Scottish Parliament Region: Glasgow

Case 200501579: Greater Glasgow and Clyde NHS Board

Summary of Investigation

Category

Health: Hospital; Maternity

Overview

The complainant (Ms C) raised a number of concerns that her ante-natal care had not been properly managed by NHS Greater Glasgow and Clyde NHS Board (the Board) and that in particular they had failed to provide adequate monitoring for potential gestational diabetes. Ms C considered that but for this failure her daughter's stillbirth might have been prevented.

Specific complaints and conclusions

The complaints which have been investigated are that the Board failed to:

(a) perform adequate urinalysis throughout Ms C's pregnancy *(upheld);*

(b) properly inform Ms C of an appointment *(partially upheld);*

(c) ensure Ms C's maternity records were available as needed (*partially upheld*).

Redress and recommendation

The Ombudsman recommends that the Board advise her of the outcome of their review of the guidance and protocol for management of gestational diabetes.

The board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 12 September 2005, the Ombudsman received a complaint from the complainant (Ms C) that Greater Glasgow and Clyde NHS Board (the Board) had failed to properly monitor her pregnancy and consequently had not detected her gestational diabetes which led to the stillbirth of her daughter on 13 May 2004. Ms C raised a number of other concerns about the arrangements made for a limited post-mortem and the time taken to respond to her complaint but these issues were resolved or an adequate explanation provided by the Board during their handling of the complaint. These issues have, therefore, not been subject to investigation by this office.

2. The complaints from Ms C which I have investigated are that the Board failed to:

(a) perform adequate urinalysis throughout Ms C's pregnancy;
(b) properly inform Ms C of an appointment; and
(c) ensure Ms C's maternity records were available as needed.

Medical History and Background to the complaint

3. Ms C's GP referred her to the ante-natal clinic on 24 October 2003 and she was given community based shared care for this, her first pregnancy. Ms C attended a number of routine ante-natal appointments. On three occasions no urine sample was obtained for urinalysis. On two occasions when a sample was obtained she was noted to have glucose in her urine. On the second such occasion (26 April 2004) Ms C had blood tests, the results of which were abnormal and were available on 30 April 2004. Ms C did not attend the follow-up appointment arranged for 7 May 2004 and no problems were detected at a routine appointment on 10 May 2004. However, on 13 May 2004 Ms C could not feel any movement and attended hospital where her baby was diagnosed as having died in the womb.

4. The Obstetric Adviser (see paragraph 6) has provided the following information by way of background. Gestational diabetes is a term used to describe the onset of diabetes mellitus during pregnancy. During pregnancy an increased level of glucose intolerance is usual and the level can increase at any time in pregnancy. If the level of glucose tolerance deteriorates sufficiently this can become frankly diabetic. Gestational Diabetes does not represent a single level of intolerance and can be of variable severity and require variable action

(or no action). This condition does not include those women who have pre-existing insulin dependant Type 1 diabetes who will have other problems to be addressed. Some women who develop gestational diabetes may continue to be diabetic after pregnancy, while for the rest the condition resolves after birth. Gestational diabetes affects 3-8% of pregnant women (of whom 19% continue to have problems after birth). The Obstetric Adviser told me that in his view there are increased risks associated with undiagnosed and untreated gestational diabetes, including unexplained stillbirth in late pregnancy.

5. The Obstetric Adviser stated that there is considerable medical debate around the diagnosis, significance, screening and management of gestational diabetes and in particular differing views about the use of a universal screening programme (see also the Boards comments at paragraph 18). It is generally accepted though that at the very least tests should be made available to those women perceived as being at greater risk. These risk factors include a first degree family history of diabetes, gestational diabetes in a previous pregnancy, glucose in the urine in a current pregnancy and a number of other factors relating to maternal age, weight and health. Testing will include routine testing of urine at all ante-natal visits (urinalysis) for the presence of glucose, with further blood tests (random blood sugar tests) and glucose tolerance tests (OGTT) following as necessary.

