meeting, quarterly audit meeting, manager's meetings, Supervisor of Midwives meetings, a quarterly report is submitted to

the Trust's Clinical Governance Group for review and discussion, minutes of meeting relayed to the Trust Board Trust's quarterly Governance Group meetings and the Risk Management Group and disseminate via the established communication systems (Refer to the policy 'Women's and Children's Clinical Governance Structure'; register number 05098)

- To measure the effectiveness of the changes to practice by reduction in similar incidents and improved outcomes

- To ensure midwifery supervision is integral to the investigatory process and learning process. Feedback from supervisory investigations is fed back at the Women's and Children's Directorate Governance meetings.

- Aim to build on the culture of reducing error rates by targeting underlying systems failures

- All staff will be able to identify clinical and non clinical risks and report incidents via DATIX, using the triggers for incident reporting

- Maternity and Gynaecology Services complaints and claims will be monitored via this central DATIX system which allows an aggregation of themes.

- The level of risk associated with incidents, complaints and claims will be assessed utilising the process set out in the Women's and Children's Clinical Governance Structure; register number 05098 and will trigger addition to the Directorate Risk Assurance Framework Registers when mitigation is not possible

3.0 Integration of Information

3.1 The DATIX electronic Risk Management reporting system allows the linking of data on incidents, complaints, PALS enquiries and claims.

3.2 The Directorate Governance Report, provided by the Women's and Children's Clinical Governance Facilitator and Head of Governance will include a quantitative and qualitative analysis of complaints and incidents identifying any trends. A separate quarterly report is presented to the Directorate Governance meeting bi-monthly by the Trust's Claims department. The PALS team also submit a separate report regarding complaints which is reviewed at the Directorate Governance meeting.

3.3 The Directorate claims and complaints report are reviewed at the Directorate Governance Meeting and the Maternity Service Risk Management Group Meeting

3.4 The Trust Patient Safety and Quality Committee will also monitor how effectively recommendations are implemented within the Maternity and Gynaecology Services through the Executive Lead and Chief Nurse, who will present exception reports and the Maternity Risk Assurance Framework for unresolved actions that require on-going monitoring

3.5 This information will be communicated out to all staff via staff memos, newsletters and notice board updates

3.6 Where specific trends are identified, those with responsibility for supplying the data will provide an explanation trend and benchmarking information

4.0 Dissemination of Information

4.1 The monthly reports will be an agenda item on the following groups: Directorate Governance Meeting, Maternity Service Risk Management Groups.

4.2 The report will also be produced for the Trust Clinical Governance Group detailed in the Women's and Children's Clinical Governance Structure Policy (05098).

4.3 In addition, the Lead Midwife for Clinical Governance will publish a summary of these reports using the following media: Maternity Service Risk Management newsletter, Risk Management Notice board, Hot Topic themes.

5.0 Maternity Service and Organisational Learning

5.1 All complaints, claims and incidents which are subject to a management investigation must include an action plan. The recommended actions will be disseminated and monitored via the Datix system

5.2 The Directorate Governance Meeting and Risk Management Group will monitor the implementation of the actions and learning arising from Serious Incidents, claims and complaints. The Patient Safety and Quality Committee will also review the aggregated analysis of data and be provided with assurance that unresolved risks are monitored via the RAF

6.0 Meetings, Groups and Forum

6.1 The local Clinical Governance arrangements within the Maternity and Gynaecology Services will provide the framework by which lessons learned from all risk events, incidents, complaints and claims are actively disseminated.

6.2 Refer to the Women's and Children's Clinical Governance Structure; register number 05098 for all meetings and forums and roles and responsibilities of individuals within Maternity services which relate to this policy.

7.0 Risk Event Reporting (DATIX)

7.1 An incident or identified risk can be defined as any event which results in or has the potential to result in injury, damage or adverse consequence.

