

Midwife, Ms E
Midwife, Ms D
A Maternity Clinic

A Report by the
Health and Disability Commissioner

(Case 08HDC18402)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mrs A (aged 38 years) gave birth to her daughter on 7 January 2008 at a public hospital. Shortly after giving birth she was transferred to a maternity clinic (the Clinic) for postnatal care.

The following night Mrs A complained to the staff midwife that she was experiencing abdominal pain. She also suffered rigors and shivering. A staff midwife, Ms B, took Mrs A's temperature at midnight and found it to be raised (38.6°C). However, it had returned to normal by early morning.

Later that morning Mrs A complained of feeling hungry and dizzy and, two hours later, she advised the staff midwife that, after speaking with her Lead Maternity Carer (LMC), she was going to the public hospital to be assessed as she felt very unwell. The staff midwife recalls thinking that Mrs A seemed alert and well, and she did not carry out any assessments on Mrs A.

Mrs A's husband picked her up and took her to the public hospital, where she was noted to be "very unwell" on arrival and had low blood pressure. She was subsequently diagnosed with puerperal sepsis¹, caused by Group A Streptococcus. Mrs A spent time in the high dependency unit and the intensive care unit and was discharged home on 22 January 2008.

This report examines the adequacy of the postnatal care provided to Mrs A by the Clinic and her LMC, and the policies and protocols for managing unwell women that were in place at the Clinic at the time.

Complaint and investigation

On 6 November 2008 the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by the Clinic and her LMC, Ms E.

An investigation was commenced on 29 May 2009. The following issues were identified for investigation:

- *The appropriateness of the care provided by the Clinic to Mrs A from 7 January to 9 January 2008.*
- *The appropriateness of the care provided by Ms E to Mrs A from 7 January to 9 January 2008.*

¹ Delayed uterine infection after childbirth.

On 3 November 2009 the investigation was extended to include the following issue:

- *The appropriateness of the care provided by midwife Ms D to Mrs A on 9 January 2008.*

Information was received from the following parties who were directly involved in the investigation:

Mrs A	Consumer/complainant
Mr A	Complainant's husband
The Clinic	A Maternity Clinic/Provider
Ms B	Provider/Clinical Manager at the Clinic
Ms D	Provider/staff midwife at the Clinic
Ms C	Provider/staff midwife at the Clinic
Ms E	Provider/LMC

Information was also received from the District Health Board.

Also mentioned in this report:

Ms F	Staff midwife at the Clinic
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Independent expert advice was obtained from registered midwife Nimisha Waller, and is attached as **Appendix A**.

Information gathered during investigation

Background

Maternity services in New Zealand

Pregnant women in New Zealand are entitled to free maternity services from midwives or general practitioners to cover their pregnancy, birth, and postnatal care.

The woman must choose an LMC (Lead Maternity Carer), who is funded by the Ministry of Health to provide maternity services. The LMC's responsibilities are set out in the Primary Maternity Services Notice, issued pursuant to section 88 of the New Zealand Public Health and Disability Act 2000. The Primary Maternity Services Notice states that the LMC is responsible for the care provided to the woman throughout her pregnancy and postpartum period.

The Clinic

The Clinic is a primary birthing facility for women having a low-risk birth. It also provides postnatal services for women who give birth at the public hospital.

The Clinic opened in December 2002. The Clinical Manager is Ms B.

The Clinic employs midwives, but women who use the facility need to engage an LMC midwife who has an access agreement² with the Clinic.

Transfer of care to specialist services

Sometimes women may require additional care beyond their LMC's responsibilities. In these circumstances, the LMC can transfer clinical responsibility for the woman's care to the appropriate service (ie, obstetric or other specialist service).

There are certain guidelines and processes to follow if a transfer of care is to take place. For instance, identifying the need for additional care, and how it is provided, is guided by the Referral Guidelines.³ These guidelines are not intended to "restrict good clinical practice". However, they do stipulate that a practitioner must record in the notes the reasons for any variation from the Referral Guidelines.

The Referral Guidelines contain a table of medical conditions. Beside each medical condition is a description of the condition, and a number (1–3) which guides the LMC's actions: level 1 — the LMC may recommend to the woman that a consultation with a specialist is warranted; level 2 — the LMC must recommend to the woman that a consultation with a specialist is warranted; level 3 — the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist.

