**Example Statement following guidance 4**

**Statement 4**

Statement relating to incident concerning patient Lucy Brown on the 10/1/2011

Statement prepared by Jane Blue Registered Midwife based on Triage.

On 1/7/2011 I received a letter stating Ms Lucy Brown has written to the NMC raising concerns about my fitness to practice. This statement is to fully explain my involvement in Lucy’s care and give my perspective on the concern. Whilst I appreciate Lucy has a perspective, I do not believe I failed to identify Lucy’s membranes had ruptured or seek appropriate medical assistance. I believe I gave the correct advice as is my normal practice. I strive to be kind and compassionate to all the women in my care.

I qualified as a midwife in 2002, and have worked at the Hospital as midwife since 2003. I have continued to extend and enhance my midwifery knowledge throughout my career. I have rotated around the unit gaining experience in all areas and have been a core midwife on Triage for the past four years, currently working 32 hours a week. On Triage I see and assess women to determine their requirements. There are several pathways for women dependant on the reason for their attendance. The options for on-going care and treatment are: transferring to another area such as the antenatal ward for additional support or monitoring, delivery suite if the woman is in established in labour or requesting medical input if the reason for attendance is outside the normal parameters for the autonomous practice of a midwife, or determine they can be discharged home if she does not have additional risk factors.

When women contact Triage the method of triage used is the SBAR principle (situation, background, assessment, recommendation). At the time Lucy contacted Traige a written SBAR telephone triage book was in use. The SBAR is a structured format that has been designed to make an assessment of maternal and fetal wellbeing and capture all relevant information. The SBAR includes specific sections to comment on medical and obstetric history, contractions, vaginal bleeding or loss, fetal movements and there is a box to tick regarding if membranes have ruptured or not. It is always my practice to complete an SBAR form with every telephone conversation. If following this detailed telephone discussion with the woman the recommendation is for her to come in to Triage, on admission, an antenatal proforma is completed. The antenatal proforma is a detailed admission sheet ensuring capture of all relevant information regarding obstetric history, risk factors, fetal movements, contractions, vaginal bleeding, pain, and there is a specific area to comment about spontaneous rupture of membranes. There is a section to document fetal monitoring, MOEWS (Modified obstetric early warning system) and an area to write clinical details, plan of care and advice given. It is always my practice to complete an antenatal admission proforma with every admission to Triage.

My involvement in Lucy’s care was on 1/7/2011 at 20.45 when she was admitted to Triage reporting contractions. Prior to arriving on Triage Lucy had spoken to another midwife on the telephone who had documented in the SBAR book and written on the admission board that Lucy was coming into the unit reporting contractions, there was no history of spontaneous rupture of membranes.

Lucy has stated that she was unhappy that only one other person could accompany her onto Triage, so just her partner Brian came onto the unit with her. This is normal practice. Triage is a very busy unit with limited space, so, in order to ensure there is room to manage potential emergencies and maintain privacy and dignity for all women we ask that all patients are just accompanied by one other person and there is a polite notice on the door leading to the unit stating this;

 ‘Due to limited space and the nature of this ward, only one person to accompany each patient in Triage. Thank you for your cooperation.’

If after full assessment a woman is found to be in established labour she will be transferred to delivery suite where two birth partners can remain with her throughout her labour.

Lucy was a primigravida (her first pregnancy), gestation 39+6, and did not have any other risk factors. I have completed an antenatal admission proforma and documented that Lucy was at this time contracting 2:10, good fetal movements were felt, there was no history of spontaneous rupture of membranes and I have documented this by ticking the box on the proforma, membranes intact. I performed a urinalysis which was normal, I checked maternal observations and MOEWS score was 0. I performed a palpation and documented fundal height measurement was 37cm, long lie, cephalic presentation, 3/5 palpable. I performed a vaginal examination with consent which her partner was present to chaperone, cervix was posterior, effaced and 1-2 cm dilated, membranes were noted to be intact on this examination, head was -2 to spines, position was not defined. I auscultated the fetal heart for one full minute and documented that it was 150bpm. The findings of the examination were that Lucy was not in established labour and in view of this we discussed coping strategies for the latent phase of labour. It is always my practice to discuss strategies such as the bath or other methods of heat therapy, Tens machine, mobilisation, adopting different positions and simple analgesia. I contacted the on call SHO and organised a prescription for dihydrocodiene analgesia which is a stronger form of pain relief which can be prescribed by medical staff for Lucy to take home to help her at this early stage of labour. Following a full assessment if a woman is found to be in early labour with no risk factors it is normal practice to encourage the woman to go home. To advise a low risk woman in the latent phase of labour to go home is clearly recommended in Trust Guidelines which state;

