Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 00HDC06573)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Ms B	Provider / Independent midwife
Ms C	Independent midwife
Ms D	Independent midwife
Mr E	Consumer's husband
Dr I	Consultant plastic surgeon at the second public hospital
Ms J	Provider / Independent midwife

Complaint

On 27 June 2000 the Commissioner received a complaint from the consumer, Mrs A, about the standard of service her baby son received from the provider, Ms B, an independent midwife. The complaint is as follows:

- *At about 10.30am on 3 June 2000 Ms B, Mrs A's Lead Maternity Carer, called to conduct an examination of the 6-day-old baby, and obtain a Guthrie test. Ms B intended to prepare the baby's heel for the heel prick by placing his heel in a cup of warm water. The water which was originally poured into the cup became cold, so Ms B reheated the water in the kettle to almost boiling, and replaced the cold water in the cup with this water.*
- *Ms B sat on the bed, placed the baby across her lap, picked up the cup, and placed the baby's heel in the cup.*
- *The baby screamed from the moment his heel was placed in the water. When Ms B removed the baby's heel from the water, she exclaimed that she had burnt him.*
- *Ms B peeled the burnt skin off the baby's heel, and pressed a baby napkin over the burn to control the bleeding. After five minutes she immersed the baby's heel in rain water which she had collected from a bowl outside the residence. (There is no running water in the residence.)*
- *Ms B then attempted to obtain blood for the Guthrie test from the baby's heel, before applying Savlon ointment and gauze, provided by Mrs A, to the burnt area on the baby's heel.*
- *Mrs A took the baby to a public hospital's Emergency Department, where he was assessed and transferred to a second public hospital for the treatment of his burn.*

An investigation was commenced on 9 August 2000.

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Information reviewed

- Antenatal and postnatal clinical records for Mrs A and the baby
- Accident and Medical Centre's records for the baby
- The second public hospital's clinical records for the baby
- ACC, Medical Misadventure Unit records for the baby
- New Zealand College of Midwives 'Handbook for Practice' (1993)
- Nursing Council of New Zealand Code of Conduct for Nurses and Midwives (1995)
- Expert advice from Ms Chris Stanbridge, independent midwife

Information gathered during investigation

On 24 November 1999 Mrs A, who was pregnant with her fourth baby, booked Ms B, independent midwife, for the management of her pregnancy and the delivery of her baby.

Ms B, a registered general nurse, was employed by a Hospital and Health Service's internal nursing/midwifery bureau as a staff midwife from April 1998 until August 1999. She completed her midwifery training in 1999 and worked as a bureau nurse at a couple of maternity units between September 1999 and January 2000.

In mid-January 2000 Ms B joined Ms C and Ms D, independent midwives, on a six-month trial as a Lead Maternity Carer in their practice. The term 'Lead Maternity Carer' refers to the general practitioner, midwife or obstetric specialist who has been selected by a woman to provide her with comprehensive maternity care including the management of her labour and birth.

Ms C and Ms D assisted Ms B in her transition from a hospital midwife to a community midwife by attending her first five deliveries and acquainting her with administrative procedures. Essentially Ms B was practising autonomously and there was an expectation that she would find her own clients and take over excess clients from Ms C and Ms D. Ms B was asked to inform Ms C and Ms D if she was unsure of a procedure or if she was experiencing problems. The three midwives met regularly to review maternity case notes and discuss concerns.

Ms B understood that Ms C and Ms D had agreed to provide her with a mentoring role, and was disappointed they did not provide her with the supervision and advice she needed. She said, "I think I was a burden to [Ms C] and [Ms D], as I needed a lot of support and was less experienced than they had expected."

Ms B supervised Mrs A throughout her pregnancy. Mrs A stated that she found Ms B's antenatal care "good, informative and supportive". On 28 May 2000 Mrs A gave birth to a baby boy at a third public hospital. She requested an early discharge and went home later that day.

