Midwife

Report on Opinion - Case 97HDC7147

Complaint

The Commissioner received a complaint about the services provided to the consumer by the provider, a Midwife.

In mid-October 1996 the consumer gave birth to a baby girl at a Hospital Maternity Unit. The consumer was assisted in the birth by the provider, a Midwife. The consumer's complaint is that:

- *The provider did not act swiftly enough during the consumer's labour. The consumer's membranes were ruptured for 30 hours and she was in labour for 36 hours.*
- *The consumer's discharge summary was inaccurate. It stated that the consumer was given 1 epidural dose, when 2 were given. It did not state that following a failed ventouse the baby was born by a difficult forceps delivery.*
- *The baby was in foetal distress during the labour and had a CTG baseline of 80 for several minutes.*
- *The provider failed on two occasions to recognise the baby had severe jaundice.*
- *The provider did not correctly record in the clinical notes details about the baby's weight loss and failure to feed.*
- *Concerned about their baby's jaundice, the consumer and her husband insisted blood tests were performed but the provider incorrectly advised them that these blood tests were not available until after the weekend.*
- *At six days old the baby had an SBR of 510 and required immediate readmission to hospital.*

Investigation

The complaint was received by the Commissioner on 26 June 1997 and an investigation was undertaken. Information was obtained from:

The Consumer
The Provider/Midwife

The consumer's medical records were reviewed. Midwifery advice was also obtained by the Commissioner.

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Details of Investigation

Labour management

This was the consumer's first baby.

The consumer's membranes ruptured one day in mid-October 1996 at 11.00am. She was examined by the provider at 11.30am. Her examination revealed that the baby was lying in the posterior position. The provider visited the consumer again at 6.15pm. At that time labour was not established, the consumer was sleeping and her contractions were irregular. The provider arranged to meet the consumer at the Hospital the following morning if her labour was not established by then.

Hospital records show the consumer's labour was established at 12.30am the next day. At 8.00am the consumer went to Hospital. At this time her contractions were still irregular. She was admitted and examined by the provider. At 9.00am the provider discussed the case with the Senior Registrar who decided to induce labour with Prostin gel. The consumer was seen by an anaesthetist who inserted an intravenous luer plug. Prostin gel was inserted at 9.10am and soon after foetal heart rate deceleration was recorded. This recovered quickly to normal and no action was taken.

By 11.00am the consumer was experiencing strong regular contractions. At 11.30am she was given intravenous antibiotics because her waters had ruptured twenty-four hours before and at 11.50am was given Entenox to control her pain. At 1.30pm the anaesthetist inserted an epidural catheter which, because of continuing painful contractions was "topped up" at 2.45pm. At 3.05pm a Syntocinon drip was commenced. At 3.30pm early and late foetal heart decelerations with slow recovery were noted. The provider stopped the Syntocinon drip, administered oxygen and telephoned the Senior Registrar, who saw the consumer and ordered the Syntocinon drip to be recommenced in 30 minutes if the heart rate had recovered. The Syntocinon drip was recommenced at 4.10pm. The provider administered one epidural "top-up" and heard the doctor refer to a second "top-up" between 4.45pm and 5.15pm.

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Details of Investigation, *continued*

Between 4.40pm and 4.45pm the consumer reported growing pressure to push and the baby's heart rate was slowing and becoming erratic. The rate recorded was between 80 to 100 beats a minute. The provider turned off the drip, administered oxygen and notified the Senior Registrar, the anaesthetist and the paediatrician. She examined the consumer and found her to be fully dilated. The provider prepared for an assisted delivery. The Senior Registrar arrived and attempted ventouse delivery but when this failed the baby was delivered by Neville-Barnes forceps at 5.19pm. The consumer required an episiotomy. The anaesthetist and paediatrician were present during the delivery.

At birth the baby weighed 3045 grams. Her apgar score was 8 recovering to 10 at one minute. She had a cephalohaematoma on her head and her face was bruised and marked.

The Commissioner's midwifery advisor viewed the medical records from the Hospital. These records contain notes written by the provider during the labour and delivery.

The reviewing midwife advised that, contrary to the Hospital records the consumer was not in established labour at 12.30am on the day of the birth. The provider had entered in the consumer's notes that labour was established by 12.30am on that day as this was what she was told by the consumer. However, the provider advised that when she examined the consumer next morning the cervix was 2cm dilated and there were mild irregular contractions. Accordingly labour had therefore not been established by the early morning that day.

