Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 04HDC00460)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Mr A	Complainant / Husband
Baby A	Consumer's son
Ms B	Midwife / Provider
First Public Hospital	Public Hospital
Second Public Hospital	Public Hospital

Complaint

On 12 January 2004 the Commissioner received a complaint from Mr A about the midwifery services Ms B provided to his wife, Mrs A. The following issues were identified for investigation:

1. *Whether the prenatal care provided by Ms B to Mrs A in 2003 was of an appropriate standard.*

2. *Whether the service provided to Mrs A by Ms B on 5 December 2003 was appropriate. In particular:*
   - *the information and advice given by Ms B when she was called by Mrs A that morning*
   - *the decision not to visit Mrs A or check her condition.*

3. *The circumstances of Ms B not answering her pager or the telephone calls made by Mr A on the morning of 6 December 2003.*

4. *The appropriateness of the actions taken by Ms B after the birth of Mrs A's baby on 6 December 2003.*

An investigation was commenced on 23 March 2004.

Information reviewed

Information was obtained from the following sources:

- Mr A
- Mrs A
- Ms B
- An Ambulance Service
- A District Health Board

Independent expert advice was obtained from Ms Elizabeth Brunton, a midwife.

Information gathered during investigation

Background
This complaint concerns Ms B, midwife, whom Mrs A consulted in 2003 regarding her fourth pregnancy. Mr A and Mrs A complained that Ms B was not available on the morning of 6 December, when Mrs A was in labour. They are dissatisfied with the prenatal care Ms B provided, because of her casual attitude towards regular check-ups, and because she gave them personal information about another pregnant woman whom they knew. Mrs A said she thought Ms B's casual attitude may have been because Mrs A had previously had three other children.

Antenatal checks
Mrs A's fourth child was due on 14 December 2003. Ms B was Mrs A's midwife of choice, as her previous midwife was unavailable. Ms B is an independent midwife and in 2003 had a small practice, providing continuity of care. She had contact with colleagues who provided back-up support during home births. Ms B is a registered comprehensive nurse and registered midwife.

The clinical notes provided by Ms B record six antenatal visits in total, which occurred on 8 June, 4 July, 28 August, 3 November, 24 November and 3 December 2003. No check-ups are recorded for Mrs A during September or October 2003.

Mrs A said that it was always left to her to contact Ms B to arrange a check-up or ask a question, and that Ms B would not make a specific time for check-ups, just a particular day. She said that Ms B did respond to messages left on her pager but sometimes not until two days after the message was placed.

Ms B did not give Mrs A any indication of how far apart the check-ups should be. Mrs A said that because it was her fourth child, she had some idea of when they should occur. She said it was not always convenient for her to stay home all day with three other children and wait for Ms B. If Mrs A was not at home when Ms B called in, she had to wait until the next month for another check-up. Mrs A was not too worried about this at the time, as it was not her first child, and everything seemed to be going well.

Ms B said that she facilitated home antenatal visits at times that would not interfere with Mrs A's school run, and it was agreed that Mrs A would contact Ms B to arrange suitable times. Ms B stated that it was a 42.5km round trip to Mrs A's house, and she did not want to travel that distance and find Mrs A not at home. She said that on occasions she did arrive to find Mrs A out and, as a result, felt it was Mrs A's responsibility to arrange another appointment time. Ms B said that she did not tell Mrs A that she would have to wait until the next month before she would visit again. She was unaware that Mrs A was unhappy with the number of prenatal visits.

Mrs A stated that Ms B did not always have all her equipment with her at the check-ups. On one occasion Ms B did not have her stethoscope, so she could not listen to the baby's heartbeat. Ms B denied that she was ill-prepared at the visits. She confirmed that she did not have her stethoscope with her at one visit because another client's children had removed

it from her bag at a visit prior to Mrs A's. Ms B said she had explained this to Mrs A at the time.

Mrs A said that she discussed a sonic aid or Doppler with Ms B but Ms B said that she does not believe in them and does not use one. Ms B disputed saying this to Mrs A and explained that she chooses not to use a Doppler routinely, as research has shown that heat radiating from the ultrasound waves through the mother's abdominal wall can cause stress to the unborn child. If she cannot locate the foetal heartbeat with a fundoscope then she will use a Doppler.

On another occasion, Ms B did not have the results of Mrs A's blood tests with her. Mrs A also said that Ms B was not very good at answering her questions, and she did not find Ms B very reassuring.

Ms B's comments in the clinical notes are brief and do not record any recommended treatment for issues raised. The first mention of the baby's heartbeat is made in week 25. Ms B has provided my Office with a copy of two laboratory reports of routine urine and blood analyses (for 12 June and 18 November), and the report for Mrs A's scan from a scanning clinic. There is no discussion of these reports recorded in the clinical notes or in Ms B's response to my Office.

