Monitoring & Reporting
Adverse Incidents

Guidelines for Supervisors of Midwives

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North of Scotland Local Supervising Authority Consortium
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Contents

Introduction .......................................................................................................................... 4

Duty to report ...................................................................................................................... 5
  Supervisor’s duty .............................................................................................................. 5
  Health Boards duty ......................................................................................................... 5

Definitions ......................................................................................................................... 5

Supervisory actions following an adverse incident ............................................................. 6

Appendix: LSA Database – reporting adverse incidents ....................................................... 8

References .......................................................................................................................... 11

Further Reading ................................................................................................................ 11
Introduction

Local Supervising Authorities (LSA) are organisations within geographical areas, responsible for ensuring that statutory supervision of midwives is undertaken according to the standards set by the Nursing and Midwifery Council (NMC) under article 43 of the Nursing and Midwifery Order 2001, details of which are set out in the NMC Midwives rules and standards (NMC 2012). In Scotland, the function of the LSAs is provided by the Health Boards, which are arranged into two Regions: the South East and West of Scotland and the North of Scotland.

Each LSA has an appointed LSA Midwifery Officer (LSAMO) to carry out the LSA function. The LSAMOs are practising midwives with experience in statutory supervision and provide an essential point of contact for supervisors of midwives to consult for advice on aspects of supervision. Members of the public who seek help or support concerning the provision of midwifery care, can also contact the LSAMO directly. LSAMOs provide leadership, support and guidance on a range of matters including professional development. They also contribute to the wider NHS agenda by supporting public health and interprofessional activities at Health Board level.

The purpose of this guideline is to explain the mechanism by which NHS organisations, private sector providers and midwives working independently will notify, via the Supervisor of Midwives (SOM), the LSAMO of any adverse incidents involving midwifery practice in accordance with Rule 10 of the NMC rules and standards (NMC 2012).
Duty to report

Supervisor’s duty

The NMC state in Rule 7 of the Midwives rules and standards that “the local supervising authority midwifery officer plays a pivotal role in clinical governance by ensuring the standards of supervision of midwives and midwifery practice meet those required by the NMC” (NMC 2012). In order to carry out this function it is necessary that all incidents relating to midwifery practice are notified to the LSAMO by a SOM through the LSA Database (see appendix).

SOMs should be familiar with the Health Boards protocol for reporting significant/ adverse Incidents.

Supervisors of Midwives in discussion with the Head of Midwifery/ management should ensure that the Health Board's risk management procedures are followed.

Employers of midwives and self-employed midwives duty

The LSA Standard, as outlined in Rule 10 of the NMC Rules and standards states that the LSA must develop a system with employers of midwives and self-employed midwives need to agree a process with the LSA to ensure that the LSAMO is notified of all adverse incidents.

Definitions

A serious incident in relation to the role of the SOM and which should be reported to the LSA is defined as an accident or incident when a woman/ and or baby, member of staff or members of the public suffers:

- serious injury
- major permanent harm
- unexpected death or the risk of death or injury
- where actions or omissions of midwives are likely to cause significant public concern

In addition to the above, the LSAMO requires notification of the following:
- all maternal deaths as defined by the Confidential Enquiry into Maternal Health (CEMH)
- all investigations of midwifery practice being undertaken by a SOM, irrespective of the outcome
- significant changes in service configuration that may have the potential for an adverse impact on women and babies
- sustained deficits in midwifery staffing
- midwives reported to the NMC by the Health Board or others
- stillbirths, neonatal deaths and late fetal deaths
- unexpected significant morbidity of a mother or baby
- major obstetric haemorrhage
- eclampsia
- renal or liver dysfunction
- unexplained/unexpected cardiac arrest

This is not an exhaustive list and where there are uncertainties the LSAMO should be contacted for advice.

**Supervisory actions following an adverse incident**

A system must be in place to ensure that a SOM is notified of any incidents that involve midwifery practice at the earliest opportunity; this may include the on call supervisor. The SOM will then be able to offer support to midwives and families as necessary.