It is the reviewing midwife's belief that labour was not established until after the Prostin gel was inserted at 9.10am and the baby was born at 5.19pm that day. Therefore the consumer's labour was about seven and a half hours rather than thirty-six hours as the medical records indicate.

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Details of Investigation, *continued*

The first instance of foetal heart deceleration responded to conservative measures. However at 4.45pm on the day of the birth, when the baby's heart rate slowed following a contraction and did not spontaneously revert to normal, the provider acted to get medical assistance and ensure quick delivery of the baby. During labour the provider spoke to the Senior Registrar by telephone and treatment was ordered as appropriate. My midwifery advisor informed me that:

"The provider managed this labour efficiently and competently within the scope of her practice. She has detected complications as soon as they arose, and accessed medical assistance promptly… Caesarean Section has a huge risk to the woman and is better avoided…[her care] *would not have changed if her caregivers were different."*

The discharge summary which is the responsibility of the Hospital staff sets out that the method of delivery was "forceps low Neville Barnes" and the care plan also sets out that this method of delivery was used "following a failed ventouse". The discharge summary and notes when considered together set out the method of delivery accordingly. The medical notes show two epidural injections administered by the anaesthetist, one "top-up" administered by the provider and one "top-up" she heard referred to by the doctor during the delivery.

The consumer and her baby were discharged two days after the birth. Prior to discharge the provider noted the baby was jaundiced and had an increased white cell count. She notified the paediatric team and performed a TCB (Transcutaneous Bilirubin Index) estimate. This was normal (15-18). The paediatric team examined the baby before she was discharged and were happy for her to go home. Her discharge weight was 2810 grams.

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Details of Investigation, *continued*

Postnatal care

The provider advised that she visited three days after the birth and recalled the consumer's mother, who is a public health nurse, was arriving that day. The provider noted, *"mother confident, fundus firm, breasts filling. The baby settled asleep today feeding well*". However because the baby was asleep and in a darkened room the provider did not see or examine her. In her complaint the consumer said the provider did not visit on that day and the notes were incorrectly written after the complaint was sent to the Commissioner. I can find no evidence that the provider altered the clinical notes after this complaint was filed. The records are chronologically recorded and the notation about this particular visit spans two pages.

Four days after birth the baby's jaundice was still present. The provider advised the consumer to feed the baby three-hourly and to keep a feeding diary which she recorded in her clinical notes for that day, but the consumer declined to do this. The consumer said she was not asked to keep a feeding diary. If she had been requested to she would have done so. The provider also recommended placing the baby in the sunlight to aid resolution of the jaundice. The provider noted that the baby had been restless and awake from 11.00pm the previous evening to 4.00am that morning. The provider reported that the consumer's milk was established and the baby was passing urine and transitional stools. The provider telephoned later that day to see how the baby was feeding. The consumer said her mother was concerned about the jaundice. The provider reiterated that the baby needed three hourly feeds and sunlight. The provider arranged to visit the following morning.

Five days after birth the baby's jaundice had deepened. The baby was more settled. The provider saw the baby pass urine and there were no urates on the nappy. The provider discussed the deepening jaundice with the paediatrician at the Hospital. The paediatrician advised leaving the Serum Bilirubin (SBR) test until the next day and then if above 300 to admit the baby to Hospital. Five days after birth the baby's SBR level was 510 and she was immediately admitted to the Neonatal Unit of the Hospital. The baby weighed 2750 grams.

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Details of Investigation, *continued*

On admission the baby was given double phototherapy. The doctor attending the baby stated that the cephlohaematoma was contributing to her raised SBR and if the bilirubin level had not dropped by the next feeding she would require an exchange transfusion. He also informed the consumer of the risks associated with raised SBR levels. Fortunately the baby's SBR level had dropped to 473 and an exchange transfusion was not necessary. On the following two days the SBR was 381 and 231 respectively. Phototherapy was discontinued on the second day. During this time the baby remained sleepy. She was breast fed and required additional fluids by tube and cup feeding. The consumer and the baby went home without a medical check after nine days.

The midwife advised that:

"normal physiological jaundice peaks at day 4 ...However, 1 in 1000 babies with normal physiological jaundice will develop jaundice severe enough to be at risk of Kernicterus. If the baby is alert and feeding well, milk supply is good and there is [sic] plenty of wet and dirty nappies, we can leave these babies alone until the level of jaundice is moderate to severe (ie exceeds 300 mmol/l). In the meantime most babies will respond to frequent feeding and sunlight."