Investigation

6. Investigation of this complaint involved reviewing Ms C's clinical records relevant to the events and the Board's complaint file. I have also met with Ms C and sought the views of a midwifery (the Midwifery Adviser) and obstetric (the Obstetric Adviser) adviser to the Ombudsman. The Board provided me with additional information requested following receipt of the Advisers' views, this included copies of relevant policies and protocols.

7. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Ms C and the Board were given an opportunity to comment on a draft of this report.

(a) The Board failed to perform adequate urinalysis throughout Ms C's pregnancy

8. Ms C complained that despite telling her own GP at her first visit that she had had neo-natal diabetes and repeating this to hospital staff at her first hospital appointment she was not referred to the diabetic clinic and not

adequately monitored throughout her pregnancy. Ms C also complained that the random blood sugar test performed on 26 April 2004 was noted to be abnormal on 30 April 2004 but nothing was done to follow this up or contact her when she missed an appointment (see complaint heading (b)).

9. Ms C's referral letter from her GP notes that Ms C had had neo-natal diabetes and this was also noted by the midwife at booking-in on her maternity record. Ms C's maternity record also records that a mid-stream urine sample should be taken at every appointment. There is no such recording for three routine appointments from a total of seven (3 November 2003, 8 December 2003, 26 January 2004) with abnormal glucose results noted at two of the remaining four appointments (8 March 2004 and 26 April 2004).

10. The Board stated in their written response to my enquiries at Ms C's medical history did not meet their protocol for further investigation of possible gestational diabetes. The Board also stated that where significant glucose is detected in the urine, a fasting sample is requested for the next appointment and only if this is abnormal is a random blood glucose performed. In Ms C's case the Board stated that she had a random blood sugar test following the second episode of significant glucose being detected in her urine sample and that the next step would have been to organise an OGTT but events overtook this possibility.

11. The Board also stated that Ms C was informed on 3 November 2003 of the importance of bringing a sample to each appointment and that when Ms C did not bring one on 8 December 2003 a mid-stream sample was taken and tested for a suspected possible UTI. This sample was not tested for glucose as fasting samples are recommended and these are best obtained first thing in the morning. The Board stated that there was no special indication that a sample was needed on the two other occasions when Ms C did not bring a sample with her.

12. The Obstetric Adviser told me that he would agree with the Board that Ms C's medical history at booking did not indicate any immediate need for referral to the diabetic clinic and that there is no universal screening process for gestational diabetes. However, the Obstetric Adviser did consider that insufficient prominence was given to Ms C's family medical history in her maternity records and that she was not adequately monitored by way of urinalysis.

13. The Obstetric Adviser stated that a report from *St Vincent's UK Task Force for UK pregnancy and neo-natal care in diabetes* (1996) suggested that the protocol for management of potential gestational diabetes should be i) urine tested for glucose at every ante-natal visit; ii) a timed random blood sugar test at booking-in and at 28 weeks or if glucose is detected in urine samples; and iii) if a timed random blood sugar test comes back abnormal then a glucose load tolerance test (OGTT) should be performed. This report goes on to set out a programme for managing gestational diabetes if it is detected. The Obstetric Adviser also referred to a recent, 2006, commentary published in the Journal of the Royal College of Gynaecologists (RCOG) indicating that they would recommended routine screening for gestational diabetes as being of benefit to all pregnant woman.[1]

14. The Obstetric Adviser expressed concern that despite it being recorded on Ms C's ante-natal booking-in record that she should additionally be asked for a mid-stream urine sample at every appointment (because of a recurrence of urinary tract infections) Ms C was not actually asked to produce a sample on every occasion and did not have a sample tested for glucose on three occasions. The Obstetric Adviser considers it would have been sensible, reasonable and in-line with practice elsewhere, to obtain a sample at the appointment itself. The Obstetric Adviser also noted that the post-natal glucose tolerance test was only performed eight days after the birth by which point the body would be expected have returned to its normal non-diabetic state and the opportunity to detect gestational diabetes would be lost.

15. It is important to note the Obstetric Adviser's view that there is no clear evidence to suggest what caused the death of Ms C's baby. Nor is it clear what degree of impaired glucose tolerance Ms C developed and whether this may have had any consequences.