Mrs A's plan was to have the baby at home. Her last two children at been born at home, and those births had occurred without any problems. Mrs A stated that Ms B had provided her mobile telephone number, her landline telephone number and her pager number. Mrs A always contacted Ms B on her landline and, if necessary, left a message. Ms B had told Mrs A that she never answered her mobile, but she did answer her pager. Ms B did not give Mrs A contact details for a second midwife in the event that Ms B was not available. There is no birth plan in the clinical notes provided by Ms B, although "Home Birth" is written at the top of one of the pages of the Pregnancy Check-Up Record.

Ms B said that she gave Mrs A a booklet that included her rights when receiving services from health professionals, and suggestions for maternity care, including the right to change her Lead Maternity Carer (LMC) if she was dissatisfied. The booklet also contained the numbers where Ms B could be contacted. Mrs A said she was given a booklet in which to make her own notes, but she does not recall whether it contained any contact details of other midwives. Mrs A said that Ms B did not advise her what to do if she was unable to be contacted.

Ms B said she met Mr A on one occasion during the prenatal check-ups, during which he did not acknowledge her. Mrs A said that Mr A was busy on that occasion and that no further attempt was made by Ms B to meet him again, or develop a relationship during any other visit. Mrs A stated that six 30-minute visits during seven months were not enough to establish a trusting relationship between herself and Ms B.

Labour and delivery

Mrs A had been having contractions intermittently for about a week prior to 5 December 2003. On the morning of 5 December she rang Ms B to say that she had been having

contractions all night. Ms B told her that practice contractions could occur before "real labour" and that she should continue as normal. Mrs A told Ms B that practice contractions had not occurred during any of her three previous pregnancies. Mrs A was concerned that Ms B did not offer to visit, or advise her to call again if contractions continued.

Ms B stated that Mrs A rang her at approximately 7am on 5 December 2003 and informed her that she had been experiencing irregular contractions. Ms B advised Mrs A that the contractions should be regular, lengthening to one minute long and strengthening, in order for labour to be established. Ms B did not arrange to visit and check Mrs A, because she did not believe Mrs A was in established labour.

Mrs A said that on 5 December the contractions came and went about every half hour during the day. She was able to go to bed that evening and get some sleep until around 3am on 6 December 2003, when she woke up and felt like pushing. She woke her husband and he paged Ms B. He received no response. He again paged Ms B twice at 3.30am. At 3.45am he called Ms B's mobile telephone, and at 4am rang her home telephone. By this time Mrs A's contractions were approximately one to two minutes apart.

Mr A then rang the first public hospital. Hospital staff also tried to contact Ms B, without success. Mr A called an ambulance at around 4.10am and it arrived at the home of Mr and Mrs A at 4.22am. Information provided by the ambulance service records that ambulance staff spent 21 minutes at the house assessing Mrs A and attempting to contact the midwife. Mrs A agreed to be transported to the second public hospital for more specialised care than could be provided by the ambulance officers at her home. As Mrs A was not prebooked into the first public hospital and no contact could be made with her midwife, Mrs A was taken to the second public hospital (the main hospital in the catchment area), in accordance with the ambulance service policy.

Mrs A unexpectedly delivered her baby in the ambulance at 4.37am en route to the second public hospital. During the birth her baby (Baby A) "fell on his head" onto the ambulance stretcher and received bruising across his forehead. The ambulance stopped and Baby A and Mrs A were checked before continuing to the second public hospital. They arrived at 5.02am. A midwife at the hospital discussed with Mr and Mrs A the possibility of using another midwife for postnatal care. They decided to do so, and did not hear from Ms B again.

Ms B stated that on the evening of 5 December she had placed her pager underneath her pillow and left her cell phone in her handbag in her car. During the night the pager fell onto the floor, and so she did not feel or hear it vibrate when Mr A attempted to contact her. She retrieved the pager when she woke sometime before 7am on 6 December and found that Mrs A and the maternity unit at the first public hospital had been calling her. Ms B has not provided an explanation for why she did not answer her home telephone on that morning.

Ms B said that she called the maternity unit at the first public hospital and a midwife informed her that Mr and Mrs A had been trying to contact her. The midwife told Ms B that Mr and Mrs A had been advised to come to the Maternity Unit early that morning, but

in the meantime they had called an ambulance and gone to the second public hospital. Ms B also received a message from a midwife at the second public hospital, advising that Mr and Mrs A had chosen another midwife for their postnatal care. Ms B stated that she did not feel confident about ringing Mr and Mrs A because of Mr A's less than forthcoming attitude when she first met him, and did not write a note to them because she did not want the meaning to be misconstrued. She said she did speak to Mr and Mrs A's new midwife to explain what had happened.

Mrs A informed me that Baby A was born with a low platelet level, and she is concerned that this should have been picked up by Ms B during antenatal checks. The records from the second public hospital show that Baby A had a platelet count of 22, and had a platelet transfusion at 11.50am on 6 December 2003.