And:
"The midwife should be able to determine the level of jaundice by looking at the colour of the baby. If the midwife thinks the SBR is over 300 she should take an SBR to monitor the jaundice accurately. If the midwife is not able to judge jaundice levels well visually she should monitor SBR's sooner. Ultimately it is the colour of the baby (ie the bilirubun level) that is important not the feeding."

The baby's jaundice was first noted two days after birth (a Thursday) but SBR levels were not assessed until the following Monday. The provider notified the paediatric registrar on Sunday and was advised that the SBR could be left until Monday. However the paediatric registrar was guided in this decision by the information given to him by the provider. The reviewing midwife believes SBR levels should have been considered on Friday and taken on Saturday because *"from the photos this baby's colour was deep enough to warrant an SBR."*

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Details of Investigation, *continued*

If the baby's colour is in question and an increase in bilirubin level suspected the treatment includes ensuring the baby has adequate fluids.

The midwife advised that the provider wrongly assumed the milk supply was established four days after birth (Saturday). She came to that conclusion because the baby was unsettled on that day because she was hungry, whereas on the following day the baby was more settled (sleepy). This could be the result of an increase in serum bilirubin rather than a satisfied infant. The midwife added that it is not always easy to assess when milk supply is established.

The provider advised that the consumer declined to keep a feeding diary and seemed confident in handling the baby. The provider largely relied on the consumer's reports on feeding the baby but this was the consumer's first experience with childbirth and looking after a newborn. With an inexperienced mother the provider needs to take additional steps to ensure that the consumer's milk supply was in fact established and the baby was feeding well. However, other indicators that the baby was feeding adequately, for example weight loss, presence of transitional stools and passing urine, were within normal limits.

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard.

...

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

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –...

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; ...

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Opinion: No Breach

In my opinion the provider did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights in relation to her management of the consumer's labour and the baby's birth.

Right 4(2)
When the consumer had not established labour on the morning of the birth the provider admitted her to Hospital, discussed labour management with the Senior Registrar, and labour was induced promptly. At the first sign of foetal distress the Senior Registrar was again notified and appropriate action taken. When the baby again became distressed the provider prepared for immediate delivery. The baby was delivered by the Senior Registrar quickly, and was well and healthy at birth.

Opinion: Breach

In my opinion the provider breached Right 4(2) and Right 6(1)(b) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)
The provider failed to take an SBR estimate and failed to assess breast-feeding was adequately established. The provider incorrectly assumed that the consumer's milk supply was established and the baby was feeding well four days after birth (Saturday). The baby was restless the night before and had transitional stools. Although the consumer appeared to be managing well, as a first time mother she may not have been as confident as she appeared. The consumer relied on the provider's professional knowledge and guidance during labour, delivery and with the early care of the baby. As normal physiological jaundice responds to adequate feeding the provider should have taken steps to ensure fluid intake was adequate.

Normal physiological jaundice peaks on day 4, but on day 5 the jaundice was more pronounced. The provider should have ensured the SBR test was taken on day 5, (a Sunday). While the paediatrician advised delay in testing, that advice was based on information supplied by the provider. The delay of an additional day placed the baby at risk.

Continued on next page

Midwife

Report on Opinion - Case 97HDC7147, continued

Opinion: Breach, ***continued***

Right 6(1)(b)

The provider noted the baby's increased jaundice on Sunday and discussed this with the baby's parents and doctor but did not discuss the options available for assessing Bilirubin levels or the risks and side effects of raised SBR. Further, the consumer and her husband were not advised that adequate fluids were essential and I found no evidence of a request that the consumer keep a feeding diary.

If the consumer and her husband had known the possible severity of risks associated with raised SBR, they may have been in a better position to decide to take the baby to hospital for tests on Sunday. In my opinion this failure to keep the consumer and her husband fully informed was a breach of Right 6(1)(b).

Actions:

I recommend that the provider apologise in writing to the consumer for the breach of the Code in relation to the post-natal care of her baby. This apology is to be sent to the Commissioner and I will forward it to the consumer.

I recommend that the provider indicates that she has had discussions with the Hospital ward staff about a general review of assessment skills when examining and supervising a jaundiced baby in Hospital and at home. I recommend that the provider send a record of the outcome of that review to the Commissioner's office.

I suggest that the provider discuss with the local medical laboratories whether Bilirubin estimates can be performed on Sunday and forward this information to the Commissioner's office. If this is not available a means of making this service available should be explored in conjunction with the Health Funding Authority.

A copy of this opinion will be sent to the Nursing Council of New Zealand and New Zealand College of Midwives for their information.