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National Treasury Management Agency

An Ghníomhaireacht um Éilimh ar an Stát
State Claims Agency

Clinical Risk Matters Series: Clinical Risk Updates and Spotlight on Maternity

Clinical Risk Unit

November 2023

Objectives

About Clinical Risk Unit

Snapshot insights from claims and incident analysis

About Clinical indemnity

Overview of claims in maternity services

Spotlight on learning catastrophic injury claims in babies in maternity services

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Clinical Risk Unit & Snapshot Insights

Presenter:

Dr Cathal O'Keeffe

Clinical Risk Matters Series: Clinical Risk Updates and Spotlight on Maternity

November 2023

Clinical Risk Unit & Snapshot Insights - Agenda

- SCA statutory risk management mandate
- About Clinical Risk Unit
- Snapshot insights from claims and incident analysis

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About Clinical Risk Unit

Our Services

We provide a number of **specialist services** to State Authorities, in line with our mandate.

Claims Resolution

Risk Management

Legal Costs Management

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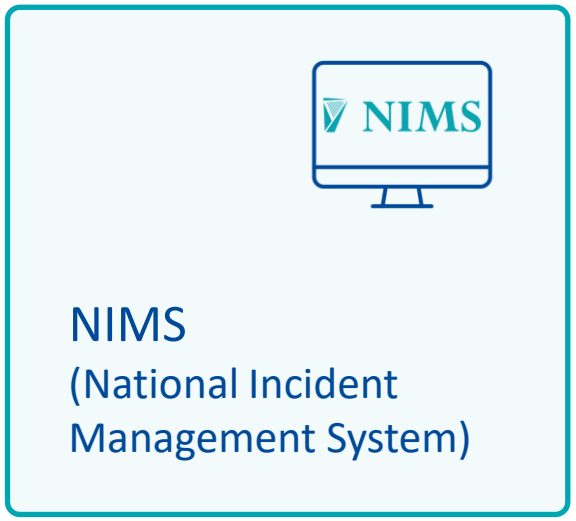
SCA's Statutory Risk Management Mandate

NTMA (Amendment) Act, 2000, Section 8(4)

The Act sets out that the SCA shall advise and assist a State Authority whenever it considers it appropriate to do so for the purpose of reducing risks that may occasion claims. Such advice may include:

- the **provision of information, instruction and training** for the purposes of identifying and taking appropriate measure to counter such risks
- the **assessment of any such risk**, including the determination of whether it could give rise to a serious hazard
- the **evaluation of the adequacy of the measures adopted by such an authority** to counter any such risk
- the provision to such an authority of **safety audits, inspections and reviews**

NIMS – the National Incident Management System



- A confidential national end-to-end incident, risk and claims management platform
- System used by State Authorities to fulfil the statutory requirement to report incidents to the State Claims Agency and for their own incident and risk management purposes

Safety and insights. Powered by data.

Incident Reporting

	Incidents Recorded
2018	197,019
2019	213,271
2020	211,260
2021	207,822
2022	246,269

More than

2.53m

incidents reported by end 2022
since the inception of NIMS

Refers to incidents reported by State Authorities via NIMS

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Benefits of incident reporting

1

Analyse and investigate incidents, learn from what went wrong and put in place risk mitigation strategies and initiatives

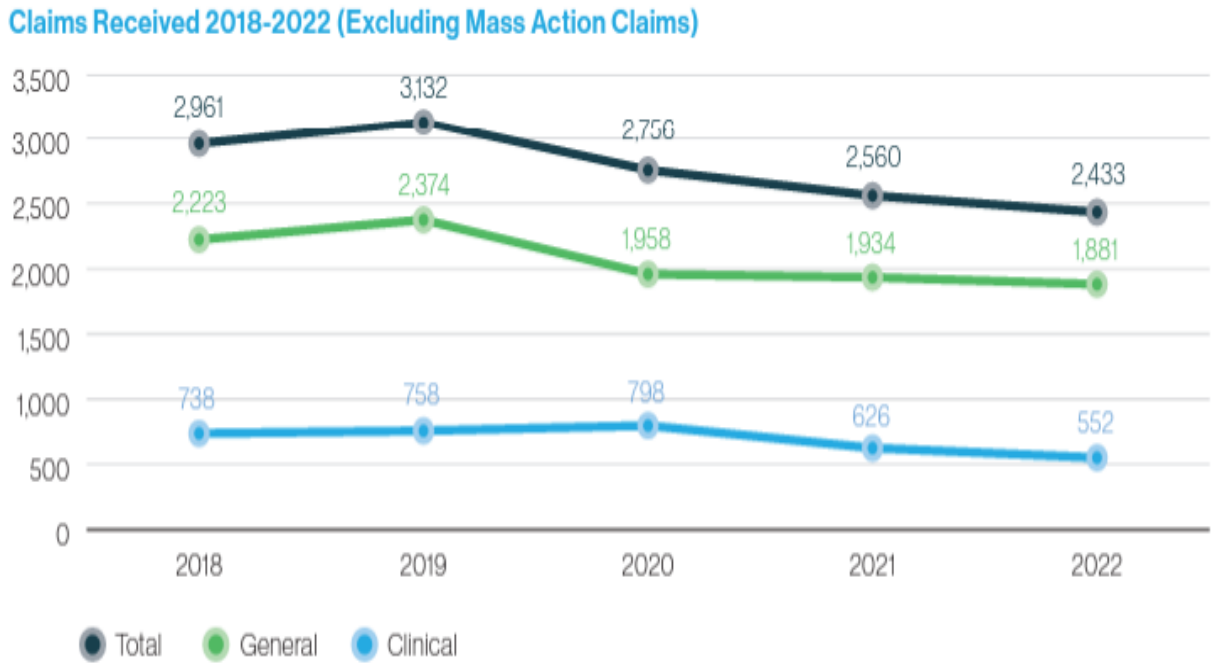
2

Contribute to the national data-set of incidents to enhance national learning and improvement

3

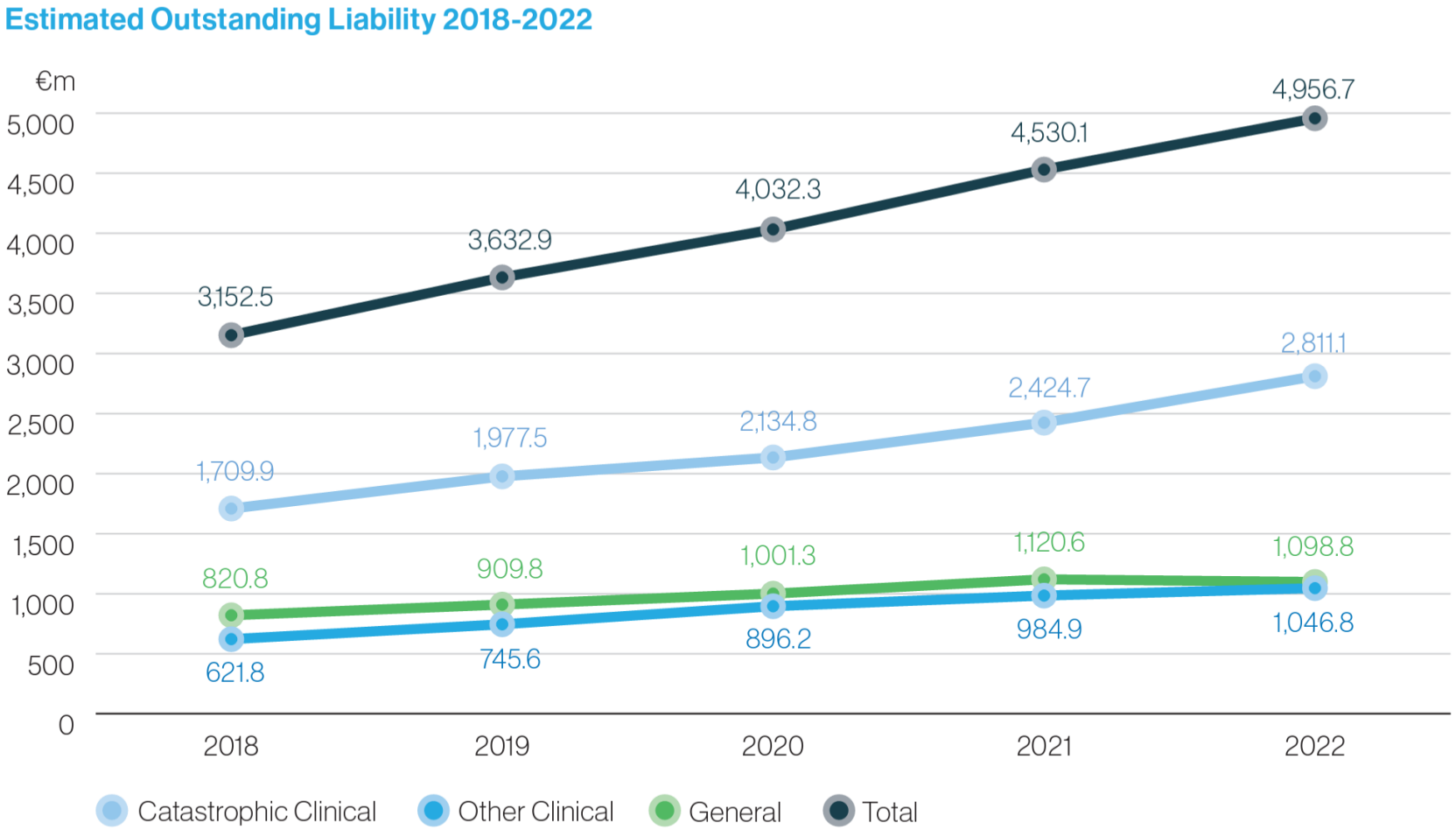
Provide early warning to us of any potential claims and gather relevant information in relation to claims

