## Inadequate documentation and standard of care (05HDC18619, 27 July 2007)

*Midwife* ~ *Assessment* ~ *Documentation* ~ *Standard of care* ~ *Information* ~ *Stillbirth* ~ *Rights* 4(1), 4(2)

A man complained about the services provided to his 23-year-old wife by her midwife. In the last month of her pregnancy, the woman was assessed at a hospital owing to possible concerns about fetal movement and blood pressure. The midwife initially had difficulty detecting the fetal heart rate by cardiotocograph (CTG). The CTG recording was subsequently interpreted as showing a normal fetal heart rate. The woman's blood pressure normalised and she was discharged from hospital.

Two days later, the woman was admitted to hospital for further assessment, with a history of abdominal pain. A further CTG recording was interpreted as normal and the woman was discharged home following the administration of pethidine. Later that day the woman was readmitted in labour and subsequently gave birth to a stillborn baby boy. The pathology report noted widespread skin deterioration and it was thought the baby had died approximately 24 hours prior to the birth.

It was held that the midwife's clinical documentation was inadequate, included inappropriate retrospective amendments, and there was no indication that an appropriate care plan had been developed. The midwife also provided inadequate information about labour and pain relief options. Overall, the assessment and care of the woman by the midwife during the two days before she gave birth was unsatisfactory. In particular, she failed to take appropriate action in relation to reports of significant pain, bleeding and reduced fetal movement. The midwife was held to have breached Rights 4(1) and 4(2).

The matter was referred to the Director of Proceedings. The Director considered the matter and has issued a disciplinary charge in relation to the midwife's inadequate monitoring of the woman during labour, and the considerable additions made by the midwife to the clinical records after the events.

## Link to Health Practitioners Disciplinary Tribunal decision:

http://www.hpdt.org.nz/portals/0/mid0882dfinding.pdf