NHS Resolution

Case story

Communication and language challenges when English is not a mother's first language

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

Advise / Resolve / Learn

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: Communication and language challenges when English is not a mother's first language

Key points:

- To highlight that communication and documentation of that communication with the mother and the birth partner is an integral part of good clinical care.[1]
- To meet GMC Good Medical Practice which states that the health care professional must take steps to meet patients' language and communication needs, so they can support them to engage in meaningful dialogue and make informed decisions about their care. The steps a health care professional takes should be proportionate to the circumstances, including the patient's needs and the seriousness of their condition(s), the urgency of the situation and the availability of resources.[2]
- To consider the importance of using reliable interpretation services when undertaking any holistic assessment at each clinical encounter.[3]
- To consider the rationale for guidance in using interpretation services as opposed to family members when sharing information to support mothers and their birth partners to make an informed choice about their care.[3]/[4]
- To highlight the importance of obtaining valid consent. [5]

Maternity Story

A mother referred to as Mrs A in her first pregnancy attends her booking appointment with her husband (Mr A) at 16 weeks of pregnancy. At this appointment, the midwife records in the electronic maternity records that the mother's language is Somali and that she does not understand verbal or written English and relies upon her husband to interpret for her. In line with her unit's policy, the midwife adds an alert to the electronic healthcare records system (a red flag). This notifies health professionals in a confidential communique that this person will need additional

support with language. This also raises the potential that this person should be considered as vulnerable with potential safeguarding issues and may need additional support regarding housing and travelling to appointments for example.

Mrs A is assessed as low risk and therefore suitable for midwife-led care however, the reason for her late booking is not explored. The information is interpreted by her husband at this appointment as it was not possible to acquire an independent interpreter who spoke Somali via the hospital telephone interpretation service at short notice. The community midwife is able to use the interpretation telephone service at subsequent appointments, although it is not consistently recorded on the electronic system if an interpreter is used at each appointment. It is noted that the husband attends every appointment and speaks limited English. Health records evidence that Mrs A is not asked about domestic abuse because her husband is always present.

Mrs A's pregnancy proceeds uneventfully. At both 28 weeks and 36 weeks of pregnancy, the midwife records that she used an interpreter and is able to discuss the importance of monitoring fetal movements and is able to undertake a full birth plan discussion. Mrs A is directed to the Trust website for further information. However, the website does not provide information in Somali. Mrs A is given an information leaflet at the 40-week appointment about the induction of labour process in English, and she is booked for an induction of labour at 41+5 weeks.

At 40+6 weeks the husband, Mr A telephones the triage unit at 15:08 hours on behalf of his wife who has started to experience painful contractions every 15 minutes. Mr A is advised that, as his wife is in the latent phase of labour, she should stay at home and monitor her contractions. The midwife discusses with Mr A to confirm there are no concerns with altered/reduced fetal movements, bleeding, or other vaginal loss. Mr A confirms that there is not and that his wife feels well in herself. He is advised to call back again when the contractions are every five minutes or, indeed, if they have any concerns with their baby's movements or there is any continuous pain or fluid or bleeding from the vagina. The interpretation service is not used to discuss this information with the husband or to confirm he understands. This is because the midwife believes Mr A can understand the questions and information given to him, although his responses are short, 'yes' and 'no' rather than descriptive.

Just over six hours later at 21:15, Mr A calls the triage unit again and speaks to a different midwife. They are advised to stay at home as the contractions are only 10 minutes apart, the mother has not experienced any vaginal fluid loss and the baby is moving well. The midwife checks the electronic system and notes that the mother does not understand English but uses her husband to interpret rather than an interpretation telephone service which is recommended in the local Trust guideline. The unit is busy and, being new to the service, the midwife is unsure how to activate the telephone interpretation service without going to find someone to show her.

At 22:37 hours the couple present themselves at the delivery suite as the mother is very distressed and the husband is anxious as he feels he is not managing to support her at home. The midwife who receives them recognises that the husband is struggling to understand what he is being asked to relay to his wife and so the

telephone interpretation service is used to support information sharing. Using an interpreter, Mrs A is able to inform the midwife that she is experiencing contractions every 2-3 minutes, that her waters ruptured just prior to leaving home for the hospital but she is unsure if she has been feeling as many baby movements as usual for the last few hours.

The midwife is able to communicate, via the telephone interpreter, with the mother to explain that she would like to undertake some maternal physiological observations (blood pressure/heart rate/respiratory rate/temperature/urine analysis) and to palpate her abdomen and to listen into her baby. Mrs A, via her husband, agrees and he explains that she is in need of pain relief. Mrs A is distressed with her level of pain and chooses to speak through her husband. The midwife sets up the use of gas and air for the mother and explains via the interpreter, who is still on the telephone line, how to use it, supported by Mr A.

At 22:43 hours the observations are all within normal limits. The baby palpates in a cephalic presentation but the midwife is unable to determine the position as the mother does not tolerate lying supine. The fetal heart is auscultated using a handheld doppler as 145 bpm over a minute. Thin meconium-stained liquor is noted on the mother's sanitary pad. Using the interpreter, consent is gained to perform a continuous cardiotocograph (CTG).

