<table>
<thead>
<tr>
<th>Title</th>
<th>Patient Story - Maternity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status</strong></td>
<td>For information</td>
</tr>
<tr>
<td><strong>History</strong></td>
<td>Patient stories are regularly presented to Trust Board and Quality Committee for learning and understanding from the patient's perception and experience of OUH services.</td>
</tr>
<tr>
<td><strong>Board Lead(s)</strong></td>
<td>Ms Liz Wright, Acting Chief Nurse</td>
</tr>
<tr>
<td><strong>Key purpose</strong></td>
<td>Strategy</td>
</tr>
</tbody>
</table>
## Summary

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>This paper presents the story of a woman who came into hospital for an elective caesarean section for twins. The babies were cared for in the Special Care Baby Unit. She spent a total of four weeks as an inpatient in hospital, under the care of the maternity services initially and subsequently post-operatively in the Surgical Emergency Unit (SEU).</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>This story highlights the difficulties the patient encountered with timely access to speaking with senior medical staff, including for a prescription for pain relief, plans for discharge and difficulties in gaining information.</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>This patient provided positive feedback regarding her experience of excellent antenatal care, information from staff in maternity and support during breastfeeding. The family also talked about their experience of compassionate care from clinical staff. The patient's case is unusual; managers in the maternity service and SEU had not had experience of a similar case in the past in terms of co-ordinating their care.</td>
</tr>
</tbody>
</table>
| **4** | **Key learning:**  

A Maternity Support worker will be allocated each day to visit patients in such circumstances to ensure consistency and good communication between departments.  

Medical rosters should ensure adequate senior medical supervision is consistently available including during holiday periods.  

Effective pain management put in place out of hours, including the preparation for removal of continuous analgesic infusions.  

Consistency of communication with families and accessibility of senior staff to discuss their care with patients, including out of hours. |

**Recommendation**

The Trust Board is asked to note the contents of the Patient’s Story and note the actions being taken.
1. Introduction

1.1. The presentation of this story at Trust Board has been discussed with the patient and her husband, who provided consent to presentation at a Public Trust Board meeting, and who are keen for the story to be shared.

1.2. The story is told from the patient’s perspective as well as her husband’s and is provided in Appendix 1.

1.3. The patient’s story was shared with the staff within the departments concerned in December 2013. The story will also be discussed at the directorate governance meetings to discuss the need for sustainable service improvements, and will be available within a library of stories for use in customer care training and wider learning on the Trust’s intranet site.

2. Background

2.1. This patient developed a haematoma following an elective caesarean section for twins, which resulted in a small bowel obstruction requiring surgery. However, the development of a haematoma is a known complication of caesarean section which usually resolves spontaneously. This was further complicated by the development of a Clostridium Difficile\(^1\) infection, secondary to the prescription of broad spectrum antibiotics. The administration of antibiotics was necessary, and surgical management while the patient was in maternity was not a suitable option. The patient spent two weeks under the care of the maternity services and then was transferred to the Surgical Emergency Unit (SEU), where she was an in-patient for two weeks. The patient has since had three recurrences of Clostridium Difficile infections and is now under the care of the gastroenterology team.

2.2. After the twins were born, they were both admitted to the Special Care Baby Unit (SCBU) due to low birth weight. One was discharged on the same day and one remained an in-patient for two days. The babies were later re-admitted to SCBU and discharged from the unit at differing times.

3. Rationale for selection

3.1. This story was selected as part of the series of patient story presentations to the Trust Board and Quality Committee.

4. Key issues highlighted and actions

4.1. The key issues highlighted were: continuity of care; the babies’ separation from their mother and therefore difficulty with maintaining breastfeeding; the lack of visible access to senior medical staff out of hours and during the August holiday period; communication between specialties, and inadequate out of hours planning for pain relief prescriptions.

\(^1\) Clostridium Difficile is a type of bacterial infection that can affect the digestive system.
One of the babies was not referred to the paediatrician initially

4.2. There was less concern about one of the babies’ weight than her twin, and she was discharged from the SCBU to be with her mother and father on the day she was born. However, the parents were not aware that they needed to see a paediatrician over the first weekend, during which time the baby lost some weight, and this caused them concern.