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Ms B visited Mrs A at home daily to check on her wellbeing and the progress of the baby. Mr E and Mrs A and their four children were living in a sleep-out attached to the main house. The sleep-out comprised two rooms. The main room contained Mr E's and Mrs A's bed, the baby's cot, a table and a television. The sleep-out was not connected to a domestic water supply.

On 3 June 2000 Ms B visited to perform a routine physical examination on the baby, who was six days old. When Ms B arrived at about 10.30am, Mrs A was at home with her baby and one-year-old child. Mr E was out with the older children.

Ms B began the examination by measuring the baby's head circumference and taking other body measurements. She asked Mrs A whether the laboratory technician who had visited the previous day to check the baby's bilirubin (test for jaundice) had taken his Guthrie test. (A Guthrie test is a blood test taken to screen newborn babies for phenylketonuria (PKU) and other congenital metabolic disorders. The blood sample is usually taken from a small prick on the baby's heel when the baby is two to three days old. The blood sample is placed on a sample card which contains 4 circles which must be filled with blood.)

Mrs A informed Ms B that the nurse the previous day had taken a blood sample to assess the baby's jaundice. Ms B made an entry in the baby's 'Well Child' book before removing his clothes to weigh him. She then asked Mrs A for a cup of warm water so that she could warm the baby's foot to make it easier to obtain a blood sample for the Guthrie test.

Mrs A switched on the electric kettle and, when the water was sufficiently warm, she poured some into the cup. She and Ms B conversed and the water became cold, so Ms B poured the water back into the kettle and turned the kettle on. After about two minutes, when the water had almost boiled, Ms B switched off the kettle, poured the water back into the cup, and placed it on the floor beside the bed.

Mrs A recalled that Ms B laid the baby across her lap, removed his booty from his right foot, picked up the cup, placed the baby's heel into the hot water and held it in place. She said that the baby was screaming from the moment his heel was immersed, and when Ms B removed the baby's heel she exclaimed, "Oh shit, I've burnt him!" Mrs A recalled that Ms B picked at the burnt skin on the baby's heel and peeled it away to reveal the raw tissue underneath. She said that Ms B picked up a cloth napkin and pressed it to the injured heel to stop the bleeding.

Ms B asked Mrs A for a first aid kit, but there was only a tube of Savlon in the sleep-out. Mrs A recalled that when she brought the Savlon to Ms B she found her pricking and squeezing the baby's heel to obtain blood for the Guthrie test. The baby was screaming and she asked Ms B what she was doing. Mrs A said that she was overwhelmed with emotion and started to cry. Ms B stopped attempting to obtain blood and applied Savlon and gauze to the baby's heel. She put on the baby's bootie, cuddled him, and apologised to Mrs A.

Mrs A took the baby from Ms B, wrapped him in a blanket and soothed him. Mrs A recalled that Ms B told her she had some homeopathic burn remedy at her home, which she would fetch. When Ms B left, Mrs A took the baby to an Accident and Medical Centre.

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Ms B recalled that Mrs A's one-year-old child was in the sleep-out when she was examining the baby, and that the child was running around and distracting Mrs A. Ms B said that she normally tests the temperature of the water before immersing the baby's foot; however, on this occasion, she did not test the water temperature before placing the baby's heel in the cup. In explaining her omission, Ms B said that when she placed the cup on the floor, the one-year-old tried to take the cup, so she picked it up to hold it out of the way. She held the baby's heel close to the cup, waiting for the water to cool before she immersed his heel. Ms B said while this was happening, the one-year-old jumped at the baby, which distracted her:

> "I either accidentally dropped the foot in the cup, or it slipped in – I don't really know. I just know that it slipped in, the baby yelled and I grabbed it out, worried that I had scalded him."

When she removed the baby's heel from the water Ms B was worried that she had burnt his heel. She advised me that she looked at the foot and found that, contrary to Mrs A's recollection, there was no bleeding or peeling skin. Ms B said that the foot appeared a little red. She said she waited for a few minutes and decided that the heel was not injured, so she pricked the heel with the lancet to obtain blood for the Guthrie test. Ms B said that the heel bled freely. When she squeezed it to transfer the blood on to the test card, she noticed that the foot was redder. She was reluctant to squeeze it any further and abandoned the test as she realised that the scald was worse than she had initially thought.