Baby A is now a healthy, happy little boy, but Mrs A is concerned that he was put in extra danger because of Ms B's unavailability for her labour and Baby A's birth.

Ms B advised that she has made the following changes to her practice since these events:

- She has her cellular phone on at night beside her bed in order to hear it ring, in case her pager should fall on the floor again.

- She now works with two colleagues and no longer provides full-time continuity of care. The contact numbers of her colleagues are also made available to all of the women she cares for to ensure a midwife is available to them at all times.

Independent advice to Commissioner

The following expert advice was obtained from Ms Elizabeth Brunton, an independent midwife:

> "Thank you for asking me to provide expert advice to the Commissioner on the above claim.
>
> I have read and I agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a Registered Midwife and a Registered General and Obstetric Nurse and have a Bachelor Degree in Psychology/Nursing. I have worked as a midwife for 24 years.
>
> I worked for 4 years in a hospital setting (post-natal and delivery suite) as a staff midwife and charge-nurse, 6 years in a Polytechnic Institution tutoring student midwives and for the last 14 years I have worked as a self-employed Independent midwife.

Purpose

To advise the Commissioner whether the services provided to [Mrs A] by [Ms B], independent midwife, were of an appropriate standard.

Background

[Mrs A] was pregnant with her fourth child, and the baby was due on 14 December 2003. [Ms B] was [Mrs A's] midwife of choice as her previous midwife was unavailable.

[Mr and Mrs A] were dissatisfied with [Ms B's] prenatal care. This was due to what they describe as a casual attitude towards regular checkups, and giving them personal information about another mother. [Mrs A] said she thought [Ms B's] casual attitude may have been because [Mrs A] had previously had three children.

[Ms B] stated that [Mrs A] was supplied with a booklet which advised that she had the right to change her Lead Maternity Carer (LMC) at any stage if she was not satisfied with the care she was receiving.

[Mrs A] stated that it was always her who contacted [Ms B to] arrange a check-up or ask a question, and said that [Ms B] would not make a specific time for check-ups, just the particular day. [Mrs A] said that it was not always convenient to stay home all day with three other children to wait for [Ms B], and if she was not at home when [Ms B] called in, she had to wait until the next month for another check-up. Mrs A was not too worried about this at the time, as it was not her first child and everything seemed to be going well. [Ms B] stated that it had been agreed that [Mrs A] would contact [Ms B] to organise times to suit. No check ups are recorded for [Mrs A] during September or October 2003.

[Mrs A] stated that [Ms B] did not always have all her equipment with her. On one occasion [Ms B] did not have her stethoscope so she could not listen to the baby's heart beat. On another occasion [Ms B] did not have [Mrs A's] blood tests with her. [Mrs A] said that [Ms B] was also not very good at answering questions, and that she did not find her very reassuring.

The plan was to have the baby at home. [Mrs A] had had her last two children at home and those births had occurred without any problems. [Ms B] had given [Mrs A] her mobile phone number, her landline telephone number and her pager number. [Mrs A] said that she always contacted [Ms B] on her landline, and if necessary left a message. She said that [Ms B] had told her that she never answered her mobile, but she did answer her pager.

[Ms B] did not give [Mrs A] contact details for a second midwife in the event that [Ms B] was not available.

[Mrs A] had been having contractions intermittently for about a week prior to 5 December 2003. On the morning of 5 December [Mrs A] rang [Ms B] to say that she had been having contractions all night. [Ms B] advised [Mrs A] that the contractions should be regular, lengthening to 1 minute long and strengthening, in order for labour to be established. [Ms B] did not arrange to visit and check how [Mrs A] was.

[Mrs A] said that on 5 December the contractions came and went about every half an hour during the day. She was able to go to bed that evening and get some sleep until around 3am on 6 December 2003, when she woke up and felt like pushing. She woke her husband and he paged [Ms B].

After no response, [Mr A] paged [Ms B] twice at 3.30am. At 3.45am he called [Ms B's] mobile telephone. At 4.00am [Mr A] rang [Ms B's] home telephone. By this time [Mrs A's] contractions were 1-2 minutes apart and she felt like pushing.

[Mr A] then rang [the first public hospital]. The hospital also tried to contact [Ms B] without success. An ambulance was called around 4.15am and arrived at [Mr and Mrs A's] A home at 4.20am.

[Mrs A] unexpectedly delivered in the ambulance at 4.37am en route to [the second public hospital]. During the birth the baby 'fell on his head' and received bruising across his forehead. The ambulance stopped and the baby and [Mrs A] were checked before continuing to [the second public hospital] .

They arrived at the hospital at 5.00am. The [Mr and Mrs A] did not hear from [Ms B] again. A midwife at the hospital discussed using another midwife for the postnatal care with [Mr and Mrs A], which they agreed to.