16. The Board provided me with a copy of the ante-natal appointment card. This indicates that urinalysis should occur at around 10-12 weeks of pregnancy and again at 16-18 weeks but that no further testing occurs until after 26 weeks. I note Ms C was not tested at either of the latter two appointment times. The

[1] Time to screen for, and treat, gestational diabetes. BJOG: An International Journal of Obstetrics and Gynaecology 113 (1), 3–4.2006

card also notes that an early morning urine sample should be brought to every appointment.

17. The Board have also provided me with the protocol for blood glucose monitoring in patients without diabetes which is in line with the Board's view at paragraph 10. I note that the protocol has no timescales for any retesting required. Ms C's urine test on 8 March 2004 showed glucose but there was no further test until 5 April 2004 (at which time the test was clear). The test on 26 April 2004 was again positive for glucose but no further discussion was planned until 7 May 2004.

18. In response to the draft of this report the Board provided me with further comments on their use of guidance and current developments in the screening for gestational diabetes. The Board noted that there is no national or international consensus on the management of gestational diabetes and referred to the 2003 NICE guideline on Routine Antenatal Care which did not follow the same recommended path as the St Vincent Task Force quoted by the Adviser. The Board also referred to the current Scottish guidance, SIGN 55, which predates the NICE guidance. SIGN 55 does recommend urine testing at every antenatal visit but again this is in conflict with the later NICE guideline which does not.

19. The Board also told me that they are currently reviewing all of its practice and protocols with respect to antenatal care which includes gestational diabetes screening. This process will have regard to all available evidence and recent publications as well as any national guidelines.

20. In response to the Board's comments the Obstetric Adviser commented that this is a controversial area but that whatever stance was taken there clearly need to be an up to date protocol or guideline for screening of gestational diabetes and there did not appear to be any clear guidelines in operation at the time of these events.

21. I have raised the question of national guidance with NHS Quality Improvement Scotland (the NHS organisation responsible for setting standards to improve healthcare in Scotland) and confirmed that there is no universal approach to gestational diabetes in Scotland. I understand that a review of SIGN 55 is planned (although there is no specific timescale for this) and

accordingly a copy of this published report will be forwarded to them for consideration as part of the forthcoming review.

(a) Conclusion

22. The appointment/booking-in card used by the Board specifies that urinalysis should occur at specific times in the pregnancy. This testing did not occur as prescribed in Ms C's case. I accept that Ms C was advised of the need to bring a sample and that a fasting sample is of most medical benefit for testing purposes. However, I consider it was unreasonable not to obtain a non-fasting sample on three occasions as this would have been medically prudent. I conclude that urinalysis did not occur in line with the Board's own procedure (or as recommended specifically in Ms C's notes) and further conclude that the failure to obtain a sample during the course of an appointment amounts to a clinical failing. The advice I have received is that the actions taken in Ms C's case fall short of being an adequate system of screening for gestational diabetes. For these reasons I, therefore, uphold this complaint.

(a) Recommendation

23. The Ombudsman notes that the Board are undertaking a review of their practice and protocols with respect to screening for gestational diabetes. The Ombudsman commends this review but notes that this case emphasises the importance of ensuring that staff are aware of guidance and that it is applied consistently. The Ombudsman has no specific recommendation to make but asks that the Board provide her with a copy of the new guidance /protocol adopted by the Board with respect to management of gestational diabetes.

(b) The Board failed to properly inform Ms C of an appointment

24. Ms C complained that the midwife had not informed her of the follow-up appointment booked for 7 May 2004 to discuss the results of her random blood test performed on 26 April 2004.

25. The Board stated that the midwife had contacted the hospital by phone on 26 April 2004 to arrange the appointment and this had been noted in the clinic appointment records. Because of a bank holiday on 3 May 2004 the next available clinic date was 7 May 2004. The midwife concerned recalled telling Ms C of the appointment but agreed that she had failed to note the information on Ms C's appointment card. The midwife apologised for this oversight and accepted that this should have been noted.

26. The Midwifery Adviser noted that there was a failure to record the appointment details in the maternity record and that this was not in line with good practice.

