Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 03HDC07983)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Ms B	Midwife, Provider
Ms C	Hospital Midwife
Ms D	Hospital Midwife
Dr E	Obstetrician / Gynaecologist

Complaint

The Commissioner received a complaint from Ms A concerning the services provided to her by Ms B, midwife. The complaint is summarised as follows:

During November and December, Ms B, midwife, did not provide Ms A with care of an appropriate standard before, during and after the delivery of her baby. In particular:

- *during labour Ms B prescribed pain relief medication for Ms A over the phone without performing a clinical assessment*
- *during Ms A's labour at a Public Hospital Ms B was not actively involved in her care*
- *during delivery Ms B tugged at the placenta which resulted in Ms A retaining placental products*
- *Ms B did not assess Ms A before she was discharged from hospital on 21 November*
- *Ms B did not respond appropriately to Ms A's symptoms of swelling and continuous bleeding between 22 November and 2 December*

During November Ms B did not fully inform Ms A about her condition. In particular, on 22 and 25 November Ms B did not provide an appropriate explanation about the uterus not contracting and the absence of after-pains.

An investigation was commenced on 15 August.

Information reviewed

- Complaint from Ms A, dated 25 May
- Notes of telephone interviews with Ms A on 11 August, 19 May, 10 August and 12 October
- Response from Ms A, received 13 October
- Responses from Ms B, dated 27 August, 31 May and 8 October
- Information provided by the Public Hospital, dated 18 March
- Notes of telephone interview with Mr A on 14 October

Independent expert advice was obtained from Ms Juliet Thorpe, midwife.

Information gathered during investigation

Background
On 20 November Ms A gave birth to her third child at the Public Hospital.

Ms B, midwife, was Ms A's Lead Maternity Carer (LMC). As LMC she was responsible for organising Ms A's maternity care. Several times during the pregnancy Ms B referred Ms A to an obstetrician, Dr E, and her GP, because of concerns about the size of the baby and the possibility of a deep vein thrombosis or venous thromboembolism. However, as both Ms A and her baby were well, Ms B remained the LMC.

Ms A was also seen by Dr E prior to her delivery, regarding induction and the prescription of prostaglandins. As a result of the discussions between Dr E, Ms A and Ms B, it was decided that labour should be induced.

Labour
Ms A was admitted to the delivery suite at the Public Hospital at about 8.00am for her induction.

Ms A had decided, at her final consultation with Dr E, to have pain relief early in the labour. Dr E had suggested to Ms B, in her letter following that consultation, that if Ms B agreed, Ms A might have a single injection of pethidine when she was 5cms dilated. Ms B advised me that when she saw Ms A at the Public Hospital for the induction they again discussed options for pain relief for the delivery. Ms B stated that, prior to the induction, she had discussed pain relief options, including pethidine and an epidural, with Ms A.

At around 9.00am a specialist administered the first round of prostaglandin gel to induce labour. At around 1.00pm a second round of prostaglandin was administered. Ms B left Ms A at about 1.45pm, when she was just starting contractions. While Ms B was away, Ms A was monitored by the hospital midwives.

Ms B returned to check on Ms A at about 7.00pm. Ms A was not yet in established labour. Ms B stated that she discussed the plan for overnight care with Ms A. Ms A was to be monitored by the hospital midwives, who would contact Ms B once Ms A went into established labour. Ms B stated that they arranged that, if the hospital staff were happy to do so, they could give Ms A pethidine for pain relief if required. Ms B advised the hospital staff that they should contact her if they were not happy to give the pethidine or were unsure of any aspect of Ms A's care. Ms B also arranged for Ms A to be given temazapam to help her sleep. This is recorded in Ms A's notes. Ms B left the delivery suite just before 8.00pm.

The progress notes record that at 10.00pm, Ms A had pethidine and temazepam as prescribed.

The notes record that at around 2.20am Ms A was uncomfortable and having contractions lasting 30-45 seconds every five minutes. Ms A requested further pain relief. The hospital midwives gave Ms A paracetamol at 2.50am and a heat pack 10 minutes later.

The notes record that at about 3.30am Ms A was attempting to sleep. However, five minutes later she again requested pain relief.

Ms B stated that she was contacted by the delivery suite at 3.30am, when Ms A went into established labour. At this point, Ms B apparently obtained "sufficient information" from the hospital midwives to establish that Ms A could safely have a pethidine injection. Ms B made her way to the Public Hospital. Ms A was given 100mgs of pethidine at 3.40am by the hospital midwives.

Delivery

Ms B arrived at the hospital and saw Ms A at around 4.30am. By this stage Ms A was in advanced labour and the second stage of labour was imminent. Ms A claimed that after commencing labour, she did not see Ms B until it was time for her to push. In response, Ms B advised me that, prior to the induction, she had discussed the process with Ms A, who was aware that she would not be with her the whole time.

According to Ms B she "cared for [Ms A] through the birth of her baby boy at [6.05am] and left again when I was satisfied [Ms A] and her baby were fine and after they were transferred to the postnatal ward". However, Ms A advised that Ms B did not become actively involved in her care. She stated:

> "When it came time for me to push, [Ms B] came and to my alarm sat against the wall while I was pushing urging me on with expressions like 'go for it [Ms A]'. I was becoming rather worried and asked my husband to go and stand at the end of the bed as I did not feel comfortable pushing myself."

The notes record that Ms B delivered a baby boy at 6.05am.

The delivery was uncomplicated but Ms A advised me that her placenta took a long time to come away and that Ms B tugged to remove it. Ms B advised me that she had no concerns about the delivery of the placenta. She said that, after giving an ecbolic [to stimulate contractions of the uterus], she used controlled cord traction to help deliver the placenta. Ms B stated that it took about 10 minutes to deliver the placenta, which is not unusual, and that on examination the placenta appeared complete and healthy looking. Ms A's total blood loss was 300mls and Ms B said the uterus was central and well-contracted. The birth record states that a complete placenta was removed.

Ms A recalled that about 10 minutes after giving birth she had a bath. There was a lot of blood in the bath and when she got out there was "a lot of blood all over the floor, the toilet and everywhere".

Post-delivery care
Ms A said that after the bath she felt very woozy and weak. She recalled that Ms B told her that they were short of space in the delivery suite and "implied I had to move to antenatal straight away … She also said I could go home if I wished."

In contrast, Ms B advised that she attended Ms A until satisfied that she was ready for transfer to the postnatal ward, which occurred sometime before 9.00am.

Ms A was transferred to a small room in the antenatal unit. She recalled that she did not see Ms B, or a nurse, until her family visited her later in the day and asked a nurse for assistance.

According to the progress notes, Ms A was seen by a second midwife and a physiotherapist about 9.00am. The next note was made at 4.20pm when Ms A was seen by a nurse. This records that Ms A continued to have "moderate to heavy" lochia [vaginal discharge] and had passed a small clot earlier in the day. Her fundus [the position of her uterus] was reported to be firm.

The notes record that at 7.00pm Ms A continued to have "moderate-heavy" lochia and her fundus was firm and at "-2 below umbilicus". Overnight Ms A was noted to have continued moderate to heavy lochia.