7.2 Refer to Trigger List for Maternity specific incidents at Appendix A. Staff should report risk events against these and the Trust Triggers. A trigger list for datixes will continue (Refer to the Trust Serious Incident Requiring Investigation Policy; register number 11025)

7.3 Guidance on how to complete a DATIX form is available on the intranet.

7.4 Incidents, risks and near misses (clinical and non-clinical) should be reported in accordance with the Women's and Children's Clinical Governance Structure; register number 04060
(Refer to Appendix A using DATIX reporting to ensure a timely response and immediate mitigation)

7.5 The reporting of 'risk events' allows the Trust to manage risks that will lead to improved safety, reduced risk and the provision of a high quality maternity service.

7.6 DATIX will be used to report on medical equipment problems and medication events/errors as well as health and safety issues.

7.7 All risk events should be investigated with appropriate remedial action implemented.

7.8 The declaration of a serious incident will be discussed at the Trust's daily Serious Incident Management Group meeting following the review of the concise report. This will be reported to the Clinical commissioning Group by the Trust's governance team in accordance with the Trust's Incident and Serious Incidents requiring Investigation Policies.

7.9 Completed and approved comprehensive reports are presented to the daily Serious Incident management group meeting upon request.

8.0 Management of Risk Event Reporting

8.1 Incident forms do not form part of the patient records and therefore should not be retained in the patient's records. Completion of an incident form does not constitute an admission of liability.

8.2 Datix reported risk events will be forwarded electronically to the Lead Midwife for Clinical Governance, the Head of Midwifery/Nursing and relevant Midwifery Managers and Team Leaders.

8.3 An immediate review of the health care records will occur if any incident raises risk concerns, this will be undertaken by the Lead Midwife for Clinical Governance, Clinical Lead for Risk Management, Head of Midwifery/Nursing and Labour Ward manager to determine if further investigation is required and remedial action necessary.

8.4 The datix will be completed by the line manager or senior midwife in charge for the area where the event occurred, within 10 days of the reporting of the risk event.

. Where an incident requires further investigation a concise report will be completed within 24 hours of the event and submitted for review via the Serious incident management Group as a response to the initial incident via datix.
(Refer to Serious Incident Requiring Investigation; register number 11025)

8.5 The daily Directorate Quality and Safety meeting reviews incident reports submitted over the previous 24 hours. The management of these incidents is decided at this meeting and the investigating officer is assigned. The meeting is chaired by the Head of Midwifery/ Head of Nursing/ Clinical Director. The meeting is attended by the Lead Midwives and Nurses. Significant incidents should be identified to the Governance Team for review at the SIMG meeting, which is jointly chaired by nursing, medical and governance representatives.

8.6 The Lead Midwife for Clinical Governance is responsible for the follow up of all reported risk events and the daily dialogue with the Head of Midwifery/Nursing regarding incidents reported.

8.7 The on-call Supervisor of Midwives will be informed of any incidents involving clinical practice issues of midwifery staff, enabling an immediate supervisory review of the

incident. Formal investigation will be initiated with advice from the Local Supervisory Authority Midwifery Officer (LSAMO).

8.8 The Lead Midwife for Clinical Governance with the Clinical Governance Facilitator will provide a trend analysis report for the Directorate Governance Meetings to identify commonalities and on-going mitigation

8.9 The Lead Midwife for Clinical Governance will meet at least weekly with the Lead Obstetric Consultant for Risk Management.

9.0 Serious Incidents (SI)
(Refer to the Trust Serious Incident Policy; register number 04060)
(Refer to Appendix B)

9.1 The framework for reporting and investigating serious incidents supports openness and learning.

9.2 The response to each incident will be proportionate to the scale, scope and complexity of the incident and will support a 'fair blame' approach.

9.3 A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in death, serious harm, allegations of abuse, adverse media coverage or a never event.

9.4 For serious incidents, the Supervisor of Midwives and Head of Midwifery/Nursing will be informed immediately by telephone/email, the incident will be escalated as appropriate the next working day to the Chief Nurse, Executive Lead and Clinical Director.

9.5 A maternal death will be escalated immediately to the on-call Executive Director and the LSAMO via the Head of Midwifery/Nursing.

