**Example Statement 2**

**PRIVATE AND CONFIDENTIAL**

Statement relating to the care of xxxxxxxxx

NMC Fitness to practice referral case ref 00000000000

Full Name: xxxxxxxxx

Designation: Band 5 Rotational Midwife (Preceptorship)

NMC pin: xxxxxxxxx

Ward/Dept: B, Made up Hospitals NHS Foundation Trust

Date of preparation: 20/5/2018

**The information provided in this statement has been taken from memory and written records**

I offer my sincere condolences to xxxxxxxx and her family for the devastating loss of her daughter in this unexpected tragedy. I can only empathise with xxxxx and her family at this sad time and acknowledge how difficult it must be for them.

I, xxxxxxxxx, am a qualified Midwife having qualified with a BSc (Hons) from The University of Anywhere in September 2017 and registered on the 11th November 2017 with the Nursing and Midwifery Council.

I am employed as a rotational Midwife (Band 5) by Made up name NHS Foundation Trust and am currently on a preceptorship programme (a period to guide and support all newly qualified midwives to make the transition from student to develop their practice further and is a structured period of transition where nurses and midwives are supported by an experienced practitioner (a preceptor). It is designed to help develop confidence and enhance competence, critical thinking and decision-making skills).

At the time of the events I am providing this statement for, I was working on Ward B Antenatal Ward on a 3 month rotation as part of my preceptorship programme as a newly qualified midwife.

The events described are in relation to the care I provided to xxxxxx on Thursday 4th January 2018.

**03:40** - I took over the care of xxxxxx at 0340 hours on Thursday 4th January 2018 which was during a night shift. My nightshift was from 1915 hours Wednesday 3rd January 2018 to 0745 hours on Thursday 4th January 2018.

xxxxxxx had been assessed on the Maternity Assessment Centre (MAC) by two other midwives prior to being transferred to my care on Ward B Antenatal Ward.

xxxxxx had been given the choice to go home instead of staying on the antenatal ward but she made the informed decision to await events on the ward. It was not necessary for her to remain on the ward because she was not in established labour. If she had wished she could have returned home, but her wishes were respected that she wanted to remain in hospital.

xxxxxx birth partners had been asked to go home by the previous midwife on MAC, so I only met xxxxxx herself. Her birth partners had been told by the previous midwife that they could return some hours later at 0800, because xxxxxx was not in established labour and there were other women staying on the ward.

Upon transfer to the ward, I received the following information in a handover from the previous midwife which was as follows:

(I reproduce this information from the clinical notes held by Made up name NHS FoundationTrust).

* **Reason for transfer**: early labour care.
* **History**: xxxxx was primiparous, her estimated date of delivery was on the date in question (40+0 weeks), her blood group was rhesus positive, she had been assessed as low risk and had received midwifery led care during her pregnancy, and that she had presented to MAC twice, once the evening prior and once that morning with a history of contractions. I was told that she had had two vaginal examinations, firstly at 21:00 in which her cervix was dilated 1-2cm with membranes intact, and at that time she was contracting 1 in 5 minutes and was re-admitted to MAC again at 02:55 after initially going home.

From this history I made an initial assessment:

* There were no major obstetric risk factors to affect the wellbeing of either xxxxxxxxx or her baby at this point.
* xxxxxx was 40+0 weeks gestation which presented no risk factors in either prematurity or post dates.
* xxxxxxxxxx had no obstetric input during her pregnancy therefore it was not assessed that she had any risk factors to affect the health of her pregnancy.
* xxxxxxx had not reported any SROM or PV bleed to either of the midwives prior to me and the membranes had been found to be intact by two midwives by vaginal examination. If they had been given any history of SROM or found this to be the case then it would be clinically indicated to do a speculum examination instead of a vaginal examination to reduce the risk of introducing infection.
* The combination of the findings of the vaginal examinations and the regularity of contractions enabled both the midwives before me and me myself to assess that she was not in established labour.
* The fact that she had gone home but then come back in a few hours later made me think that she was finding it difficult to cope with the pain of the contractions at that point which prompted her to come back in again at her own wish.
* **Observations**: I was informed that xxxxx recent vital signs were scoring 0 on the Maternal Early Obstetric Warning Scoring System (MEOWS). I was informed that she was contracting 1 in every 5 minutes. The findings of the most recent vaginal examination she had at 03:10 were a cervix dilation of 2cm, effaced and membranes were intact.