Ms A was discharged home at 11.30am on 21 November. Ms A recalled that she left hospital without Ms B or any other nurse checking her or her baby. However, the notes indicate that that morning, prior to her discharge home, Ms A was reviewed by a hospital midwife, Ms D. Ms D noted on the Obstetric Midwifery Referral that "all is well" and that she had informed Ms B of Ms A's discharge in person. Ms D also recorded in the progress notes:

> "PNL (post natal lochia) [satisfactory]. Feels her bleeding is heavy, particularly when she stands up. Fundus [firm and central] below [umbilicus]. [Midwife] [Ms B] aware of discharge home."

Home care
Ms B said that, on the basis of the information she was given about Ms A's discharge, she did not believe an urgent home visit was required.

She first visited Ms A at home at 9.30am on 22 November.

Ms A said that, at that time, she expressed concern to Ms B about her large stomach, her lack of after-pains and the fact she could not feel her uterus contracting down when breast-

feeding. She said Ms B did not examine her baby at this visit and did not provide any "constructive answer" to her questions.

Ms B recorded in the post-natal notes that Ms A's lochia was heavy but not offensive and that she had no fever or suprapubic pain (which can be signs of infection or retained products of conception (RPOC)). Ms B stated that because Ms A had some swelling, she enquired whether she had any epigastric pain, frontal headaches or urinary retention, which could be symptoms of a more serious problem. Ms A did not have any of these symptoms. Ms B recalled that she also took Ms A's temperature and pulse and measured her fundal height. She stated:

> "I was upset to see that I have not recorded taking [Ms A's] temperature pulse or fundal height on my post natal visits. I always check fundal height but on this occasion my documentation is lacking. I also always check temperature and pulse although I have written no fever indicating I was checking but am disappointed in my lack of documentation."

Ms A recalled that on 22 November, Ms B touched her stomach and said that "everything is fine", although she also went red in the face. Ms B told her that the swelling was "hormonal". Ms A could not recall any specific details about any of the other postnatal visits, including whether Ms B carried out any physical examinations, except that Ms B had at one point looked at her stomach and that she kept saying that the problems were "hormonal".

On 23 November Ms B visited Ms A and recorded that her postnatal bleeding was "improving". No other problems were noted.

Ms B next visited Ms A on 25 November. Ms A again expressed her concerns about her large stomach, lack of after-pains and failure to feel her uterus contracting. Ms B's notes of this visit record that Ms A's postnatal bleeding was moderate, her emotions, appetite and sleeping were good and she did not have any fever. There is no comment in the notes about Ms A's uterus, swelling or lack of after-pains. Ms B recalled that, after the first three home visits, she did not have any concerns about Ms A's postnatal progress.

Later that night Ms A noted severe swelling in her feet. According to Ms A, she rang Ms B about 10.00pm in tears and "pleaded" with her to visit. Ms B refused to attend and told her that the problem was just hormonal. According to Ms A, the swelling increased overnight and spread to her arms and legs. She again rang Ms B in the morning (26 November) to seek advice. Ms B again told her that the swelling was hormonal. Ms A recalled that she rang Ms B again the next day (27 November) as the swelling had not gone down. Ms B once again told her that it was hormonal. There is no record of any telephone call in Ms B's notes. Mr A confirms that the first telephone call occurred, as he was present at the time.

On 29 November Ms A visited her general practitioner. He ordered blood tests and told Ms A to go to hospital if her condition did not improve over the next two days.

Later that same day Ms B made her 10-day postnatal visit. She recorded that Ms A was "still swollen" and a "bit shivery", she had moderate postnatal bleeding and her uterus was "very tender". She noted that blood tests had been done and "? Reactive to Voltaren", as Ms A had suggested that she was possibly having a reaction to the Voltaren she was taking. Ms B recalled that it was not until this visit that Ms A informed her that she had been to see her GP that day and the previous day. She was concerned that Ms A was complaining of a very tender uterus and was "pale and sweaty". Ms B prescribed Ms A a course of the antibiotic Synermox and arranged to see her again on 1 December.

The postnatal care notes record that Ms B prescribed the Synermox on 1 December, although the notes for that day also record "still taking antibiotics", suggesting that the Synermox had been prescribed previously (on 29 November) as stated by Ms B, and not 1 December as recorded.

On 30 November Ms A was still bleeding "continuously and heavily" and her stomach was still swollen. She went to the Emergency Department at the Public Hospital, where she was examined and had further blood tests. She was told to return on 2 December for a scan.

Ms B visited Ms A on 1 December and recorded in her notes that Ms A looked better, was still taking her antibiotics and had less oedema. Ms A recalled that Ms B told her not to go back to the hospital as "everything was fine".

On 2 December, Ms B went on leave and handed over Ms A's care to another midwife.

Ms A returned to the Public Hospital on 2 December. The scan showed that she had RPOC in her uterus and her cervix was still open. Ms A had a dilatation and curettage (D&C) operation the next day and a further D&C on 19 December to remove the RPOC.

Response to provisional opinion

Ms B's lawyer made the following submission in response to my provisional opinion.

Ms B's lawyer submitted that Ms A's complaint must be viewed in light of her seeking reassurance from other health professionals, both during and after her pregnancy. Regardless of the care provided by Ms B, Ms A was someone who needed assurance from other medical practitioners.

Use of pethidine

Ms B's lawyer argued that my provisional finding – that "it was not appropriate to put the responsibility of assessment on the hospital staff" prior to administering the pethidine – was not "an accurate reflection of events". She noted that the use of pethidine was discussed thoroughly and agreed between Ms B, Ms A, the obstetrician and hospital staff. Ms A had

told Ms B that she was terrified of contractions and her ability to cope with them just prior to delivery, and Ms B had taken this concern seriously.

In addition, Ms B's lawyer stated:

> "[T]he report and expert opinion does not reflect the relationship between [Ms B] and hospital staff. [Ms B] has 30 years midwifery experience. The hospital midwife [Ms C] is also very experienced. Both have worked together often and communicate well.
>
> [Ms B] was confident that her discussions with [Ms C] canvassed the issues needed to be considered when determining whether to administer pethidine and both experienced nurses were well aware of any possible effects on the baby and mother. While it is accepted that a vaginal examination did not take place it is not accepted that a vaginal examination was 'required' in order to fulfil the requirement of reasonable care and skill. The standard of care must take into consideration the experience and skill of the midwives and their ability to communicate with one another."

Involvement in care

Ms B's lawyer contested my advisor's description of Ms B's care as "basic". She advised that Ms B's practice is to "sit or stand where there is room and act upon the requirements of the situation or any request of the woman". She also submitted that Ms B's delivery notes document her observations, which could not have been observed from the other side of the room.

Response to swelling and bleeding

Ms B's lawyer advised me that Ms B discussed with Ms A what is "normal and abnormal in all aspects of post-natal care" and what issues to contact her about between visits.

Ms B's lawyer stated that, when Ms B visited Ms A on 22 November, she assessed her condition, including the bleeding and any reasons for swelling. She also looked for signs of infection, retained products or any other condition, such as a circulatory problem. Ms B recalls discussing with Ms A the swelling and impact of hormones.

Ms B's lawyer submitted that Ms B continued to monitor these issues at her visits on 23 and 25 November. However, as Ms A had moderate lochia, was sleeping and eating and did not have any fever, there was no cause for concern or for daily visits.