Coordination of care and identifying the causes of illness

4.3. In the first week, when the mother was in the maternity ward, a junior doctor was not able to provide her or her husband with sufficient information about her condition in order to provide reassurance. However a Consultant Obstetrician did see the patient on a number of occasions and was involved in the decision making around the plans of care put in place. The lady’s husband then had to ask to see a more senior doctor, who examined her, explained the possible causes of her condition, and suggested a plan to undertake further investigations.

4.4. It was not until the second week, when the patient came under the management of care of a specific registrar, that the patient felt that care was properly coordinated and consistent. She was under the care of different surgical registrars on different days and the patient felt this prevented the doctors from diagnosing the cause of her condition in a timely manner.

4.5. The cause of the complication was a haematoma which was diagnosed and managed conservatively, which was an appropriate clinical decision. The sequence of events that followed relates to an infection which was treated with antibiotics and bowel obstruction caused by the haematoma and the sepsis. Broad spectrum antibiotics were required which then let to the development of a *Clostridium Difficile* infection.

4.6. The patient was transferred back to the observation ward, where she was under the care of different doctors every day. This is due to the way rotas were arranged to ensure sufficient medical staffing cover for 24 hours a day, 7 days a week within employment guidance.

4.7. The patient’s husband also described difficulties in “getting answers” from medical staff, when under the care of the surgical team.

Communication between maternity and the Surgical Emergency Unit

4.8. When the patient was moved from the maternity unit to the main hospital she was separated from her babies, as one baby was in the SCBU and one was with their father in a family room. This made it difficult for the patient to continue to breastfeed and see her babies. The patient and her husband had to organise and work out how to maintain a breastfeeding routine and ensure the mother saw her daughters, as well as needing to be in the SEU throughout the day for treatment and observation.

4.9. There was a perception by the patient and her husband of a lack of sufficient communication between the surgical teams and maternity services, resulting in the patient’s husband trying to access information from senior medical staff himself.
4.10. The patient felt this could have been resolved if there was a key worker or a designated individual responsible for patient liaison to support and advise, for instance on how to transport the twins between the two buildings, facilitating breastfeeding and coordinating care between the maternity unit and the surgical team.

4.11. Managers in the maternity service and SEU had not had experience of a similar case in the past, when a mother and twins were in the hospital at the same time needing care in different departments. There is a protocol on SEU to provide guidance for occasions when mothers are admitted with a baby, and the baby needs to stay with the mother on the ward. This protocol includes putting the mother and baby in a side room and away from the exits (to reduce the risk of abduction). Even though this patient’s story is an uncommon situation, the trust can learn from this feedback by improving the way care is coordinated between departments over a prolonged period of time. The role of a designated individual for patient/family liaison is being considered by the maternity and SEU services.

Pain relief

4.12. On the SEU, the patient’s pain relief was managed during normal working hours when the pain relief team were involved, but on one occasion there was a lack of consistency in pain management out of hours. This was related to the decision to remove an epidural late in the evening without adequate pain relief prescribed to enable continued pain management. The delay in prescribing pain relief resulted in the patient experiencing pain over a period of time before it was controlled.

4.13. The standard procedure for removing epidurals on SEU is to ensure that there is an analgesic prescription in place before removal. This issue will be addressed through training and clinical supervision.

Senior medical and surgical cover

4.14. The patient and her husband observed a reduction in the level of senior medical cover out of hours during the August holiday period, especially when the new junior doctors commenced their placements. This led to an inconsistency of care and reduced continuity. The patient and her husband were frustrated when staff were unable to answer their questions but also the medical staff did not escalate or seek senior advice without the patient and her husband requesting it.

4.15. It has been identified that there is a need to improve on the visibility and access of senior surgeons on the emergency surgical wards, and this has been fed back through junior medical staff and Surgical Nurse Practitioners, and more senior medical appointments have been made to address this issue.

Lack of communication between staff resulted in an uncoordinated discharge (SEU)

4.16. A doctor requested a Magnetic Resonance Imaging (MRI) scan for this patient, but the radiographer was concerned that the patient was having an MRI following two episodes of surgery. The patient was planned to be discharged home that day, but a doctor was not available to discuss the need for the MRI with the radiographer. The patient had told her husband not to visit with her daughters that
day, but just to come to collect her. As the doctor was not available to make the decision about the MRI, the patient made the decision to discharge herself.