Further information about the process of transferring a woman's care from her LMC to a secondary service is contained in the New Zealand College of Midwives Transfer Guidelines. These stipulate that once it has been identified that a woman has additional care needs, there must be a documented discussion amongst all relevant parties (the woman, her support people, the LMC, the core midwifery service, and the obstetric service) to determine who should provide the woman's midwifery care (the LMC, the core midwife, or a combination of both).

If the independent LMC continues to provide midwifery care, there also needs to be a documented discussion regarding midwifery roles and responsibilities, as the LMC may need support and assistance from a facility's core midwifery staff in order to continue providing care.

Once it is deemed appropriate to transfer the woman's care back to the LMC, "handback of care" occurs, following a documented, three-way discussion amongst the woman, the LMC and the specialist.

² The access agreement is a contract between a birthing unit and a practitioner (LMC) who wishes to use the birthing unit's facilities. The agreement, which sets out the various obligations of each party, can be found in Schedule 3 of the Primary Maternity Services Notice.

³ The Referral Guidelines are the Guidelines for Consultation with Obstetric and Related Specialist Medical Services. They identify clinical reasons for consultation with a specialist, and are published by the Ministry of Health from time to time. The Access Agreement (between birthing units and LMCs) specifically refers to the Referral Guidelines, and requires that they be taken into account when providing services.

Postnatal care

The Clinic — 7 January 2008

On 7 January 2008 at 2.51am Mrs A (38 years) gave birth to her daughter at the public hospital. Later that morning (4.40am), she and the baby were transferred to the Clinic for postnatal care.⁴

At 11.45am on 7 January, staff midwife Ms F was called by Mrs A, who was complaining of “afterpains”.⁵ Ms F gave Mrs A Synflex,⁶ and charted it to be given every six hours. At 1.30pm Ms F noted that “Synflex has been effective for afterpains”.

Mrs A told HDC that she complained of stomach pain to the staff midwife at 11pm on 7 January. Mrs A also advised HDC that “a little later” she started “having rigors⁷ and shaking profusely”, and she called the staff midwife for further help. This is not consistent with the clinical record, where it is documented that at 2.30am Mrs A called the midwife and expressed concern that the baby was hungry and not getting enough. It is also documented that Mrs A was hungry and was given toast and jam.

At 5am on 8 January, staff midwife Ms D has recorded: “[Mrs A] requesting Synflex — given as charted.” An un-timed entry on 8 January (presumably written before the next entry, which is timed at 12pm) from Mrs A’s LMC, Ms E, noted that Mrs A asked to go home after lunch the next day. Ms E discussed the request with the staff midwife, who said she “would see”, as Mrs A “didn’t sleep well last night [due to] unsettled baby, and she needs pain relief frequently”. Ms E also recorded: “Obst[etrically] well. [Postnatally] well.”⁸

Mrs A was given Synflex at 1.40pm, and at 10.00pm that night she was noted to be “well postnatally”.

Mrs A’s notes from midnight on the night of 8 January (morning of 9 January) describe how Mrs A buzzed the staff midwife (Ms B) as she was “feeling hot and cold, shivers ++”. Ms B took Mrs A’s temperature (37.6°C)⁹ and her pulse, which was normal (88 beats per minute). Mrs A told HDC that “being an experienced mother of [three], I had experienced rigors before prior to my breast filling with milk ... but ... not to this extent”.

⁴ The Clinic’s documentation protocol requires the woman’s LMC to complete a postnatal care plan for the woman prior to handing over care to the Clinic staff midwife. There does not appear to be any postnatal care plan documented by Mrs A’s LMC, and the postnatal care plan that was documented by the Clinic simply states: “Assess blood loss — fundus. Support with [breastfeeding] (experienced mum).”

⁵ A common occurrence for up to 48 hours after the birth of second and subsequent babies, due to contraction and involution of the uterus.

⁶ A non-steroidal anti-inflammatory drug used to treat pain and inflammation.

⁷ A rigor is an episode of shaking or exaggerated shivering, which can occur with high fever. It occurs for a variety of reasons and is often a sign of significant and sometimes serious infections.

⁸ Ms E also advised HDC that on this visit to Mrs A she “did all the basic postnatal and obstetric checks. Everything was normal and [the] care plan followed its normal course as usual.”

⁹ 37°C is considered to be a normal temperature.

Mrs A recalls explaining to Ms B that she knew something was wrong, but Ms B “put it down to breast milk”. There is no record of this discussion, but Ms B recalls Mrs A being sure that her shivering was “caused by tiredness and milk coming in”.

