



Case story

Identifying and assessing risk factors to facilitate informed decision making in maternity care



Early Notification

Case story guidance

Background

In [Advise, resolve and learn Our strategy to 2025](#), our second strategic priority is to share data and insights as a catalyst for improvement and our third is to collaborate to improve maternity outcomes. Aligned with these aims we have gathered together learning from our Early Notification Scheme and produced a number of case stories to help support learning from harm identified through claims.

These resources

Our case stories are illustrative and based on recurring themes from real life events. These experiences have been highlighted and shared with you, to help identify potential risks in your clinical area, promote learning and prevent fewer incidents like these occurring in the future.

How to use the case stories

There are various ways you may use the case stories, from individual self-directed learning to support continuous professional development to using them in a team environment. The idea is that by learning from the experience of others, maternity unit staff will be able to change their approach to care.

As you read or discuss the examples of incidents that we are sharing we ask you to consider the following:

- Could this happen in my organisation?
- What changes within my organisation or team might I consider after reading the material, including individual practice?
- What information should I share with the team?
- How can I share the learning from this case story?
- Who else needs to know?

Practical applications

1. Consider the key elements of the case story and through reflection apply the learning to influence your practice in the future.
2. Use this case study as a point of discussion at appropriate multi-disciplinary team meetings, safety huddles, and/or human factor's training.
3. Use this case study to create a multi-disciplinary simulation in the clinical area or on mandatory training.
4. Review your claims scorecard to identify whether there are any themes which relate to this case story and identify where improvements could be made.

Case Story

This case story is illustrative based on a range of examples of real events. NHS Resolution is sharing the experience of those involved to help prevent a similar occurrence happening to patients, families and staff. As you read about this incident, please ask yourself:

- Could this happen in my organisation?
- Who could I share this with?
- What can we learn from this?

Topic: Identifying and assessing risk factors to facilitate informed decision making.

Key points:

- Obtaining accurate medical and previous obstetric history is crucial for identifying pre-existing risks and anticipating potential complications¹.
- Comprehensive knowledge relating to pre-existing health conditions, previous pregnancies, and surgery can influence decisions around care during pregnancy and delivery planning².
- Ensuring all of the relevant information is available allows clinicians to give informed recommendations, enabling the woman to make decisions about her care with a full understanding of the potential risks and benefits, individual to her circumstances³.
- Performing standardised risk assessments during triage telephone calls reduces variation in practice and enables clinicians to identify potential risks including symptoms that may indicate possible complications. This ensures that any planned care and advice is personalised and considers the woman's individual risks and circumstances⁴.
- Documenting risk assessments during triage telephone calls including details of the advice given ensures all clinicians are aware of risks or concerns that need to be considered when planning care or providing subsequent advice.⁵
- Risk is a dynamic process and risk assessments should be performed at each clinical encounter to enable identification of potential risk factors to help reduce the risk of adverse outcomes for the woman and her baby¹.

Maternity Story

Ms P booked for maternity care in her second pregnancy at eight weeks gestation. The booking appointment took place with a community midwife at a local GP surgery. During the booking appointment Ms P informed the midwife that she had a caesarean birth during labour to deliver her first baby at another hospital. Ms P reported struggling to recover after the first caesarean and expressed interest in delivering her second baby vaginally. The midwife did not ask any further questions to establish the details of the caesarean birth and assumed that it had been

uncomplicated. Ms P was provided with a 'Birth after previous caesarean'⁶ leaflet and was informed that she would receive an appointment for a 'Previous caesarean section' group information session between 24- and 28-weeks' gestation. Following this she would have an appointment with an obstetrician to discuss and agree on the planned mode of birth.

The antenatal period was uneventful, and Ms P attended all of her scheduled appointments and routine first trimester and anomaly ultrasound scans. Ms P attended the group information session and was informed of the risks regarding uterine rupture following one previous uncomplicated lower segment caesarean and the recommendations for care and additional monitoring during labour. Ms P remained keen to have a vaginal birth.

At 32 weeks gestation Ms P attended an appointment with an obstetrician. Ms P informed the obstetrician that her first baby was delivered via emergency caesarean after becoming 'distressed' during labour. The obstetrician did not seek any further information regarding the circumstances of the previous caesarean or make a request for the operation notes from the trust where Ms P had delivered. The obstetrician was therefore not aware that there had been difficulty delivering the baby and an inverted T incision had been performed on the uterus. This would have altered the information provided to Ms P to enable her to make an informed decision when planning her preferred mode of birth. The previous caesarean was deemed to have been uncomplicated and the options for delivery were discussed with Ms P. Ms P felt fully informed of the risks associated with having a vaginal birth after one previous lower segment caesarean and agreed to see an obstetrician at 40 weeks to discuss post-dates management had she not yet gone into spontaneous labour.

At 39+2 weeks gestation Ms P phoned the maternity triage to report that she was experiencing uterine contractions approximately one to two times every ten minutes (1-2:10). She reported good fetal movements and no vaginal loss and stated that she was currently coping at home. Ms P informed the member of staff over the telephone that she was having a 'vaginal birth after caesarean' and had been informed to let the hospital know when she thought labour was starting. Ms P was advised to remain at home and to call back when she was regularly contracting 2-3:10 or sooner if she had any concerns. After approximately two hours Ms P contacted triage again and said that her contractions were now 2-3:10, she spoke to a different member of staff who was unaware Ms P had had a previous caesarean as the details of the first call had not been documented and the details of her previous delivery were not revisited. An assumption was made that Ms P had a previous vaginal delivery and advice was given accordingly. After confirming that there was no vaginal bleeding or additional concerns, Ms P was told to call again when her contractions were 4:10, lasting 60 seconds. An hour later Ms P phoned triage again whilst on her way to the hospital, she reported being in a lot of pain and that she unsure if the baby was moving.