(b) Conclusion

27. The Board have accepted that the appointment was not noted on Ms C's maternity record card as it should have been and have apologised for this. The Board noted that the appointment was recorded on the hospital appointment list and that the midwife recalled informing Ms C of the appointment. Ms C considers that she was not informed. I do not believe there is any evidence that will resolve the difference of view as to whether Ms C was informed or not. However, I accept that the appointment was made but not properly recorded. I, therefore, partially uphold this complaint.

(b) Recommendation

28. As the Board have already made an apology for the omission in recording and this issue is the basis for my partially upholding the complaint, the Ombudsman has no further recommendation to make.

(c) The Board failed to ensure Ms C's maternity records were available as needed

29. The Board stated in their response to my enquiries that Ms C's notes were available at the clinic for her appointment on 7 May 2004 (a Friday) and then returned that evening. The notes would then be filed on Monday morning (10 May 2004) but by this point the driver would have already left with the notes for the peripheral clinics that day. In the case of Ms C her appointment that day was at such a clinic and the notes had not yet been processed. There is an electronic system to track notes but this was not available for the clinic Ms C attended.

30. The Obstetric Adviser expressed concern that the Board did not adopt the common practice in most units in the UK of expectant mothers carrying their own notes between the community and the hospital which ensures these are more readily available especially in circumstances where there is more than one clinic involved. The Obstetric Adviser also noted that he would expect any missing results to be checked in advance of the appointment or otherwise before the patient left the clinic either by phone or computer.

31. In a previous report (TS.0135_03) published on 20 December 2005, the Ombudsman recommened that the Board consider adopting the Scottish Woman Held Maternity Record (SWHMR) and inform her of the outcome of the action it is taking in this regard. The Board subsequently noted that it was their intention to move to a woman held record although this was subject to the implementation of a wider electronic record system both for the Board and NHS Scotland as a whole. The Board informed me that the SWHMR was introduced to all their hospitals from 7 May 2007.

(c) Conclusion

32. In the event I have seen no evidence to suggest that the failure to make the records available at the appointment on 10 May 2004 altered Ms C's care in any way. However, I am concerned that there was the potential for this to occur and that there continues to be such a possibility. I, therefore, partially uphold this aspect of the complaint.

(c) Recommendation

33. The Ombudsman commends the Board for its recent introduction of the Scottish Woman Held Maternity Record and has no further recommendation to make.

20 June 2007

Annex 1

Explanation of abbreviations used

Ms C	The complainant
The Board	NHS Greater Glasgow and Clyde
NICE	National Institute of Clinical Excellence – an organisation which sets clinical standards for NHS organisations in England and Wales
RCOG	The Royal College of Obstetricians and Gynaecologists
SIGN 55	Scottish Intercollegiate Guidance Network – Guideline 55 Management of Diabetes
The Medical Adviser	A medical adviser to the Ombudsman
The Midwifery Adviser	A midwifery adviser to the Ombudsman
UTI	Urinary Tract Infection
SWMHR	Scottish Woman Held Maternity Record

Annex 2

Glossary of terms

Diabetes Mellitus	A severe, chronic form of diabetes caused by insufficient production of insulin
Gestational Diabetes	Diabetes that develops during pregnancy
Neo-natal diabetes	Diabetes occurring in early infancy
OGTT Glucose Tolerance Test	A test which measures the body's ability to use glucose
Random Blood Sugar Tests	A test which measures blood glucose regardless of when the subject last ate
Urinalysis	Testing of urine

Annex 3

List of legislation and policies considered

St Vincent's Task Force report
A report by the St Vincent's UK Task Force fro UK pregnancy and neo-natal care in diabetes (1996)

2006, report by the Royal College of Gynaecologists
Time to screen for, and treat, gestational diabetes. BJOG: An International Journal of Obstetrics and Gynaecology 113 (1), 3-4.2006

SIGN Publication No. 55 Management of Diabetes ISBN 1899893 82 2
Published November 2001

NICE Guideline on Routine Antenatal Care in the Healthy Pregnant Woman
October 2003