According to Mrs A’s notes, Ms B gave Mrs A Panadol and encouraged her to feed her baby, as the baby appeared to want a feed. Mrs A believes the midwives on duty “cared more about lactation for the baby, than my situation”. She recalls two midwives “trying desperately to latch the baby on my breast while I was having rigors ... in the end they gave in and gave my daughter formula milk”.

Ms B believes that Mrs A’s recollection of this event is incorrect. She notes that there was only one midwife caring for Mrs A at any one time, and advised that the decisions around feeding the baby are “discussed and agreed between the client and the midwife”. She also advised that “[s]taff are aware of women’s rights and informed consent”.

Mrs A’s notes record that she requested formula for her baby as she felt too unwell to feed, and her nipple was tender. It also records that her baby was given 25mls of formula.

Half an hour later, at 12.30am, Ms B took Mrs A’s temperature, which was elevated (38.6°C). Mrs A was noted to be “[f]eeling a bit better [and] not as shivery”.

According to the Referral Guidelines, a level three referral is recommended (the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist) for cases of “puerperal sepsis” (described as temperature greater than 37.6°C and maternal tachycardia) and a level two referral is recommended (the LMC must recommend to the woman that a consultation with a specialist is warranted) for cases of “pyrexia¹⁰ of unknown origin with rigors or shock” and for cases where the woman’s temperature is greater than 37.5°C.

Although Mrs A was displaying symptoms where a level two referral was recommended (and possibly a level three referral), there is no evidence to indicate that Ms B turned her mind to the Referral Guidelines.

Ms B advised HDC that she followed the DHB protocol for puerperal infection, explaining that this was the protocol staff followed at the time if a woman had a raised temperature.

The DHB protocol for puerperal infection states that the diagnostic criteria for puerperal infection is where the woman has an elevated temperature (over 38°C) on any two consecutive days of the first 10 days postpartum, or a fever over 38.6°C during the first 24 hours postpartum. If either of these criteria are met, then further investigation is required, including: full history taking and physical examination, blood tests, urinalysis, cervical or uterine swabs, wound cultures (if appropriate), and pelvic ultrasonography.

¹⁰ Elevated body temperature.

As the DHB protocol did not require Ms B to carry out any further investigations at that stage, she planned to observe Mrs A closely and take her temperature hourly. She advised HDC that if Mrs A's temperature had remained over 38°C, or spiked again, she would have taken action in accordance with the DHB protocol.

Ms B advised HDC that she had not realised at the time that the DHB protocol was inconsistent with the Referral Guidelines. Accordingly, she planned to consult with the DHB to bring their protocols in line with the Referral Guidelines.¹¹

Consultation with LMC

Ms B advised that it was the responsibility of the Clinic staff to inform LMCs about deviations from normal, but did not think it was necessary for her to contact Mrs A's LMC in the middle of the night to advise her about Mrs A's raised temperature, explaining that:

“[The Clinic] staff are responsible for informing LMC[s] about deviations from the normal. However, we have close relationships with LMC[s] and our staff are frequently trusted with their decision making. During the night, staff might decide not to wake up an already overtired LMC to inform her about her client's health status unless the condition is serious.”

However, Ms B accepts that it would have been appropriate for Ms E to have been informed about Mrs A's elevated temperature later that morning.

9 January — Ms C

At 1am another staff midwife, Ms C, took over Mrs A's care. Ms B advised HDC that she gave Ms C a detailed account of Mrs A's history since arriving at the Clinic, including her raised temperature, and the need to observe her closely because of this.

Ms C reviewed Mrs A at 1.20am. She took Mrs A's temperature (37.8°C) and noted that Mrs A was feeling exhausted and was unable to sleep. Ms C also noted that Mrs A's breast was filling with milk and recalls discussing with Mrs A the need to empty her breast (Mrs A had told her that she had experienced elevated temperatures in the past when her milk came in). Ms C recalls that Mrs A did not want to feed the baby off her breast, but agreed to use a pump to express the milk, and this is recorded in Mrs A's notes.