Ms B later advised me that she had filled three of the circles on the Guthrie sample card.

As there was no running water in the sleep-out, Ms B went outside to collect some rain-water she had seen in a container outside the building. She immersed the baby's foot in the cold water to minimise tissue damage from the burn. She held the baby's foot in the water for three to five minutes. The heel continued to bleed from the heel prick and tinged the water red. Ms B said she used a cloth napkin to wipe the baby's heel when she removed it from the water. She then asked Mrs A for a first aid kit. Mrs A fetched some gauze and Savlon which Ms B applied to the baby's heel.

Ms B then left Mrs A's house. She informed me that it was her intention to return to her house to collect homeopathic remedy for the baby's foot.

Mr E said that he was with the older children watching workmen at the front of the property when Ms B "rushed past". Shortly afterwards his wife came out of the sleep-out carrying the baby and told him that there had been an accident, and that she was taking the baby to the Accident and Emergency Department. Mr E said that his wife telephoned him from the Medical Centre to inform him that the baby had to be transferred to a public hospital for treatment. Mr E collected some baby bottles and clothing and took them to his wife at the Medical Centre. He said he had not long returned home when Ms B arrived carrying surgical dressings. Mr E commented that Ms B had her male partner with her, which he did not think appropriate, as he had not met the man.

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Ms B stated that she did not accompany Mrs A to the Medical Centre as she felt at the time that Mrs A did not want her near. Ms B said that she returned with the homeopathic burn remedy, spoke with Mr E and then called on her counsellor, as she was upset about the accident and "needed someone to talk to".

After speaking with Mr E, Ms B recorded the incident in the baby's clinical records for 3 June 2000 as follows:

> "… held [word altered] baby's foot, (it slipped into) [added above original line of text] the cup & the baby cried & immediately took baby's foot out of cup & throw out the water and put baby's foot into cold water. The baby's foot, the skin, was peeling. I apologised profusely and mother went to A & E to see the doctor at [the Medical Centre] who instructed her to go to A & E [at the second public hospital] & then to [the ward], so that baby can be assessed whether it may need a skin graft or not."

The baby was seen by Dr F at the Medical Centre. Dr F recorded that the baby's right heel was bare of skin and bright red. Skin was hanging off the heel and there was blistering to the plantar aspect of the foot, anterior to the heel. The baby did not appear to have a brisk reflex when his heel was touched with a cotton bud. Dr F discussed management of the burn with the plastic surgery registrar at a public hospital, who advised him to apply saline soaks to the heel and arrange for the baby to be transferred to hospital.

Dr G, senior house officer at the public hospital, admitted the baby at 2.30pm on 3 June 2000. Dr G recorded:

> "Burn caused by immersing the R foot in hot water to warm the foot for prick to do Guthrie Test at 10.30 this morning. About 20 mins later the mother noticed vesicles over the R heel. …"

The baby was admitted to a ward of the public hospital. The burn to his heel was photographed and treated with a suction dressing to improve the blood supply to the area. Treatment was then changed to tulle and Bactigras dressings and silver sulphadiazine cream. The nursing notes record that Mr E and Mrs A requested that, should Ms B contact the ward to enquire after the baby, she was not to be given any information. The records show that Ms B contacted Ms H, registered nurse, on 6 June 2000 enquiring whether the baby required a skin graft. Ms H informed Ms B that the family had requested confidentiality regarding the baby's condition.

Dr I, consultant plastic surgeon, stated that over the following two weeks the baby healed completely and did not require skin grafting or further intervention. Dr I advised that it was to Ms B's credit that she had used rain-water to cool the burn, as retained heat contributes to further tissue damage. He said that a newborn baby's skin is very thin and will blister very quickly, and that although Ms B may have rubbed off the skin, many factors determine the severity of a burn, for example how long the foot was in the water, and the temperature of the water.