Ms B's lawyer also noted that, while Ms A had concerns about her swelling and level of bleeding, these issues were assessed by other health professionals and there is no indication that there was any sense of urgency about these problems, or concern about the care provided by Ms B.

Ms B does not recall Ms A's telephone calls on 25, 26 and 27 November. Ms B's lawyer stated that "it is unlikely that the calls or pleading occurred as [Ms B] would have responded given her diligent responses to [Ms A's] concerns during the antenatal period".

Ms B's lawyer stated that is it Ms B's usual practice when prescribing antibiotics to advise the woman to see her GP if she has not improved within 24 hours and that this is "responsible advice as [Ms B's] scope of practice limits her options in such circumstances". Ms B's lawyer also submitted that Ms B knew when she prescribed the antibiotics that Ms A was returning to the Public Hospital the next day. Further, Ms A had demonstrated that she would independently seek medical advice if concerned.

Ms B's lawyer stated that it is unreasonable to criticise Ms B for "not following up blood tests taken [on 29 and 30 November]" when it is not clear whether the test results were available before Ms B handed over care on 2 December.

Documentation
Ms B's lawyer noted that Ms B admits that her documentation does not record all the care she provided to Ms A. However, she does not accept that there is no evidence to show a partnership in the decision-making process. Ms B's lawyer submitted that, while the decisions were not documented, there is evidence that the relevant issues were discussed. Further, where Ms A had particular concerns, Ms B referred her to an obstetrician, whose advice was then considered in the decision-making process.

Ms B's lawyer stated that Ms B has reviewed her record-keeping as a result of this case.

Independent advice to Commissioner

The following expert advice was obtained from Ms Juliet Thorpe, an independent midwife:

> "I have been asked to provide independent advice regarding the midwifery care provided by [Ms B]. The specific purpose – to provide independent advice about whether [Ms A] received a reasonable standard of care and skill from [Ms B], midwife. I have also been asked to provide clinical input, which will assist you in ensuring that all issues during the investigation have been explored.
>
> I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am an independent midwife who has been registered for twelve years and have been providing an independent midwifery service to the women of Christchurch for ten years. I am an active member of the New Zealand College of Midwives (NZCOM) and am presently a midwifery reviewer for the Canterbury/West Coast region NZCOM Standards Review Committee.
>
> **I have closely read the following supporting information prior to writing this advice.**
>
> A Letter from [Ms A] to the Commissioner, dated 25th May.

B Record of telephone call between [Ms A] and [investigator] on 11th August

C Letter from [Ms B] to the Commissioner, dated 27th August.

D [Ms A's] medical records.

I have consulted with a midwife [...] regarding the issues raised in this opinion. [She] is also a nominated expert advisor for the New Zealand College of Midwives.

Expert Advice Requested

In your opinion, was it appropriate for [Ms B] to prescribe Pethidine for [Ms A] over the phone?

Pethidine is a systemic opioid. Some women find that it helps them to relax between contractions when in labour. It is not without considerable side effects, which should always be explained to the woman before administering the drug (NZCOM Consensus Statement, 1996). Pethidine crosses the placenta and can affect the baby's breathing if given within 2hrs of birth. The baby may be born with Pethidine still in its system and this can not only affect its ability to breathe spontaneously when born but affect its ability to feed at the breast (NZCOM, 2003). It is therefore important that a careful midwifery assessment is made prior to the drug being given.

In my opinion I believe that if [Ms A] was at the point in her labour where she was requiring pharmaceutical pain relief, a thorough midwifery assessment by her Lead Maternity Carer (LMC) was warranted. It is clearly stated in the Service Specifications of Section 88 that it is the responsibility of the LMC to provide 'the primary care from the time of established labour, including assessment of the woman at a maternity facility and regular monitoring of the progress of the woman and her baby' (NZ Ministry of Health, 2002). This would involve close observations of the labour. Frequency, length and strength of the contractions would be observed, as well as discussion with the woman as to what she was feeling/wanting. It would be expected that alternative pain relieving options would be offered to the woman, before Pethidine was administered. These may include position changes, heat, water (bath), massage, acupressure, guidance, reassurance and support. As [Ms A] was a multigravida (this was not her first labour) it would also have been reasonable to do a vaginal examination to assess if the birth was imminent so as to make a safe plan involving pain relief.

The hospital midwife on duty documented in the notes that at 0220 [Ms A] was uncomfortable, having contractions every 5 minutes which lasted 30-45 seconds and that she was requesting pain relief. She was given paracetamol and then a heat pack 30 minutes later. At 0330 the notes state that [Ms A] was going to try and sleep and 5 minutes later she was again requesting pain relief. I can only assume that this was the information the hospital midwife gave [Ms B] prior to her prescribing Pethidine over the phone. [Ms B] says in her statement that 'I was given sufficient information to establish that [Ms A] could safely have the Pethidine injection for pain relief'. As LMC, it is my opinion that [Ms B] should have seen [Ms A] before prescribing the Pethidine and that it

was not appropriate to put the responsibility of assessment onto the hospital midwife. To be able to safely administer Pethidine to a labouring woman it is my opinion that this responsibility lay with [Ms B], the LMC, in discussion with [Ms A], at the time that the pain relief was required.

Did [Ms B] have an appropriate level of involvement in [the baby's] delivery?

[Ms B] was notified of [Ms A's] need for pain relief at 0340 and was in attendance at 0430. By this stage [Ms A] was in advanced labour and 'feeling pressure in bottom' which would indicate that the second stage was imminent. The baby was born at 0605 and [Ms B] was present at the birth and attended [Ms A] until 0815.

The documentation is scant and gives no indication of [Ms B's] involvement other than providing the barest essentials. It therefore makes it difficult to form an opinion about [Ms B's] involvement other than it would appear that [Ms B] was present and provided adequate care. [Ms A] feels that [Ms B] did not adequately support her, who 'sat against the wall while I was pushing'. It appears that [Ms A] was not happy with this level of support and as there wasn't a clearly documented birth plan outlining [Ms B's] role in labour, it is impossible to know what was discussed antenatally.

In regard to care plans, Section 88 Service Specifications define it as 'the process by which the LMC and the woman develop a plan of care for the woman and her baby and the documentation of this plan throughout the individual clinical notes pertaining to this woman' (p.7, MOH, 2002). In [Ms B's] statement she says 'I always explain that midwifery care is run on a partnership where a woman and her midwife makes decisions on care together'. There is no evidence of this in the documentation of the midwifery notes. I would expect to see evidence of discussion regarding support in labour and what [Ms A] and [Ms B's] expectations were of each other during this time. With regard to what is reasonable care however, [Ms B] attended [Ms A] on request of the hospital staff and appeared to provide appropriate, if basic, care.

Did [Ms B] deliver the placenta in an appropriate manner?

Once again as there is no documentation of any antenatal discussion regarding management of the placenta's delivery, I can only assume that [Ms B] discussed with [Ms A] that she would manage the birth of her placenta actively and that [Ms A] was in agreement. It is usually recommended that when labour is being actively managed (induced) the birth of the placenta is also managed actively (NZCOM Consensus Statement: Management of Third Stage, 1996). This involves giving an oxytocic drug (syntocinon) following the birth of the baby, clamp and cut the umbilical cord, and then deliver the placenta by controlled cord traction (CCT). CCT involves applying firm traction to the cord assisting the placenta out, as the uterus contracts. This usually takes anything from 5 to 20 minutes from the time the baby is born.