10.0 Investigation and management of Serious Incidents (SI) and Never Events

10.1 When a SI has been identified, the following process must be followed in line with the Trust Serious Incident Policy, in or out of hours.

10.2 The table below outlines the reporting structure for serious incidents

Who	**Reports to: in normal office hours**	**Reports to: out of hours**
Staff member who identifies possible serious incident	Midwifery Manager Lead Midwife for Clinical Governance, Head of Midwifery/Nursing	Midwifery Manager on call Who informs the Head of Midwifery/Nursing
Unit leader or site Manager /Midwifery manager on call	Head of Midwifery/Nursing Executive Lead If a **serious criminal act** is suspected, the **police** should also be informed **immediately**	Executive On call
Head of Governance Chief Nurse	Chief Executive, Chief Medical Officer	

10.3 **The Head of Midwifery and Chief Nurse** will determine whether the incident is a SI, the Head of Governance will report the serious incident to Mid Essex CCG as relevant.

10.4 **The Head of Midwifery** will allocate an Investigating Officer (IO).

10.5 **The Investigating Officer** will establish an event log as a contemporaneous record of what actions are taken, to include the following:

- Notify the consultant in charge of the patient's care that the incident is a SI
- Communicate with and update the patient and their relatives
- Offer support and maintain a dialogue as the investigation progresses
- Arrange for the release of staff who were present at the time of the incident to a) draft a statement and b) and assess the impact of the incident on them.
- Assess the need for counselling for the staff involved
- Explain to staff on duty what has happened and keep them briefed
- Assess the potential for press interest and advise Head of Midwifery/Nursing who will liaise with the Director of Communications where appropriate. .
- Reinforce the need for staff to maintain confidentiality
- Assess the requirement to liaise with the police/security team and making arrangements to do so when appropriate
- Liaising with the legal team, Head of PALS and Complaints about any potential coroner's case
- Confirm the senior midwife on duty has ensured that a Datix form is completed by staff involved in the incident prior to leaving duty

10.6 All investigation notes and photocopies of maternity records (including CTG's) should be archived within the maternity services: the electronic record of the investigation will be stored in the designated file on the m-drive, the hard copies of the risk event form, maternity records and investigation, including interviews and statements will be stored by the Maternity Clinical Governance team as well as being attached to the Datix.

10.7 Where a helpdesk process is required, this will be managed by the Head of Midwifery and the Director for Communications.

10.8 The midwife in charge has responsibility for ensuring that all related records are kept secure until such time as they are handed over to the Head of Midwifery.

10.9 **Within 24 Hours -** If it is agreed that an incident is a SI, the **Head of Midwifery/Nursing and Chief Nurse** will consider the level of investigation required on the basis of the available information. This level can be escalated or de-escalated in the light of subsequent information and with the Chief Executive's/Chief Nurses agreement.

10.10 Other notifications will be undertaken by appropriate staff, e.g. infection prevention team will inform the Health Protection Agency.

10.11 The Investigating Officer will appoint a case panel as part of the investigation team.

10.12 For Concise (24 hour) and Comprehensive (Level 2) Investigations, the Investigating Officer and will be appointed by the Head of Midwifery or in her absence the Lead Midwife for Clinical Governance.

10.13 The Investigating Officer will be a senior clinician or midwife, expert in the relevant field, but not involved with the incident, and will be conversant with the SI process.

10.14 They will complete a 24 hour concise report to determine the main facts and identify any significant risks, which require immediate action.

10.15 The 24 hour report will be forwarded to the Head of Midwifery/Nursing for presentation at the next day's SIMG meeting.

10.16 The SI may be de-escalated following receipt of the concise report.

10.17 **Level 2 comprehensive reporting within 45 days**

10.18 The IO will be familiar with the requirements for Serious Case Reviews for child protection issues where these are relevant to the Trust investigation process.

10.19 The Level 2 investigation will use Root Cause Analysis to determine the root cause of the incident. Where deemed beneficial through the investigation process, an external agency will be involved to provide an unbiased input. The terms of reference for the investigation will be determined at the daily Quality and Safety Meeting.