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The baby was discharged on 9 June 2000 and referred to the District Nursing Service for follow-up dressings. Arrangements were made for him to attend the Plastic Surgery outpatients' clinic in a week's time.

Ms B arranged for Ms J, midwife, to continue the postnatal care of the baby. Ms J stated that Ms B provided her with the full clinical notes relating to Mrs A and the baby. As the baby had already received postnatal care, Ms J said that her involvement was to arrange his discharge to the Plunket Nursing Service. She advised that Ms B discussed with her the incident involving the baby's heel. She was aware that the district nurses were dressing the burn.

As a result of the accident to the baby, Ms B arranged a meeting at the maternity hospital with senior maternity staff, and Ms C and Ms D, to discuss her access agreement. Ms B said that she had two clients due to deliver in late June 2000, and asked Ms C and Ms D to take these women as clients. Ms C and Ms D declined. The hospital midwives agreed to provide back-up assistance to Ms B. She continued to provide a service to the clients already booked with her. After these women had delivered, Ms B surrendered her access agreement and stopped practising midwifery.

Ms B stated that following this incident she contacted the New Zealand Council of Midwives' Resolution Committee to inform the committee that she was no longer practising. The Resolution Committee advised Ms B that if she were to consider practising as a midwife again, they would require that "strict supervision and mentoring would need to be put in place".

When asked about the discrepancy in her recollection of events – recording in the clinical records that the skin was peeling, and later stating that there was no bleeding or peeling of skin – Ms B stated that when she wrote the report for the Commissioner she did not have the clinical records to refer to.

In relation to her alteration to the clinical notes of 3 June 2000, Ms B said that she altered the phrase "put baby's foot into the cup" to read "baby's foot, it slipped into the cup", when she was writing up the notes approximately two hours after the incident. Ms B said that when she was writing she realised her error and that "put baby's foot" implied intention. She said that she amended it "then and there".

The National Testing Centre (NTC) based at another public hospital performed Guthrie tests. The NTC informed the Accident Compensation Commission that it had received a completed Guthrie card for the baby, dated 3 June 2000, on 7 June 2000. It was not possible to test the sample as it had been contaminated. The NTC requested that a second sample be collected. A second blood sample for PKU testing was obtained from the baby on 12 June 2000.

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Independent advice to Commissioner

The following expert advice was obtained from an independent midwife:

"I have read the documentation sent to me (A to L and including the re-photocopied midwife's notes relating to the visit on the third of June).

I consider [Ms B] failed to act in accordance with accepted practice in relation to the care provided to the baby when obtaining a blood sample on 3rd June 2000, and in several aspects of her documentation.

I believe [Ms B] failed to meet the standard of care expected through the New Zealand College of Midwives Standards for Midwifery Practice in standards six and seven.

Standard six – 'Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk'. I take this standard to include the baby, although not specifically noted as such.

Although it is common to use warmth to increase the blood flow to the area from which a heel prick blood test is to be taken, it is essential to ensure the mechanism used is safe. Using a flannel wrung out in hot water has the advantage of it being handled by the midwife and thus her being aware of the temperature of the cloth before it is applied to the infant's foot. Although it isn't unusual to use a bowl of warm / hot water it is expected the midwife will test the temperature of the water before immersing the infant's foot.

It appears the water was very hot, to have caused the blistering and burn described by the midwife and mother, and later attendants.