From the notes it would appear that [Ms B] gave syntocinon 5iu intramuscularly after the birth (time not documented) and then delivered the placenta 10 minutes after the

birth. I assume the cord was also cut during this time (not documented). This seems to have occurred without any complication. In [Ms A's] statement she said that there were problems with the placenta. 'It took a long time to come away and [Ms B] tugged at it to remove it'. From the notes the placenta was born within the expected time and as it was actively managed would have required some 'tugging'. If there had been problems with the delivery of the placenta, I would have expected it to have taken longer to be delivered and there would have been a greater blood loss with the delivery. Estimated blood loss was 300mls, which is an average blood loss volume for a normal birth. [Ms B] noted that the uterus was central and w/c (well contracted) which would indicate that all was well. At 0645 [Ms B] examined the placenta and found it to be complete and healthy which would also indicate that the third stage had been managed well. It is my opinion that [Ms B] managed the delivery of the placenta in an appropriate manner.

Should [Ms B] have assessed [Ms A] prior to her discharge on 21st November?

Each hospital/midwife have their own arrangements as to whose responsibility it is to discharge a midwifery client. In the Service Specification under Section 88, every woman is required to have a full midwifery assessment every day while in hospital, following the birth of their baby. Whether this is done by a hospital midwife or the LMC midwife depends on the arrangements between those concerned and should always be in consultation with the woman. 'Daily visit by the LMC while the woman is receiving inpatient Postnatal Care unless agreed otherwise with the woman and the Maternity Facility' (p.14, MOH, 2002). If the hospital midwife has any concerns about that woman, prior to discharge, contact should be made with the LMC and the LMC should see the woman before she is discharged. I can only assume that [Ms B] had such an arrangement with the staff at [the Public Hospital].

From the notes, on the 21st Nov [Ms A] appeared to be well. She said in her statement that a 'nurse' checked neither her nor her baby, before going home. In the notes however it seems that she did get a midwifery assessment as it states that her uterus was 'f&c' (firm and central) and felt below her umbilicus. [Ms A] is noted as being concerned about her bleeding which she felt was heavy. If the bleeding was to be considered of concern to the assessing midwife, [Ms A's] uterus would not have been below the umbilicus nor firm. The midwife in the hospital obviously felt that [Ms A] was experiencing normal bleeding for two days postnatal and was happy for her to go home. She contacted [Ms B] about this who arranged to follow up at home the next day. This seems to be appropriate care.

Should [Ms B] have taken any additional steps when advised of [Ms A's] swelling and bleeding between 22nd November and 2nd December?

[Ms B] saw [Ms A] on the 22nd November and noted that her bleeding was heavy yet there was no documentation concerning palpation of the uterus. On the 23rd November she visited again and wrote 'improving' under the column for lochia (postnatal bleeding). Once again no note of how the uterus was involuting (contracting down) or any comment about unusual swelling. She visited on the 25th November and noted the

lochia to be moderate and again no comment about [Ms A's] uterus. She didn't visit [Ms A] again for another four days although had three phone calls from her over this time when [Ms A] stated her concern about unusual swelling in different parts of her body. When she did visit on the 29th November, she documented that [Ms A] looked pale and sweaty, her lochia was still moderate and her uterus was tender. Although there is no documentation of this (until the 1st December), [Ms B] says she prescribed [Ms A] a course of antibiotics (Synermox) on this day. [Ms A] had already seen her GP that day and the day before, and the GP had taken bloods to assess for infection. [Ms B] then arranged to visit again in two days time. In the meantime [Ms A] had gone to A&E as she was not happy with how she was feeling. [Ms B] had her last visit with [Ms A] on the 1st December, before going on holiday, and noted that [Ms A] looked better, she was still taking her antibiotics and had less oedema.

I have several concerns about the care provided.

It is reasonable practice to palpate a woman's uterus every day for the first 5 to 7 days, especially if the bleeding had been unusually heavy, or the woman has any concerns. What one expects to see is a gradual reduction in the height of the uterus as it contracts down. After the birth the uterus is commonly felt at, or slightly above, the umbilicus and then it gradually moves down at approximately a centimetre a day. Each day it is useful to compare with the day before, so that it is clear the involution is occurring, as it should. It may not be necessary to palpate the uterus every day if the woman is experiencing a reduction in her bleeding and feeling well. When a woman has retained products there tends to be a stasis in the involution where the height of the uterus doesn't reduce or may even move up towards the umbilicus. The amount of bleeding doesn't tend to lessen and may even increase. The uterus is also tender on palpation. These are warning signs that the uterus is unable to contract down, as there is something left behind.

There is no documentation that [Ms A's] uterus was palpated at any visit during this time. As this is such a routine part of basic midwifery care I can only assume that fundal height was assessed but not documented, as [Ms B] said was the case in her statement. [Ms B] would also not be expecting any problems with retained products, as the placenta had been healthy and complete.

As [Ms A] was concerned about her abdomen and her bleeding it is unusual that [Ms B] did not make a note of the fundal height, as it would be a crucial part of her assessment with regard to [Ms A's] particular concerns. [Ms B] said that [Ms A] had no fever or supra pubic pain on the 22nd November, yet there is no documentation of this on that day, other than the bleeding was heavy and not offensive. As the case notes and [Ms B] and [Ms A's] statements offer conflicting arguments, it is difficult to assess if appropriate care was provided. If [Ms B] did not palpate [Ms A's] uterus, as the notes would suggest, this would not be reasonable care. If she did do a thorough midwifery assessment but did not document this adequately, then that is also not appropriate.

My second concern is that [Ms B] did not respond to [Ms A's] concerns about her oedema (swelling). It is not uncommon for women to have varying degrees of fluid retention after the birth of their baby and is rarely a problem. The fact that it concerned [Ms A] enough for her to ring her midwife three times in three days meant that [Ms A] considered it to be a problem. [Ms B] should have followed up on this by seeing [Ms A] at her home and completing a full midwifery assessment.

Thirdly, when a woman has a condition which warrants a course of antibiotics and has been noted as pale and sweaty, it would be appropriate practice to follow up with a visit within 24 hours. At this visit it would be important to palpate the uterus, check bleeding, get a general picture of the woman's well being and see if there had been any adverse affects of the antibiotics. Taking the woman's temperature at the time of prescribing the antibiotics and checking it again 24 hrs later would also give an indication that the treatment was having a beneficial effect. If not, then it would be appropriate to refer to a secondary care provider for a second opinion (p.35, MOH, 2002). The GP had taken blood to assess [Ms A's] well being and it would have been reasonable care to have made contact with the GP and followed up on these blood results.

It is my opinion that [Ms B] should have taken the following steps in her assessment of [Ms A] between the 22nd November and 2nd December. She should have palpated [Ms A's] uterus and documented her findings. She should have visited [Ms A] between the 25th November and the 29th November when [Ms A] phoned her three times with concerns. She should also have seen [Ms A] 24 hrs after prescribing her antibiotics to assess the benefit of the treatment, followed up on the blood results and generally reassessed the well being of her client.

