

### Maternity eLearning case story modules

**Lynn Tilley RM** 

Safety and Learning Lead (EN Team), NHS Resolution

Dr Ellie Rayner

National Obstetric Clinical Fellow, NHS Resolution

**Annette Anderson RM** 

Head of Early Notification (Clinical),

NHS Resolution



## Session outline



- How we use unique datasets improve and share learning
- Development of innovative learning materials
- Take back to the unit messages





# **Strategic Priorities**







Priority 1.

Deliver fair resolution.

All of our services will focus on achieving fair and timely resolution, wherever possible keeping patients and healthcare staff out of formal processes to minimise distress and cost.



Priority 2.

Share data and insights as a catalyst for improvement.

Ensuring that our unique datasets help derive usable insights that benefit patients and the healthcare and justice systems.





Priority 3.

Collaborate to improve maternity outcomes.

Bringing together key parties to determine what further improvements can be made within our areas of expertise to support the government's maternity safety ambition.





Priority 4.

Invest in our people and

systems to transform our business.

Develop our people, systems and services so that we can continue to deliver best value for public funds.

## Learning resources





Detailed analysis of EN cases – Trusts of concern

Feedback on EN summit cases

#### Illustrative case stories:

- Placental Abruption
- Cord Prolapse
- Maternal Hyponatremia
- Antenatal CTG monitoring



### **Background to eLearning Module**

- An immersive learning experience
- Raise awareness of the Early Notification Scheme and legal process
- View clinical care through a claims lens
- Sharing learning from Early Notification cases
- Contribute to the learners professional development



### Introduction to e-Learning Module

- Introduction to NHS Resolution
- Overview of legal process

## Overview







### 9 Common Clinical Themes

Gestational Diabetes

Vaginal Birth After Caesarean (VBAC)

Reduced Fetal Movements

Vaginal Bleeding

Fetal Monitoring Abnormalities

Competing Demands for Midwife/
Obstetrician

Incorrect Management of Resuscitation

Group B Streptococcus

Poor Feeding/Low Blood Sugar



#### 9 Common 'Suboptimal Care' Themes

Quality of Discussion/ Referral Lost/Not **Incorrect Care Pathway** Documentation Chased Delay in Diagnosis Failure to Escalate Acuity not Escalated Communication Equipment not Language Difficulties Checked Issue/Handover



#### 9 Sets Of Topics Allocated To 3 Case Stories

Case Story 1 Natalie

Case Story 3 Rezan

Antenatal

**During Labour** 

Postnatal

**Antenatal Counselling** 

- Quality of Discussion/ Documentation
- Vaginal Birth After Caesarean

Fetal Monitoring in Labour

- Delay/No Escalation
- Fetal monitoring abnormalities

Neonatal Resuscitation

- Equipment not checked
- Incorrect management of resuscitation

Monitoring of Pregnancy

Case Story 2

Sarah

- Referral Lost/ not chased
- •Reduced Fetal Movements

Risk Assessment at Presentation in Labour

- Delay in Diagnosis
- Vaginal Bleeding

Recognising Deteriorating Newborn

- •Communication/Handover
- •Group B Streptococcus

Risk Assessment at Booking

- Incorrect Care Pathway
- •Gestational Diabetes

**Decision for Delivery** 

- Acuity not escalated
- •Competing demands for Obstetrician

**Postnatal Support** 

- Language Difficulties
- •Poor Feeding/Low Blood Sugar

Advise / Resolve / Learn



### Take back to the unit messages



- Tell us other resources would you like to see to support you in clinical practice
- Wide variety of learning resources directly related to claims data at national and local level
- Access and use case stories in your department/individuals



### Thank you

Please contact us at:

annette.anderson4@nhs.net
lynn.tilley1@nhs.net
eleanor.rayner3@nhs.net

