Postnatal care provided to woman with pyrexia (08HDC18402, 7 September 2010)

Maternity Clinic ~ Primary birthing unit ~ Midwives ~ Lead maternity carer ~ Standard of care ~ Postnatal care ~ Pyrexia ~ Abdominal pain ~ Assessment and monitoring ~ Puerperal sepsis ~ Transport to hospital ~ Communication amongst providers ~ Documentation ~ Rights 4(1), 4(2), 4(5)

A 38-year-old woman complained about the standard of postnatal care she received from a primary birthing unit and her lead maternity carer (LMC). After giving birth at a hospital, the woman was transferred to the maternity clinic for postnatal care. The following night she complained of abdominal pain to a staff midwife. She also suffered rigors and shivering. A staff midwife took the woman's temperature at midnight and found it to be elevated (38.6°C). The woman was given painkillers and her temperature had returned to normal by early morning.

Later that morning the woman complained of feeling hungry and dizzy, and two hours later she advised the staff midwife that, after speaking to her LMC over the telephone, she had decided to go to hospital to be assessed as she felt very unwell. The staff midwife did not carry out any assessments on the woman, and there is no evidence that an ambulance was offered to her.

The woman's husband picked her up from the birthing unit and took her to hospital, where she was noted to be "very unwell" on arrival and had low blood pressure. She was subsequently diagnosed with puerperal sepsis, caused by Group A Streptococcus. The woman spent time in the high dependency unit and the intensive care unit, and was discharged home 13 days later.

It was found that the maternity clinic breached Rights 4(1) and 4(2). It was directly liable for not having a policy for managing elevated postnatal maternal temperatures in a manner consistent with national guidelines, and for not having clear policies about communication between LMCs and the birthing unit's midwives. It was vicariously liable for the failure by its staff to adequately consider, and discuss with the woman and her LMC, referral to specialist services.

One of the birthing unit's staff midwives was found in breach of Rights 4(1), 4(2), and 4(5) for failing to monitor and assess the woman, failing to consult the woman's LMC about the woman's transfer to hospital, and failing to keep detailed and accurate notes about the woman's condition and transport to hospital.

The woman's LMC was found in breach of Right 4(2) of the Code for departing from professional standards relating to documentation.