On 22 and 25 November did [Ms B] provide [Ms A] with an appropriate explanation about the uterus not contracting and the absence of after pains?

It is unusual for a woman who has had her third baby not to have after pains. These pains occur as the uterus contracts down and are most commonly felt when the baby is feeding during the first two or three days following the birth. Some women never get them but [Ms A] said she had them with her previous babies and was surprised not to this time. In [Ms A's] statement she said that [Ms B] gave her no constructive answer when she asked her about this. As there is nothing in the notes to indicate that it was even discussed I cannot make any comment. The fact that this was an important issue for [Ms A] at the time, and [Ms B] has no memory of it, indicates that there may have been a significant communication problem between this woman and her midwife.

Are there any aspects of the care provided to [Ms A], which you consider warrants either?
- further exploration by the investigation officer?
- additional comment?

I would like to make additional comment about [Ms B's] documentation. She acknowledged in her statement that she did not document fundal height or temperature

in the notes and has sought to remedy this with future clients. The lack of documentation throughout [Ms A's] pregnancy, birth and postnatal midwifery notes is not of a reasonable standard expected by the midwifery profession and has made assessment of the midwifery care very difficult. I can only assume that the care has not been given if it is not documented. The format used does not allow for comprehensive documentation as it involves tick boxes and only allows room for abbreviated notes. The notes do not demonstrate informed decision making or any discussion that may have occurred between [Ms A] and [Ms B] regarding aspects of [Ms A's] care.

I have consulted the **NZCOM Handbook for Practice** to assess [Ms B's] documentation in relation to the professional body's standards of practice (NZCOM 2002).
The NZCOM Standards, which relates to this case are

Standard 2: The midwife upholds each woman's right to informed choice and consent throughout the childbirth experience.
To meet this standard I would expect to see decisions clearly identifiable after a process of information giving and discussion. A clearly identified and documented plan of care as the result of these discussions. No plan was evident.

Standard 3: The midwife collates and documents comprehensive assessments of the woman and/or baby's health and well being.
To meet this standard, midwifery care, advice and consultations need to be clearly documented. The documentation should be a narrative-style, which is easily understood by the woman, and there should be evidence of a care plan, which is constantly updated following any new information that may impact on care. For example, when induction is being proposed there should be clear documentation of the rationale for induction, what was discussed and any decision made. There is no evidence of this in [Ms A's] notes.

Standard 4: The midwife maintains purposeful, on going, updated records and makes them available to the woman and other relevant persons.
To meet this standard the notes need to show every contact with the woman including phone calls made and details of the discussions of these calls. There was no evidence of any phone communication between [Ms A] and [Ms B]. There is also no indication that [Ms A] held her notes during her pregnancy and childbirth experience. The NZCOM recommends that women have access to their notes and the notes then become a referral source for the advice and recommendations given at each visit. The woman can use the notes as a reminder of what to look out for, things to try and when to make contact with their midwife if they have any concerns. As there is no documentation of recommendations or advice in the notes I can only assume that they were not used for this purpose.

In summary, it is my opinion that [Ms B] should have made a midwifery assessment herself, prior to prescribing Pethidine for [Ms A] in labour and that it was not appropriate for her to do so over the phone.

[Ms B] provided reasonable care to [Ms A] in labour and managed the delivery of the placenta appropriately.

[Ms A] appears to have been assessed by a midwife prior to discharge and was found to be well. [Ms B] visited her at home, within 24 hrs of discharge as required in the Service Specifications of Section 88 and this was appropriate care.

[Ms B's] documentation shows no evidence that she had checked [Ms A's] uterus in the postnatal period. [Ms B] says in her statement that she provides thorough care however it is unfortunate that her documentation does not reflect this. Had she not palpated [Ms A's] uterus, as the notes would suggest, this would not be considered reasonable care.

I believe that [Ms B] should have visited [Ms A] between the dates of the 22nd and the 25th of November when phoned three times by a concerned [Ms A]. It would have been appropriate to make a full midwifery assessment of [Ms A] during this time.

[Ms B] did not provide appropriate care by failing to follow up with [Ms A], within 24 hours, after prescribing her antibiotics on the 29th November.

Overall the documentation is of a standard which does not meet the recommendations of the New Zealand College of Midwives Standards of Practice (NZCOM, 2002)."

Additional advice

The following additional expert advice was obtained from Ms Thorpe, after Ms B and the Public Hospital provided further information:

"This advice is in addition to the report I sent you on the 30th November regarding the midwifery care provided by [Ms B] to [Ms A]. I have reread the report I sent you last year and all of the supporting information as below.

- Record of telephone call between [Ms A] and investigator on 11 August, labelled 'A' (Page 1)
- Letter from [Ms A] to the Commissioner, dated 25 May, labelled 'B' (Pages 2-11)
- Letter from [Ms B] to the Commissioner dated 27 August, labelled 'C' (Pages 12-14)
- Medical records, labelled 'D' (Pages 15-53)
- Letter from […] to the Commissioner dated 18 March (received 4 May) and attachments, labelled 'E' (Pages 54-208)
- Record of telephone call between [Ms A] and investigator on 19 May, labelled 'F' (Page 209)
- Letter from [Ms B] to the Commissioner dated 31 May, labelled 'G' (Pages 210-211)

Expert Advice Required

In your report of 30 October you advised that [Ms B] managed the delivery of [Ms A's] placenta in an appropriate manner. Could you please explain how [Ms A] could have retained some placental product?

Having reviewed the clinical notes again and reread my original report the only conclusion I can come to is that there was an adherent piece of placenta which was more firmly attached to the uterine wall than the rest of the placenta. When the controlled cord traction was applied the main body of the placenta was delivered leaving a small piece behind. [Ms B] noted that the placenta was complete so there were no obvious missing pieces. These are usually visually obvious when examining a placenta afterwards. It is difficult to know if [Ms A's] memory of [Ms B] 'tugging' at the placenta is indicative of difficulty with the birth of the placenta contributing to retaining part of it, or simply controlled cord traction which is the expected treatment when actively managing the third stage. Whether it was either of these situations the care of [Ms A] at the time following the birth of the placenta seems appropriate with regard to the assessment of her well being.

Copies of [Ms B's] access agreement with [the Public Hospital] are enclosed along with relevant maternity guidelines and procedures for intrapartum care. Having reviewed these, can you please comment on [Ms B's] interactions with staff at [the Public Hospital] and her responsibilities with respect to that organisation and its employees?