As a result of those factors, this added to the overall clinical picture and assessment I made of xxxxx wellbeing:

* xxxxx wellbeing was stable at that time and she was not acutely unwell.
* In addition to the prior vaginal examination, there had been minimal changes in the few hours in that xxxxx had returned home and she still was not currently in established labour. The examinations had been carried out by two different midwives who had both found similar findings.
* The fact that the membranes were felt to be intact did not give any risk factor for infection, and the vital signs did not show any evidence of this. The membranes had been found to be intact by two separate midwives by vaginal examination, and xxxxxxxx has given no history of SROM either to me or the previous midwives therefore I had been given no indication that the membranes had ruptured.
* I was advised that the intermittent auscultation of the fetal heart carried out had been normal, showing me no sign of fetal distress at this point.
* xxxxxxx had not reported any reduced fetal movements up to this point therefore hadn’t expressed any concerns over her baby’s wellbeing.
* Analgesia had recently been given by the previous midwife (60mg of dihydrocodeine, 500mg of paracetamol), therefore I knew that her pain had been assessed and attended to just prior to her transfer to the ward.
* **Plan**: The midwife had stated - Early labour care and analgesia.

As a result of the information given to me in the handover and the information contained in the patient notes I also came to the same conclusion that at that time xxxxxxxxx required general early labour care and analgesia. It was neither an obstetric nor medical requirement that she needed to be an inpatient on the ward, but her own wish to which we were more than happy to adhere to for her comfort and reassurance.

**03:44** - Following transfer to the ward I spoke to xxxxx shortly after her arrival.

I made my introductions to xxxxxxxx and told her that I was going to be the midwife looking after her for the remaining of the night shift (until 0715). She was placed into a bay of 6 beds with other women, directly opposite the nurses station. I cannot recall how many other women were in the bay with xxxxxx at the time, but I have subsequently learned that there were 11 women admitted on the ward who were spread across the different bays of the ward to afford them some privacy during the night time. I recall at least one other woman being in the bay with xxxxxxxx at that time but cannot remember if there was more than one, I am definitely aware that she was not on her own in the bay. There was no reason for xxxxxx being put in the bay opposite the nurses station in terms of medical or obstetric risk, it was just convenient to space the women out to give them all some privacy instead of putting them all next to each other. I am definitely sure that due to her being so close to the station that myself or any of the other 3 staff on shift at that time would have been able to hear her had she been calling for help. I told xxxxxx to inform me if there was anything that she needed, and as part of the

regular orientation routine I will have made sure that the call buzzer was in reaching distance for xxxxxxxx if she wanted to summon any attention or to ask for any assistance, to which any of the staff on duty would have answered. xxxxxx was given a jug of water and a cup. Due to the time of night and the fact that there were other women staying in the same bay, I will have asked xxxxx if she wanted her curtains pulling around her bed, as I wanted to respect her privacy and dignity and promote her comfort in the hope that she may be able to get some rest. In addition to xxxxx and the other women I was caring for in this bay, I also had women to care for in other rooms/bays also, so I was unable to spend all of my time during my shift in this bay but xxxxxx was made aware that she could ask for help if needed via her call buzzer.

I documented and signed the handover that I had been given from the previous midwife.

I reviewed the patient notes and from the information contained in those notes and from speaking to xxxxxxxxxx I ensured I had a accurate and concise documented summary of xxxxxx history and presentation, which was:

Cares taken over by myself, working with a student midwife. History noted: P0, 40+0, A Pos, anterior placenta clear of os, ulcerative colitis, fibroid noted on dating scan, estimated fetal weight at 30+4 1575g with normal liquor volume and doppler, attended MAC x2 yesterday evening/this morning history of contractions, first vaginal examination at 21:00 cervix was posterior, 1-2cm dilated and effaced with the head -2 to the spines, went home not in established labour, returned at 02:55 and with a second vaginal examination at 03:10 the cervix then was posterior, 2cm dilated, effaced, with the head -2 to the spines, did not want to go home, instead would like to await events on the ward, currently tightening 2:10 but short lasting, no PV loss or SROM, reports normal fetal movements, had dihydrocodeine at 03:30, declines bath at present.

At this point the clinical picture continued that xxxxxx was in early labour, admitted to the ward for observation and support, who had no current developing risk factors. I offered her a bath to try and help manage the discomfort she was feeling.

xxxxxx did not report to me any PV bleed, or any history of SROM at any point at home nor in hospital.

As a result of all of the information I wrote the following plan for xxxxxxxx care:

* 4-6 hourly maternal observations
* 2 hourly fetal heart auscultation
* Analgesia as required
* Monitor PV loss, uterine activity and fetal movements
* Escalate any concerns

**04:10** – xxxxxxxx reported to me that she had reduced fetal movements. I listened to xxxxxx concerns and discussed this with her and she told me she had been feeling her baby move but not as normal. I suggested that we commence a CTG monitoring to assess her baby’s wellbeing due to the concerns that she had raised.