4.17. The patient had not had a prescription for analgesic medication to take home but the nurses compensated by administering a late night dose and she returned to the ward the next morning for her next dose.

**Information about Clostridium Difficile**

4.18. The patient felt she was not given sufficient information about *Clostridium Difficile* and the possibility that it could recur. This meant that she did not recognise the signs and symptoms when they recurred.

5. **Areas of good practice identified by the patient**

5.1. Excellent care from midwives in the antenatal period for women with a twin pregnancy.

5.2. The staff in maternity were very helpful by finding out if medications were suitable during breastfeeding.

5.3. The overwhelmingly positive comments relate to dedicated clinical staff who went out of their way to provide patient centred compassionate care.

5.4. The use of a family room helped the patient and her husband to care for their new babies together.

5.5. The patient’s husband said that the staff caring for the babies were “incredibly focussed” and he felt they were “in great hands”.

5.6. The patient was given a private room on the SEU to enable breastfeeding and visits from the babies. The room was cleaned every morning.

6. **Conclusion**

6.1. This story illustrates from the patient and her husband’s perspective the care and communication between two services that are geographically distant but required a co-ordinated approach to the holistic care of the family as a whole.

6.2. The story highlights the challenges that this family experienced and how the clinical staff tried to manage these challenges. It is an uncommon situation for a mother to be cared for between two services and staff were unfamiliar with the challenges of the nature of the elements of co-ordination required to manage the family’s care appropriately. However, there are a number of learning points identified within this patient story that could be used and translated across in principle to other departments.
7. Next steps

7.1. The patient's story is presented in Appendix 1.

7.2. An action plan is presented in Appendix 2.

7.3. This story will be used as a teaching tool within these directorates and across the wider Trust.

8. Recommendation

8.1. The Trust Board is asked to note the contents of the Patient’s Story and note the actions being taken.

Liz Wright
Acting Chief Nurse

Report Prepared By:

Lily O’Connor
Infection Prevention and Control Lead

Ella Reeves
Patient Experience and Involvement Manager

January 2014
Appendix 1 – patient story

From the patient’s perspective

Introduction

I spent 4 weeks in the JR recently. I went into give birth to my two daughters in July 2013. It was an elective caesarean, because I had a very good pregnancy, but towards the end of my pregnancy I developed pre-eclampsia and cholestasis, and one of my daughters had a raised Doppler.

All the service I had leading up to the C-section was absolutely first class. I had lots of check-ups and the C-section went to plan. It was all very good and straightforward.

Birth of my daughters

Both girls were born of a low weight so they had to go to the Special Care Baby Unit and one of them was released the very same day, and the other was kept in for two days. I’m going to call them Pumpkin and Poppet, because at the time we hadn’t named them their official names. The smallest one was called Poppet and the larger one was called Pumpkin. Pumpkin was released straight away to us and we went to the maternity ward where we had a family room where Dad could sleep with us and help, which was absolutely amazing and really needed because I was recovering from a C-section and needed extra help. I would say that a family room is a necessity for anybody who has had twins.

The Special Care Baby Unit and recovery from the C-section

Unfortunately, Pumpkin, for whatever reason, didn’t get referred to a paediatrician, so for the first weekend she didn’t see anybody so lost a bit of weight. Poppet spent the whole weekend in the Special Care Baby Unit and was allowed out to us on Monday, having put back on some of the weight that she had lost. I was still recovering from my C-section and I had a problem with my bowel, but that was all being seen to and I was on morphine so I was feeling a lot better.

Re-admission of my daughters to the Special Care Baby Unit and my admission to the Observation unit

Unfortunately, five days after giving birth to the girls, I woke up and developed very bad stomach pain and collapsed in the maternity ward. I had to be rushed down to the Observation Unit. On the same day, it was a bit of day of days, the girls also had to be rushed into the Special Care Baby Unit because they had both lost weight again. Although Poppet had just been released to us, she had suddenly lost 10% of her body weight and then she spent two weeks in the Special Care Baby Unit being tube fed.

That happened on the Wednesday after the Friday I had the girls, and I was released from the Observation Unit the next day, having been stabilised and receiving pain control with morphine, but it was very inconclusive as to what had happened to me. I was released
back onto the maternity ward, with the possibility of having an infection or the possibility of
having had a haemorrhage, it wasn’t really known, and there was also the possibility I
might have a gall stone.

