From: Maternity and Newborn Safety Investigations
To: Corinne Harrison
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MNSI logo

The leading body for maternity and newborn safety investigations in England

September 2024

A monthly bulletin for stakeholders, clinical and non-clinical staff working in maternity, neonatal care and patient safety.

MNSI responds to the National Maternity Inspection Report

The Maternity and Newborn Safety Investigations programme (MNSI) welcomes today's publication of the Care Quality Commission's (CQC) National Maternity Inspection Report. The recommendations made within call for:

- Consistent collection of demographic data to improve maternity outcomes for all women / birthing people
- Improved communication with women / birthing people and their families to ensure that all leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth
- Additional, ring-fenced capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.

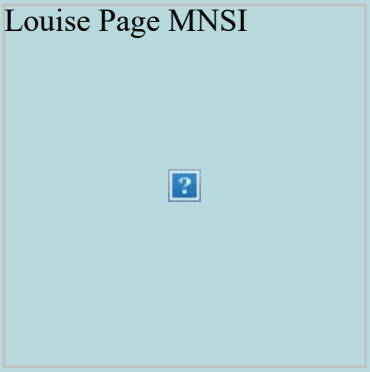
Sandy Lewis, MNSI Director says:

".. Inconsistent approaches to triage and challenging communication with women / birthing people and their families have consistently appeared as themes that contribute to unsafe care for women in our investigations. We have outlined

approaches to improve communication and taking a more consistent approach to triage both for individual trusts and more widely through our National Learning Reports.. "

Read our response to the National Maternity Inspection Report here

MNSI to attend joint congress of the International Society of Obstetric Medicine (ISOM) and Society of Obstetric Medicine of Australia and New Zealand (SOMAZ)



We will be attending the joint congress of the International Society of Obstetric Medicine (ISOM) and Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) which is a unique opportunity to collaborate and share knowledge with experts and leaders in obstetric medicine from around the world.

We will be attending to present our work on maternal deaths related to epilepsy, pulmonary embolism and haemophagocytic lymphohistiocytosis (HLH) as well learning from a thematic review of deaths in the first trimester of pregnancy. It will be an opportunity for us to gather best practice and learning from others working in maternity care from across the globe which we will use to support our work in England.

Our attendance at the congress was made possible due to collaborative working of the MNSI team with the regional maternal medicine network in NW London and the specialist HLH team at University College London University Hospitals NHS Foundation Trust.

We will share more on our attendance and the learnings we gather in the next edition of this bulletin

Find out more about ISOM / SOMANZ

Latest Webinar

Safety spotlight

webinar banner

Why it made sense at the time: Local rationality questions for healthcare investigations

Earlier this year we ran a webinar inspired by Louise Roe's blog "Why it made sense at the time: Local rationality questions for healthcare investigations"

You can now watch the webinar back at the link below and explore the importance of:

- How questions are asked in safety investigations
- The local rationality principle
- How the local rationality question tool was developed
- Putting the tool into practice to improve safety investigations in the future.

We will be releasing a series of Q&A blogs addressing all the questions and answers that were submitted during this webinar and developing further webinars to share this work so keep up to date with us on LinkedIn.

Catch up on the webinar here

Incomplete observations generating incorrect EWS

MNSI has investigated a number of patient safety events where an incomplete set of observations generated an early warning score (EWS) via an electronic patient record (EPR) system.

It was not always apparent to the user that the score was based on an incomplete set of observations and in some circumstances led to delayed escalation in patient care.

To prevent future safety events of this nature in the future it is worth considering the below questions:

- Does your EPR system generate an EWS even if the observations entered are not a complete set (e.g. only pulse and BP have been entered)?
- Does your EPR system alert you that an EWS is based on an incomplete set of observations and remind the user to complete all the observations?

How can you enable staff to complete all observations and ensure they are generating an EWS correctly?

Other news

Subject Matter Advisors

We're on the look out for Subject Matter Advisors to support us in our investigations and to make maternity care in England safer. We are particularly interested in hearing from consultants working in haematology, pathology and general practice.

For more information or to express an interest in these roles please email Enquiries@mnsi.org.uk

Coming soon: Our Annual Report 2024

Our Annual Report for 2023 / 2024 will be published in October. Keep an eye out on our website and social media for more information.

Follow us on LinkedIn to be kept up to date.

Follow us on LinkedIn

Upcoming events

26 September: The National Maternity Safety Conference

9 October: Baby and Pregnancy Loss Conference

9 - 15 October: Baby Loss Awareness Week

17 - 20 October: International Joint Congress of the International Society of Obstetric Medicine (ISOM) and the Society of Obstetric Medicine of Australia and New Zealand (SOMANZ)