¹¹ The DHB advised HDC that private facilities in the DHB's region (like the Clinic) are not required to follow the DHB's protocols. However, the DHB was aware that private facilities do tend to base their own policies/protocols/procedures and guidelines (PPPGs) on the Hospital's documents. With regard to the discrepancy between the Referral Guidelines and its own policy on puerperal infection, the DHB advised HDC that its PPPGs are reviewed and developed based on best practice. It also pointed to the different purposes of each document. While the Referral Guidelines are a tool to guide the primary practitioner on when to refer the patient to a secondary/tertiary service, the DHB's protocol is designed to guide practitioners in the secondary/tertiary service, who will triage the patient based on more information than just the maternal pulse and temperature. The DHB also advised that it has not changed its protocol on puerperal infection in light of this, as the protocol is still current and no concerns had been raised about the protocol (prior to HDC approaching it for comment). I accept the explanation offered by the DHB for the differences between its policy and the Referral Guidelines, in particular the different purposes of the two documents.

Mrs A requested a sleeping tablet, and it is recorded that Ms C gave her one at 2am.

Ms C checked on Mrs A at 3.15am and noted that she was “sound asleep”. Mrs A was still asleep when Ms C checked on her again at 4.30am. She did not want to wake Mrs A to take her temperature as “sleep is what she needs now”.

Mrs A advised HDC that during the night of 8 January and early hours of 9 January she was not able to sleep because of “agonising cramp pains”; she also felt nauseous and had diarrhoea. She recalls that the midwives “just continued to give me pain killers for after birth pains ... not taking into account how agonising my pains were”.

As discussed above, it is documented in Mrs A’s clinical notes that Mrs A was observed asleep at 3.15am and 4.30am; however, there is nothing in her notes about her experiencing “agonising” pains. There is a note that Mrs A buzzed staff for pain relief at 4.40am. Ms C gave her Synflex, and her temperature was taken (37.7°C).

There is also a note that Mrs A complained to Ms C at 5.15am that she was feeling sick and had cramps in her uterus. Ms C recorded that Mrs A’s vaginal loss was normal and her uterus was well contracted. Her temperature was 36.6°C. Mrs A requested further pain relief and she was given two tablets of Panadol. However, Mrs A advised HDC that the pain killers had “no effect”.

Mrs A advised HDC that her diarrhoea “became worse and yellow in colour and very offensive”. Mrs A recalls asking Ms C to view the diarrhoea and that she did so “but did nothing about it”.

Ms C did record at 5.15am that Mrs A “had [a] bowel motion” but there is no mention of diarrhoea. She does not recall Mrs A having any concerns about the bowel motion, and she advised HDC that she did not investigate it further as she assumed, by “the way Mrs A presented herself”, that Mrs A would have alerted her if there was anything unusual.

Ms C recalls spending some time with Mrs A, who appeared “very confident” and not “unusually unwell”. Ms C also recalls having a conversation with Mrs A where Mrs A explained to her that “she knows her body, that she has had children before and she is a nurse”. Ms C also recalls Mrs A telling her that she was feeling exhausted from lack of sleep and “if she could only sleep she would feel better”.

Ms C advised HDC that she was not too concerned about Mrs A as Mrs A’s temperature remained under 38°C, and the Clinic protocol defines pyrexia as a temperature over 38°C. Ms C also noted that Mrs A’s temperature was decreasing during her shift, and that Mrs A slept, which “she hadn’t done for days and it usually makes a huge difference to a woman’s well being”. If Mrs A’s temperature had reached 38°C or above, Ms C advised HDC that she would have contacted Mrs A’s LMC and the public hospital.

Ms C accepts that it would have been appropriate to inform Ms E about the elevated temperature later that morning, but she cannot recall whether she discussed this at handover with the next staff midwife.¹²

Ms C did not take Mrs A's pulse once during her shift. She advised HDC that:

“[t]aking a woman's and baby's temperature and pulse go normally hand in hand. I have no explanation why I haven't taken [Mrs A's] pulse during that time ...”

9 January — Ms D

At 7am another staff midwife, Ms D, took over Mrs A's care. She did her “normal rounds to meet the clients” but left Mrs A undisturbed, as there was a “do not disturb” sign on Mrs A's door. Neither Ms B nor Ms C can recall putting up this sign, but both agree that the sign would only have been put up at Mrs A's request, as there is no reason for the sign to be up outside visiting hours. Mrs A does not recall requesting a “do not disturb” sign, and there is no record of this request in Mrs A's notes.