[Ms B] explained that her pager had been underneath her pillow on the evening of 5 December and her cell phone was in her handbag in her car. At some stage during the evening the pager fell onto the floor and [Ms B] did not hear it when [Mr A] attempted to contact her in the early hours of 6 December. [Ms B] contacted [the first public hospital] when she checked her pager at 7.00am, and was told [Mrs A] had had her baby, and wanted to use another midwife for the postnatal care. [Ms B] explained what had happened to the hospital staff, but did not attempt to contact [Mr and Mrs A].

[Mrs A] said that the baby was born with a low platelet level, and is concerned that this may have been able to be picked up before the baby was born. The records from [the second public hospital] show the baby had a platelet count of 22, and had a platelet transfusion at 11.50am on 6 December 2003.

Privacy issue

[Mr A] also raised an issue about [Ms B] revealing information about another mother that was known to them. Access to health information and medical records are dealt with under the Health Information Privacy Code 1994, which is administered by the Privacy Commissioner. [Mr A] has been given the contact details of the Privacy Commissioner if he wishes to take this issue further.

Complaint

The complaint was summarised as follows:

1) *Whether the prenatal care provided by [Ms B] to [Mrs A] in 2003 was of an appropriate standard.*

2) *Whether the service provided to [Mrs A] by [Ms B] on 5 December 2003 was appropriate. In particular:*

   - *the information and advice given by [Ms B] when she was called by [Mrs A] that morning*
   - *the decision not to visit [Mrs A] or check her condition.*

3) *The circumstances of [Ms B] not answering her pager or the telephone calls made by [Mr A] on the morning of 6 December 2003.*

4) *The appropriateness of the actions taken by [Ms B] after the birth of [Mrs A's] baby on 6 December 2003.*

Expert Advice Required

To advise the Commissioner whether, in my professional opinion, the care [Mrs A] received from [Ms B] was of an appropriate standard. In particular:

- Please comment on [Ms B's] prenatal care of [Mrs A]. In particular, were the prenatal checks appropriate, and did they occur with sufficient regularity?
- Should the foetus' heart rate be checked at every visit?
- What is the usual procedure for reporting test results to the mother?
- Was the birth plan appropriate? In particular should [Mrs A] have been given the contact information of a second midwife in case [Ms B] was not available?
- What notes should be taken regarding the prenatal check ups?
- Are [Ms B's] records appropriate?
- Was the advice [Ms B] gave to [Mrs A] on the morning of 5 December 2003 about her contractions appropriate? Should she have arranged to visit [Mrs A]?
- Should [Ms B] have followed up when she did not hear from [Mrs A] later on 5 December 2003?
- What arrangements should have been in place on 5 and 6 December 2003 for midwifery care, when [Mrs A] was in labour?
- Would you have expected [Ms B] to have attempted to contact [Mrs A] after the baby was born to explain what had happened?
- Are there any other matters which you believe to be relevant to this complaint?

Comment to Expert advice required:

- Please comment on [Ms B's] prenatal care of [Mrs A]. In particular, were the prenatal checks appropriate, and did they occur with sufficient regularity?

I believe that the frequency of [Ms B's] prenatal care was below an acceptable standard. The total number of visits documented in [Ms B's] notes was 6 and this covered a period from 14 weeks till 38 weeks pregnant. The client, [Mrs A], recalls only 4 visits.

There is an accepted standard of 'routine' visits provided in the pre-birth period:

Monthly till 28-30 weeks, 2 weekly till 36 weeks and weekly till the birth. If the initial visit was at 14 weeks as in this case, that would be an average of 11 visits.

It is not unusual that a woman having her second or third child may not need or want the accepted standard number of visits and the frequency of visits is decided during discussion between the midwife and the client.

Frequency of visits up to week 25 was of an acceptable standard.

No visits were made between week 25 and 34, nor between week 34 and 37.

For adequate assessment of maternal and fetal wellbeing it would be expected that there was at least one visit between these two periods respectively.

Changes in the baby's growth and the maternal health may not always be noted by the client. It is professional and safe practice for there to be adequate visits throughout the pregnancy to detect deviations from the normal and to treat/refer the client before the problem becomes irreversible or detrimental to their health.

The assessments made by [Ms B] at each visit appear to be appropriate and showed that the pregnancy was progressing normally.

Information recorded is at best minimal. The format of the notes is not conducive of a full description of each visit and problems stated do not have a follow-up comment or resolution.

- Should the foetus' heart rate be checked at every visit?

It is important to check that the baby is alive at each visit.

The most common way to achieve this is to hear the heart beating using a pinnards stethoscope or a sonic-aid/doppler.

Some clients do not like the use of the doppler due to the strength of its high sound wave frequency.

Adequacy of the baby's movements is also proof of wellbeing and some women choose to be guided by the frequency and normality of the pattern of movements rather than have the heart rate listened to.

Prior to about 24-26 weeks it is difficult to hear the baby's heart beat with the pinnards stethoscope and if the sonic-aid was not used, the midwife and client would rely on the presence of baby movements.