**Nobody knew what was wrong with me**

On the Friday, a week after the girls were born, we were back in the maternity ward and
we were seen by the junior doctor, who unfortunately didn’t fill us with very much
confidence. She didn’t seem to grasp the severity of the situation and we didn’t know what
was wrong with me, and I didn’t feel like there was a plan to investigate further and work
out what had gone wrong with me and why I was still feeling so ill.

My husband had to step in at that point and demand to see someone more senior. The
registrar came to see us and helped us to put some plans in place and gave us some
ideas of what could be going on.

**Care at the weekend**

Then we went into another weekend, and what we found was that when you went into a
weekend at the hospital everything grinds to a halt, and only major serious cases are seen
over the weekend. You feel like you are in limbo land at the weekend because nothing
moves forward, so I still did not know what was wrong with me. I was put on very strong
antibiotics at this time.

**Investigations**

There was some debate between the registrar and the consultant, about whether I needed
a CT scan. There was a lot of to-ing and fro-ing, and I had various ultrasound scans and
eventually I had a CT scan, which was still inconclusive as to what was actually going
wrong with me, but he actually felt that with all the results from my blood tests I probably
didn’t have an infection, I was thought to have had a haemorrhage or a blood clot.

**Continuing to breastfeed**

During this time we were in the maternity ward in our family room, which was great, and
Poppet was still in the Special Care Unit which meant I could continue breastfeeding
because we were all together, and I had one of the girls, which was great, because I was
really insistent that I could continue with breastfeeding because it’s very important to me
that I was able to do that.

The staff were great at helping me find out if my medication was suitable for breastfeeding.

**Coordination of care**

This was going onto the second week in hospital and then we were put into the care of
one registrar. That was great, because up until he stepped in, we had lots of different
people seeing us and different registrars on different days and it felt very inconsistent, no
one really getting to grips with what was going wrong with me. During that time, he did
more tests and it was decided that I’d had a small haemorrhage (haematoma) and that I
could be discharged. Even though I was feeling really ill, they said I had lost blood and it would take time for me to recuperate. The blood would sort itself out and I would absorb it into my body and I would get better.

Going home and deteriorating again

We came back home for 24 hours, but within that 24 hours I went really downhill very quickly again, and I had to be rushed back into the Observation Unit again where I was seen by the team but it was still inconclusive as to what was going on with me.

Surgery

I was still being very sick with bile, and the consultant saw me at that stage and said that we would see how I went over the weekend, and if I still wasn’t feeling better over the weekend they would need to do an operation on me to see what was going on. That’s what happened: two weeks into our hospital stay, I had surgery for an obstructed bowel and then followed two weeks in the surgical ward. That’s when things got really difficult for me and my husband.

Different hospital departments

We had Poppet in the Special Care Unit, I was in the surgical unit, and Dad and Pumpkin were in the maternity unit. Meanwhile I was trying to recover from the second major surgery and continue to breastfeed Pumpkin, although I couldn’t breastfeed Poppet because she was in the Special Care Baby Unit.

I think that is where we felt things got really sticky for us, because we fell between the gap: we were originally a maternity case, and then became an emergency surgical case. We were in three parts of the hospital and logistically it became really, really difficult for us.

The learning process

I have been really grateful that I have been asked to give this feedback to help if anything can be done for families in a similar situation. I understand we are an unusual case but learning can be taken from this that would be helpful for other people in this situation.

Fortunately, my husband and I are strong people and we were able to cope with this situation, but there were quite a few things to learn from this which I will talk about.

I will talk about the positive experiences I had first because I think it is important to focus on the positive first of all. In terms of prior to all this actually happening, the treatment I had leading throughout my pregnancy was absolutely first class.

Regular appointments

I could not believe how amazing the service was. It was to the point we had so many appointments at the JR we were there nearly every week basically, but it was great knowing because having twins you are more at risk of miscarriage, and other
complications, and that was great having that reassurance. It was also good meeting a lot of people, for example, midwives and getting used to being at the hospital.

**Outstanding individuals**

The individuals we came across at the JR were some amazing individuals and I think without that, our situation would have been made even worse, it was a very difficult situation. There were some amazing midwives in the maternity centre, and nurses in the surgical centre who really, really care, and that really came across and that was great.

**The family room**

I don’t know how we would have coped without a family room.