Ms D did not see Mrs A until 9am, when Mrs A buzzed her complaining of feeling dizzy and hungry. Mrs A also recalls describing to Ms D the stomach pains and diarrhoea she had been having overnight. However, the notes only record Mrs A's complaint of dizziness and hunger.

Ms D arranged for Mrs A to be given breakfast, but she did not take any vital sign readings, as she believed Mrs A's dizziness was due to being hungry. Ms D also advised HDC that the Clinic does not routinely take “well women's temperatures”, and she had noted that Mrs A's temperature had stabilised when last taken in the early hours of that morning.

Mrs A advised HDC that she was unable to keep her breakfast down. She recalls telling Ms D that she had vomited up her breakfast and she was feeling very unwell. She also recalls vomiting up a glass of juice in the presence of Ms D and asking Ms D to take her blood pressure, as she “knew [she] was not retaining anything orally”. Mrs A recalls that her blood pressure was not taken, and that “[the midwives] were very reluctant to take baseline observations”.

There is no record of Mrs A requesting that her blood pressure be taken on 9 January, and Ms D does not recall Mrs A requesting this. Ms B also disputes Mrs A's claim that there was a “reluctance” to take her baseline observations, noting that, despite being well postnatally, Mrs A's blood pressure was taken at her request on 8 January. Mrs A's notes from 1.40pm on 8 January record:

¹² Ms E advised HDC that there was an understanding between the Clinic and LMCs that, if there are any concerns or abnormal developments with the mother or baby, then the Clinic will contact the LMC immediately. This is consistent with what Ms B advised. Ms E also advised that had she been informed by the Clinic about Mrs A's elevated temperature she would have revisited Mrs A and completed a new postnatal care plan.

“ ... BP is 110/70.¹³ Taken as [Mrs A] was concerned re: ‘puffy hands and feet’ and her BP went up to 150/85 last birth. Reassured that puffiness is normal at this stage”.

Ms B also denies that any of the midwives were aware that Mrs A was not able to “retain anything orally”, and there is nothing in Mrs A’s notes to indicate this.

Request for medical input

Mrs A advised HDC that, as she felt “things were not getting headway”, she asked Ms D if she could see her doctor. Mrs A recalls that Ms D told her that she (Mrs A) would have to contact her LMC herself. Mrs A found this “unbelievable” as she thought the midwives at the Clinic were supposed to contact the woman’s LMC with any concerns, and let the LMC decide what further action to take, if any.

Mrs A also recalls that she was “very fragile and struggling to even talk” at this stage, but as she was in a lot of pain, she did not feel she had any choice. She therefore telephoned her LMC herself.

Ms D denies that Mrs A asked to see her doctor, advising that after 9am she had no contact with Mrs A until 11am, when Mrs A told her that she had telephoned her LMC, who had arranged a consultation with the doctors at the public hospital.

Ms D also does not agree with Mrs A’s description of her physical condition, advising HDC that:

“[Mrs A] appeared to be coping well, she was up and about, chatting and feeding her baby with ease ... she was certainly not as she stated in her complaint ‘fragile and struggling even to talk’.”

Ms B advised HDC that had Mrs A been as she described, “[o]ur staff would have contacted [her] LMC or [the District Health Board] for transfer out”.

Contact with LMC

At approximately 10.45am on 9 January Mrs A telephoned Ms E and described her condition. Ms E told Mrs A that she would telephone her back once she had liaised with the doctor. Mrs A then recalls that Ms E telephoned her back and told her that she should ask her husband to pick her up and take her to hospital.

Mrs A was surprised that an ambulance was not offered, especially in these circumstances, where she was in a poor state of health and Ms E was aware of their social situation (her husband was caring for their three children, all aged under five years, they were quite new to New Zealand, and they had no relatives to assist with childcare).

Ms E recalls that Mrs A told her that her temperature had gone over 38°C on two occasions,¹⁴ that she was sick, and felt unwell. Ms E told HDC that:

¹³ 110–140/70–80 is considered normal.

¹⁴ The records show that it had gone over 38°C on one occasion.

“this was a clear case of level three referral and there wasn’t much I could do other than refer her as soon as possible to the Delivery Suite. It was out of my scope of practice.”