As mentioned in my initial report I had concerns about the expectation of [Ms B] that the [Public Hospital] midwifery staff would be happy to administer pethidine to [Ms A]. I said '*in my opinion I believed that if [Ms A] was at the point in her labour where she was requiring pharmaceutical pain relief, a thorough midwifery assessment by her Lead Maternity Carer (LMC) was warranted'*. This requirement is clearly stated in the Service Specifications of Section 88 and as part of her Access Agreement with [the Public Hospital] she is required to provide 24-hour availability as LMC. The Guidelines and Procedures for Intrapartum Care also state with regard to pethidine that 'women may need help and support from the midwife, either to avoid pharmacological analgesia or to choose between different methods of pain relief. Generally as a first option it is best to use methods which interfere the least with ambulation, eating, drinking, and foetal well-being.' (Guidelines and Procedures: Pain relief p.83). The staff at [the Public Hospital] had offered [Ms A] non-pharmacological methods and when that changed I do not believe it should have been the role of the facility and its staff to make LMC assessments/ decisions. Pethidine had been discussed antenatally (letter dated 05/11/03) with [Ms A] by [Dr E] (Obstetrician) and [Ms B] (0810 hrs, 19/11/03). Even so I believe that the LMC Access Agreement and the Guidelines and Procedures of [the Public Hospital] show an expectation that the LMC provides the labour care and all that it entails with back-up midwifery care as required. Many midwives have informal arrangements with the staff at the maternity facility they use. For example [Ms B] apparently had such an arrangement with the postnatal staff who were available to do a postnatal discharge midwifery assessment of [Ms A] on the 21/11/03. From my initial report:

'Daily visit by the LMC while the woman is receiving inpatient Postnatal Care unless agreed otherwise with the woman and the Maternity Facility' (p.14, MOH, 2002). If the hospital midwife has any concerns about that woman, prior to discharge, contact should be made with the LMC and the LMC should see the woman before she is discharged. I can only assume that [Ms B] had such an arrangement with the staff at [the Public Hospital].'

It seems apparent that [Ms A] had the same informal arrangement with Delivery Suite midwives as they were happy to administer pethidine to [Ms A]. [Ms B] may well have organised this so that [Ms A] did not have to wait for [Ms B] to come from home before being able to have analgesia. The potential complications arising from giving pethidine in labour, however, should not be the responsibility of the [Public Hospital] staff and within the expectation of the Access Agreement and the Procedures and Guidelines I still believe [Ms B] should have been the one to make the assessment and give the pethidine. It is difficult to say whether anyone is actually at fault here as [Ms B] is the one who made the request of the staff yet the staff also accepted that responsibility.

Was it appropriate for the Lead Maternity Carer to hand care over to [the Public Hospital] staff during [Ms A's] labour?

I am not aware at any stage that [Ms B] formally handed care over to [the Public Hospital]. There was certainly no indication that this was required at any stage during the labour. From my reading of the notes [Ms B] was [Ms A's] LMC throughout the labour and there was no requirement for obstetric/secondary care involvement. [Ms A] was seen by an Obstetrician in regard to the induction and the prescription for prostaglandins but as both mother and baby were well, [Ms B] stayed as her LMC. At no time would it have been appropriate to completely hand over care to the [Public Hospital] staff. During the evening of the 19/11/03 from 2000hrs until 0430hrs (20/11/03) [the Public Hospital] staff's role should only have been to monitor [Ms A] and contact [Ms B] as soon as labour established. This would be normal practice and entirely appropriate as an expectation of the facility by the LMC. Their role was not to provide labour midwifery care although it appears that they did provide this.

[Ms B] requested that they contact her when labour established and there is obviously confusion about when this was because it was not long after [Ms B] arrived back at the hospital that [Ms A] progressed into the second stage of labour. I believe that the staff should have contacted [Ms B] sooner and not taken on such an active midwifery role in the labour. It is possible however, that by [Ms B] asking them to give pethidine to [Ms A] as required (she was given it twice, 2200hrs and 0340) she was abdicating some of her responsibility as LMC thereby indicating that although she was not handing over care, she was happy for the staff to provide a more active role.

In summary I believe that [Ms B] worked within the requirements of her Access Agreement with [the Public Hospital] by documenting that she would be available to [Ms A] at [Ms A's] and the staff's request. Whatever informal agreements she had with the staff were not documented. As I mentioned in my initial report the brief

documentation has made it difficult to gain an accurate picture of events but I hope that my opinion has been of assistance."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

RIGHT 6

Right to be Fully Informed

3) *Every consumer has the right to honest and accurate answers to questions relating to services …*

Other relevant standards

The Nursing Council of New Zealand's *Code of Conduct for Nurses and Midwives* (2001) states:

"Principle Two

…

The nurse or midwife:

…

2.9 accurately maintains required records related to nursing or midwifery practice".

The New Zealand College of Midwives (NZCOM) *Standards of Practice* (Midwives Handbook for Practice, NZCOM, 2002) states:

"Standard two

The midwife upholds each woman's right to informed choice and consent throughout the childbirth experience.

…

Standard three

The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

…

Standard four

The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons."

The "Maternity Services – Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000" (Ministry of Health, 2002) (the Maternity Services Notice) states:

"**Part C Service Specifications & Quality Requirements**

…

4.4 Labour & Birth

4.1.1 The [LMC] will be responsible for ensuring that all of the following services are provided …

(a) all primary care from the time of established labour, including assessment of the woman at a maternity facility and regular monitoring of the progress of the woman and her baby;

(b) management of the Birth; and

(c) all primary care until two hours after delivery of the placenta …

4.5 Services Following Birth

The [LMC] will be responsible for ensuring that all of the following services are provided for both the mother and baby …

4.5.1 Visits to assess and care for the mother and baby in a Maternity Facility and at home until four to six weeks after Birth, including:

…

(b) a daily visit while the woman is receiving inpatient Postnatal Care unless agreed otherwise with the woman and the Maternity Facility;

…

4.5.2 Review and update the Care Plan and document progress, care given and outcomes, ensuring that the Maternity Facility has a copy of this Care Plan where the woman is receiving Inpatient Postnatal Care.

…

4.5.3 Where a birth has occurred in a Maternity Facility, the [LMC], in discussion with the woman and the Maternity Facility, will determine when the woman is clinically ready for discharge."

Opinion: Breach – Ms B

Pain relief

Ms A complained that, during labour, Ms B prescribed pain relief medication for her over the phone without performing a clinical assessment.

Ms B advised that she discussed the plan for pain relief with Ms A on the morning of 19 November and that it was for hospital staff to administer pethidine if they were happy to give it and Ms A was contracting and uncomfortable. Her lawyer submitted that the use of pethidine during labour was agreed by Ms B in consultation with Ms A, Dr E and the hospital staff.

My independent midwifery advisor, Ms Thorpe, commented that, if Ms A was at the point in her labour where she required pharmaceutical pain relief, a thorough midwifery assessment by her LMC was warranted. Ms Thorpe reviewed Ms B's access agreement with the Public Hospital and advised me that it required Ms B to be available 24 hours a day to provide LMC services. The Maternity Services Notice states that it is the responsibility of the LMC to provide "all primary care from the time of established labour, including assessment of the woman at a maternity facility and regular monitoring of the progress of the woman and her baby".

Ms Thorpe noted that this includes close observation of the labour, including observing the frequency, length and strength of contractions and discussing with the woman what she is feeling and wanting. It also means offering alternative pain relieving options to the woman before administering pethidine. This may include position changes, heat, water (bath), massage, acupressure, guidance, reassurance and support. I note that Ms A had been given pethidine at 10.00pm, paracetamol at around 2.50am and a heat pack at 3.00am by staff at the Public Hospital. In addition, as Ms A was a multigravida (this was not her first labour) it

would have been reasonable to do a vaginal examination to assess if the birth was imminent, so as to make a safe plan involving pain relief.