As well as [Mrs A's] letters which describe '… the burnt skin being peeled away …, … bleeding … … cold water …, … pressure …, then … pricking [the baby's] heel and squeezing it for blood …' (document A and B)
there are:
– two explanations from [Ms B] which describe '… no bleeding or peeling skin … a little red … it seemed okay and … I could go ahead with the test … … getting redder … … the foot was reddened but not blistered and there was no broken skin when I left' (document C – letter to the Health and Disability Commissioner), and 'The baby's foot (the skin) was peeling' (re-photocopied notes from [Ms B's] notes, presumably written at or near the time of her visit);

– [Mr E's] comment '… didn't think it looked too bad' (document E);

– assessment of the heel 'bare of skin and bright red' by the GP at [the Medical Centre] (document I);

– the history taken by the admitting doctor at [the second public hospital] from (presumably) [Mrs A] – 'Guthrie test at 10.30 this morning about 20 minutes later the mother noticed vesicles (fluid filled blisters) over the right heel → Emergency Department' (document J);

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around the time of the foot submersion, taking of the blood test, and management of the burn. It seems unclear when the severity of the burn became apparent, but it seems inappropriate to have proceeded with the blood test given the possibility of a scald or burn, and the distress of the baby. The accepted first aid for a scald or burn (which could be expected given the tender skin of a newborn's foot was submerged, even briefly, in very hot water) is submersion in cold water for at least ten minutes, not to apply lotions or ointment, and seeking medical attention if there are any concerns.

There appear to have been a number of features (situational, stress, and personal) that may have distracted the midwife's attention. However, I believe it remains her responsibility to provide a safe environment for herself and her work.

In my opinion [Ms B] did not meet this standard in that she didn't test the water temperature before the baby's foot was submerged (either intentionally or accidentally), her first aid management was tardy and only partially appropriate, and she hadn't recognised her own health status was compromised.

Standard seven:- 'The midwife is accountable to the woman, to herself, to the midwifery profession, and to the wider community for her practice' of which one of the criteria is that she 'clearly documents her decisions and professional actions.'

[Ms B's] documentation of her visit to [Mrs A] and the baby on the third of June is brief and inconsistent with her description of the events which she presents in her letter to the Health and Disability Commissioner (document C).

In the photocopy of [Ms B's] notes, the question could be raised as to whether the last two lines of the first page of entry on 3/6/00, and the entry for that day on the next page, were added at some later time. It is acceptable to add further notes after an event, but they should be appended with the date and time they were added.

In these notes she notes 'Rang wd […] to find out about baby, had an unsettled night and commenced on Morphine and …'. In her letter to the Health and Disability Commissioner (document C) she states '… learning that he had been given Morphine and panadol as I was never told this.'

These are inconsistent and don't meet her obligation to clearly document her professional actions, nor the updating records at each professional visit.

In response to the ACC report to [Mrs A] dated 12 12 00 by [Ms K] (document K) which on the third page, bullet point two, implies [Ms B] must have squeezed the baby's foot to get the blood sample: it is occasionally possible to get sufficient blood from the heel prick to fill some or all of the circles of blood required for the Guthrie Test without 'milking' or squeezing the foot.

[Ms B] had made efforts to get support for her practice as a relatively new practitioner and appears to have been coping with major, and therefore significant, factors in her personal and professional life. Given these extenuating circumstances and what sounds

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to have been a busy and possibly cramped household situation, the chances of an accident occurring are significant.

Midwifery in the best of circumstances is a demanding multifaceted profession where practitioners are vulnerable to many pressures, a huge range of normal, and a variety of management of care practices. [Ms B] made good efforts to get support for her practice and learning in the first year of independent midwifery. The bulk of her care to [Mrs A] was that of a reasonable practitioner."

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.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Professional standards

The New Zealand College of Midwives 'Handbook for Practice' (1993) states:

CODE OF ETHICS

THE STANDARDS FOR MIDWIFERY PRACTICE

STANDARD SIX
Midwifery actions are prioritised and implemented appropriately with no Midwifery action or omission placing the woman at risk.

STANDARD SEVEN
The Midwife is accountable to the woman, to herself, to the Midwifery profession and to the wider community for her practice.

…

- clearly documents her decision and professional actions.

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New Zealand Nursing Council 'Code of Conduct for Nurses and Midwives' (1995)

PRINCIPLE FOUR

The nurse or midwife justifies public trust and confidence.

