Nursing Times Inadequate staffing implicated in stillbirths and neonatal death

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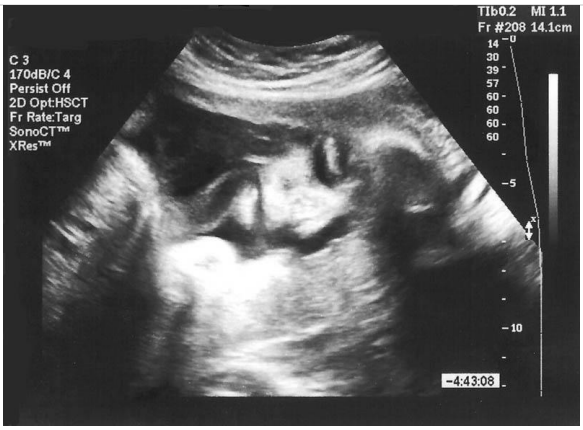

Staffing and workload issues have been identified as a major factor in stillbirths and neonatal deaths during labour, following a national review.

The MBRRACE-UK report looked at the quality of care for stillbirths and neonatal deaths of babies born at term who were alive at the onset of labour and not affected by a major congenital anomaly.

“It is concerning that the report found that staffing levels and capacity contributed to some of the poor outcomes”

Gill Walton

This type of death occurred in 225 pregnancies in the UK in 2015 and represents about 5% of perinatal deaths overall, noted the report authors from the University of Oxford.

Overall, they found that stillbirth and neonatal deaths have more than halved in the UK from 0.62 to 0.28 per 1,000 total births since 1993, representing a fall of around 220 intrapartum deaths per year.

However, despite the fall in the mortality rate, such deaths remain an important group for concern, highlighted the researchers.

They said this was not least because, in the vast majority, the mother was directly receiving maternity care when the baby died or when the event occurred that led to the baby’s death.

To investigate further, the analysis focused on 78 of the 2015 cases to identify potentially avoidable failures of care during labour, delivery and any resuscitation, that may have caused the death.

The care provided for the mothers and babies was reviewed in detail against national guidelines and standards by a panel of clinicians, including midwives, bereavement midwives and neonatal nurses.

“Despite the fall in stillbirth and neonatal mortality, these deaths remain a major cause for concern”

Lesley Regan

In the panels’ view, for 80% of the deaths different care may have resulted in a different outcome for the baby.

A key finding was that capacity issues involving inadequate staffing and resources were a problem in 21 of the cases – representing around a quarter – said the report authors.

In a further seven cases, the notes identified issues that could be related to problems with staffing or capacity, said the report. As a result, staffing and capacity problems were implicated in at least a quarter of the cases and potentially 35.9% of them.

“The majority of staffing and capacity problems were related to delivery suite, with the remaining issues relating to neonatal care provision,” it stated.

In addition, the review found heavy workload contributed to delays in induction in one third of women being induced.

Other main findings from the review included that not all women who had had a caesarean section in a previous pregnancy had had a clear discussion about their birth plan.

“The majority of staffing and capacity problems were related to delivery suite”

MBRRACE-UK report

There were also problems recognising when women moved from early to established labour and appropriate monitoring was not instituted as a consequence;

In addition, guidelines were not followed when monitoring the baby’s heart rate leading to delays when babies needed to be delivered urgently.

However, for most babies, where resuscitation was attempted it was delivered effectively by clinical staff present at the delivery based on the Neonatal Life Support programme, said the report.

Overall, the report concluded that the quality of bereavement care was variable, with a lack of joint midwifery, obstetric and neonatal input.

Meanwhile, one in three neonatal deaths did not have a post-mortem examination or placental histology carried out, and the majority of reviews into intrapartum-related deaths were of poor quality and did not follow guidance for serious incident reviews.

The report's publication comes as health secretary Jeremy Hunt announced a new maternity strategy to reduce the number of stillbirths – Safer maternity care: progress and next steps.

- Updated maternity strategy to reduce the number of stillbirths

Independent investigation is to be offered to families who suffer stillbirth or life-changing injuries to their babies, along with other measures to cut stillbirths, Mr Hunt said in a speech today.

Commenting on the MBRRACE-UK findings, the Royal College of Midwives said it welcomed the report and recognised the achievement in an overall reduction in stillbirths and neonatal deaths.

"There is however much to take away from its findings that will go towards not only helping midwives, but the entire maternity team improve how they deliver the safest possible care for women and their babies," said RCM chief executive and general secretary Gill Walton.

Gill Walton

"It is concerning that the report found that staffing levels and capacity contributed to some of the poor outcomes particularly around the time of labour and birth," said Ms Walton.

"The increasing complexity of women being cared for in our maternity services exacerbates this issue," she said. "We must ensure we have enough midwives and obstetricians to provide safe care throughout the maternity pathway and adequate facilities in all birth settings."

She added: “The RCM believes that there needs to be a supernumerary labour ward co-ordinator in place in every single maternity service to have a helicopter view of birth activity in all settings and we have already begun leading on work in partnership with NHS Improvement.

Professor Lesley Regan, president of the Royal College of Obstetricians and Gynaecologists, said: “Despite the fall in stillbirth and neonatal mortality, these deaths remain a major cause for concern.

“The finding that for 80% of babies, different care may have led to a different outcome, echoes the findings from the RCOG’s Each Baby Counts programme,” she said.

She added: “It is crucial that lessons are learnt from each death and that frontline staff are given the resources they need to deliver safe care to every woman and baby.”