At 23:25 hours the CTG records a pathological trace with late decelerations to 60 bpm for over 30 minutes with slow recovery to a baseline of 140bpm. The midwife explains via the husband that she needs to perform a vaginal examination (VE). The findings are as follows: cervix 9 cms, the presenting part of the baby's head level with ischial spines. Left occipital anterior position. No membranes, cord or placenta felt. Fetal heart auscultated at 145bpm following.

At 23:37 hours the midwife alerts the labour ward coordinator (LWC) via the call bell that she requires an urgent obstetric review. An obstetrician attends rapidly and via the husband explains that she needs to repeat the VE due to the deteriorating CTG. The husband explains that his wife is in a lot of pain and needs further pain relief urgently but that she consents to the VE.

At 23:42 hours the obstetrician performs a VE and the cervix is 10 cms dilated. She asks the mother to push but the mother is too distressed and does not understand. The husband tries to explain to his wife what she is being asked to do.

At 23:57 hours a decision for an instrumental delivery is declared. The obstetrician recognises that Mr A is struggling to explain the plan of care to his wife and requests the use of an interpreter via the telephone interpreting service again so that she can undertake consent for an assisted birth. The midwife manages to get an interpreter who speaks Somali on the telephone after six minutes but the telephone signal quality is very poor and the line keeps getting disconnected (it is a different interpreter to the person used previously) so the obstetrician has no option but to continue to explain via the husband the plan of care recommended.

At 00:08 hours the CTG continues to have late decelerations with slow recovery to the baseline which has dropped to 125bpm with reduced variability. The contractions

are four in every ten minutes. Mrs A is using gas and air but is very mobile around her bed which is making monitoring the baby challenging, and Mr A repeats that his wife needs stronger pain relief. The midwife offers Mrs A, a choice of analgesia for pain relief, using the interpreter to explain pros and cons of each. Mrs A chooses diamorphine.

By 00:10 hours Mrs A receives a diamorphine injection to help manage her pain level. After receiving further pain relief Mrs A can focus on what her husband is trying to explain to her about the need for an instrumental birth. Together with the telephone interpreter and Mr A, the obstetrician is able to gain informed consent to undertake a forceps birth in the room.

Mrs A is positioned for a forceps delivery in the room. The neonatal team are bleeped to attend in anticipation of a baby that may require resuscitation.

A pudendal block (a technique to provide pain relief prior to an instrumental delivery when the mother's pain relief is not optimal, in this case she did not already have an epidural) is administered along with perineal infiltration with local analgesia, prior to the forceps being applied and a baby boy is delivered after two pulls, in poor condition. The baby is transferred to the waiting neonatal team and he is given Newborn Life Support (NLS). The baby is initially pale and floppy with a heart rate below 100bpm. Five inflation breaths are given with good chest rise seen and the baby's heart rate increases to between 60 and 100bpm. Ventilation breaths are given as the baby is not breathing. At five minutes of age, the baby's oxygen saturation levels are 95%, they are breathing on their own in air and the PEEP mask (positive end-expiratory pressure) is removed. The APGAR score and cord gases are as follows:

Apgar	1 minute	5 minutes	10 minutes
	2	**7**	**9**
Cord gas	pH	Base excess	Lactate
Arterial	7.04	-19.10	6.3
Venous	6.96	-13.30	8.6

The baby responds well to resuscitation but there are ongoing concerns regarding reduced tone and increased respiratory effort. The baby is shown briefly to the mother before being transferred to the neonatal unit for assessment at 20 minutes of age. It is noted that there are no risk factors for sepsis.

The midwife hands over to the neonatal team that Mrs A speaks Somali and does not understand English, that her husband has been interpreting for her but needs support with technical and medical terminology, so they have been using an interpreter via the telephone. The senior member of the neonatal team uses the interpreter telephone service to explain to Mr and Mrs A what has happened and what will happen next. She undertakes initial duty of candour including an apology[6] and explains that they will receive more information about their baby and be able to go and see him as soon as Mrs A is able to.

When the parents visit their son two hours later the neonatal intensive care unit (NICU) nurse uses the telephone interpreter service to communicate with them. She

documents in the electronic records so that everyone looking after their baby is aware that Mrs A needs support with understanding English and that Mr A needs help with medical terms. The neonatal team plan regular updates using ideally the same interpreter on the twice daily ward round to improve communication between the parents and the neonatal medical and nursing team.

The baby receives 72 hours of therapeutic cooling and an MRI at seven days of age shows evidence of a hypoxic ischemic episode. The baby is discharged to the care of the parents on day ten with further follow-up in the community.

Learning Points

This case highlights the importance of effective communication -recognising any additional needs of patients and their partners, or support persons and not to assume that you are being understood or indeed that you can understand what is being said to you in return.