Claims Position (to end-2022)



https://www.ntma.ie/annualreport2022/

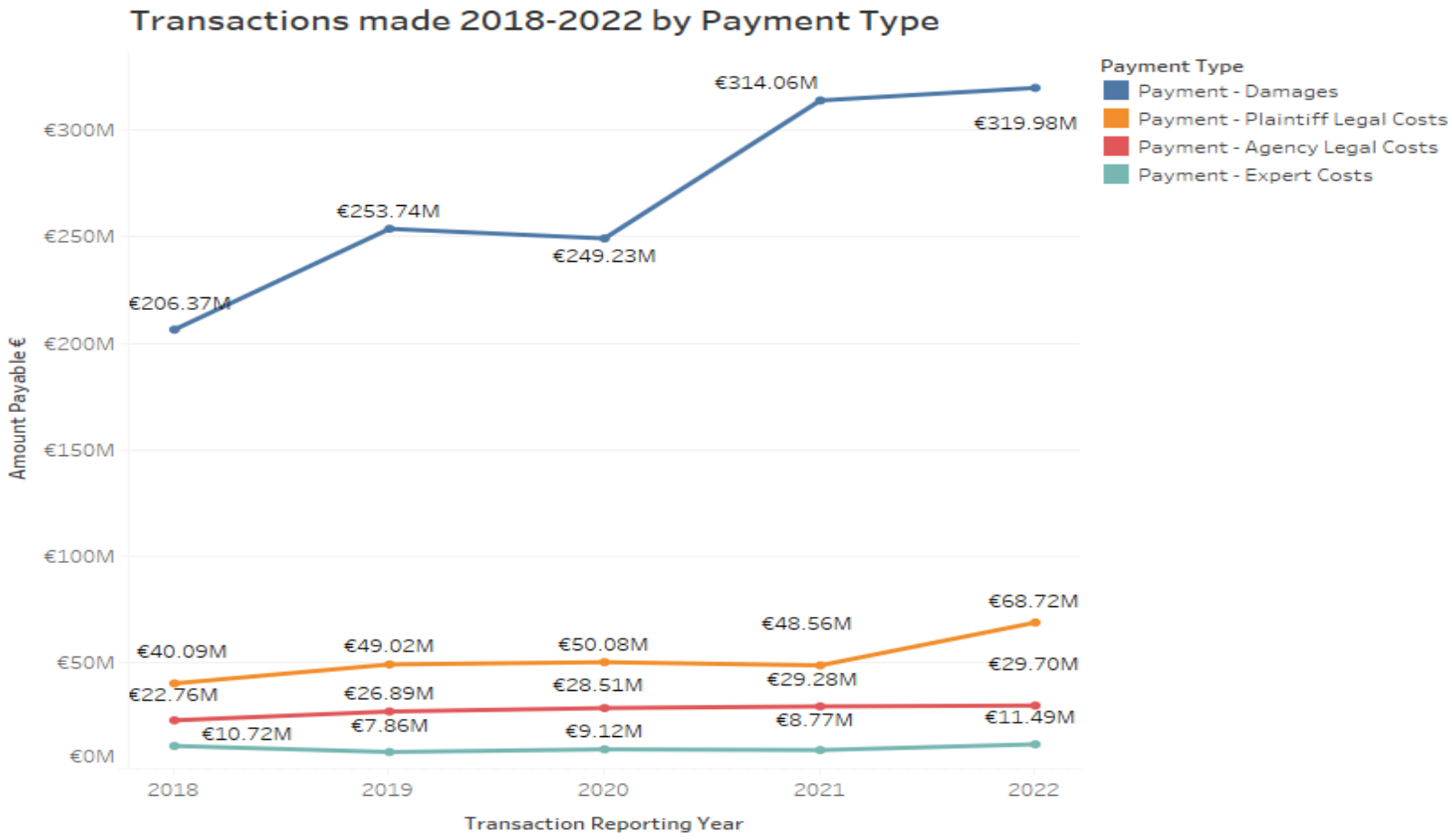
Estimated Outstanding Liability



Figures may not total due to rounding.

Reference: Annual Report & Financial Statements, NTMA 2022

Transactions made 2018 - 2022 by payment type for service user claims



Figures correct as of 31/12/2022

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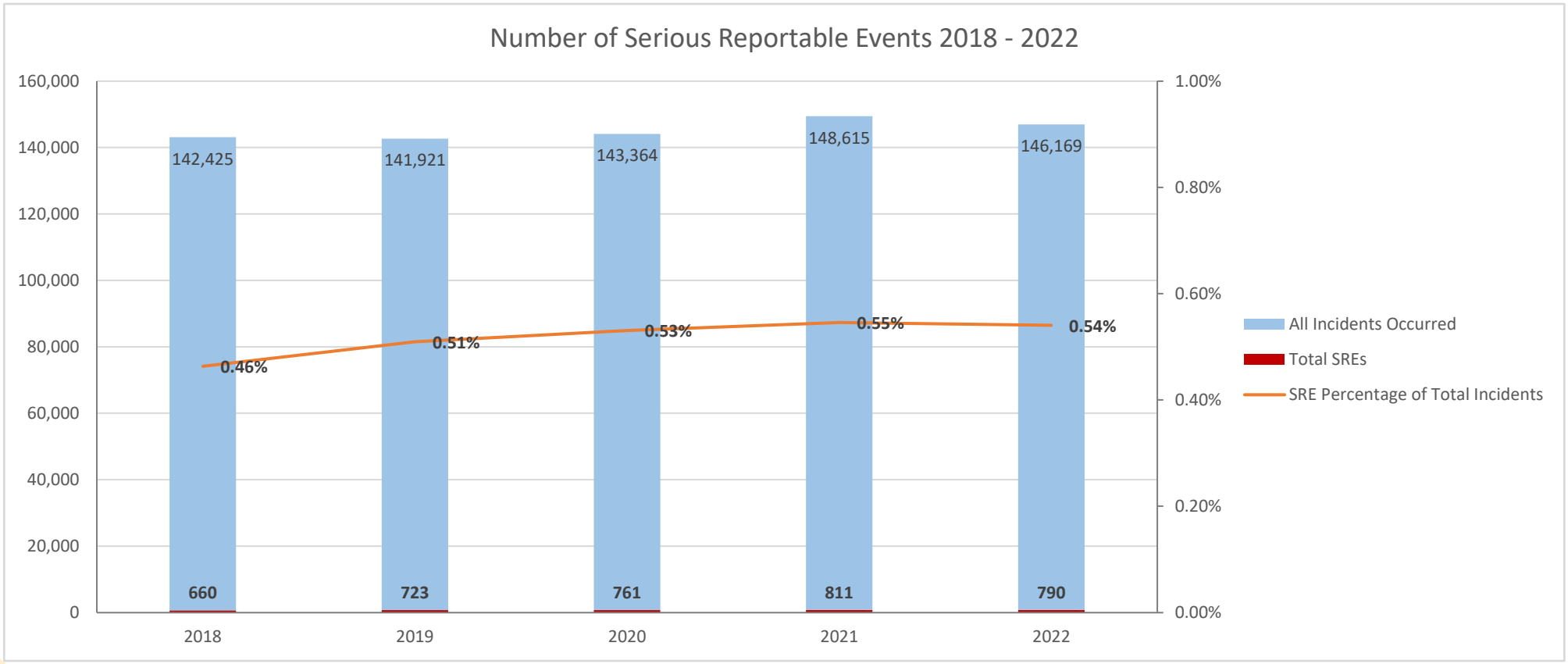
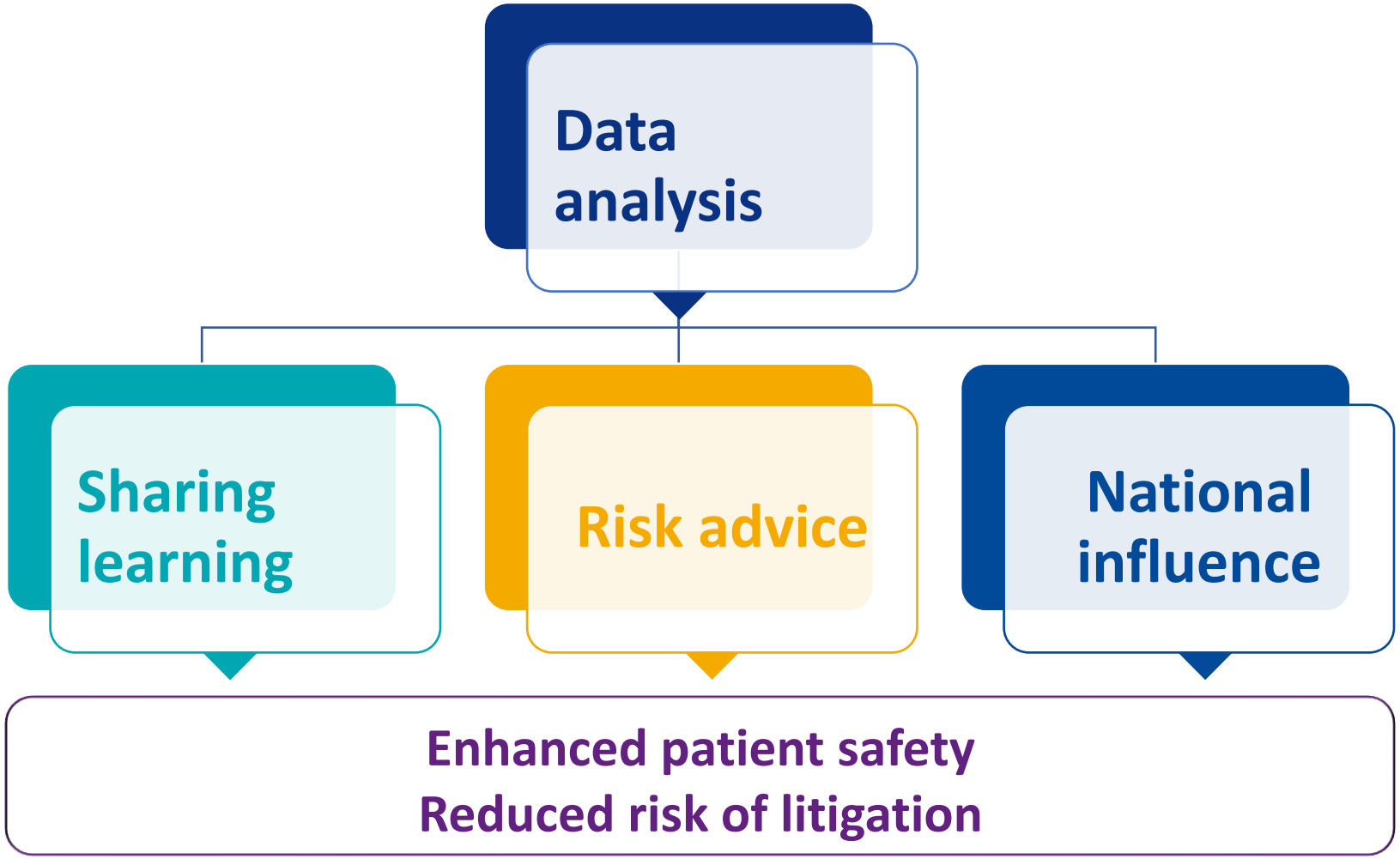
State Claims Agency