[Ms B] did not document hearing the heart beat till 25 weeks' gestation and this would be acceptable if the midwife did not possess a sonic-aid or the client did not want it to be used. [Mrs A] would have been feeling the baby move since about 16 weeks though there is no mention in the notes of baby movements till 25 weeks.

- What is the usual procedure for reporting test results to the mother?

In general all results of any test done by the client are reported to back to them.

If the test is within normal range the results may not be discussed until the next visit.

Any anomalies must be reported to the client as soon as possible so that the next step in correcting/understanding the anomaly can commence.

Most women want to know what their test results are and usually the midwife will have discussed the reporting-back timeframe.

- Was the birth plan appropriate? In particular should [Mrs A] have been given the contact information of a second midwife in case [Ms B] was not available?

There was no evidence of a 'birth plan' in the documentation supplied or a record of any discussion regarding home birth preparation in the midwifery notes. The only notation stating 'homebirth' was on the top of the 'pregnancy check-up record and on the front of the midwifery notes under 'planned place of birth'.

Assumptions can be made from the word 'homebirth' but it is important to have an actual detailed plan to ensure that the parents are fully prepared, emotionally, physically and environmentally. In detailing the plan together, the midwife can ensure that professional and safety standards are being met for the mother and the baby. The parents will also know what to expect of their midwife on the day and what would happen if a hospital transfer was required.

A care plan is also a legal requirement as stated in section 88 of the N.Z. Public Health and Disability Act 2000.

[Mrs A] should have been given the contact information of a second midwife and preferably should have met her during the pre-birth period.

All independent midwives are required by law in section 88 to nominate a back-up practitioner.

SECTION 88 OF THE N.Z. PUBLIC HEALTH & DISABILITY ACT 2000

[The Notice pursuant to section 88 states:]

'3.2 The Lead Maternity Carer is required to make every effort to attend as necessary during labour and to attend each birth. In the occasional circumstances where it is not possible to attend … the Lead Maternity Carer will make appropriate other arrangements.

3.3 The Lead Maternity Carer will be available twenty-four hours, seven days per week to provide phone advice to the woman and attendance if required for urgent problems, either personally or by the [B]ack-up to the Lead Maternity Carer.

3.4 Subject to the consent of the woman ... the respective responsibilities of the Lead Maternity Carer and any other Authorised Practitioner **will be clearly documented in the Care Plan**.

4.4.2 For a home birth … the Lead Maternity Carer will:

(a) arrange for a second Authorised Practitioner to be available to attend the birth.'

- What notes should be taken regarding the prenatal check ups?

Prenatal check up information includes:

– emotional wellbeing of mother and family
– updating birth plan
– physical wellbeing, blood pressure, weight and urinalysis if appropriate, assessment of physical problems and review of issues from last visit, discussion of needs and expectations.
– baby's wellbeing, palpation of the uterus to determine gestation, growth, amniotic fluid adequacy, baby's presentation, position, descent.

Discussion of baby's movements, frequency and if any changes in type of movement.
Listening to baby's heart beat.

All of the above are required to be recorded in the client's notes.

- Was the advice [Ms B] gave to [Mrs A] on the morning of 5 December 2003 about her contractions appropriate? Should she have arranged to visit [Mrs A]?

Yes, [Ms B's] advice was appropriate on the morning of the 5th of December. There appeared to be no imminency of birth and labour sounded to be in a latent phase. [Fourth] labours do have a reputation of being fiddly initially and it is appropriate to field enquiries by phone. It is not unsafe practice that [Ms B] did not arrange a visit for that day though many midwives would have arranged to visit or at least a phone call at some stage during the day to reassure the client and the midwife that all was well. [Mrs A] could also have requested a visit.

- Should [Ms B] have followed up when she did not hear from [Mrs A] later on 5 December 2003?

Yes, a follow up phone call if not a visit would have been in keeping with professional and safe practice.

- What arrangements should have been in place on 5 and 6 December 2003 for midwifery care, when [Mrs A] was in labour?

Arrangements for care should have been finalised from 36 weeks pregnant onwards outlining possible scenarios for birth and coping strategies, hospital transfer, safe and warm home environment, equipment required, contact details, child care for the siblings.

[Ms B] should have been aware that labour was likely to progress and been on the alert for contact from her client. She would have some idea of the length of labour to expect from the previous birth histories.

[Ms B] should have ensured that her home phone was working even though she believed that her pager was at hand. I do have some confusion that [Mr A] was unable to reach [Ms B] on her home phone yet the hospital was able to leave a message on it later that [morning].

Arrangements should have been made for the clients to have the phone contact for a back-up midwife if [Ms B] was unable to be contacted.

- Would you have expected [Ms B] to have attempted to contact [Mrs A] after the baby was born to explain what had happened?

Yes I believe it was a professional responsibility of [Ms B] to make contact following the birth regardless of her feelings towards [Mr A]. She had a contract with her client and did not fulfill that contract.