Criteria
The nurse or midwife

4.6 takes care that a professional act or any omission does not have an adverse effect on the safety or well being of patients/clients.

Opinion: Breach – Ms B

In my opinion Ms B breached Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights in the following respects:

Rights 4(1) and 4(2)

Principle 4.6 of the New Zealand Nursing Council 'Code of Conduct' requires that a nurse or midwife "takes care that a professional act or any omission does not have an adverse effect on the safety or well being of patients/clients".

Ms B did not test the temperature of the water, which was near boiling, before immersing the baby's foot and causing a scald to the heel
Ms B reheated water which had cooled while she was preparing the baby for a heel prick test at 10.30am on 3 June 2000. Ms B intended to use the heated water to assist blood flow to the heel so that she could obtain sufficient blood to fill the four circles on the Guthrie card. My expert advised that it is not unusual to warm the baby's foot in a bowl of warm water before undertaking a heel prick blood test, but it is expected that the midwife will test the temperature of the water before immersing the infant's foot. Ms B said that she normally tested the temperature of the water before immersing the baby's foot, but she did not do so this day as she was distracted by the one-year-old child who was present.

I accept my expert's advice that Ms B did not provide the baby with a service with reasonable care and skill when she failed to test the water temperature before submerging his foot in near boiling water, thus causing a severe scald to the baby's heel. The presence of the burn to the baby's foot indicates that Ms B did not take sufficient care when providing services to the baby.

Ms B peeled the burnt skin off the baby's and applied Savlon to the scald to the baby's heel
Mrs A stated that Ms B picked at the scalded skin and peeled it away leaving the raw tissue exposed, and then attempted to staunch the blood from the baby's heel by pressing a napkin against the heel. Ms B disputed this, stating that there was no bleeding or peeling of the skin. However, she did admit that after submerging the baby's foot in the cold water as a

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first aid measure, she found that the heel was still bleeding and wiped it with a cloth napkin. Nonetheless, I note that Ms B wrote in the baby's clinical records that his skin was peeling.

I have received different accounts about what happened to the baby's heel. Mrs A alleges that Ms B peeled off the skin, while Ms B could not recall the presence of peeling skin. The doctor who assessed the baby at the Medical Centre recorded that the heel was bare of skin and bright red. I have received comments from a consultant plastic surgeon who said that a baby's skin is very thin and the baby's skin may have been rubbed off when wiped by the napkin. It seems probable that when Ms B removed the napkin she had used to staunch the blood, the skin came away.

Ms B appeared to be uncertain about the severity of the burn to the baby's heel initially, but was sufficiently concerned to administer a form of first aid by immersing the baby's heel in cold water for "three to five minutes", and applying Savlon cream.

My midwifery expert commented that Ms B's first aid management was tardy and only partially appropriate and did not meet the accepted standard. The accepted first aid for a scald or burn is to immerse the area in cold water for at least ten minutes. Lotions and ointments should not be applied, and medical attention should be sought if there are any concerns about the severity of the burn. However, I note Dr I's comments that it was to Ms B's credit that she thought to use rain water to cool the burn.

After the incident Ms B left the house, informing Mrs A that she would return with first aid supplies. Mr E advised me that Ms B rushed past him. Mrs A then left the property with the baby in order to take him the Medical Centre. There no evidence that Ms B gave Mrs A any advice on the treatment of the scald. Ms B left Mrs A to decide for herself to take the baby to the Medical Centre. In my opinion Ms B did not provide services to the baby with reasonable care and skill once she became aware of the burn to his heel.

Ms B performed a heel prick blood test on the baby's burnt heel

Ms B said that when she looked at the baby's heel after removing it from the cup of water, she decided that it was not injured so she pricked the heel with the lancet to obtain blood for the Guthrie card. She said that the heel bled freely. When she squeezed the heel to transfer the blood onto the card, she noticed that heel was very red and realised that the scald was worse than she had initially thought. Ms B stated that she then abandoned her attempts to take a blood sample from the baby's heel. She later advised me that she recalled obtaining sufficient blood from the baby's heel to fill three circles on the Guthrie card. However, the NTC records show that it received a completed Guthrie card for the baby, dated 3 June 2000. It appears that Ms B did not abandon her attempt to collect the blood sample for the Guthrie card, and indeed sent the completed card to the National Testing Centre one or two days later.