I note Ms Thorpe's comments that pethidine can have adverse effects on the baby if given within two hours of birth. In these circumstances, where close observation, vaginal examination and discussion with the woman were advisable, Ms B should have attended before requesting that the hospital staff administer pethidine at 3.40am.

Ms B stated that she "was given sufficient information to establish that [Ms A] could safely have the pethidine injection for pain relief". However, I accept my advisor's comments that, in the circumstances, as Ms A's LMC, Ms B should have seen and assessed Ms A before requesting the administration of pethidine at 3.40am. It was not appropriate to put the responsibility of assessment onto the hospital staff.

It was submitted that Ms B and the hospital midwife were "very experienced" and "worked together often and communicate well". Both were apparently aware of possible effects of the pethidine. I have no reason to doubt the experience and close working relationship between Ms B and Ms C, and I accept that the hospital midwife was happy to give the pethidine. However, I do not accept that the midwives' experience and working relationship lessened Ms B's obligations as Ms A's LMC.

In my opinion, by failing to assess Ms A prior to authorising the administration of pethidine, Ms B did not provide services with reasonable care and skill and therefore breached Right 4(1) of the Code.

Response to swelling and bleeding

Ms A complained that Ms B did not respond appropriately to her symptoms of swelling and continuous bleeding in the days following her baby's birth.

Palpitation of uterus

Ms Thorpe advised me that it is reasonable practice to palpate a woman's uterus every day for the first five to seven days after delivery to check that it is contracting down, especially if the bleeding has been unusually heavy, or the woman has any concerns. Ms Thorpe considered that recording the fundal height would be a crucial part of assessing Ms A, with regard to her concerns about her abdomen and swelling, and that if Ms B did not do this her care was not of a reasonable standard.

Ms B stated that she did palpate Ms A's uterus at the postnatal visits but did not document this. Ms A recalled Ms B touching her stomach at the first home visit on 22 November, but cannot recall whether she did so at the other home visits. In the circumstances, I accept Ms B's statement that she did palpate Ms A's uterus at the postnatal visits but did not record this.

Response to Ms A's concerns on 22-29 November
It was submitted that, when Ms B visited on 22, 23 and 25 November, she monitored Ms A's level of bleeding and checked for possible reasons for the swelling, infection, retained products and other conditions, such as a circulatory problem. However, Ms A did not have any symptoms that would cause concern or require daily visits.

Ms A stated that, in addition to the visits on 22, 23 and 25 November, she complained to Ms B about swelling via telephone on three consecutive days (25, 26 and 27 November). The first of these calls was confirmed by Mr A, who was present at the time. However, Ms B does not recall these telephone calls.

In my view it is probable that Ms A did make these telephone calls, even though Ms B does not recall them. Ms A is in no doubt about making the calls and has provided a detailed account of the first call on 25 November. Mr A also confirms that the first call occurred. I am not convinced that this evidence is outweighed by the assertion that Ms B would have responded to the calls because of her "diligent" antenatal care.

Ms Thorpe advised me that, given Ms A's level of concern, Ms B should have seen Ms A at her home and completed a full midwifery assessment. Ms B failed to do so.

Follow-up after prescribing antibiotics
Ms Thorpe advised me that when a woman has a condition which warrants a course of antibiotics and has been noted as pale and sweaty, it is appropriate to undertake a follow-up visit within 24 hours. At this visit it is important to palpate the uterus, check bleeding, get a general picture of the woman's wellbeing and see if there have been any adverse affects from the antibiotics. Recording the woman's temperature at the time of prescribing the antibiotics and again 24 hours later allows the midwife to assess whether they are having a beneficial effect; if not, it is appropriate to refer to a secondary care provider for a second opinion.

It was submitted that it is Ms B's usual practice when prescribing antibiotics to advise the woman to see her GP if she has not improved within 24 hours and that this is "responsible advice as [Ms B's] scope of practice limits her options in such circumstances". Furthermore, Ms B knew, when she prescribed the antibiotics, that Ms A was returning to the Public Hospital the next day and that Ms A would independently seek medical advice if concerned.

I am not convinced by Ms B's submission. She prescribed the antibiotics on 29 November and did not learn of the hospital visit until her visit to Ms A later on 1 December, 48 hours after the prescription. I accept Ms Thorpe's advice that a follow-up visit should have occurred within 24 hours. It was not sufficient to rely on Ms A to contact her own GP. Given Ms A's poor health nine days postnatally, and her evident concerns, Ms B should have been more proactive in her follow-up after prescribing antibiotics.

Follow-up of blood tests
Ms Thorpe also advised that, as Ms A's general practitioner had taken a blood sample to assess her wellbeing, it would also have been reasonable for Ms B to have contacted the GP and followed up on the blood results. In my view Ms B should have checked with the GP whether the test results were available, before she handed over care on 2 December.

Summary
I accept Ms Thorpe's advice that Ms B failed to take a number of steps in response to Ms A's condition between 22 and 29 November. In particular, she did not visit Ms A between 25 November and 29 November to assess Ms A's symptoms and general well-being; she did not follow up Ms A within 24 hours of prescribing antibiotics and did not record Ms A's temperature before prescribing antibiotics or 24 hours later; and she did not consult with Ms A's GP about the results of the blood tests. In my opinion, in not carrying out these tasks, Ms B did not provide services with reasonable care and skill and therefore breached Right 4(1) of the Code.

Record-keeping

The *Code of Conduct for Nurses and Midwives* (the Code of Conduct) requires midwives to "accurately [maintain] required records related to … midwifery practice".

In addition, the NZCOM's *Standards of Practice* require a midwife to collate and document "comprehensive assessments of the woman and/or baby's health and wellbeing" and maintain "purposeful, on-going, updated records", and the Maternity Services Notice defines a care plan as "the process by which the LMC and the woman develop a plan of care for the woman and her baby and the documentation of this plan throughout the individual clinical notes pertaining to this woman".

Ms B advised me that she always explains to her clients that midwifery care is a partnership, in which a woman and her midwife make decisions on care together. However, there is no evidence of this partnership in the midwifery notes. Ms Thorpe advised that she would expect to see evidence of discussions about support in labour and what Ms A and Ms B's expectations were of each other during this time. No such discussions are documented in the notes. It is not a satisfactory answer for Ms B to say that in fact all the relevant issues were discussed.

Furthermore, following delivery, Ms B did not document fundal height or temperature in the notes. Ms Thorpe advised me that recording the fundal height would be a crucial part of assessment with regard to Ms A's particular concerns about her abdomen and swelling. I note that Ms B has acknowledged this and has undertaken to do so for future clients.

Ms Thorpe advised me that the documentation throughout Ms A's pregnancy, birth and postnatal midwifery notes does not meet the standard expected of a midwife. The format used does not allow for comprehensive documentation as it involves tick boxes and allows room only for abbreviated notes. The notes do not demonstrate informed decision making

or any discussion that may have occurred between Ms A and Ms B regarding aspects of care.

I accept my expert advice. In my opinion, Ms B's record-keeping did not meet professional standards and therefore breached Right 4(2) of the Code.

I acknowledge Ms B's statement that she has reviewed her record-keeping in light of this case.

Opinion: No breach – Ms B

Involvement in care
Ms A complained that during her labour Ms B did not become actively involved in her care and did not support her.