- Are there any other matters which you believe to be relevant to this complaint?

[Ms B] mentions that [Mrs A] had information regarding changing her LMC if she was not satisfied with her midwife and I wonder if there was a poor relationship between all parties which influenced [the] quality of [Ms B's] care. [Ms B] had the opportunity to terminate her care and find her client another midwife if she was dissatisfied too."

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.

Relevant standards:

Section 88 of the New Zealand Public Health and Disability Act 2000

The Notice pursuant to section 88 which sets out the terms and conditions for the provision of Maternity Services states:

"PART C:

…

3.2 The Lead Maternity Carer is required to make every effort to attend as necessary during labour and to attend each birth. In the occasional circumstances where it is not possible to attend … the Lead Maternity Carer will make appropriate other arrangements.

3.3 The Lead Maternity Carer will be available twenty-four hours, seven days per week to provide phone advice to the woman and attendance if required for urgent problems, either personally or by the Back-up to the Lead Maternity Carer.

3.4 Subject to the consent of the woman ... the respective responsibilities of the Lead Maternity Carer and any other Authorised Practitioner will be clearly documented in the Care Plan.

…

4.1 … The Lead Maternity Carer will …

(c) commence and document a Care Plan to be used and updated throughout all Modules covering, as minimum, the items listed in Appendix III …

APPENDIX III

ITEMS TO BE COVERED IN CARE PLAN …

(a) schedule and location of visits for pregnancy care;

(b) how continuity of care will be achieved;

(c) how to access the Lead Maternity Carer in urgent situations;

…

(f) referral to other midwifery, medical, social and diagnostic services;

…

(j) location of birth and other services including booking in to facility or arrangements for home birth;

(k) presence of others at birth

(l) birth environment and position for birthing

…

(q) requirements for postnatal care …

4.4.2 For a home birth … the Lead Maternity Carer will:

(a) arrange for a second Authorised Practitioner to be available to attend the birth."

Standards of Practice, New Zealand College of Midwives Handbook for Practice, 2002:

"Standard Four:

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

Criteria
The midwife:

- Reviews and updates records at each professional contact with the woman
- Ensures information is legible, signed and dated at each entry
- Makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman's knowledge and consent
- Ensures confidentiality of information and stores the records in line with current legislation."

Opinion: Breach – Ms B

Prenatal care
Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), patients are entitled to have services provided with reasonable care and skill. Right 4(2) provides that patients have the right to have services provided in accordance with relevant standards. In the context of services provided by a midwife, those standards include the Notice pursuant to section 88 of the New Zealand Public Health and Disability Act 2000 (the section 88 Notice) and The Standards of Practice for midwives.

Mr A's complaint centres on Ms B's lack of availability when Mrs A gave birth on 6 December 2003. However, Mr A and Mrs A also had concerns about the care provided by Ms B during the prenatal period, and in particular her lack of regular check-ups.

Check-ups
Mrs A received only six prenatal check-ups from Ms B during her pregnancy. In response to the complaint, Ms B stated she was unaware that Mrs A was dissatisfied with the number of visits, and that she facilitated home visits at times that would suit Mrs A, bearing in mind the length of the return trip involved.

My advisor, Ms Brunton, stated that:

> "[t]here is an accepted standard of 'routine' visits provided in the pre-birth period:
>
> Monthly till 28-30 weeks, 2 weekly till 36 weeks and weekly until the birth. If the initial visit in this case was at 14 weeks as in this case, that would be an average of 11 visits.
>
> It is not unusual that a woman having her second or third child may not need or want the accepted standard and number of visits, and the frequency of visits is decided during discussion between the midwife and the client."

There is no record of such a discussion between Mrs A and Ms B in her notes.

Ms Brunton noted that the frequency of visits up to week 25 of Mrs A's pregnancy was adequate, and that Ms B appeared to make appropriate assessments at the visits that did occur. However, Ms Brunton stated: "For adequate assessment of maternal and foetal wellbeing it would be expected that there was at least one visit between [weeks 25 and 34 and between weeks 34 and 37]." These are important developmental periods, and changes during these periods may not be evident to the client. There were no visits during these periods.

Overall, Ms Brunton considered that "the frequency of [Ms B's] prenatal care was below an acceptable standard".

I consider that if the extent of Ms B's travel to see Mrs A was a factor in scheduling visits, Ms B should always have booked a meeting for a specific time. Her explanation that she left it up to Mrs A to re-schedule missed appointments is not satisfactory. It is the LMC's

responsibility to contact the patient and ensure the minimum number of set appointments are scheduled and kept.

Mrs A raised the issue that Ms B did not always have her equipment with her, and on at least one occasion was unable to listen to the baby's heartbeat. Ms B has provided a somewhat remarkable explanation for why her stethoscope was not in her bag at one visit. Prudent practice required Ms B to check she had all her equipment upon leaving one client's home, prior to visiting another. While Ms B's explanation as to the absence of her stethoscope is not satisfactory, I accept her explanation for choosing not to use a Doppler as a matter of routine. However, this should have been discussed with Mrs A so that there was no confusion or concern.