Number of service user serious reportable events in the period 2018 – 2022



Figures correct as of 31/12/2022

Clinical Risk Unit



About Clinical Risk Unit incident and claims analysis process

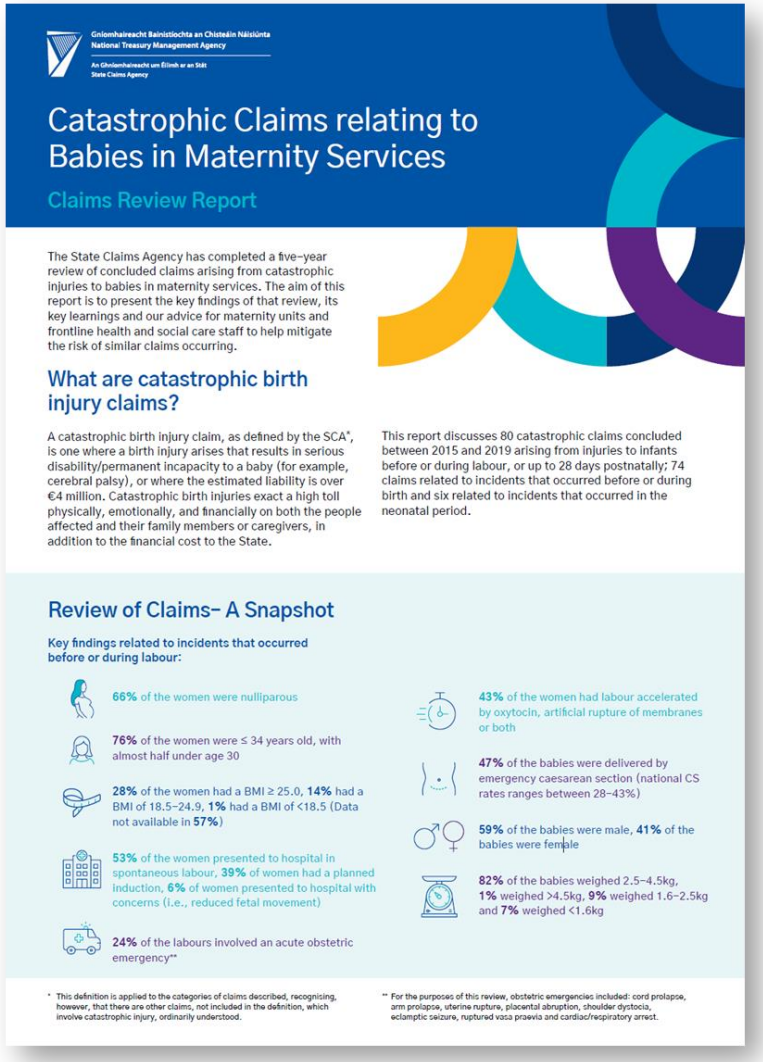
Process developed to comprehensively review and analyse service user incidents and claims which are reported on NIMS

Aims to extract learning from incident and claims, thereby **enhance patient safety**

Attempts to capture national trends, develop **risk advices**, and **share learning**

Analysis draws on the **multi-disciplinary** professional expertise of the CRU team

Current claims projects



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State Claims Agency

Catastrophic Claims relating to Babies in Maternity Services

Claims Review Report

The State Claims Agency has completed a five-year review of concluded claims arising from catastrophic injuries to babies in maternity services. The aim of this report is to present the key findings of that review, its key learnings and our advice for maternity units and frontline health and social care staff to help mitigate the risk of similar claims occurring.

What are catastrophic birth injury claims?

A catastrophic birth injury claim, as defined by the SCA*, is one where a birth injury arises that results in serious disability/permanent incapacity to a baby (for example, cerebral palsy), or where the estimated liability is over €4 million. Catastrophic birth injuries exact a high toll physically, emotionally, and financially on both the people affected and their family members or caregivers, in addition to the financial cost to the State.

This report discusses 80 catastrophic claims concluded between 2015 and 2019 arising from injuries to infants before or during labour, or up to 28 days postnatally; 74 claims related to incidents that occurred before or during birth and six related to incidents that occurred in the neonatal period.

Review of Claims– A Snapshot

Key findings related to incidents that occurred before or during labour:

- **66%** of the women were nulliparous
- **76%** of the women were ≤ 34 years old, with almost half under age 30
- **28%** of the women had a BMI ≥ 25.0, **14%** had a BMI of 18.5–24.9, **1%** had a BMI of <18.5 (Data not available in **57%**)
- **53%** of the women presented to hospital in spontaneous labour, **39%** of women had a planned induction, **6%** of women presented to hospital with concerns (i.e., reduced fetal movement)
- **24%** of the labours involved an acute obstetric emergency**
- **43%** of the women had labour accelerated by oxytocin, artificial rupture of membranes or both
- **47%** of the babies were delivered by emergency caesarean section (national CS rates ranges between 28–43%)
- **59%** of the babies were male, **41%** of the babies were female
- **82%** of the babies weighed 2.5–4.5kg, **1%** weighed >4.5kg, **9%** weighed 1.6–2.5kg and **7%** weighed <1.6kg

* This definition is applied to the categories of claims described, recognising, however, that there are other claims, not included in the definition, which involve catastrophic injury, ordinarily understood.

** For the purposes of this review, obstetric emergencies included: cord prolapse, arm prolapse, uterine rupture, placental abruption, shoulder dystocia, eclamptic seizure, ruptured vasa praevia and cardiac/respiratory arrest.

Claims. Learning. Actions. Implementation. Monitoring.

C.L.A.I.M

Initiative

Data analysis & research: Current analysis

Radiology

Dermatology

Emergency Department

Medication

Transfer of Care

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Snapshot insights from incidents & claims

Risk Management: Clinical Risk Insights

- Clinical Risk Insights is the regular newsletter issued by the Clinical Risk Unit
- Each edition includes articles on managing clinical risk, information on upcoming webinars and events, and notifications of any updates to NIMS, the National Incident Management System.

Clinical Risk Snapshots - Focus on medication: SALAD incidents

Focus on medication: SALAD incidents

In this article, Mark McCullagh, Clinical Risk Advisor, spotlights incidents involving sound-alike look-alike drugs (SALADs) and reviews what health and social care services can do to minimise their occurrence.

READ ARTICLE

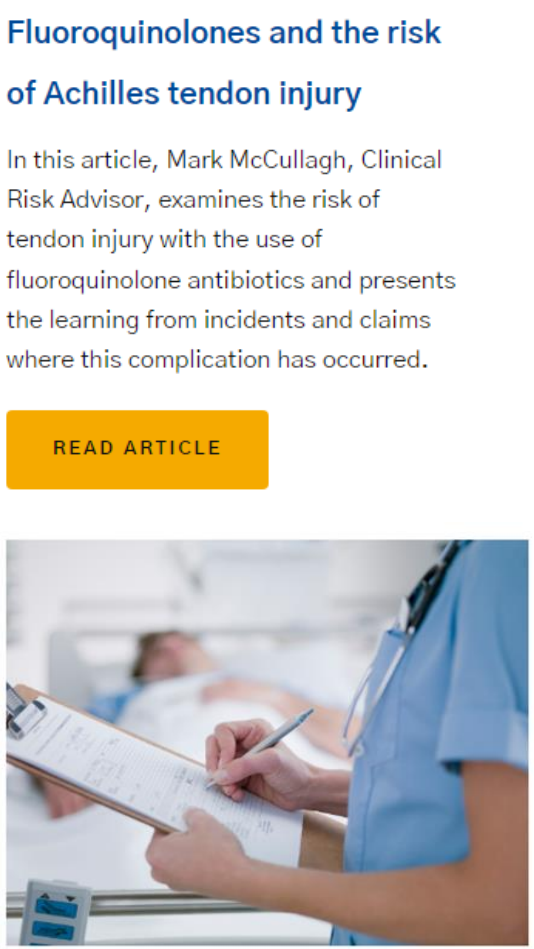
- Sound-alike look-alike drug (SALAD) incidents result from confusion between different drugs with similar names, labelling and/or packaging, or between different strengths of the same drug.
- SALAD incidents are reported on NIMS on an ongoing basis. Examples include those involving insulins, which the World Health Organisation (WHO) has listed as high-risk (high-alert) medications.

Read more here >>

Clinical Risk Snapshot - Focus on medication: SALAD incidents

Key take home messages

Clinical Risk Snapshots– Fluoroquinolones (FQ) and the risk of Achilles tendon injury



- Fluoroquinolones (FQs) are broad-spectrum antibiotics commonly used to treat respiratory, urinary, and gastrointestinal tract infections.
- FQs have been associated with serious adverse effects, including tendonitis and tendon rupture, which can occur within 48 hours of commencing treatment or can occur months after discontinuation.
- The Clinical Risk Unit undertook a review of incidents and claims in relation to tendon injuries associated with FQ use.

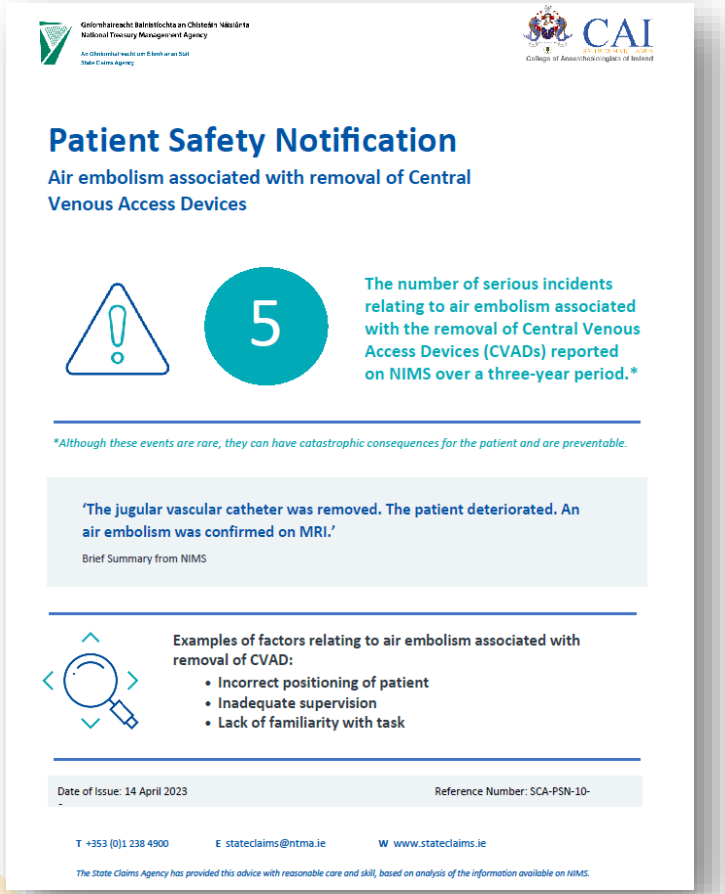
Read more here >>

Clinical Risk Snapshot – Fluoroquinolones (FQ) and the risk of Achilles tendon injury

Key take home messages

- Take care in those **aged over 60**, those with **renal impairment** and **solid organ transplant recipients**
- **Avoid concurrent administration** of a **corticosteroid**
- **Advise patients of the risk of** tendon injury
- **Be aware that tendon injury can occur within 48 hours** of commencing a FQ or can occur months after stopping treatment

Clinical Risk Snapshot - Patient Safety Notification: Air Embolism



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CAI
College of Anaesthesiologists of Ireland

Patient Safety Notification

Air embolism associated with removal of Central Venous Access Devices

5

The number of serious incidents relating to air embolism associated with the removal of Central Venous Access Devices (CVADs) reported on NIMS over a three-year period.*

*Although these events are rare, they can have catastrophic consequences for the patient and are preventable.