**Good care from pain nurses**

The pain nurses when I was in the surgical ward gave me a really high class service. There was one element of that service that was a let-down, which I will talk about in a minute, but it wasn’t due to the actual pain nurses, it was after-hours care. They made sure every day they came to see me and that my pain was being managed and that I was okay. Those were the key highlights.

**Falling in the gap between services**

The issues that we came across were when we fell in this gap of being in the maternity ward and surgical ward, and there was an issue in terms of we didn’t feel that there was any one person looking after us. My partner had to deal with being Mum: Dad was Mum, because I was very ill. He had to get Pumpkin logistically to me in the surgical unit so I could continue breastfeeding, and also he had to go and see Poppet and get me to see Poppet in the Special Care Baby Unit.

The logistics of all that was very difficult, as when Poppet was let out of the Special Care Baby Unit and discharged, I was still in hospital and I obviously still wanted to be with my children, so my husband had to bring them around in their cots, and he wasn’t allowed to bring two separate cots around. You weren’t supposed to wheel one cot around the hospital, let alone two, so that really made it difficult. He had to bring one cot around and in the end we had to have both babies in the cots, which was obviously dangerous because we had to make sure they didn’t fall asleep and suffocate each other.

In terms of organisation of the day, I had to see so many doctors and pain people and the physiotherapist, which meant I couldn’t get to see Poppet in the Special Care Baby Unit. In my world of business I would see that there was an issue there, in fact there wasn’t very good communication or someone there overseeing that. For example, Dad needs this, Mum needs this, and how can we make sure that all works together and we have that communication and that we support these individuals.

We found that we were out there on our own just trying to make things work and trying to keep our family together and get sleep and all that kind of thing. I think there is a process
where you need a patient liaison person for a particular case like this of people who have been in hospital longer than a week or two week stay, providing long term overseeing of people. That was the one major issue I felt we really struggled with.

**Delays receiving pain medication**

The other thing was the pain management, which was very, very good, but unfortunately when my epidural was taken out for the surgical procedure I had had, it was during the end of the day in the afternoon, and after I had the epidural I needed something for the pain relief and there wasn’t a doctor around, who could sign off the prescription from the pain nurses. I was told that it would be done by 10.30pm so I had to wait for a very, very long time in agony. I was rolling around in my bed waiting for a doctor to be found, and I did feed that back to the pain nurses at the time and wrote out a feedback form.

**Care during holiday season**

The other thing leading on from that, because we were in hospital for four weeks during July/August, it’s obviously a time of holidays and we found there was a lack of senior doctors in the hospital at the time. There were a lot of junior doctors and a lot of new doctors because obviously there is a big handover at that time. We found that it made the situation difficult; because there weren’t that many experienced doctors there. There also didn’t seem to be a lot of doctors around, hence me having to wait until 10.30pm to get that pain medication.

**Discharge**

The other thing that made matters worse was when I did come to leave the hospital after four weeks of being there, I had problems with my discharge, so I was told I would be discharged the next day after my final sign off by the doctors, but that I would need an MRI scan because I was getting pain from my epidural site. On the day I was due to be discharged there was a lot of miscommunication about that basically. The registrar that was looking after me on the surgical ward wanted me to have an MRI scan because the epidural was causing me back pain. I was referred for an MRI scan, but for some reason I wasn’t able to get an MRI scan, because the machine had broken down or something and I had to wait to the next day. Then the person who was doing the MRI scan didn’t want to do the MRI because they were worried about the fact I had had two major surgeries and then was having the MRI scan. That person needed to talk to my registrar to ask if I needed the MRI scan or not before I could either go ahead and have it (or not), and be discharged. There was a lot of miscommunication, which eventually ended up with me thinking I was going to be discharged, and telling my husband not to come in that day with the girls. I thought I was going to be discharged and I asked him to just come and collect me. The nurses kept saying “yes the doctors know that you are waiting and a decision will be made and you will be allowed to be discharged”. Whatever happened, the doctor was very busy, he was in surgery, and then didn’t come and see me, and it got to 7pm or 8pm I was still thinking I was going to be discharged, but in the end I wasn’t allowed to be discharged and one of the junior doctors came and just told me “no, you can’t leave
today”. She wasn’t able to explain eloquently the reasons why as she didn’t really understand the situation, but just had a second hand message, which again leads to the fact that there are not so many senior doctors during the holiday periods.