My advisor commented that it is important to check that the baby is alive at each visit, and the most common way to do this is to use a Pinnards stethoscope or a sonic-aid/Doppler. Ms B did not note that she had listened to the baby's heartbeat until week 25. My advisor commented that until weeks 24 to 26 it is difficult to hear the baby's heartbeat with the stethoscope alone. If the mother did not wish to use a sonic aid or Doppler, recordings of the baby's movements would be sufficient to determine whether the baby was still alive. However, in this case there is no record of baby movements until week 25, although Mrs A should have been feeling the baby move from about week 16.

I agree that it is very important for the midwife to check that the baby is alive at each visit. There is no evidence to confirm that this check occurred prior to week 25. In my view this falls below the standard of care required under the Code.

Mrs A wanted to give birth at home. "Home birth" was written on the top of the "Pregnancy check-up record" and on the front of the midwifery notes under "Planned place of birth". However, there was no evidence of a birth plan in the records or any note of a discussion regarding this. A plan is important to prepare the mother regarding the birth, and is also a legal requirement under the section 88 Notice.

Ms Brunton also advised that Mrs A should have been given the contact details of a second midwife in the event that Ms B was not available (as required under the section 88 Notice), and preferably should have met her during the pre-birth period.

I accept Ms Brunton's advice that overall the number of prenatal check-ups was below an acceptable standard, and particularly so during significant developmental periods. It is unacceptable that Ms B did not always have the equipment she required to check that the baby was alive at each visit. The birth plan is very important and there is no evidence of a plan in the notes. In addition, Ms B did not provide Mrs A with the contact details of a back-up midwife in the event that Ms B could not be contacted in an emergency. In my view Ms B's prenatal check-ups fell below the standard of care required, including the section 88 Notice. Therefore Ms B breached Right 4(2) of the Code.

Records

Ms B's maternity notes for Mrs A are brief, and do not contain any discussion of issues she raised, or the advice given. In addition, no record is made of the arrangement for organising

check-ups, reporting test results, or the birth plan (apart from it being a home birth), and no contact details of a back-up midwife appear on the documentation.

Ms Brunton advised that the prenatal check-up information that should be recorded includes:

"– emotional wellbeing of mother and family

– updating birth plan

– physical wellbeing, blood pressure, weight and urinalysis if appropriate, assessment of physical problems and reviews of issues from last visit, discussion of needs and expectations

– baby's wellbeing, palpation of the uterus to determine gestation, growth, amniotic fluid adequacy, baby's presentation, position, descent

– discussion of baby's movements, frequency and if any changes in type of movement

– listening to baby's heartbeat."

My advisor said that the assessments noted by Ms B at the visits that did occur appeared to be appropriate. However, Ms Brunton also noted that the information recorded by Ms B is minimal, and the format of the notes is not conducive to a full description of what occurred during each visit. In addition, problems that are noted do not have follow-up comments or any stated resolution or explanation given to Mrs A.

Mrs A was concerned that Ms B did not have her blood and urine test results available at one of the visits. Given that Baby A was born with a low platelet count, Mrs A has asked whether this was something that Ms B should have tested during antenatal checks, or discussed with her. Mrs A is worried that her blood test results were not discussed with her. I note that Ms B has not specifically addressed the issue of test results, although she has provided my Office with copies of Mrs A's laboratory test results and scan report. (I understand that Mrs A has since been reassured by her general practitioner that Baby A's low platelet count could not have been predicted by her blood tests in this case.)

My advisor commented that, in general, all results of tests are reported back to clients. If the results are normal the tests are not usually discussed until the next visit. If any abnormalities do show they must be reported to the client as soon as possible. The reporting back timeframe for test results is usually discussed between the client and the midwife.

Ms B has made no mention in the records about the arrangement for reporting test results to Mrs A, or any discussions about them. This is inadequate.

The Midwifery Standards of Practice state that the clinical records should be "purposeful, on-going [and] updated". The notes Ms B made are incomplete, and show no clear purpose or plan, and therefore do not comply with these standards.

The clinical notes recorded by Ms B are not sufficient to provide a complete record of the care she provided to Mrs A, and they omit important information. They fail to meet not only the midwifery standards of practice, but also the requirements of the section 88 Notice. In my opinion, therefore, Ms B breached Right 4(2) of the Code.

Pre-delivery
On the morning of 5 December Mrs A telephoned Ms B to tell her that she had been experiencing contractions the previous night. Ms B did not believe Mrs A was in established labour and did not arrange to visit her.

Ms Brunton advised that:

> "[a]rrangement for care should have been finalised from 36 weeks pregnant onwards outlining possible scenarios for birth and coping strategies, hospital transfer, safe and warm home environment, equipment required, contact details, child care for the siblings".

