**Example Statement following guidance 1**

**Statement**

**Name: xxxxxxxxxx**

**Job title: Midwife Band 6**

**Professional address:** The Made up Teaching Hospitals NHS Foundation Trust,

**Subject of statement:** Unexpected admision to neonatal unit

I am employed by The Made up Teaching Hospitals NHS Foundation Trust. I qualified as midwife in April 2004. My previous experience includes 8 years working as a rotational midwife in all aspects of maternity providing antenatal, intrapartum and postnatal care.

I have worked in my current job for 4 years 4 Months and in the outpatient department for 2 years and 3 months.

This statement is based on a review of the records. I have no clear recollection of the events on that day.

I was involved in the care of Patient xx on date 2nd of January 2016.

My last involvement in her care was on 2nd of January 2016.

I am responding to a request for a written statment by Matron Brown

- due to baby being born in poor condition and a complaint from xx.

The area where I worked on 2nd of January was Maternity Assessment Unit. I can’t remember exactly if on 3rd January I was working in Maternity Assessment as from my record of duty I was supposed to be in to support shortage of staff. However I really can’t remember that day.

I have made attempts via my manager to locate the Admissions book from January 2016 to confirm my workload that day, but the book cannot be located at this time.

The unit has 4 beds, where we provide care to women who are pregnant and suffer diffrent types of pregnancy conditions such as: raised blood pressure, pre-eclampsia, obstetric cholestasis, small baby for gestational age, complicated pregnancies with

diabetes, twins, preterm rupture of membranes, rupture of membranes at term, patients at risk of pre-term birth, and clients with reduced fetal movements.

Admissions to Maternity Assessment are planned follow ups, and unplanned - for women, who are referred urgently by the Triage Unit, Community Midwife, GP, or self referred.

My shift starts at 7am and finish at 7pm including 30 min lunch break.

I recall that we were very busy at that time due to holidays and heavy flow of the patients.

My duties during my shift include: Admitting patient to the PAS computer system, checking general well being - Blood pressure, pulse, oxygen level, urinanalysis, abdomal palpation including measuring abdomen, I take a medical history, establishing if the client is low risk with care provided just by a midwife or high risk with consultant led care and care which is provided by Multidisciplinary team. My role is to check if there is any cause for concern, monitoring heart rate - intermittent auscultation or cardiotocogram as per Trust fetal monitoring policy, requesting scans, collecting, blood tests, urine samples and swabs. I also get the results from tests sent at earlier appointments. I assess if the client needs a doctor review. I plan care and referr to special agencies : Fetal assessment unit, Fetal medicine Unit, Diabetic team, Prenatal mental health team, community midwives, physiotherapy department.

I also pick up the phone calls from Triage Unit with referrals, from community midwives- with requests to chase their blood tests and also deal with requests regarding interpretation of guidelines and advice regarding plan of care for patients. I often receive phone calls from patients with questions regarding their own plan of care, blood results, rebooked appointments-patients who call to say their are late, or request scan but for some reason didn’t received appointment, questions about antenatal classes and their availability.

On Mondays we see patients with Twins pregnancies, who needed monitoring.

On Tuesdays we see patients from Preterm clinic for intramuscular injections.

On Wednesday we see diabetic patients, who needed monitoring.

With reference to the clinical notes on 2nd of January 2016 I admitted xx to Maternity Assessment. She was referred by her community midwife with a history of decreased fetal movements for over a week.

This was her first attendance in to Maternity assessment / hospital with decreased fetal movements.

xx was 27 years old, in her first pregnancy and thirty nine and three days pregnant. She spoke communicative English and didn’t required an interpreter.

From her history I knew that she was late booked at 21+3 weeks in her pregnancy. She did not attend antenatal care from beginning of the pregnancy but so far all tests and scans she had performed were normal.

She had raised Body Mass Index of 32. Otherwise apart from being booked late didn’t have any other risk factors.

At initial assessment in community on that day the baby was in good position- cephalic- head down, engaged in pelvis 3 parts of the head.

The first entry in the notes is not my writing. I recall a student Midwife was working with me that day but I cannot recall who. My documentation begins at 16.30hrs. I did however have overall responsibility for this case.

On admission xx was feeling well, didn’t report any concerning symptoms or problems. Her observations were normal with blood pressure 128/83, pulse 94, temperature 36.6.

Urinanalysis was negative.

She had a previous scan on 5th of December 2016 at thirty two weeks and five days was normal with estimated fetal weigh of 2076 grams and normal amount of amniotic fluid around the baby, also normal blood flow in placenta.

After initial assessment cardiotocogram was commenced to monitor fetal heart rate.

Due to the unit being very busy and the fact that I was engaged with other patients, xx remained on the fetal monitoring for a full hour. Monitoring was discontinued at 16.30hrs as was totally normal and very reassuring. On CTG monitoring we seen plenty of fetal movements. Findings from monitoring were explained to xx.

I have documented that xx was not reassured by the monitoring.

I have documented within my plan of care that I wasn’t sure if baby’s presenting part was cephalic . I can see from the records that I arranged for a scan to confirm the presentation. I cannot recall who performed this scan, but I have documented that it was Cephalic.

As per guidelines- Protocol for Managment of Women with Decreased Fetal Movements after 39 weeks of gestation but before 40 weeks of gestation xx needed a doctor review to make plan of care.

We don’t have doctor, who works permanently in Maternity Assessment, therefore in those situations we ask a doctor who works in Antenatal Clinic to review patient.

I asked Doctor Spaniel for a review. I cannot recall if Dr Spaniel came to see xx or if I discussed her history and my findings with her alone.

I have documented that Doctor Spaniel agreed to offer xx Induction of Labour.

I assumed that xx will agree to induction of labour and therefore started write in the follow up part of the notes- IOL. I needed to call the antenatal ward to book a day for it, but then thought I should double check with xx first.

When I explained what Induction of labour is and how the process works, xx said that she didnt want me to book it yet and she would like to think about it. As an alternative, I offered her an appointment for the next day (3rd January 2016) at 1pm.

I have documented that i gave her an IOL leaflet at this time.

Our guidelines about reduced fetal movements states that clients who are not reassured with fetal monitoring should be offered an appointment next day to perform further monitoring for reassurance. I asked her to let me know tomorrow what is her decision regarding induction of labour.

By our Trust guideline - Protocol for Managment of Women with Decreased Fetal Movements- if the client is over 37 weeks pregnant and attends with decreased fetal movements, we offer a membrane sweep, which is mechanical/ manual way of stimulating the cervix to induce natural labour.

I offered xx a vaginal examination as per guidelines, to which she gave verbal consent. I found the cervix to be posterior, long -4 cm, thick and os closed. I was unable to perform membrane stretch and sweep. The fetal heart rate was listened to post examination and was 145bpm. There was no evidence of amniotic fluid or any unusual discharge.

xx received an appointment next day 3rd of January 2016 at 1pm and before discharge I strongly advised her to come back to hospital if reduced fetal movements happen again.

I cannot clearly recall if I was working on the 3rd January. I have no memory of any further contact with xx.

This statement is true to the best of my knowledge and belief, based on the information available to me at this time.

**Name: xxxxxxxxxxx**

**Job title: Midwife**

**Signature: xxxxxxxx**

**Date:22/07/2016**