'The jugular vascular catheter was removed. The patient deteriorated. An air embolism was confirmed on MRI.'

Brief Summary from NIMS

Examples of factors relating to air embolism associated with removal of CVAD:

- Incorrect positioning of patient
- Inadequate supervision
- Lack of familiarity with task

Date of Issue: 14 April 2023 Reference Number: SCA-PSN-10-

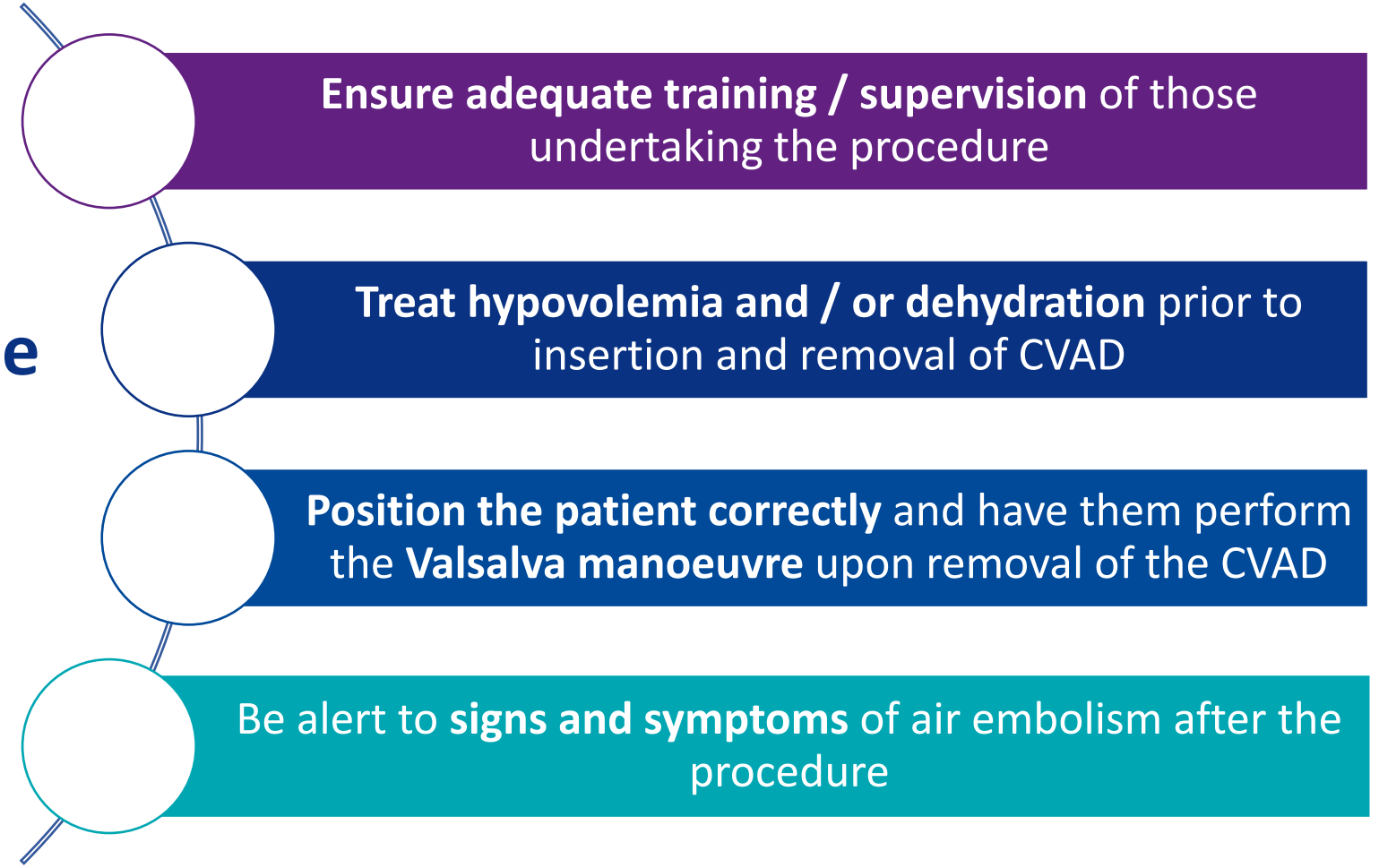
T +353 (0)1 238 4900 E stateclaims@ntma.ie W www.stateclaims.ie

The State Claims Agency has provided this advice with reasonable care and skill, based on analysis of the information available on NIMS.

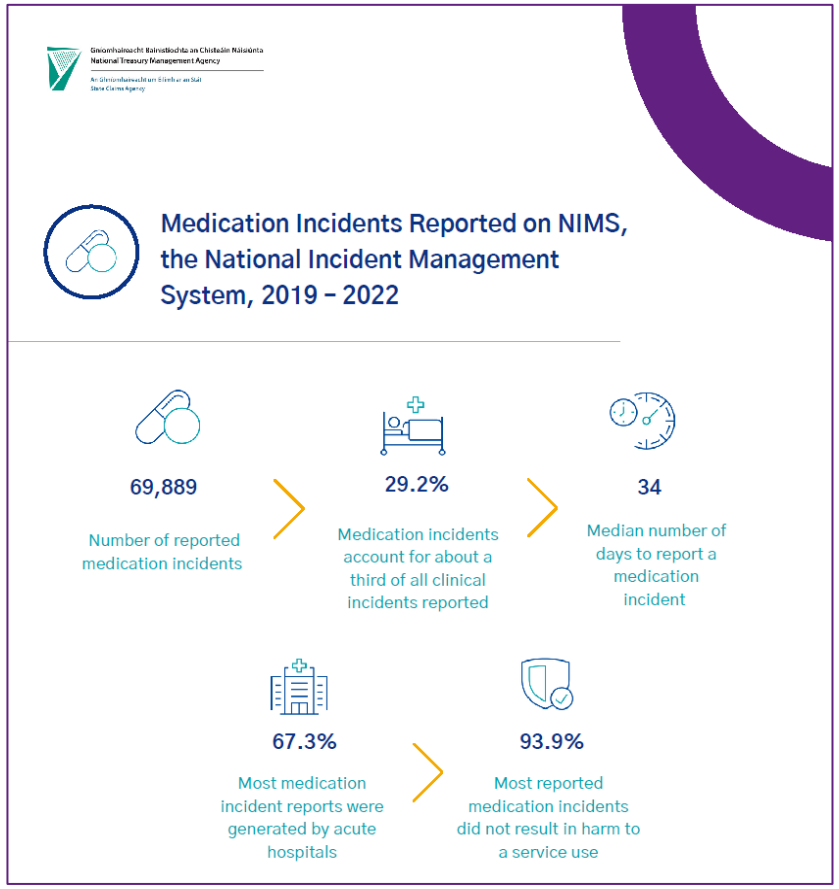
- The Clinical Risk Unit has noted the occurrence of serious incidents relating to the removal of Central Venous Access Devices (CVADs) and issued a patient safety notification.
- Air embolism can occur if a patient is incorrectly positioned during the removal of a CVAD.
- Although these events are rare, they can have catastrophic consequences for the patient and are preventable.

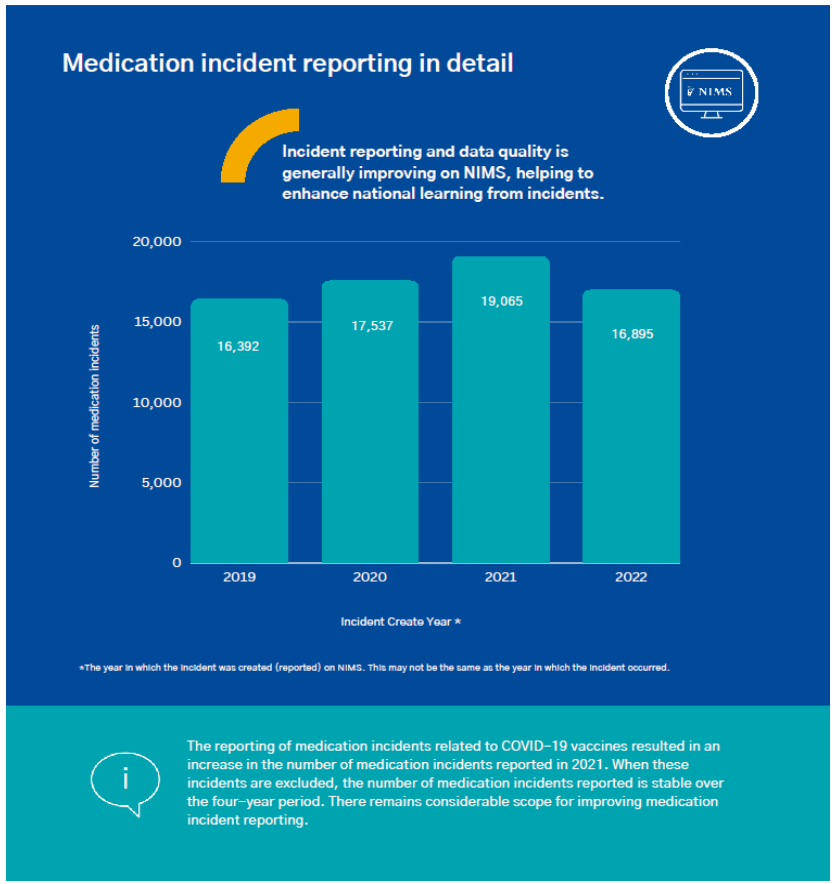
Risk Management: Patient Safety Notification (PSN)

Key take home messages



Data Analysis: Medication infographic - coming soon





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FAQs, articles and upcoming learning events

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Further questions, training requests

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About Clinical Indemnity

Presenter:

Marie Hutton

Clinical Risk Matters Series: Clinical Risk Updates and Spotlight on Maternity

November 2023

About Clinical Indemnity - Agenda

- History of Clinical Indemnity in Ireland
- Legislative basis for the State Claims Agency
- Legislative basis for the Clinical Indemnity Scheme
- Clinical Indemnity FAQs

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History of Clinical Indemnity

History of Medical Indemnity in Ireland for the Provision of Professional Medical Services

- State Insured Hospitals
  - (Irish Public Bodies)
- Term of Consultants employment in Public hospitals for Consultants to be insured
  - State reimbursed 80% of cost of insurance
  - 20% paid by practitioner to cover private practice
- Medical Defence Union (MDU)
- Medical Protection Society (MPS)
- Non-Consultant hospital doctors - post insured – not individual

Dunne -v- National Maternity Hospital
1988 – 1990

- Court Proceedings against:
  - Consultant
  - Non Consultant Hospital Doctor(s) (NCHD)
  - Hospital (Nurses/Midwifes)
- To Defend Action
  - Each had Insurance company who instructed a firm of Solicitors
  - Each firm of solicitors instructed Junior Counsel
  - Each instructed Senior Counsel (2)
  - Each fully investigated the claim (Experts)

- (NOTE - NCHDs - The post was covered - rotated 6 monthly)

History of State Claims Agency

Army hearing loss claims expected to cost €300m

https://www.irishtimes.com/news/army-hearing-loss-claims-expected-to-cost-300m-1.1112135

Relevant Legislation

- **National Treasury Management Agency (Amendment) Act 2000**
  - Functions of the State Claims Agency:
    - Management of claims
    - Provision of risk management advices to State authorities

- **Statutory Instrument (S.I.) 63 of 2003 National Treasury Management Agency (Delegation of Functions Order) 2003**

- **S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.**
  - Part C states; *" State authorities to which an order under paragraph (j) of the definition of "**State authority**" applies*"

- **S.I. No. 570 of 2009 National Treasury Management Agency (State Authority) Order 2009 specifically names the Health Service Executive**

Clinical Indemnity Scheme

Clinical Indemnity Scheme

- State indemnity is provided to State Authorities in respect of the provision of professional medical services

Relevant legislation is S.I. No. 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 Section 2.