Ms E denies that she told Mrs A that her husband would need to pick her up. She recalls telling Mrs A that she would ask the staff at the Clinic to call an ambulance to transport her to the women’s assessment unit, and that she would also discuss Mrs A’s condition with the registrar on duty in the delivery suite. She recalls that Mrs A “quickly responded” that she wanted her husband to take her to the assessment unit. Ms E asked her if she “was OK with that” and Mrs A was “adamant” that her husband would bring her to the assessment unit. As Ms E knew that Mrs A “was a strong woman”, she decided to leave the matter at that. Ms E’s recollection of this conversation is detailed in her notes. However, the notes appear to be written retrospectively (but not annotated as such) and, while dated, no time is recorded. With regard to Ms E’s failure to discuss Mrs A with the Clinic midwives prior to referring Mrs A to the public hospital, she advised HDC:

“When [Mrs A] called me and reported that her temperature had reached 38 degrees on two occasions on the night in question I knew right away that this was a level three referral and I referred her to secondary care. I could not sit on it. Any woman with a temperature of 38 degrees could develop puerperal sepsis ... She needed to come to hospital as soon as possible to be examined by specialists ... I had to act quickly to ensure that [Mrs A] was given the appropriate care by doctors immediately.

...

I knew [Mrs A’s] history. I was the LMC. I looked after her from antenatal, labour, delivery, and birth. She had told me what she remembered on the night in question of how she felt and what she went through. I had passed over the information to the Women’s Assessment Unit at [the] Hospital where she was referred to. [The Clinic] was fully aware that [Mrs A] was coming to the hospital.

...

[The Clinic] should have called me earlier if there was any concern about [Mrs A’s] health. I know [the Clinic] and the LMC have an understanding that [if there are] any concerns or abnormal developments about the health of the mother, [the Clinic] will contact the LMC immediately. [The Clinic] has done this in the past prior to this case ... If I had sought information from [the Clinic], it would not have changed the final outcome of [Mrs A’s] treatment because of the reasons given by [the Clinic] for not calling me. It would have been merely an academic exercise.”

Ms E — transfer arrangements

Ms E recalls that following her telephone conversation with Mrs A at 10.45am on 9 January she went to the public hospital delivery suite to look for the registrar; however, the registrar was in theatre. Ms E then consulted the charge midwife at the

assessment unit and advised her that she should expect Mrs A, who had a temperature over 38°C and was two days postnatal.

Ms E advised HDC that she waited for Mrs A to arrive. As she was not sure which part of the hospital Mrs A would arrive at, she spent the next hour and a half moving between the assessment unit, the delivery suite and the antenatal unit, looking out for Mrs A. During this time she was also calling Mrs A's cell phone, but did not receive an answer.

When Mrs A had not arrived by 12.10pm¹⁵ Ms E called the Clinic and asked to speak with Mrs A. She was informed that Mrs A had left the premises and was on her way to the delivery suite. She then called Mrs A's cell phone again, with no response. After 15 minutes she tried Mrs A one last time but as there was still no response she left to carry on with her work.

Care prior to transfer

Mrs A advised HDC that she asked for assistance from the staff midwife (Ms D) with a shower as she could not stand up, and this assistance was given.

Ms D advised HDC that she recalls helping Mrs A into the shower and holding Mrs A's baby while she showered. She does not recall that Mrs A "could not even stand straight as she states".

Ms D also advised HDC that, as Mrs A had already consulted her LMC and arranged transfer to the public hospital she did not consider it necessary for her to do anything further except help Mrs A have a shower and pack up her belongings as she waited for her husband to pick her up. She added that "in a primary birthing unit women are free to be involved and aware of their own self care and Mrs A was aware of this and seemed confident in her actions and decision making".

At 11am Ms D recorded the following in Mrs A's notes:

"Has rung [Ms E] for referral to hospital doctors as she is feeling very unwell ... I helped [Mrs A] have a shower and now feeding baby. Awaiting husband to pick her up."

Ms B advised HDC that the Clinic midwives would usually assess a woman's health prior to transfer; however, in Mrs A's case, this did not happen as she had a "do not disturb" sign out and "we respect client's privacy especially after a couple of sleep deprived nights". While acknowledging that an assessment should have been carried out, Ms B noted that Ms E was already informed about Mrs A's condition, and transfer to the public hospital had already been arranged.

Accordingly, Ms B does not consider that the failure to carry out an assessment "changed [Mrs A's] health outcome ... as staff at [the] DHB would have ordered appropriate tests".

¹⁵ Ms E advised HDC that the travel time between the Clinic and the public hospital is approximately 15 minutes.