- As part of the booking risk assessment, it should have been recognised that Mr A spoke limited English and therefore he should not have been asked to interpret for his wife. Plans should have been made to book an interpreter for every subsequent appointment. The health records were limited and did not make it clear that an interpreter was used for every appointment. This meant that future risk assessments and sharing of information, such as monitoring fetal movements, to keep Mrs A and her baby safe may not have been understood.
- Do not rely on using friends or family members to interpret for women, always aim to assess first using open questioning to assess understanding and then use a recognised interpreter service if required. Once you can establish that the mother and/or her birth partner can understand it may be that a plan is made to use an interpreter if there are medical terms for example that need explaining. This should be added to the mother's personal pregnancy care plan.
- Trusts are advised to be aware of limitations with their local interpretation services as some less common languages can be challenging to find a person who can speak the mother's or her families dialect and who has the necessary medical understanding to be able to interpret appropriately. Cultural sensitives need to be considered as it may be important for an interpreter to be female, for example, to speak to another woman, and it may be essential to avoid a local person who may be known to the woman for confidentiality reasons. Ideally such considerations should be put in place once a woman has booked for care and her need for an interpreter is recognised in preparation for future appointments and care in labour.
- Because an interpreter was not used at the booking appointment to ensure Mrs A did not have any risks, she was assessed as low risk. At a following appointment an interpreter should have been used to revisit the booking risk assessments to ensure Mrs A was on the correct pregnancy pathway. It was unclear from the health records if this was revisited. Other risk assessments

may have been incomplete due to the language challenges, such as the domestic abuse questions. In this case the policy was not followed to ensure Mrs A was able to be seen without her husband but with an interpreter to ensure these questions were asked. MBRRACE[6] highlights the increased morbidity and mortality for women from black and Asian backgrounds. Language challenges can play a significant part in this.

- Offering a leaflet in English -offer in their own spoken language if they are available. Be aware in case the woman cannot read her own spoken language to provide easy read/pictures or an audio and /or visual recording of the information if possible.
- Telephone triage – when speaking through a partner ideally use an interpreter service so that you can speak with the woman directly.
- Ensure all members of staff new to an area are fully inducted so that they are confident where to seek additional support or information, such as how to access telephone interpretation services before being left to manage a triage service alone.
- Offer women who need an interpreter an earlier assessment in the unit. It is easier to risk assess in person to ensure the woman's needs are appropriately recognised and a plan made ensuring staff on duty are aware of the need for an interpreter when they do attend.
- Informed consent can only be undertaken if women understand what is being said to them. Clinicians are obliged to discuss all reasonable opinions with patients (GMC 2020)[5]. In an emergency a partner may be the only option but follow-up with an interpreter at the earliest opportunity.
- In stressful situations, such as during labour, a partner may not be able to interpret as well as they were able to do when it was a regular antenatal appointment for example. They will have their own needs so always aim to use an an interpreter if there is any question that the partner does not understand.
- Good practice using an interpreter whilst in NICU and documenting clearly in the electronic health records so everyone looking after the baby is aware.
- Good practice to aim for continuity in the use of the same interpreter and planned regular updates which supports the parents and improves communication between them and those caring for their baby.

Considerations for your hospital

- Is there clear guidance on how to access and use an interpreter service?
- It is possible to have a three-way conversation using a telephone service, between the hospital, patient and interpreter. Does your Trust telephone exchange allow this?

- Does your Trust website have plain English and ideally easy to read options and the ability to translate information into alternative languages? This maybe formal translation/interpreter services or the use of a web-based APP.
- Does the multi-disciplinary teaching programme include discussion of holistic as well as the clinical assessment in cases involving the need to use an interpreter, and the practicalities of achieving this?
- What changes can you make to be able to offer support to women and their partners at stressful times such as the use of laminated cards with frequently asked questions and answers on them to support informed choice? Can you engage with your local community groups to design such resources?
- During antenatal appointments is your Trust able to offer extra time and provide interpretation services for those that need them?
- Does your Trust offer leaflets or signpost to online resources which are in the woman's preferred language?
- Does your Trust audit the use of your interpretation services, including user feedback, to inform improvement initiatives? For example, has your Trust considered employing an interpreter on a regular basis for the most frequently spoken second language in your area?

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 events[7]. 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. The Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates. Nursing and Midwifery Council 2015

updated October 2018 The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates - The Nursing and Midwifery Council (nmc.org.uk)

2. Good Medical Practice. General Medical Council 2024 good-medical-practice-2024---english-102607294.pdf (gmc-uk.org)

3. Ockenden Report – Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. December 2020 OCKENDEN REPORT - MATERNITY SERVICES AT THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST (publishing.service.gov.uk)

4. Three Year Delivery Plan for Maternity and Neonatal Services - NHS England. March 2023 NHS England » Three year delivery plan for maternity and neonatal services

5. Decision Making and Consent. General Medical Council 2020 gmc-guidance-for-doctors---decision-making-and-consent-english_pdf-84191055.pdf (gmc-uk.org)

6. NHS Resolution Saying Sorry June 2017 Saying Sorry

7. MBRRACE-UK Saving lives Improving Mothers' care -Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21, published 12 October 2023 MBRRACE-UK_Maternal_Surveillance_Report_2023.pdf (ox.ac.uk)

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