I accept the advice that it was inappropriate for Ms B to proceed with the blood test given that the baby was obviously distressed immediately following his heel being immersed in hot water, and that there was a possibility he had sustained an injury to his heel from the hot water. Ms B's actions had an adverse effect on the wellbeing of the baby, and amounted to a failure to provide midwifery services with reasonable care and skill.

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In all these matters Ms B failed to provide the baby with a service that complied with the care and skill reasonably expected of a midwife in these circumstances, and did not comply with the professional standards promulgated by the New Zealand College of Midwives and the New Zealand Nursing Council. Therefore, in my opinion, Ms B breached Rights 4(1) and 4(2) of the Code.

Other comments

Ms B did not accurately record
The New Zealand College of Midwives 'Standards for Midwifery Practice' state that a midwife is accountable to the woman, to herself, to the midwifery profession, and to the wider community for her practice. One of the criteria for this standard is that she clearly documents her decisions and professional actions.

Some hours after the incident on 3 June 2000 Ms B recorded that when she removed the baby's heel from the hot water, and immersed it in cold water, "the baby's foot (the skin) was peeling". However, Ms B later refuted this, and advised me that "the foot appeared OK, it just seemed a little red".

Ms B's documentation of her visit to Mrs A and the baby on 3 June 2000 is brief, and inconsistent with her later description of the events. Ms B explained this discrepancy stating that she did not have the clinical records to refer to when she wrote her response to Mrs A's complaint. It appears that Ms B amended her original record of the incident on 3 June 2000 at a later date. Ms B stated that she completed her notes within hours of the incident occurring and made the changes to her initial notes "then and there" when she realised that her original wording was an incorrect representation of the facts. My expert advised that although it is acceptable to add further notes after an event, they should be appended with the date and time they were added.

I agree with the comments of my advisor. Accurate record keeping is an essential part of the provision of health care services. Inaccurate records can unnecessarily muddy the waters. I appreciate that at times it may be necessary to add to clinical records retrospectively, although this should occur infrequently. Where it is necessary to add to clinical notes, it is imperative to include the date and time.

Ms B did not advise Mrs A to seek follow up assessment and treatment for the baby's burn
Standard 7 of the New Zealand College of Midwives 'Standards for Midwifery Practice' states that the midwife is accountable to the woman and herself. Ms B did not accompany Mrs A to the Medical Centre to provide the staff with an account of the injury to the baby's heel. Even if she felt Mrs A did not want Ms B to accompany her to the Medical Centre, Ms B could have telephoned the clinic to inform the staff about the circumstances of the incident. As the health professional primarily responsible for the baby's welfare, Ms B was best placed to provide the secondary medical service with the information they required to provide the baby with appropriate treatment.

My midwifery expert commented that there may have been a number of factors that distracted Ms B's attention and led to the scalding of the baby's heel. However, Ms B had

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a professional responsibility to the baby and Mrs A, to fully inform the health professionals treating the baby's foot of the nature of the accident to ensure he received appropriate care.

Actions taken

- Ms B contacted the New Zealand Council of Midwives' Resolution Committee regarding this incident and offered to participate in a practice review.
- In July 2000 Ms B stopped practising as a midwife.
- In April 2002 Ms B forwarded an apology for Mrs A, in response to the Commissioner's provisional opinion.

Other actions

- A copy of this opinion will be sent to the Nursing Council of New Zealand.
- A copy of this opinion, with details identifying Ms B but other personal identifying details removed, will be sent to the Chief Executive Officer of the New Zealand College of Midwives.
- A copy of this opinion, with all identifying details removed, will be sent to the New Zealand College of Midwives and the Maternity Services Consumer Council, for educational purposes.

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