10.20 The IO **will** undertake the following:

- Using the Trust's formal template request statements and when required arrange to interview staff involved in the incident
- Ensure that copies of the notes, incident forms, and other relevant documentation are available for staff asked to interview or for statements
- Determine the terms of reference and arrange a panel review within the target timescale of 45 days for reporting to the Clinical Commissioning Group. Extensions may be agreed with the Clinical Commissioning Group. to enable an effective comprehensive investigation
- The management of support for staff directly involved in the investigation will be discussed at the daily Quality and Safety Meeting. It may be determined, from the nature of the incident, that consideration needs to be given to whether the individual (s) involved should restrict their duties or be suspended, either for their own safety or well being or that of others, including patients
- Fitness to practice/purpose concerns should be raised by the IO to the Head of Midwifery

10.21 A Panel Review Group will be arranged to review the findings of the IO, all evidence at this meeting will be anonymised to ensure objectivity. Panel members will be experts in the realm of the incident; but also must not be involved in the incident to maintain objectivity.

10.22 The purpose of the Panel Review Group is to identify: contributory factors, care and service delivery problems, root causes and recommendations for learning.

10.23 The Head of Midwifery will notify the contact Supervisor of Midwives to ensure the supervisory team alert the LSAMO of the Serious Incident. A supervisor will be allocated to undertake a separate investigation on the advice of the LSAMO.

11.0 Cross Organisational Learning

11.1 The Head of Midwifery/Nursing is a member of the CCG CQRG which aims to facilitate provider/commissioner transparency and learning and sharing of safety lessons.

11.2 The Trust also reports serious incidents externally to the CCG.

12.0 Monitoring Effectiveness of Risk Reduction Measures

12.1 This will be the primary responsibility of the Lead Midwife for Clinical Governance, Head of Midwifery, Clinical Director and Executive Lead for Maternity Services. The clinical governance structures within the Trust will support the reduction and management of risks within Maternity Services.

12.2 Where high level risks have been identified, the implementation and effectiveness of mitigation plans will be monitored by the Patient Safety and Quality committee and the Governance Team through the process outlined in the Risk Management Strategy.

12.3 The RAF will be reviewed bi-monthly at Directorate Governance Meetings and at least quarterly at the Patient Safety and Quality Committee.

13.0 ANNB Screening Serious Incidents

(Refer to Maternity Risk Management Strategy; register number 05098)

14.0 Management of Incidents, Complaints and Claims

14.1 Incidents, complaints and claims will be assessed on an individual basis and undergo a root cause analysis as appropriate in accordance with the guidance of the Trust Incident Reporting Policy; registration number 09100.

14.2 Review and discussion of incidents, complaints and claims will be an agenda item at the following forums/meetings:

- Multidisciplinary Risk Management Group
- Directorate Governance Meeting
- Labour Ward Forum
- Manager's Meetings

14.3 Please refer to the Trust Learning from Experience Policy Register No.?? for full details of the organisation wide approach to investigation, analysis and learning from incidents, complaints and claims.

14.4 The Trust guidance (refer to Trust Risk Management Incident Policy Register number 09100) applies to all types of incidents, whether clinical or non-clinical, including those giving rise to complaints or claims.

14.5 All Maternity Services complaints are forwarded to the Head of Midwifery/Nursing for allocation of an Investigating Officer.

14.6 The completed investigation with recommendations and learning will be forwarded to the Head of Midwifery/Nursing for approval and agreement of Action Plans with a strategy for sharing learning evident in the response.

14.7 The Head of Midwifery/Nursing will forward the investigation template and response to Complaints and PALs.

14.8 All complaints will be responded to in line with Trust Complaints Policy; register number 04082.

14.9 All complaints are logged centrally on the DATIX system by the PALS Department.

15.0 Learning from Incidents, Complaints and Claims

15.1 This should be read in conjunction with the Trust Serious Incident Policy; register number 04060 and Learning from Experience Trust policy; register number 10088.