I was left in a situation where I was left in hospital four weeks, was absolutely tearing at the walls to get out and see my family, hadn’t breastfed all day, and was left with the decision that if I want to go home and see my daughters, I would have to self-discharge myself, so I had to do that. Unfortunately, then I wasn’t able to take the drugs that I needed without being properly discharged, because they were very strong. The nurses very kindly gave me my 10pm tablet which would see me through to the next morning and my husband came and collected me, but obviously we had to all go back in the next morning with my daughters and hang around the whole day before we could see a doctor who could discharge me and say whether I needed the MRI scan, and eventually it was decided that I didn’t need it. It capped it all off because it had been a very difficult journey. That was due to miscommunication and lack of senior doctors over the holiday periods I think.

Diagnosis of Clostridium Difficile (C-Diff)

The other issue I ended up having at the very end of my stay was that I was diagnosed with C-Diff. I don’t know how I caught that, whether it was the girls (because babies can carry C-Diff too), or whether I caught it in the hospital, or whether it was because of the fact I’d had quite strong antibiotics in the maternity ward (that is probably most likely).

I completely understand all of that, but the main bit of feedback I have about that is obviously during my time in hospital it was great, my room was cleaned every morning, probably unnecessarily but it was done, and I was sent out of hospital with my tablets, got home, and started feeling a lot better, but two weeks after stopping the antibiotics, because I was on a two week course, I started to feel ill again, and it wasn’t told to me when I left hospital that this could be something that could relapse.

I didn’t know much about C-Diff apart from the leaflet that was given to me. I went for a week at home feeling really awful and not knowing what it was because I didn’t have diarrhoea with it very much, so if I had been told I could possibly relapse and it was a potentially likely thing, I could have jumped on that more quickly and gone to the doctors or even had antibiotics that I could have taken straight away. I think it would have helped to just have a bit more information. I was told what C-Diff was and what it meant, but it wasn’t communicated to me that actually it can be quite difficult to get rid of and you need to jump on this if it comes back again. So that would be my feedback on that, and when you come off the antibiotics you should really boost your good bacteria by taking probiotics.

In summary

Those are the key things. To summarise, the main things that I would say needed improving on are:
Family/patient liaison.
The difficulty of having been in the maternity unit and going to the surgical unit.
Breastfeeding and trying to have that family unit.
Pain control after hours and making sure there are people who can take over from the pain nurses.
Medical cover over the holiday periods and also weekends
Communication.

If that leads to any more questions then I am quite happy to come back and help further.

Husband’s story

Weekend cover

We would really like to reiterate the fact that we felt the hospital was run Monday to Friday, and in the evenings and weekends, even though the patients and partners were all there, there were not enough senior people and doctors and decision makers, maybe I say this unfairly because there were some on duty, there were some on duty but not enough to answer some of the questions.

Getting answers

My wife was in quite an emotional state, but it was difficult for me as a husband to deal with that, knowing that I couldn’t get the girls to her, because there was no one to find. I was quite “to the point” with the junior doctors who couldn’t answer my questions. I would much prefer someone to be friendly and polite, accepting they don’t have that knowledge and pacify me, rather than think they have some knowledge that they do not have and not be able to communicate it with me. That was very frustrating.

Good care for our daughters in the Low Dependency Unit

On a positive note, the Low Dependency Unit staff are incredibly focussed. When you become a parent, your primary concern is for the wellbeing of your child. You really felt they were in great hands.

Outstanding individuals

As my wife said, it was the individuals that we met that made our experience positive from midwives, the scans, all the way up to the doctors who came in after surgery, the doctor being called in, and me spotting him walking through the corridor and me almost stalking him reminding him of my face that my wife was still in the hospital, and he did come back in his own time because he was concerned about us.
It was luck that my wife’s surgeon was on at the John Radcliffe and was able to see my wife over a weekend and he was the surgeon who operated on the Monday. That was a big culture shock moving from the maternity hospital to the main hospital.

**Enabling breastfeeding**

You could sense a change as I pushed my children over to be breastfed that we called it “baby hospital” and “grown up hospital”, and we were lucky and people were very good and organised to give my wife a room on her own so she was able to breastfeed and given some privacy.