Professional medical services means —

a. services provided by registered medical practitioners or registered dentists of a diagnostic or palliative nature, or consisting of the provision of treatment, or the conduct of research in respect of any illness, disease, injury or other medical condition (as amended by S.I. No. 628 of 2007),

b. services provided by other health professionals in the performance of their duties, including pharmacists, nurses, midwives, paramedics ambulance personnel, laboratory technicians, or

c. services connected with the provision of health or medical care provided by persons acting under the direction of a person to whom paragraph *(a)* or *(b)* applies.

Enterprise Liability

Hospital A

Hospital B

Clinical Indemnity State Authorities

Non consultant hospital doctors, nurses and midwives, allied health professionals and clinical staff

Certain other ancillary health and social care providers

HSE

including voluntary health and social care sector

Public health doctors, nurses and midwives, other community-based clinical staff

Dentists providing public practice

Clinical Indemnity Scheme

Covered

- Professional medical services provided in public hospitals, clinics and healthcare facilities
- Clinical care during transfer of patients
- Representation at Coroners' Inquests
- Good Samaritan acts within island of Ireland

Principle of "enterprise liability" applies – the health and social care service assumes vicarious liability for the acts and omissions of its employees providing professional medical services.

Not Covered

- *Private hospitals
- Private practice in private settings
- Disciplinary hearings
- Criminal cases
- GPs

NB: Supplementary professional/indemnity insurance required

**except in in relation to specific government led initiatives such as Safety Net.*

Obligations of State Indemnity

Under the National Treasury Management Agency (Amendment) Act 2000, Section 11 states State authorities must:

Report adverse incidents/claims to the State Claims Agency

Furnish all necessary and requested information and documentation to the State Claims Agency

Permit and assist the State Claims Agency to investigate adverse incidents/claims

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Clinical Indemnity FAQs

Clinical Indemnity Query:

Is a visiting consultant to a hospital covered under the Clinical Indemnity Scheme?

Providing the visiting consultant is acting with the authority and consent of the hospital, the consultant will be covered under the Clinical Indemnity Scheme while providing professional medical services in the hospital.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

Clinical Indemnity Query:

A dentist is coming to work in the HSE a temporary basis, will they be covered under the Clinical Indemnity Scheme?

Once the dentist is acting with the authority and consent of the HSE, the dentist will be covered under the Clinical Indemnity Scheme for the provision of professional medical services.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

Clinical Indemnity Query:

A member of clinical staff, appropriately qualified, offered to run a mindfulness course to clinical personnel in the hospital, would they be covered under the Clinical Indemnity Scheme?

This is not the provision of professional medical services and so the member of clinical staff will not be covered under the Clinical Indemnity Scheme for this purpose.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

Clinical Indemnity Query:

A member of clinical staff is participating in fellowship programme in another country while contracted to the HSE. Will Clinical Indemnity extend to non-Irish locations?

The benefit of Clinical Indemnity does not extend beyond the shores of Ireland, save where a medical team is accompanying a patient for handover to a hospital outside the jurisdiction of Ireland.

The relevant legislation is Statutory Instrument (S.I.) 63/2003 – National Treasury Management Agency (Delegation of Functions) Order 2003 and S.I. 628/2007 National Treasury Management Agency (Delegation of Functions) (Amendment) Order 2007.

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Spotlight on Maternity

Presenters:

Dr Karen Power

Cliodhna Grady

Clinical Risk Matters Series: Clinical Risk Updates and Spotlight on Maternity

November 2023

Agenda

Overview of the maternity services 2018-2022

Catastrophic injury claims in babies in maternity services

- Analysis of NIMS data (quantitative data)
- Analysis of claims files (qualitative data)
- Advice for frontline staff

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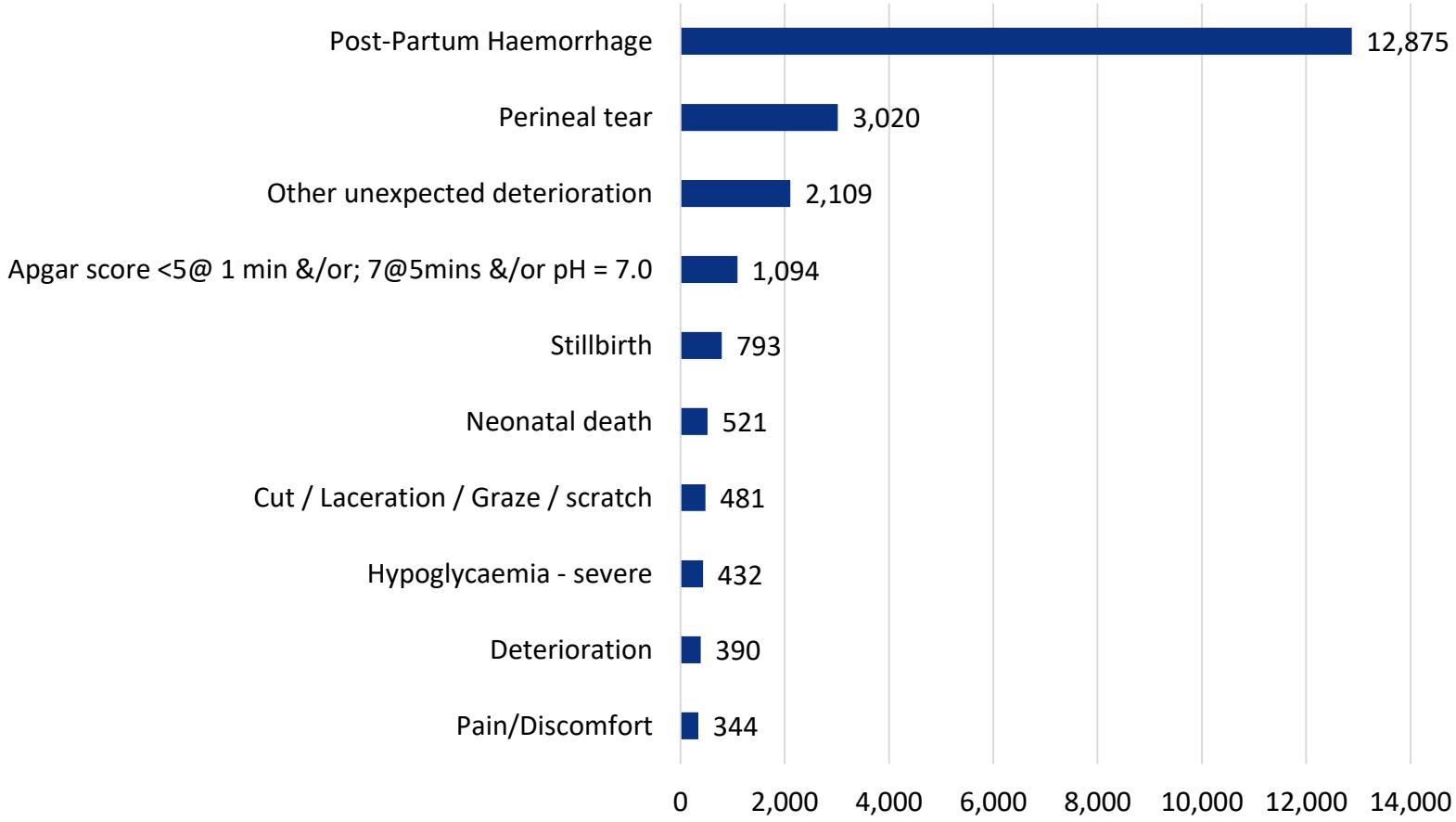
Overview of the maternity services 2018 - 2022

Maternity overview of incidents: 2018-2022

61,454 incidents reported in a five year period

12,290 per year on average

Top 10 categories for type of injury 2018-2022



Report Run Date 31/10/2023

Maternity overview of claims concluded: 2018-2022

726 claims concluded

"Sub hazard type"

59% related to labour/delivery

"Type of injury"