**04:16** - The CTG was commenced.

**04:45** - The CTG was discontinued after 30 minutes, as it appeared to be normal.

xxxxxxxx said that she wasn’t reassured by movements at this point however the CTG trace was normal and had picked up some fetal movements.

CTG monitoring of the fetal heart rate, initially for 20 minutes, provides an easily accessible means of detecting fetal compromise. The presence of a normal fetal heart rate pattern (i.e. showing accelerations of fetal heart rate coinciding with fetal movements) is indicative of a healthy fetus with a properly functioning autonomic nervous system (Royal College of Obstetricians and Gynaecologists, 2011).

I received a second opinion from my senior (Band 6 Midwife) who was the midwife in charge of the ward at that time. My Senior reviewed the trace, assessed it as normal, and signed her confirmation.

The trace had a baseline of 145bpm, the variability was >5bpm, there were accelerations present and no decelerations, and maternal pulse was 90bpm. The second midwife agreed with my initial categorisation as normal.

The CTG trace was classified as normal by both myself and my senior midwife using the National Institute of Health and Care Excellence (NICE) guidelines for the interpretation of cardiotocograph traces.

Due to the trace being normal, there was no developing sign of fetal hypoxia or distress. I discussed with xxxxxxx the fact that the CTG trace was normal to reassure her concerns, however I advised her to continue to monitor her baby’s movements and encouraged her to inform me again if she still felt worried about her baby’s movements and that we could repeat the electronic fetal monitoring again if she still had concerns. I documented the plan that we discussed. Therefore she was well informed that she could ask for my assistance again if she wished, the plan was made for her to address any further concerns regarding fetal movements to ensure fetal wellbeing. The uterine tightenings were 1-2:10 and remained short lasting so at this point she was not in established labour.

**06:13** - xxxxxxx came to the nurses station where I was in the company of the Midwife in charge. xxxxxx was tearful reporting that her contractions were regular and asking when we would be doing another vaginal examination.

At this point the tightenings remained irregular at 1:10 and were still short lasting so she was not in established labour.

I advised xxxxxxx because the contractions remained irregular and short lasting unfortunately there was no clinical indication to re-examine her cervix as there was likely to be minimal changes and frequent vaginal examinations increase the chance of introducing infection. This was also confirmed and agreed by the Midwife in charge of the ward who was present.

xxxxxxxx asked if she could have more analgesia. I advised her that she had not passed the minimum interval time yet to be able to have more dihydrocodeine but informed her that she could have a further dose at 07:36 hours. I reminded her that she had been prescribed 500mg paracetamol at 03:36 hours. I asked her how much paracetamol she had at home to ensure that I would not be exceeding the maximum amount and it was safe to give her some more and calculated that she’d had 2.5g in 24 hours up to then. I advised xxxxx she could therefore have another 500mg paracetamol.

The midwife in charge and I spoke to xxxxxx together, we informed her that further pain relief such as Entonox and epidurals are not available on the antenatal ward. I cannot recall if we discussed with her of the option to have diamorphine at that point, which is a possibility but not usual practice to have on the antenatal ward, but I am aware it was discussed with xxxxx and this discussion documented by the previous midwife on MAC that it is available to have but may slow labour down so xxxxx was aware that this may have been an option. xxxxx was not in established labour, so unfortunately she was unable to go to the Delivery Suite at that moment in time and we are not able to give one-to-one care on the antenatal ward due to having other patients to look after too.

I offered xxxxx a bath again to try and improve her comfort to which she accepted she would.

Prior to her going in the bath she reported to me she had some pink mucous loss, which is normal in the latent phase of labour due to cervical changes. The history of this mucous loss she provided did not indicate that the membranes had ruptured, so again I had no reason to suspect that the membranes had ruptured. xxxxxxx never reported any PV bleed of any sort of any blood clots.

**06:14** - I gave xxxxxxx 500mg paracetamol prior to her getting in the bath and helped her by getting her a cup of water, intending to alleviate and help with her pain management.

I cannot recall which person it was exactly but either the healthcare assistant working on the ward or the student midwife retrieved some towels (which are kept in a linen cupboard behind a closed door) for xxxxxx and started running the bath for her, they showed her to the bathroom some time later once the bath had finished running. The bath has a call buzzer within reach if a woman wants to summon assistance while in the bath and an emergency cord that they can pull if they need urgent attention, so xxxxxxx could have requested help had she needed it.

**07:15** – Report to the day shift staff began, I finished my shift and handed over care to the receiving midwives. I was not present when xxxxxxx came out of the bathroom therefore did not have any further conversation with her about clots that she reported to be in the bath.

Signed ......................................................... XXXXXX

Dated 20th May 2018