On arrival at the Labour ward Ms P was very distressed, reporting an intense stabbing abdominal pain and vaginal bleeding. The midwife was unable to differentiate between the fetal and maternal heart when attempting to auscultate and requested an urgent obstetric review. The obstetrician located the fetal heart with a portable ultrasound scan machine, and it was estimated to be approximately 60

beats per minute (bpm). A decision was made for a category 1 caesarean section under general anaesthetic. The baby was delivered 12 minutes after the decision to deliver was made, and a uterine rupture was confirmed at delivery.

The baby girl was delivered in poor condition. Arterial cord pH was 6.91, with a base excess of -18.7 and lactate of 11.7. Venous cord pH was 6.98, with a base excess of -15.3 and a lactate of 8.4. She required extensive resuscitation and met criteria for 72 hours of therapeutic hypothermia (cooling). An MRI on day seven showed changes associated with chronic partial hypoxia and a diagnosis of stage 3 hypoxic ischaemic encephalopathy (HIE) was made. She was discharged home on medication to control seizures, with feeding support from the community paediatric team and follow up appointments with physiotherapy.

Learning points

This case highlights the following important points:

- Obtaining a thorough and comprehensive medical and previous obstetric history is critical for identifying risks and possible complications that may impact on the plan of care and advice given¹.
- Informed decision making and informed consent requires women to be supported to understand the options available to them regarding their care and should include potential associated risks, benefits and consequences of each option^{3,7}. This information should be included in a personalised care and support plan⁷.
- Telephone triage services should be operated by appropriately trained clinicians and be available twenty-four hours a day, seven days a week to provide evidence-based advice based on a woman's risks and individual circumstances⁵.
- All telephone triage consultations should be performed and documented using a structured risk assessment on a standardised template⁴.
- Details of any telephone triage consultations including risks identified and the advice given should be available and accessible to clinicians providing subsequent care or advice⁴.

Considerations for your hospital

- Are there standardised questions asked at booking when it is identified a woman has had a previous caesarean?
- Is there a process to risk assess at each clinical encounter?
- Is there a process in place for staff to obtain and review previous medical records if needed, including records held by other healthcare providers?

- Are risk assessments performed during the maternity care pathway clearly documented and easily accessible to those providing care?
- Are appropriately trained staff supported to complete a documented personalised plan of care in conjunction with the woman that reflects the options available to them including the potential risks and benefits of each option?
- Is the triage telephone appropriately manned by suitably trained staff 24/7?
- Is there a standardised documented risk assessment completed during triage telephone calls, including the advice given?

What has happened as a result?

This case story is illustrative. If a similar case were to occur in real life, then it would be referred to NHS Resolution's Early Notification Scheme. NHS Resolution's in-house, specialist teams will review all available information about the care received, to decide whether there is any evidence of substandard care which could potentially result in compensation.

The expertise of NHS Resolution is used to proactively assess the legal risk and provide early support to families where liability is established.

NHS Resolution supports an open, transparent discussion between clinicians and families following adverse events⁷. The scheme is also designed to improve the experience for NHS staff by time limiting the need for protracted involvement in the legal process and rapidly share learning.

It is very important to note that no amount of money is comparable with the loss of a child or a child living with lifelong neurological injuries. Where poor outcomes occur as a result of deficiencies in care, NHS Resolution aims to resolve all such claims or cases fairly and as quickly as possible.

The current compensation cost to the NHS for a baby who has long term severe brain injury is on average £13.5 million. The human costs to the babies, families and clinical teams involved are immeasurable.

Resources:

1. Antenatal Care- National Institute for Health and Care Excellence (NICE)- August 2021 [Antenatal care \(NICE.org.uk\)](https://www.nice.org.uk/guidance/ng201)
2. Birth after Previous Caesarean Birth (Green top Guideline No.45)- Royal College of Obstetricians and Gynaecologists (RCOG) October 2015 [Birth after Previous Caesarean Birth \(RCOG.org.uk\)](https://www.rcog.org.uk/guidance/green-top-guidelines/gtg45)
3. Shared decision making- National Institute for Health and Care Excellence (NICE)- June 2021 [Shared decision making \(NICE.org.uk\)](https://www.nice.org.uk/guidance/ng16)
4. Maternity Triage (Good Practice Paper No.17)- Royal College of Obstetricians and Gynaecologists (RCOG) December 2023 [Maternity Triage \(RCOG.org.uk\)](https://www.rcog.org.uk/guidance/good-practice-papers/gpp17)

5. Assessment of risk during the maternity pathway investigation report- Health Services Safety Investigations Body (HSSIB) March 2023 [Assessment of risk during the maternity pathway \(HSSIB.org.uk\)](#)
6. Birth after previous caesarean- Patient Information Leaflet- Royal College of Obstetricians and Gynaecologists (RCOG) July 2016 [Birth after previous caesarean patient information leaflet \(RCOG.org.uk\)](#)
7. Three year delivery plan for maternity and neonatal services- NHS England- March 2023 [NHS England » Three year delivery plan for maternity and neonatal services](#)
8. NHS Resolution Saying Sorry June 2017 [Saying Sorry](#)



Resolution

8th Floor
10 South Colonnade
Canary Wharf
London, E14 4PU
Telephone 020 7811 2700
Fax 020 7821 0029
Email nhsr.safety@nhs.net

Arena Point, Merrion Way
Leeds LS2 8PA
Telephone 0113 866 5500

www.resolution.nhs.uk



Part of NHS Resolution's
maternity campaign 2022/25
#ImprovingMaternityOutcomes