15.2 Implementing recommendations from incident investigations will demonstrate that the Maternity Service is learning from risk events/incidents, complaints and claims. Learning will contribute to improved safety and quality of the patient experience.

15.3 Outcomes will be at shared at departmental level through established communication systems.
(Refer to Women's and Children's Clinical Governance Structure; register number 05098)

15.4 Learning outcomes will be shared to ensure minimising risks of recurrence; these will be through formal feedback to the maternity service and support and implementation of training and updates for individuals involved in the incident.

15.5 Learning outcomes from incidents, complaint and claims will be disseminated through a variety of forum:

- The monthly trends and analysis of incidents presented at the monthly Directorate Governance Meeting to identify emerging trends. In addition, these trends and analysis will be displayed on the risk management boards in the clinical areas
- At the monthly Risk Management meeting as an agenda item
- During the annual mandatory training session on risk management
- Through the provision of stats and the Maternity Dashboard on the risk notice board, and circulation to staff
- Supervisor of midwives monthly meeting as an agenda item
- Case review sessions held on the Labour Ward
- Presentation of admissions to the neonatal unit, both planned and unplanned at the monthly perinatal mortality and obstetric audit meeting
- Learning from incidents is feedback on a monthly basis prior to the perinatal mortality and obstetric audit meeting
- The maternity services liaison committee – complaints and risk events

16.0 Monitoring of Action Plans

16.1 The Lead Midwife for Clinical Governance will log centrally the recommendations and Action Plans from each Serious Incident Investigation; these will be monitored ensure actions are completed within set timescales.

17.0 Staffing and Training

17.1 All midwifery and obstetric staff must attend yearly mandatory training which includes learning from incidents, complaints and claims –training is delivered by the Lead Midwife for Clinical Governance
(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis. Register number 09062)

17.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal and revalidation.

18.0 Supervisor of Midwives

18.1 The supervision of midwives is a mandatory responsibility that provides a mechanism for support and guidance to every midwife practising in the UK. The purpose of supervision is to protect women and babies, while supporting midwives to be fit for practice'. This role is carried out on our behalf by local supervising authorities. Advice should be sought from the supervisors of midwives who are experienced practising midwives who have undertaken further education in order to supervise midwifery services. A 24 hour on call rota operates to ensure that a Supervisor of Midwives is available to advise and support midwives and women in their care choices.

19.0 Audit and Monitoring

19.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

19.2 As a minimum the following specific requirements will be monitored:

- Maternity specific data set for incident reporting maternity service's process for learning from experience, including case reviews
- Arrangements for the regular review and discussion of all incidents, complaints and claims by the relevant local committee/group
- Arrangements for ensuring that all serious untoward incidents (SUIs) undergo a root cause analysis, involving as appropriate unbiased external input
- Arrangements for ensuring that lessons learnt from all incidents, complaints and claims are actively disseminated to all staff
- Process for providing board assurance that lessons learnt from SUIs are implemented and monitored
- Process for monitoring compliance with all of the above requirements, review of results and subsequent monitoring of action plans

19.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 19.2 will be audited. A minimum compliance 75% is

required for each requirement. Where concerns are identified more frequent audit will be undertaken. This is not undertaken, can we discuss this further with audit lead?

19.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

19.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

19.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

19.7 Key findings and learning points will be disseminated to relevant staff.

20.0 Guideline Management

20.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competencies are maintained and the ability to access the current approved guidelines via the Trust's intranet site is monitored.

20.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

20.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

20.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for further training; possibly involving 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

21.0 Communication

21.1 A quarterly 'maternity newsletter' is issued and available to all staff including an update on the latest 'guidelines' information such as a list of newly approved guidelines for staff to acknowledge and familiarize themselves with and practice accordingly.

21.2 Approved guidelines are published monthly in the Trust's Focus Magazine that is sent via email to all staff.

21.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

21.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

22.0 References

Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards: 2012/2012

Care Quality commission (2009), Essential standards of quality and safety: compliance with section 20 of the health and social care act 2008

NHSLA (July 2009 Serious Incident reporting policy including the procedure to be followed for safeguarding children

NPSA (March 2010) National framework for reporting and learning from serious incidents requiring investigation,

Institute for Healthcare Innovation (2009) 2nd edition global trigger tool for measuring adverse events

Royal College of Obstetricians and Gynaecology (2007) Towards Safer Childbirth, London.

