NHS Resolution

Case story
The latent phase of labour

This case story is fictional but based on real events and lessons learnt through cases referred to NHS Resolution's Early Notification scheme. We are sharing the experience to improve the quality of care provided to all patients, families and staff.

As you read the story, please ask yourself:

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

Topic: Timely recognition of established labour.

Key points:

- Communication with the mother and birth partner is an integral part of good clinical care.[1]
- Record keeping and storage of all maternity telephone contacts and assessments is a requirement.[1]
- When a mother is in the latent phase of labour a risk assessment should be undertaken to determine the most appropriate place of care.
- Maternal and fetal wellbeing should be assessed in hospital should include the assessment of the frequency, strength and length of contractions.[2]
- Early recognition of transition between the different phases of labour is important.

Maternity story

A mother in her first pregnancy was assessed to be suitable for midwifery-led care when in labour. At 40+6 weeks the mother contacted the maternity unit. She was experiencing painful regular contractions and was advised that labour was still in the early stages and to stay at home. After six hours the mother self-referred to the maternity assessment unit for further assessment.

On arrival a vaginal examination was performed and the findings confirmed the mother was in the latent phase of labour and advice was given to return home to await until labour became established.[3] Over a 24 hour period the mother contacted the maternity assessment unit two more times. Each time the mother was informed that she was still in the latent phase of labour.

On the fourth occasion the mother was very distressed and for the second time self-referred to the maternity unit but requested to stay in hospital. A vaginal examination was performed and cervical dilation confirmed that she was in the latent phase of labour. The mother was transferred to the antenatal ward and analgesia was administered, she was encouraged to rest and was then to be discharged home if she wished.

After six hours the mother ruptured her membranes and the liquor was noted to be stained with significant meconium. The labour was progressing rapidly and birth was

imminent. The mother was immediately transferred to the labour ward and ten minutes later gave birth to the baby.

The baby was born in poor condition. The neonatal team began resuscitation and transferred the baby to the neonatal intensive care unit for ongoing care including therapeutic cooling for seizures.

During the six hours of admission prior to the birth no clinical observations of either the mother or the fetus were performed. It is apparent that the mother was in labour and therefore this was a missed opportunity to have identified any signs of fetal distress earlier.

Considerations for your hospital

- Does your trust have up-to-date guidance on the management of the latent phase of labour for all birth settings, including those occurring in the community?

- Does local guidance cover:

    - What is appropriate advice to give to mothers with regard to staying at home and when to call back again? And how to document the calls?

    - How do you identify risk factors when assessing women by telephone?

    - How to ascertain that a woman should remain at home?

- How do you take into consideration how often the woman has contacted the maternity unit in the last 24 hours which includes the number of attendances?

- What clinical observations are undertaken during the latent phase of labour when woman are on the antenatal ward? Do they include both maternal and fetal observations?

- Does your trust undertake regular audits of the management of the latent phase of labour that includes birth outcomes?

- Do you have a patient feedback mechanism for women about their experience of the latent phase of labour? And how do you act upon this feedback?

What has happened as a result?

This case story is fictional. If a similar case were to occur in real life, then it would be referred to NHS Resolution as part of the Early Notification scheme.

The expertise of NHS Resolution staff in clinical negligence claims-handling is used for cases referred to the scheme to proactively assess the legal risk, investigate care, and provide early support to families where liability is established. 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 sharing learning from avoidable harm.

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 average damages payment for a baby with a long term severe brain injury where liability has been admitted is approximately £10 million, the human costs notwithstanding.

The human costs to the babies, families and clinical teams involved are immeasurable.

Resources:

1. Nursing and Midwifery Council, The Code, Professional standards of practice and behaviour for nurses, midwives and nursing associates, updated version 2018

2. Saving Babies Lives Care Bundle, Version 2, 'A care bundle for reducing perinatal mortality' (2019) NHS England

3. Intrapartum Care for healthy women and babies – Clinical guidance NICE National Institute for Health and Care Excellence, published December 2014, revised 2018 nice.org.uk/guidance/cg190

4. Midwifery care in labour guidance for all women in all settings, RCM Midwifery Blue Top Guidance No.1, November 2018