Failure by hospital midwives to adequately detect and monitor neonatal hypoglycaemia, and to document a plan of care; failure of DHB to respond appropriately to a complaint (05HDC16723, 28 June 2007)

Midwives ~ District health board ~ Neonatal hypoglycaemia ~ Rights 4(1), 4(2), 10

A woman complained about the services provided to her by Grey Hospital maternity staff. In 2004, she was admitted in early labour to the maternity unit of Grey Hospital. She was assessed by her lead maternity carer (LMC), who identified abnormalities on the CTG, and an obstetrician was asked to review the patient. He decided that the baby would not tolerate hours of hard labour and recommended a Caesarean section. The baby was delivered by Caesarean section three hours later, weighing 2735gms (6lbs), with a good Apgar score.

During the afternoon and evening of his first day, the baby developed feeding problems. Three hospital midwives were responsible for the baby's care during this time. At 8.30am the following day the baby was found to have very low blood sugar levels. At that time there was restricted communication between the regional hospital's maternity and paediatric teams, so a physician was called to review the baby. A treatment regime was ordered and the neonatal paediatric team at the closest major public hospital was consulted. The neonatal paediatrician continued to monitor and advise the regional hospital staff on the baby's treatment. However, his condition did not improve and he was airlifted to the major hospital later that day. He suffered neurological damage as a result of his hypoglycaemia.

It was held that, by virtue of her inadequate documentation and failure to formulate a care plan, the first midwife did not meet professional midwifery standards and breached Right 4(2).

The second midwife did not recognise that there had been a change in the baby's feeding pattern, and did not consider assessing his blood sugar level or asking a doctor to assess him. In relation to the care she provided to the baby, she breached Right 4(1). In addition, her inadequate documentation was a contributing factor in the baby's condition not being identified in a timely manner. She did not formulate and document a plan of care for the baby. She did not meet professional midwifery standards and also breached Right 4(2).

Like her colleagues, the third midwife did not formulate and document a plan of care. In relation to this aspect of her care, she did not meet professional midwifery standards and breached Right 4(2).

The DHB failed to meet its obligation to resolve the woman's complaint to the Commissioner. Its response was neither speedy nor efficient. In these circumstances, West Coast DHB breached Right 10 of the Code. As a result of this investigation the DHB reviewed its policy regarding the detection and monitoring of neonatal hypoglycaemia, and its complaint policy.