Following an adverse incident or the recognition of circumstances indicating lack of competence, a SOM, should undertake a supervisory investigation (NMC 2012) in accordance with Guideline L: Guideline and process for investigation into a midwife’s fitness to practise by a Supervisor of Midwives on behalf of the Local Supervising Authority which is available online @ [http://www.midwiferysupervision-noslsa.scot.nhs.uk/index_Information_for_Supervisors_of_Midwives.htm](http://www.midwiferysupervision-noslsa.scot.nhs.uk/index_Information_for_Supervisors_of_Midwives.htm).

Wherever an investigation into midwifery practice is indicated, the midwife(s) involved must have an identified support SOM who is independent of the investigatory process.

The LSAMO must be informed that a supervisory investigation has commenced and the
investigating SOM must provide a report of the outcome to the LSAMO within 45 working days. Where circumstances are such that a final report cannot be completed within the timeframe, regular updates should be provided to the LSAMO through the LSA Database. In addition there must be ongoing communication regarding the progress of the investigation between the investigating SOM, the midwife(s), the clinical risk coordinator, complaints coordinator, Head of Midwifery/manager and any other relevant individuals. The LSAMO will provide ongoing advice and support to SOMs throughout the process.

Frequently a case requires investigation under the Health Board’s clinical governance procedures as well as statutory supervision of midwives. In order to minimize distress, information should be shared, including statements and other documentation. Interviews may also be undertaken jointly, providing everyone present is clear about the purpose of the meeting and the capacity in which they are operating.

On conclusion of the investigation it is the SOM who will recommend to the LSA what action, if any, needs to be taken. Possible actions for the midwife/midwives involved include

- no action
- local action plan
- local supervising authority practice programme
- referral to the NMC with LSA suspension from practice

In addition to this the SOM may make recommendations for the organisation in relation to clinical governance issues and systems failures.
## Appendix: LSA Database – reporting adverse incidents

### Details of Incident
- **Region**: Please select...
- **Date and time of making report**: DD/MM/YYYY
- **Name of NHS organization(s) involved**: 
- **Trust/PCT incident reference number (to be used in all correspondence)**: 

### Names and contact details of lead manager/director
- **Name**: 
- **Job Title**: 
- **Telephone**: 
- **Email**: 

**Guidance**:
- Enter the date and time you were notified of the incident, **not** the time of the incident.
- Enter Health Board’s name and address.
- Enter Datix number/ or equivalent.
- Enter details for Midwifery manager or Head of Midwifery.
Ensure you include full details from the maternity records

- AB - 23 yr old primigravida, BA husband - 25 yrs old
- ie midwives band 6 x 2 midwife band 7 consultant obstetrician
- Ensure you include full details from the maternity records

Enter your contact details

name and address of ward/ unit (ie CMU)
<table>
<thead>
<tr>
<th><strong>Other information not in the public domain</strong></th>
<th>Ensure you include full details from the maternity records</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Provide a brief overview of any other material factors that are not and should not enter the public domain, or indicate whether other information is available)</td>
<td>ie ward/department closures</td>
</tr>
<tr>
<td>Describe any immediate action taken to protect and/or improve patient/visitor/staff safety</td>
<td>ie risk management processes, supervisory investigation</td>
</tr>
<tr>
<td>Next steps</td>
<td>ie Procurator Fiscal, CEMH</td>
</tr>
<tr>
<td>Has, or will information on this incident be reported to any other agency/body? (Specify e.g HSE).</td>
<td>ie is this likely to be in the local newspaper</td>
</tr>
<tr>
<td>Information about actual or likely media interest, including draft response/line to take</td>
<td>You can save a draft and complete the form later, but ensure that you do this otherwise a notification will not be sent to the LSAMO</td>
</tr>
</tbody>
</table>

Please complete all sections of the form. Clicking on the Save button will send an email alert as well as saving the contents of the form to the database.

Please [click here](#) to send any questions or comments about this website.
References
The Nursing and Midwifery Order. SI 2002 No. 253. Available online at
NMC 2012, Midwives rules and standards. London: NMC

Further Reading
Maternal Death Guidelines for Supervisors of Midwives. June 2012 available online @
www.midwiferysupervision-noslsa.scot.nhs.uk
NMC 2012 Supervisors of midwives: How they can help you
Scottish Perinatal and Infant Mortality and Morbidity Report 2010 available online @
http://www.healthcareimprovementscotland.org/programmes/reproductive__maternal__child/pro
gramme_resources/spimmr_2010.aspx