No information has been provided to indicate that any of these arrangements had been made.

The section 88 Notice requires the LMC to arrange for a second midwife to be available to attend a home birth. It is unclear from the information provided whether Ms B had organised another midwife to attend the birth.

Ms Brunton stated that Ms B's advice was appropriate during the morning of 5 December. It was not necessary that Ms B arrange a visit to see Mrs A that day, although many midwives would have arranged a visit or made a phone call to reassure themselves and the client that all was well. Ms Brunton also advised that Mrs A could have asked Ms B to visit her.

I agree that a follow-up telephone call from Ms B (if not a visit) later that day would have been good professional practice. In my view Ms B's standard of care fell short in this respect.

Delivery
Mr A was unable to contact Ms B when Mrs A went into labour in the early hours of 6 December. As he did not have the contact details of another midwife, he had to call the public hospital.

My advisor noted that Ms B should have had some idea of how the labour was likely to progress given Mrs A's histories of previous pregnancies. Accordingly, Ms B should have made sure that her telephone, mobile and pager were working properly, and were to hand.

Ms B has not provided an explanation for why she did not hear her landline telephone when Mr A called her at 4am (although she has provided an explanation for her pager and mobile telephone, which in any event I consider to be unsatisfactory). What is clear is that Mr A was not able to contact Ms B on her pager, mobile telephone or landline telephone between 3am and 4am on 6 December.

It appears that after Mr A spoke to the first public hospital, the Maternity Unit tried to call Ms B on his behalf, but got no response on her cellphone and was not able to leave a message. Ms B stated that the list of contact numbers at the first public hospital maternity unit had her home telephone number crossed out, and she believes that if it had not been crossed out, the midwife would have been able to contact her. The midwife at the second public hospital was able to leave a message on Ms B's home telephone later that morning.

The section 88 Notice states:

> "3.2 The Lead Maternity Carer is required to make every effort to attend as necessary during labour and to attend each birth. In the occasional circumstances where it is not possible to attend … the Lead Maternity Carer will make appropriate other arrangements.
>
> 3.3 The Lead Maternity Carer will be available twenty-four hours, seven days per week to provide phone advice to the woman and attendance if required for urgent problems, either personally or by the back-up to the Lead Maternity Carer."

In my view, Ms B's actions fell well short of what was required of her under the section 88 Notice and, as a result, breached Right 4(2) of the Code.

Follow-up
Mr A and Mrs A decided to change midwives after their baby was born, and were not contacted by Ms B again.

Regardless of Mr and Mrs A's decision to change midwives, Ms B had a professional responsibility under Right 4(2) of the Code to contact Mr and Mrs A following the birth, and to provide an explanation for what had occurred. Her explanation as to why she did not do so is unsatisfactory.

Other comment
Mr A raised a further issue in his complaint about Ms B having revealed information about another pregnant woman who is known to them. Privacy of health information and medical records are dealt with under the Health Information Privacy Code 1994, which is administered by the Privacy Commissioner. Mr A has been given the contact details of the Privacy Commissioner if he wishes to take this issue further.

Summary
Ms B had a contract with Mrs A to provide prenatal care, care during the birth, and postnatal care. Implicit in that contract is the obligation to provide services of an

appropriate standard. Ms B has not provided adequate reasons for her actions and, in my view, she departed from appropriate standards in her failure to:

- perform the minimum number of required check-ups (particularly during important developmental periods);
- provide contact information for a back-up midwife;
- maintain adequate records;
- prepare a detailed birth plan;
- follow up Mrs A's progress on 5 December 2003;
- ensure she could be contacted on the morning of 6 December 2003; and
- explain to Mr and Mrs A why she could not be contacted on 6 December.

In these circumstances, I am of the view that Ms B breached Rights 4(1) and 4(2) of the Code.

Actions taken

Ms B has provided a written apology to Mrs A and Mr A.

Ms B has advised me that she has reviewed her practice and made the following amendments as a result of this complaint:

- She now engages thorough care plans and birth plans as recommended by the section 88 Notice.

- She has enhanced the standard of her documentation and endeavours to maintain thorough and accurate records.

- All women receive the recommended number of antenatal visits: that is, monthly to 28-30 weeks' gestation, fortnightly until 36 weeks, then weekly visits until birth. This is stated in the care plan she provides to clients.

- She ensures that all care coincides with the Standards of Practice outlined in the New Zealand College of Midwives Handbook for Practice, the Code of Health and Disability Services Consumers' Rights, and the section 88 Notice.

- She discusses with the woman concerned all results of diagnostic tests and ultrasounds she receives and records them in her notes. Original copies of test results are kept in the clinical notes.

Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand with a recommendation that the Council consider whether a review of Ms B's competence is necessary and/or whether Ms B should be required to practise subject to supervision.

- A copy of this report will be sent to the Nursing Council of New Zealand.

- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.