17% of claims related to anxiety/trauma/PTSD

In 74% of claims

the case was settled

In 45%

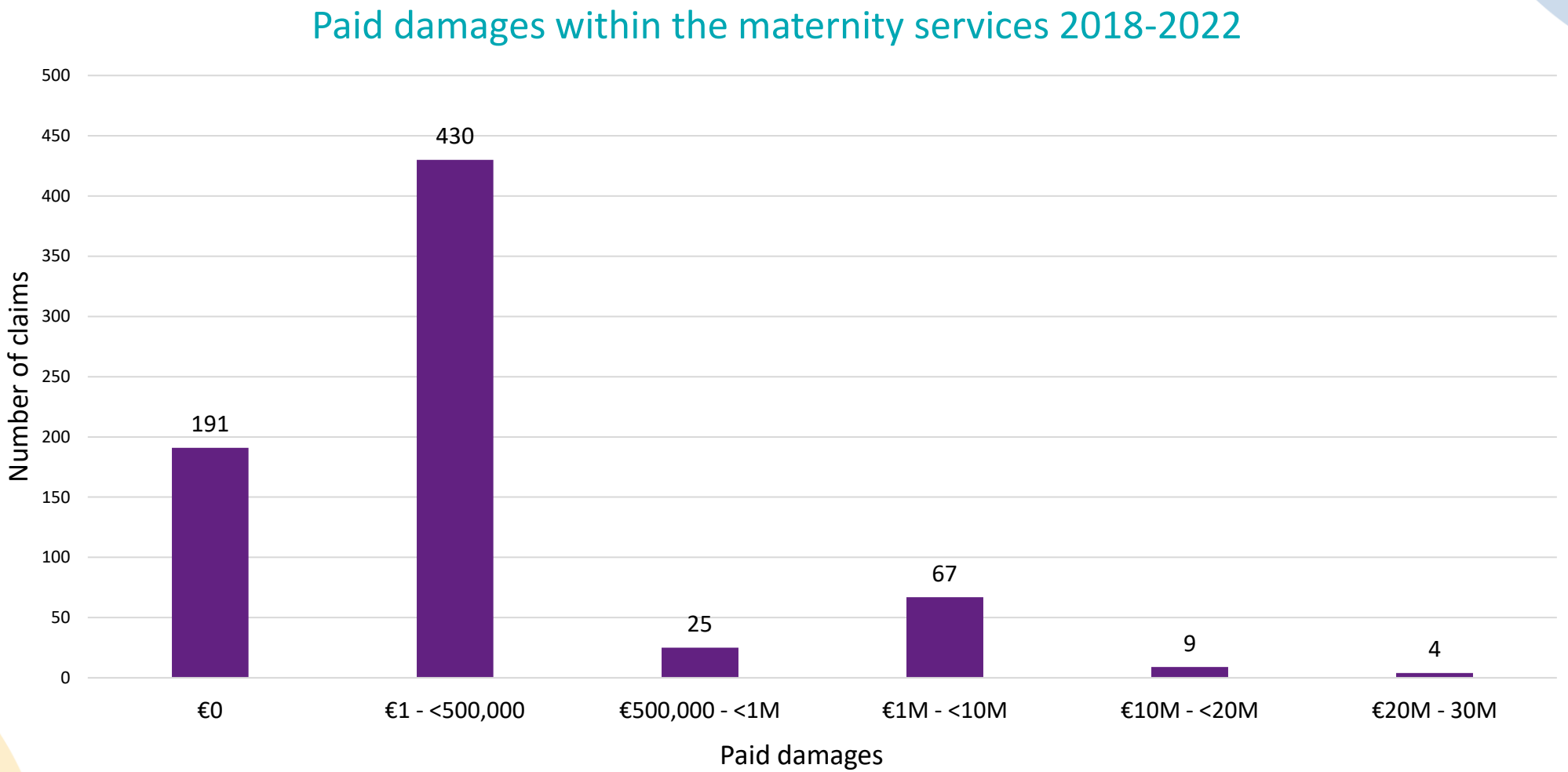
the incident was rated as moderate in severity

€534 million

in paid damages

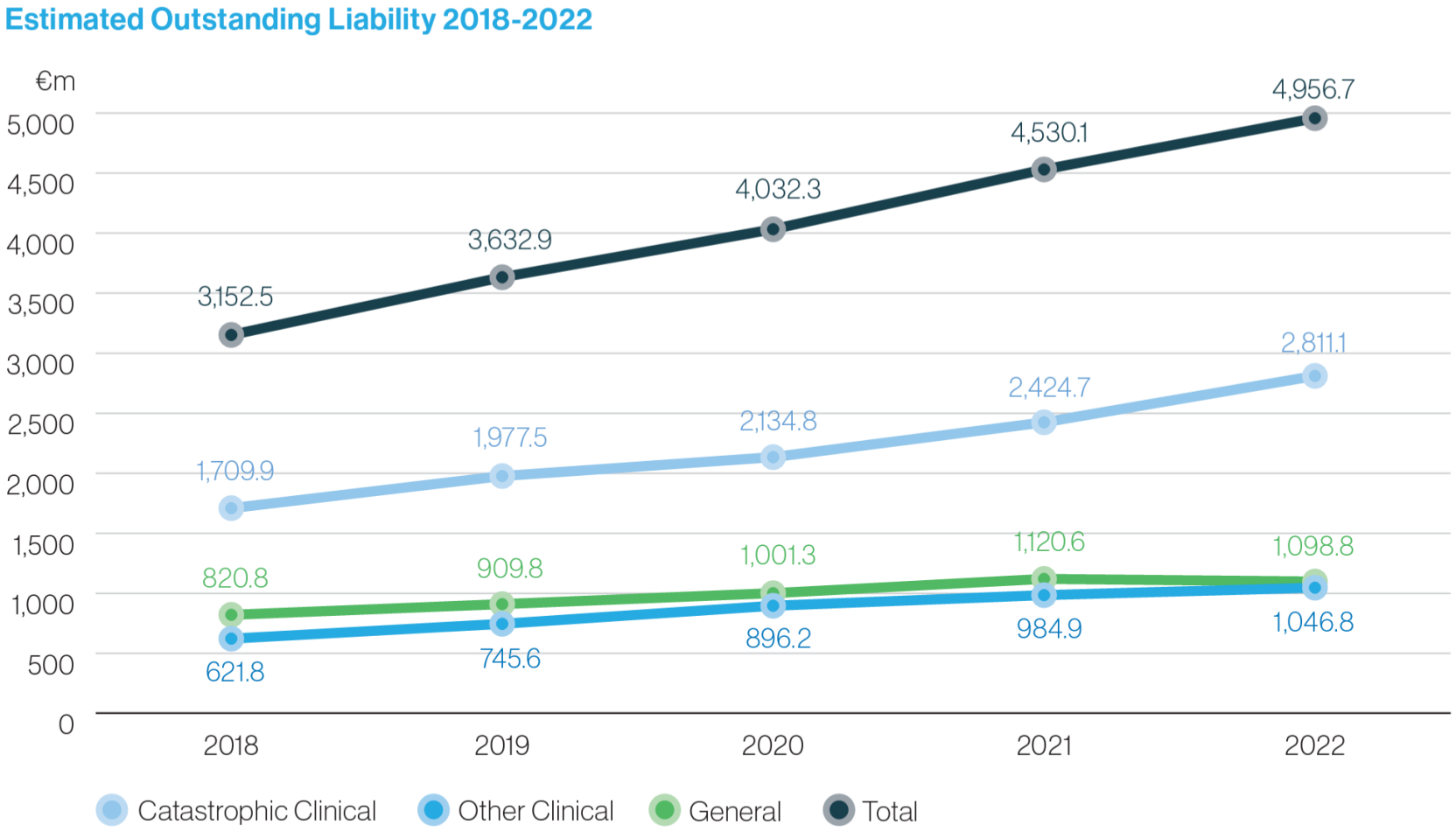
13% of claims were catastrophic

Maternity overview of claims concluded: 2018-2022



Report Run Date 31/10/2023

Estimated Outstanding Liability



Figures may not total due to rounding.

Reference: Annual Report & Financial Statements, NTMA 2022

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Catastrophic injury claims in babies in maternity services – a five-year review

Inclusion criteria

All service user-related clinical claims

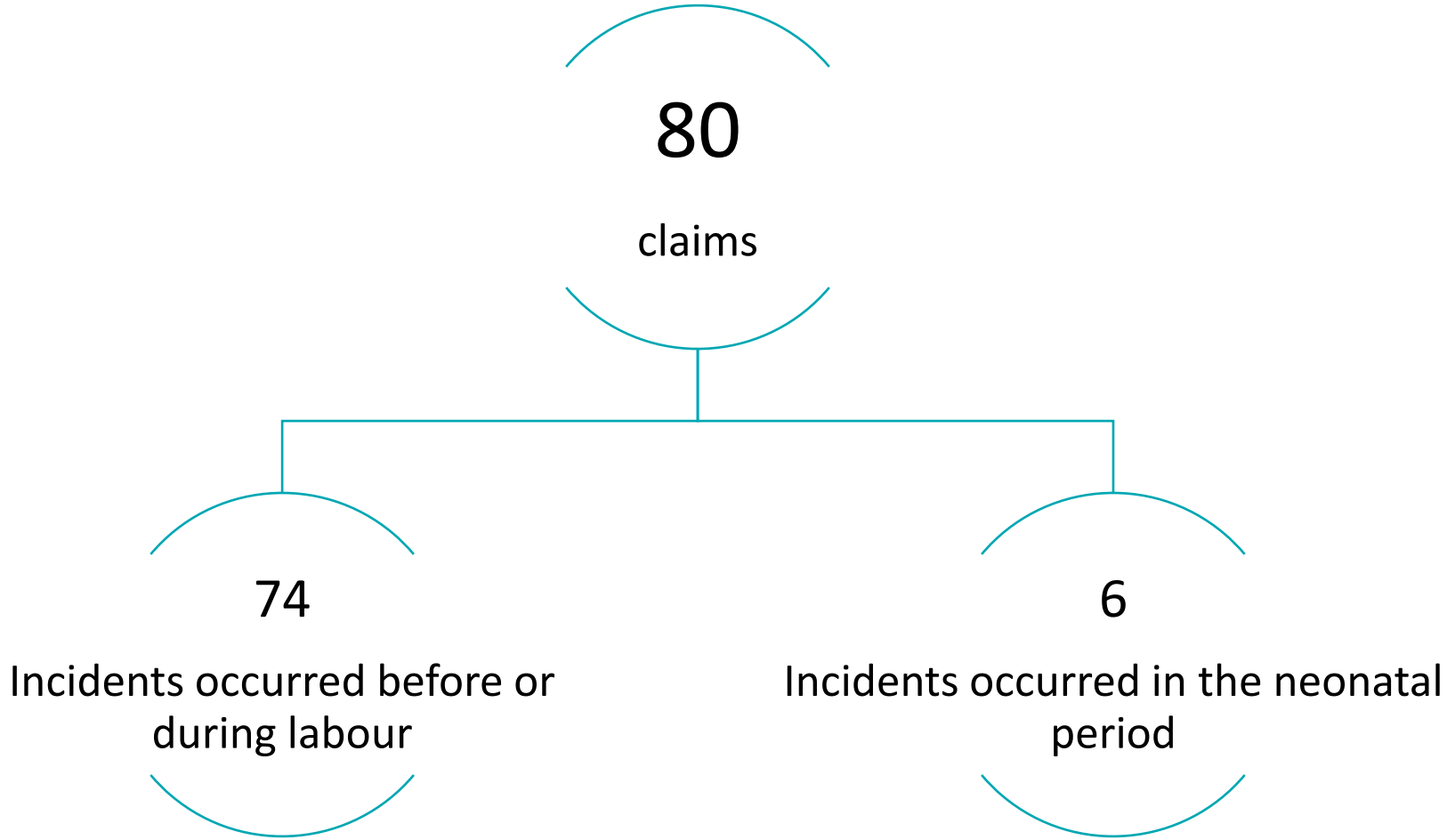
- defined as catastrophic
- related to an infant aged up to 28 days
- concluded and settled during the period January 1, 2015 to December 31, 2019 inclusive

SCA definition of a catastrophic claim

For the purposes of claims resolution, we define certain claims as “catastrophic”. These include, amongst others:

- Birth injury resulting in serious disability/permanent incapacity (e.g., cerebral palsy or permanent brain damage, developmental delay and/or the need for lifelong care)
- Claims where the Estimated Liability is €4,000,000 or greater.