**Feeling lost in the system**

On the flipside of that, I also felt when my wife was in the family room in the maternity unit, quite clearly she was in a lot of pain, no one knew what to do. I did think maybe she was being lost in the system and that she should actually be in the main hospital.

**Doctors recognising when to seek further help**

It was two doctors who were on call on the weekend who did actually say to each other “we don’t actually know what is wrong”, and accepted that and therefore got my wife’s surgeon in. That was a good thing: they accepted they didn’t know and called someone else in.

**Reflecting on the experience**

Apart from that, it’s 15 weeks ago the children were born and we’ve had time to reflect on the experience beginning in hospital. Some of it is quite painful to look back on and quite emotional in terms of my frustration and my worry. There were also nice people who were very helpful, but you are looking for a cure which people expect to be told, and very often people can’t give that answer. I think it’s important for people to realise that, and we did, we understood and were patient, but I was also able to listen and communicate and push when I had to at times, for answers. If I hadn’t been able to communicate that, I do worry for people who maybe English is a second language and people who may not know how to deal with certain situations that would be a concern.

**Feeling left on my own**

Generally speaking the maternity unit was absolutely fabulous, just as my wife said, and it was just an unfortunate set of circumstances that occurred for us to have to spend, for me it was 29 nights in a family room. I sometimes felt a little bit left on my own, and to be fair, that’s what I would be if I was at home if I didn’t have a family network to support. I don’t begrudge and I don’t think I should have a midwife running around looking after my children for me. However, maybe they thought because they saw I was able to deal with them they left me on my own, and I do wonder if I had a behavioural issue, then who would have come to help.
Patient: I must admit my husband is a very capable person and I think a lot of men wouldn’t be able to have coped with one baby, let alone two babies like you had to do.
### Appendix 2: Action plan

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action</th>
<th>Progress</th>
<th>Who responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral:</td>
<td>Improved co-ordination through a liaison CSW/named midwife member of staff</td>
<td>February 2014</td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td>• One of the babies was not referred to the paediatrician initially:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the parents were not informed they needed to request this.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination of care and identifying the causes of illness</td>
<td>Improved co-ordination through a liaison CSW/named midwife member of staff</td>
<td>February 2014</td>
<td>Clinical Director</td>
</tr>
<tr>
<td>• In the first week when the patient was in the maternity ward, the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>house doctor was not able to tell the patient and her husband the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>causes of the patient’s condition deteriorating, and there was no plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to find out.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Until the second week, when the patient was put under the care of</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>one registrar, the patient felt that care was uncoordinated and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>inconsistent.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination of care and identifying the causes of illness</td>
<td>Improved co-ordination through a liaison CSW/named midwife member of staff</td>
<td>February 2014</td>
<td>Head of Midwifery/Deputy Matron SEU</td>
</tr>
<tr>
<td>• The patient’s husband described difficulties “getting answers” later</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>on, when under the care of the surgical team.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication between maternity and surgical services:</td>
<td>Improved co-ordination through a liaison CSW/named midwife member of staff</td>
<td>February 2014</td>
<td>Head of Midwifery/Deputy Matron SEU</td>
</tr>
<tr>
<td>• Difficulties being able to breastfeed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• There was a lack of communication between the surgical and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>maternity services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain relief</td>
<td>Improve training for ward staff about ensuring a replacement pain prescription is ready before removing an epidural – using protocol and Royal Marsden manual</td>
<td>13 February 2014 and future training sessions.</td>
<td>Deputy Matron for SEU</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Senior medical and surgical cover</td>
<td>Increased recruitment through business plan for consultant staff and Surgical Nurse Practitioners to provide improved level of clinical supervision to junior medical staff</td>
<td>April 2014</td>
<td>Clinical Director and Matron</td>
</tr>
<tr>
<td>Providing information to patients</td>
<td>Review patient information leaflet for C.Difficile</td>
<td>This is being developed with Oxford Health and Oxfordshire GPs and the content is due to be finalised by April 2014</td>
<td>Infection Control Manager</td>
</tr>
<tr>
<td></td>
<td>Improve training for ward staff about giving information about C.Difficile</td>
<td>To be included in the next training on 13 February 2014 and future training sessions.</td>
<td>Deputy Matron for SEU</td>
</tr>
</tbody>
</table>

resulting in the patient’s husband trying to access information from senior medical staff himself.