Ms B was notified of Ms A's need for pain relief at around 3.30am and was in attendance by 4.30am. By this stage Ms A was in advanced labour and the indications were that the second stage was imminent.

The documentation is scant and gives no indication of Ms B's involvement other than providing the bare essentials. For example, there is no clearly documented birth plan outlining Ms B's role in labour. It is therefore difficult to establish what was discussed antenatally and how involved Ms B was in the labour.

Ms Thorpe advised me that what she can determine from the notes and from the accounts of what occurred is that Ms B attended Ms A at the request of hospital staff and appeared to provide "appropriate, if basic, care" and worked within the requirements of her access agreement with the Public Hospital.

Despite Ms A's concerns about the lack of support provided to her, I am satisfied, on the basis of my expert advice, that Ms B did provide satisfactory care during the delivery. Accordingly, Ms B did not breach the Code in respect of this matter.
I note that it appears that a lack of clear expectations about the maternity care to be provided by Ms B would have contributed to the concerns raised by Ms A.

Tugging at placenta
Ms A complained that after her baby's birth the placenta took a long time to come away and that Ms B tugged to remove it.

Ms Thorpe advised that it is usually recommended during an induced labour that the birth of the placenta is also managed actively. This involves giving an oxytocic drug (Syntocinon) to stimulate contractions of the uterus following the birth of the baby, clamping and cutting the umbilical cord and then delivering the placenta by controlled cord traction, which involves

applying firm traction to the cord assisting the placenta out as the uterus contracts. This usually takes between five and 20 minutes from the time of birth.

From the notes it would appear that Ms B gave Syntocinon intramuscularly after the birth (the time is not documented) and delivered the placenta 10 minutes after the birth. Although it is not documented, it is reasonable to assume that the cord was cut during this time without complication.

Ms Thorpe advised me that the notes of the birth indicate that the placenta was delivered within the expected time and that, because it was actively managed, it would have required some tugging. If there had been a problem with the delivery of the placenta, she would expect it to have taken longer to be delivered and there would have been a greater blood loss with the delivery.

Ms Thorpe concluded that, in this instance, a piece of adherent placenta was more firmly attached to the uterine wall than the rest of the placenta and that a small piece of this remained when controlled cord traction was applied. Ms B's notes record that the uterus was central and well contracted and that at 6.45am she examined the placenta and found it to be complete and healthy. It is now clear that the placenta was not complete. Ms Thorpe advised that if a piece is missing, this is usually visually obvious. I conclude that this was one of those unusual occasions when it was not.

I am satisfied that Ms B managed the delivery of the placenta in an appropriate manner. Accordingly, Ms B did not breach the Code in respect of this matter.

Pre-discharge assessment
The Maternity Services Notice requires that the LMC visit daily every woman receiving inpatient postnatal care, unless otherwise agreed with the woman and the maternity facility. Ms Thorpe advised me that whether this visit is made by a hospital midwife or the LMC depends on the arrangements made by the parties and should always be in consultation with the woman.

Ms Thorpe also advised me that if the hospital midwife had any concerns prior to discharge, she should have contacted Ms B, who should have then seen Ms A before she was discharged. From the Public Hospital notes, Ms A appeared to be well at the time of her discharge. Ms D's notes indicate that she considered that "all [was] well" and that, although Ms A was concerned about her bleeding (which she felt was heavy), Ms A's uterus was firm and central and was below her umbilicus.

Ms Thorpe advised me that the bleeding would have been of concern to Ms D only if Ms A's uterus was not firm or below the umbilicus. Instead, Ms D felt that Ms A was experiencing normal bleeding for two days postnatally and was happy to allow her to go home. She contacted Ms B about this, who arranged to follow up at home the next day. Ms Thorpe advised me that this seemed to be appropriate care.

I accept my advisor's comments. In my opinion, it was appropriate for Ms B to rely on Ms D's assessment. In doing so, she provided appropriate care at the time of discharge and therefore did not breach the Code in respect of this matter.

Again, however, this complaint highlights the importance of all parties understanding the obligations of those involved in the woman's care.

No further action

Information provided to Ms A
Ms A complained that in the days after her baby's birth, Ms B did not fully inform her about her condition and, in particular, explain the significance of her uterus not contracting and the absence of after-pains. She advised me that, as this was her third baby, she felt it was unusual not to have after-pains when breast-feeding, which had happened with her two previous children.

Right 6(3) of the Code requires that consumers be given honest and accurate answers to questions relating to services. Ms A said that Ms B did not give her any constructive answer to her questions about the failure of her uterus to contract and her lack of after-pains. Ms B cannot recall Ms A raising these issues with her.

Because of the conflict in evidence I am unable to conclude whether Ms B breached the Code in her answers to Ms A. In the circumstances, I do not consider that further investigation of this matter is likely to resolve the matter. Accordingly, I do not intend to take any further action in respect of this issue.

However, I take this opportunity to remind Ms B of the importance of effective communication with consumers and of the need to provide clear and comprehensive answers to all questions asked about her services.

Other comments

Responsibility of the LMC and hospital midwives
This case highlights the importance of clear communication between providers, and the need for well understood policies and guidelines for the care of women, where a number of midwives are involved. In this case, Ms B was an independent midwife practising under an access agreement with the Public Hospital. She had primary responsibility for Ms A's care during labour and delivery as her LMC. However, once Ms A was admitted to the delivery suite at the Public Hospital, her care appeared to be shared with midwifery staff in the delivery suite under an "informal" arrangement.

During the course of Ms A's labour, Ms B left her in the care of the hospital midwives. At 3.30am she was contacted by the hospital midwives about the change in Ms A's condition. Ms B advised them that they could administer pethidine, as previously arranged.

Ms Thorpe advised me that this was contrary to the expectations outlined in Ms B's access agreement with the Public Hospital and with the hospital's relevant guidelines and procedures. Ms Thorpe commented that the arrangement for giving pethidine may have been organised so that Ms A did not have to wait for Ms B to come from home before getting pain relief. However, the potential complications arising from giving pethidine in labour were not the responsibility of the hospital staff. Ms Thorpe advised me that the role of the hospital midwives should only have been to monitor Ms A and to advise Ms B when she entered labour. Their role was not to provide labour midwifery care. Ms Thorpe commented that any expectation of such an active role should have been discouraged.

It appears that, in this case, there may have been unclear expectations as to the respective roles and responsibilities of the LMC and the hospital midwives – not only between the providers themselves but between Ms A and her LMC. If expectations are not clear, the woman may be left unsure about who is coordinating her care and concerned that important information given to one provider during the course of labour may not be passed on to her lead carer.

Happily, this situation did not lead to any harm to Ms A or her baby in this case. However, I encourage all providers to ensure that there are clear, well understood policies and guidelines so that, at every step of the labour and delivery process, each provider's key responsibilities (especially those of the LMC) for the woman's care are clearly identified, both to the woman and those involved in her care.

Recommendations

I recommend that Ms B:

- Apologise in writing to Ms A for breaching the Code. This apology is to be sent to the Commissioner and will be forwarded to Ms A.

- Review her practice in light of this report.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Midwifery Council of New Zealand, and the Public Hospital.

- A copy of this report, with all details identifying the parties removed, will be forwarded to the New Zealand College of Midwives and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.