Claims overview



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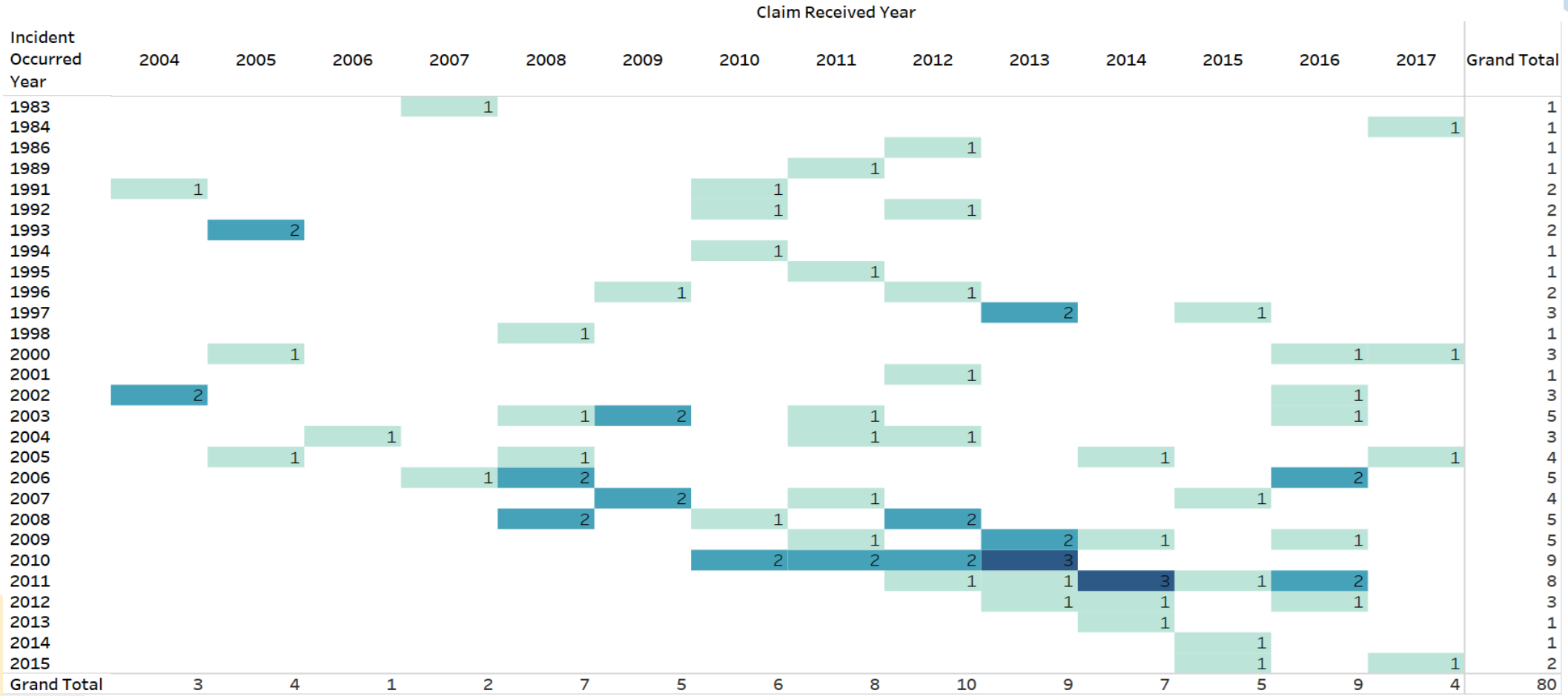
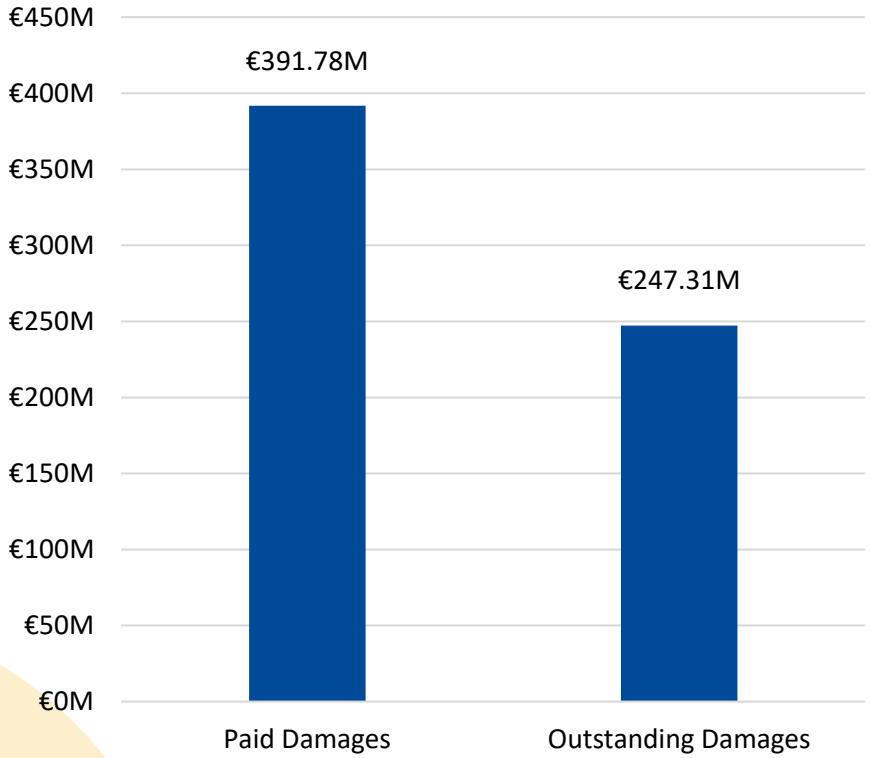
NIMS analysis

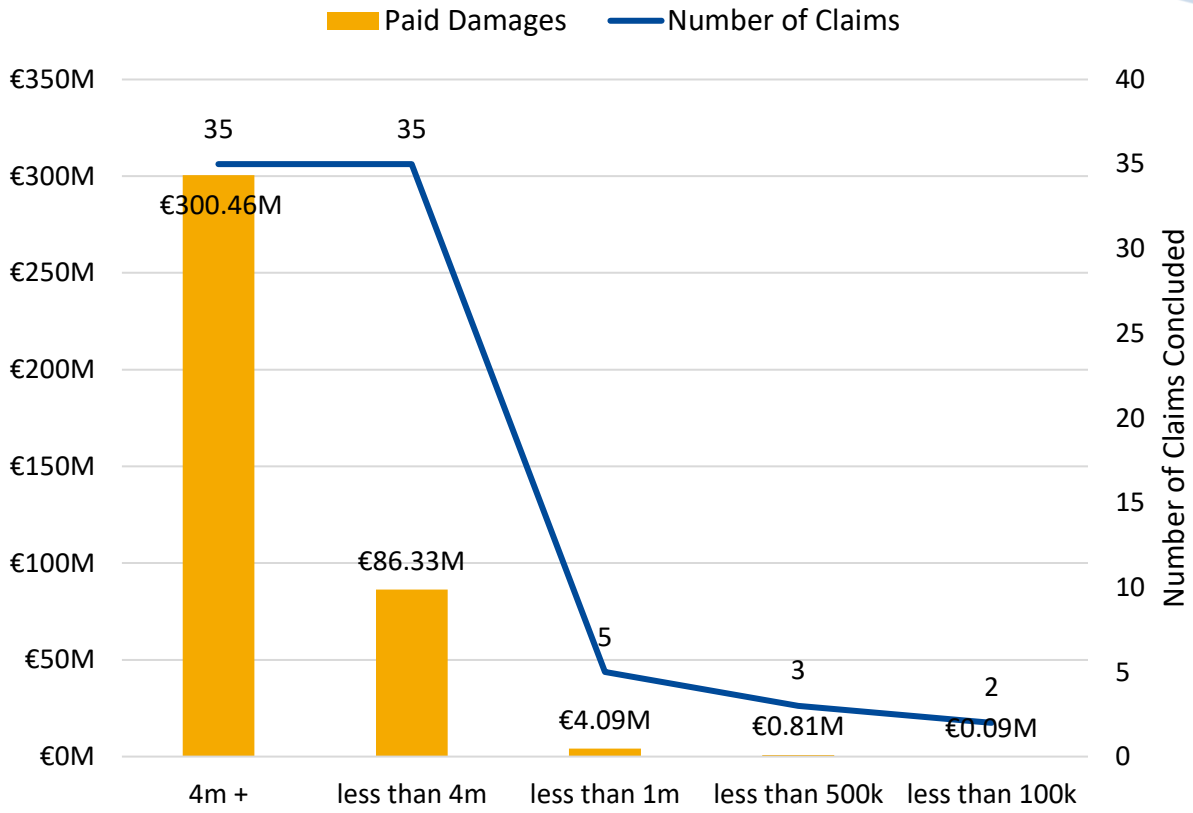
Catastrophic claims concluded by year of incident and claim create date



Incident Occurred Year	Claim Received Year														Grand Total
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	
1983				1											1
1984														1	1
1986									1						1
1989								1							1
1991	1						1								2
1992							1		1						2
1993		2													2
1994							1								1
1995								1							1
1996						1			1						2
1997										2		1			3
1998					1										1
2000		1											1	1	3
2001									1						1
2002	2												1		3
2003					1	2		1					1		5
2004			1					1	1						3
2005		1			1						1			1	4
2006				1	2								2		5
2007						2		1				1			4
2008					2		1		2						5
2009								1		2	1		1		5
2010							2	2	2	3					9
2011									1	1	3	1	2		8
2012										1	1		1		3
2013											1				1
2014												1			1
2015												1		1	2
Grand Total	3	4	1	2	7	5	6	8	10	9	7	5	9	4	80

Catastrophic claims concluded by paid damages, outstanding damages and value band *(Correct as of February 2022)*





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Analysis of claims files

Review of Claims – A Snapshot

Key findings related to incidents that occurred before or during labour:

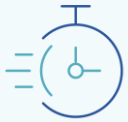
66% of the women were nulliparous

76% of the women were ≤ 34 years old, with almost half under age 30

28% of the women had a BMI ≥ 25.0, **14%** had a BMI of 18.5-24.9, **1%** had a BMI of <18.5 (Data not available in **57%**)

53% of the women presented to hospital in spontaneous labour, **39%** of women had a planned induction, **6%** of women presented to hospital with concerns (i.e., reduced fetal movement)

24% of the labours involved an acute obstetric emergency*



43% of the women had labour accelerated by oxytocin, artificial rupture of membranes or both

*For the purposes of this review, obstetric emergencies included: cord prolapse, arm prolapse, uterine rupture, placental abruption, shoulder dystocia, eclamptic seizure, ruptured vasa praevia and cardiac/respiratory arrest.