NHS England (2015) Serious Incident Framework: Supporting Learning to Prevent Reoccurenc

Appendix A

Trigger List for Maternity Incident Reporting

<table>
<tr><th colspan="2">Labour Ward/Midwifery-led Units/Community</th></tr>
<tr><td>

Unplanned homebirth/BBA
Severe infection
Severe PET/Eclamptic fit
Prolonged 2nd stage (over 5 hours)
Rupture of uterus (fetal parts in the abdomen)
Difficult intubation
Failed forceps or ventouse
Failed instrumental delivery/2nd stage Caesarean section
Maternal injury during delivery (bladder/bowel)
Third degree tear
Fourth degree tear
PPH > 500mls or symptomatic vaginal birth
PPH > 1000ml caesarean section
Woman requiring blood transfusion
Return to theatre
Retained swab/instrument
Maternal death

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Undiagnosed breech
Misdiagnosis of antenatal screening tests
Failure to recognise fetal compromise
Cord prolapse
Shoulder dystocia
Delay in delivery of 2nd twin leading to adverse outcome
Low Apgars < 6 at 5 minutes
Arterial cord pH of 7.1 or below
Difficult resuscitation due to equipment/inexperience
Birth trauma to baby
Unexpected fetal abnormality
Unexpected admission to NNU at term
Seizure within 24 hours of birth
Stillbirth, Intrapartum Death, Neonatal Death
Hysterectomy

</td></tr>
<tr><th>Antenatal/Postnatal</th><th>General/Organisational</th></tr>
<tr><td>

Missed screening follow up: maternal/neonatal
Late booker (>22 weeks)/unbooked woman
Severe APH
Severe PET/Eclamptic fit
Maternal collapse
Secondary PPH
Severe infection/wound breakdown
Faecal or urinary incontinence
Postnatal readmission of woman/baby
Puerperal psychosis
Congenital abnormality
Admission to NNU of term baby
Neonatal septicaemia
Neonatal seizures within first 24 hours
Neonatal Fractures

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Misidentification of patients
Failure to gain consent
Wrong procedure carried out
Breach of confidentiality
Abnormal results not recognised
Medication errors
Unavailability of health records
Unavailability/failure of facilities or equipment
Failure to escalate concerns
Staffing levels
Delays to patient care due to capacity
Any other adverse event
Complaints by patients/visitors against staff
Closure of NNU due to capacity
Closure of standalone birthing units
Pressure Ulcers
Unplanned admission to ITU
DVT/pulmonary embolism

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Appendix B

Minimum Set of Reportable Maternity which may be potential Serious Incidents (level of harm to be assessed)

Maternal	
• Maternal Death • Maternal unplanned admission to ITU • Peripartum hysterectomy • Significant postpartum haemorrhage where care or service delivery problems contributed to the outcome • Unidentified retained swab or instrument	
Neonatal	
• Intrapartum Death • Antenatal Intrauterine Death where there were identified care or service delivery problems • Unexpected neonatal death where the death was not anticipated as a significant possibility 24 hours before the death nor was a result of extreme prematurity • Unexpected admission to NNU in infants over 37 completed weeks of gestation that have persistent low Apgar scores of less than 6 at 5 minutes where there are also neonatal seizures or cord pH of less than 7.1	
Organisational	
• Closure of the acute Maternity Unit which impacted upon patient care. • Any other incidents where circumstances suggest a claim may result	

Appendix C

A Serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death
- Serious harm where the outcome requires life saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Scenario that prevents a provider organisations ability to continue to deliver healthcare services
- Allegations of abuse
- Adverse media coverage or public concern about the organisation
- Core 'Never Events' – wrong site surgery, retained instrument, in-hospital maternal death from postpartum haemorrhage after elective caesarean section.

NHS England (2015)