‘Women thought not to be in labour with no risk factors should be encouraged to return home with advice to return if contractions increase, or if there is concerns about reduced fetal movements or vaginal loss’ (Guidelines for Triage)

Following our discussion Lucy agreed to go home take analgesia and try the other coping strategies we had discussed. I assured Lucy that she could ring Triage at any time if she felt the contractions were stronger or more frequent, if her membranes ruptured, if she did not feel she could cope at home or she had any concerns about fetal movements, pain or vaginal loss.

From my documentation at no time did Lucy state she was unhappy with or had any concerns about going home. This pregnancy was low risk and I had undertaken a full assessment. At this time Lucy was in the latent / early stage of labour I have not documented any evidence of spontaneous rupture of membranes, the forewater’s, the section of the membranes in front of the baby’s head were intact on vaginal examination. If there had been any suspicion of ruptured membranes my practice would be to carry out a speculum examination to establish if there was liquor draining from the vagina and to prevent the transmission of infection. Additionally it is appropriate for women to go home to await the onset of regular contractions with ruptured membranes, however, the advice would be to observe the colour of the liquor draining to establish if there was any blood staining or evidence the baby may have opened their bowels, this was not discussed as there was no disclosure of ruptured membranes during this episode of care.

My further involvement in Lucy’s care was a telephone conversation on 10/1/2011 at 23.49. My recollection of this telephone conversation is from my documentation in the SBAR telephone contact book. Lucy had contacted Triage reporting contractions 1-2:10 minutes these appeared to be irregular. I again checked Lucy’s obstetric and medical history and she informed me that she was a primigravida, gestation 39+6, low risk pregnancy, she gave no history of ruptured membranes or vaginal loss and was feeling good fetal movements.

Lucy states in her complaint that she discussed vomiting during this telephone conversation I do not recall and have not documented that any vomiting was reported. My impressions from the conversation were that Lucy remained in the early stages of labour. Telephone conversations with women in early labour are a daily part of my role as a triage midwife. I speak to the woman herself, so I can use this conversation not only to ask the questions on the SBAR form, but to listen to the woman’s behaviour constantly assessing how often she is contracting, how long contractions last and how she is coping with the contractions. I have documented that Lucy did not have a contraction for seven minutes during our conversation, I documented this as part of my assessment that labour remained in the early stages. Trust Guidelines support advising women with infrequent contractions to remain at home stating;

‘If review in Maternity Assessment Centre is felt to be inappropriate e.g infrequent contractions women will be given advice about when to call again’. (Guidelines for Triage)

From my assessment Lucy was having infrequent contractions and as a low risk woman in the early stages of labour, with no history of spontaneous rupture of

membranes, I felt it was appropriate, as per the guidelines, that she could remain at home, however, I advised Lucy that if she felt that she was unable to cope at home that she could come into Triage for a further assessment. I have documented this discussion and that Lucy decided to stay at home until the contractions became more regular. I have documented that I again discussed with Lucy coping strategies for early labour that she could try at home. As per my normal practice at the end of any telephone conversation I assure women they can call back at any time if they wish to be seen or have any questions or concerns regarding fetal movement, spontaneous rupture of membranes, bleeding or pain.

Following this telephone conversation I had no further contact with Lucy: further telephone triage and care was provided by other midwives in the trust. During Lucy’s admission to Triage and during our telephone conversation I treated her with kindness and compassion at all times. I did a full assessment to determine that she was in the early stages of labour and did not fail to identify spontaneous rupture of membranes asking and clearly documenting about vaginal loss. I gave Lucy analgesia to go home with and discussed coping strategies for the early stage of labour. When Lucy telephoned Triage I encouraged her to stay at home and discussed coping strategies, but, also gave her the option to come in if she felt she was not coping and advised she could ring back at any time if she had any concerns.

I am very sorry for Lucy’s loss and send my sympathy to Lucy and her family.