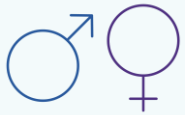
Review of Claims – A Snapshot

Key findings related to incidents that occurred before or during labour:

78% of the babies were born at 37-<42 weeks gestation
15% of the babies were born preterm (<37 weeks)
7% of the babies were born ≥42 weeks gestation

26% of the babies would be considered small for gestational age if their metrics were plotted on a standardised fetal growth chart

82% of the babies weighed 2.5-4.5kg, **1%** weighed >4.5kg, **9%** weighed 1.6-2.5kg and **7%** weighed <1.6kg



59% of the babies were male, **41%** of the babies were female

47% of the babies were delivered by emergency caesarean section (national CS rates ranges between 28-43%)

No home births, water births or elective caesarean sections featured

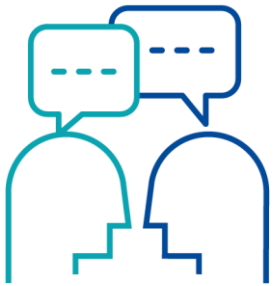
Claims related to post-natal events

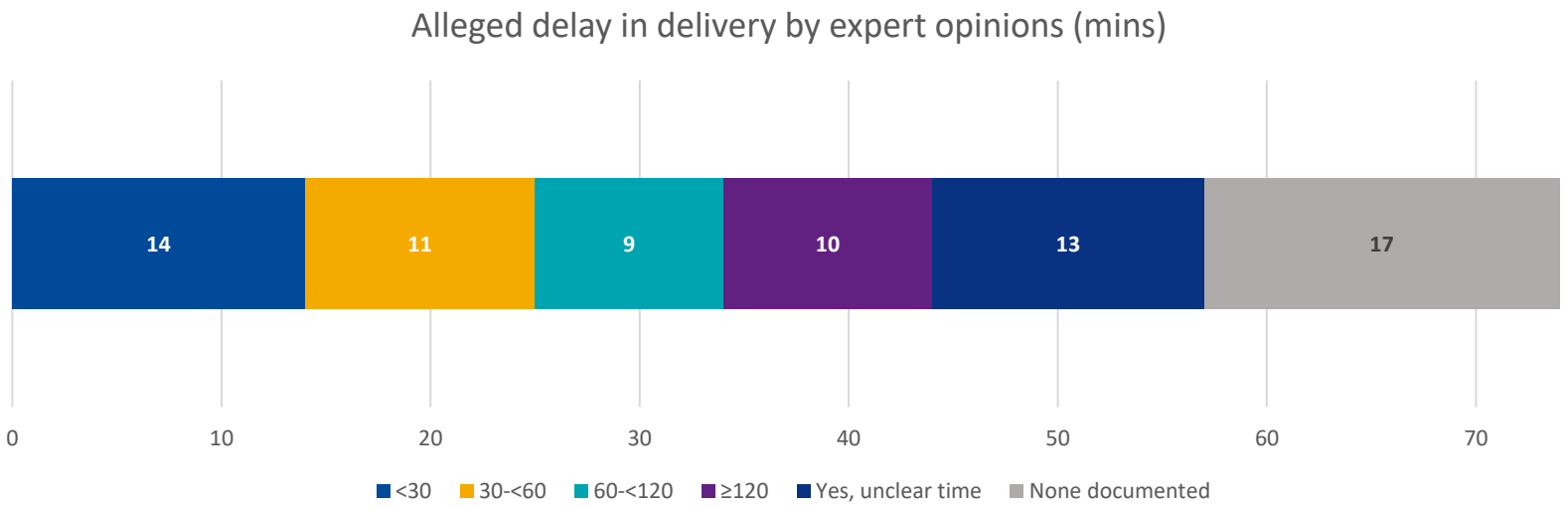
Six claims related to incidents that occurred in the postnatal period. Issues identified in these claims included:

- a failure to adequately monitor the neonate,
- a failure to adequately diagnose or treat neonatal infections, and
- inadequacies related to pharmacological therapeutic interventions

Issues identified by expert opinion

In at least 77% (n=57) of claims experts opined that there was a delay in delivery





64% (n=93) had delayed delivery in the NHS Resolution 2022/2023 report "The second report: The evolution of the Early Notification Scheme"

Issues identified by expert opinion

	% (of 74)	n	There was evidence of…
1.	64	47	Absent or poor quality documentation (e.g., times not annotated, notes not signed, signatures unidentifiable, missing notes)
2.	61	45	Failure to interpret or recognise an abnormal or pathological CTG
3.	51	38	Failure to monitor fetal heart/uterine contractions appropriately (e.g., failure to apply fetal scalp electrode when indicated, failure to monitor fetal heart between labour ward and delivery suite)
4.	50	37	Delay in escalation (e.g., failure to request a review of suspicious CTG)
5.	36	27	Inappropriate use of oxytocin (e.g., hyperstimulation, previous uterine scar, fetal distress, absence of assessing fetal wellbeing)
6.	31	23	Inadequate assessment (e.g., abdominal palpation, vital signs, vaginal examination)

95% of claims featured at least one of these issues
85% of claims featured at least two of these issues
59% of claims featured three or more of these issues

Issues requiring attention

- Management of obstetric emergencies
- Fetal monitoring
- Safe use of oxytocin
- Monitoring and escalation
- Communication
- Documentation
- Adherence to guidelines

Advice for Maternity Units

Based on our analysis of the claims in this review, we advise that all maternity units should consider implementing:

- A standardised approach to fetal monitoring and documentation of findings, e.g., intermittent auscultation of the fetal heart / CTG proforma sticker.
- A standardised approach to monthly reviews of perinatal clinical incidents, which have given rise to suboptimal outcomes. This is an opportunity to identify and learn from issues that may have contributed to adverse outcomes.
- Regular audit of clinical documentation (at least annually) on a random selection of births. Substandard documentation should be highlighted directly to the staff involved and as a regular part of ongoing competency and training.
- A process to ensure mandatory multidisciplinary training for all relevant staff in relation to fetal monitoring and management of obstetric emergencies and neonatal resuscitation, in addition to regular skills and drills.
- A mechanism to capture data on cases of impacted fetal head/difficulty delivering the head during caesarean section.

Advice for the Health and Social Care Staff

Based on our analysis of the claims in this review, we advise that all staff should:

- Recognise deviations from normal and ensure appropriate and timely intervention/decision-making when clinical concerns are present.
- Escalate concerns regarding fetal and maternal wellbeing to the senior midwife and obstetrician without delay; clear lines of escalation should be communicated at each shift.
- Anticipate the need for multidisciplinary assistance (e.g., neonatal paediatrician, microbiologist) and communicate this as soon as possible to the relevant team members.
- Check equipment at the start of every shift and before accepting each woman into the delivery suite/labour ward.
- Maintain situational awareness and be aware of the importance of room layout and storage.
- Follow the Start Smart and Then Focus approach for antimicrobial therapy[1].

Documentation

- Maintain legible, complete, and contemporaneous clinical documentation.
- Document all clinical examinations/reviews, rationale for decisions, reasons for delays, personnel involved and all timings of events.
- Use retrospective notes only when necessary and clearly identify the record as retrospective.
- Assign a nominated staff member, where possible, during emergencies to record timing of medication administration, interventions, personnel present, additional assistance summoned etc.

Communication

- Use communication tools such as ISBAR/ISBAR$_3$ to impart relevant clinical information during handover[2].
- Ensure clear verbal communication when highlighting the urgency of a situation; in an emergency, where possible, assign one team member to coordinate phone calls to theatre, laboratory, and other clinical personnel.

Staff caring for women in the antenatal and intrapartum period should:

- Ensure the woman is assigned to the correct pregnancy care pathway in accordance with her determined risk group[3].
- Perform adequate assessment of any presenting complaints, taking all relevant history into account at each antenatal interaction.
- For women planning a VBAC: obtain and document informed consent which should include the communication of risks, benefits and alternative modes of delivery.
- Perform fetal assessment to include regular ultrasound scans when deemed appropriate and in line with local and national policy. Additional surveillance ultrasound scans may be required in certain circumstances e.g., when intrauterine growth restriction (IUGR) is suspected.
- Be aware of the risk factors for neonatal encephalopathy[4].

Fetal monitoring

- Recognise that CTG interpretation should not occur in isolation and should be undertaken as part of a holistic assessment of fetal and maternal wellbeing[5].
- Ensure appropriate and timely intervention/decision-making when abnormalities are present.
- Ensure the fetal heart rate is confirmed by a pinard stethoscope before and during electronic fetal monitoring, in addition to taking the mother's pulse manually.
- Ensure the CTG recording is complete and that it includes the fetal heart rate, tocograph, accurate date and time, and maternal pulse. The midwife should document the CTG findings on a regular basis, and should document more frequently with a suspicious or pathological CTG.
- Ensure the correct placement of the tocograph transducer for accurate detection of uterine activity in conjunction with manual palpation of uterine contractions.
- Ensure alarms are enabled, audible and maintained on all CTG machines.
- Consider a "fresh eyes and ears" approach to fetal monitoring; have a colleague perform a fresh review of the fetal heart rate during intermittent or continuous fetal monitoring which is documented with time and signature[6].

Intrapartum care

- Know when oxytocin is indicated/contraindicated and the appropriate dose and method of administration for the different clinical scenarios in which is it used.
- For women undergoing a VBAC or trial of labour after caesarean section:
  - Augmentation of labour should be in consultation with senior clinical input throughout.
  - Be alert to potential complications such as uterine rupture or dehiscence.
- Undertake fetal blood samples where indicated and repeat within the appropriate timeframe, where necessary.
- Be aware of and able to recognise the signs of an obstructed labour.
- In the case of an instrumental delivery, document the assessment prior to the delivery including the station and presentation of the fetal head, the presence or absence of caput, formation of moulding, abdominal examination etc.
- Ensure timely transfer to theatre when a decision is made for a caesarean section, based on the assigned emergency category, and ensure that all relevant members of the multidisciplinary team are available.

Staff caring for women and babies in the postpartum period should:

- Be aware of the potential for sudden unexpected postnatal collapse (SUPC) of the newborn.
- Know when passive cooling and Therapeutic Hypothermia (TH) is indicated/appropriate and ensure prompt referral to a specialist centre where indicated.
- Ensure adequate information is provided to mothers to detect early onset of jaundice and what action to take if it occurs.

If you require further information, or references, please get in touch with us via stateclaims@ntma.ie

Scan the QR Code to learn more about our Clinical Risk Unit.

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FAQs, articles and upcoming learning events

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Further questions, training requests

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