Transport arrangements and departure from the Clinic

According to Ms B, the staff midwife on duty (Ms D) offered to call an ambulance for Mrs A as “[u]nwell clients always get transferred by ambulance”;¹⁶ however, Mrs A declined the offer as she wanted her husband to take her.¹⁷

Mr A recalls receiving a telephone call from his wife, asking him to pick her up and take her to the public hospital. On arrival at the Clinic he noted that his wife was moving very slowly and she was the “weakest” he had ever seen her. He recalls asking the staff midwife (Ms D) why an ambulance had not been arranged given his wife’s condition, and that Ms D did not reply — she was “speechless”.

Mrs A advised HDC that she was barely able to stand when leaving the Clinic, yet no one saw her out of the Centre or helped her and her husband to carry her luggage to the door.

Ms D’s recollection is at odds with Mr and Mrs A’s. She recalls that Mrs A was “happy waiting for her husband to pick her up, there was no urgency and she walked out with her family”. She also recalls thinking “it was a bit strange” that Mrs A was going back to hospital as she “seemed fine”.

Ms B’s advice to HDC differed from Ms D’s recollection. Ms B advised that none of the midwives were aware of Mrs A’s departure as she discharged herself at approximately 12pm and did not advise any of the midwives that she was doing so.

The Clinic and LMCs — discharge arrangements

Ms E advised HDC that it is normal practice for the woman to leave the Clinic after 48 hours postnatally if there are no concerns. Ms E normally discharges her women from the Clinic in consultation with the Clinic staff. If, however, she is attending a birth or out in the community, the Clinic will assess the woman, and discharge her after consulting Ms E. If there is any deviation from normal, the Clinic will call her to discuss the next plan of care, or she will attend to the woman, depending on the circumstances. Ms E advised that she did not discuss Mrs A’s discharge with staff at the Clinic because they did not call her, and the circumstances surrounding Mrs A’s transfer was a “one-off” case.

Variance in recollections

Ms B advised HDC that, after reviewing Mrs A’s clinical notes, and speaking with staff, she “can offer no explanation [for] the variance in care perceived by Mrs A and that recorded in the notes and recollections of staff”. She further advised that:

¹⁶ The Clinic’s “Transfers Out” protocol recommends that when clients are being transferred out of the Clinic to the public hospital they be “transported by ambulance service only”. This protocol also requires the staff midwife to ensure that the client is escorted by her LMC in the ambulance. If this is not possible, then the staff midwife may escort the woman (provided another midwife is available to give appropriate and safe care to clients at the Clinic). If it is not possible for either the LMC or a staff midwife to escort the woman then the staff midwife is to “negotiate with St John and document why the client was not escorted”.

¹⁷ Ms D did not mention in any of the information she provided HDC that she offered to call an ambulance for Mrs A.

“[i]f [Mrs A] had been presenting as she has claimed in her letter, this would have been recorded in her clinical notes¹⁸ ... If our staff had been concerned about [Mrs A’s] condition they would have taken steps to ensure [Mrs A] received the appropriate care (including transferring her to hospital as required).”

The public hospital

Mrs A’s husband picked her up from the Clinic and they are recorded as arriving at the women’s assessment unit (at the public hospital) at midday¹⁹ on 9 January.

The notes from the public hospital record that Mrs A appeared very unwell on arrival, and her symptoms are listed as “faint, abdominal cramps, fever, [low] blood pressure 70/50”. The history given by Mrs A on admission was of abdominal cramps for two days, diarrhoea for one day, vomiting for one day, and fever for one day. Bloods were taken and blood cultures were taken later when her temperature increased to 38.2°C. She was put on intravenous antibiotics and fluids, and given pain relief, as she appeared to be in “excruciating pain”.

It was suspected that Mrs A was suffering from puerperal sepsis; however, the cause of infection was unknown. Faecal specimens were taken to the laboratory at 4.30pm. At 6pm she was transferred to the High Dependency Unit (HDU) with a plan to have a scan, possibly followed by surgery.

Ms E recalls that at 5pm on 9 January she had a phone call from the women’s assessment unit to inform her that Mrs A had been admitted and she was unwell. Ms E went to see Mrs A, who was being assessed by doctors at that stage. When Mrs A was taken away for surgery shortly afterwards, Ms E looked after Mrs A’s three young children and new baby for two hours until she handed their care over to a staff nurse at 7.30pm.

At approximately 9pm that night, a general surgeon performed a laparoscopy,²⁰ laparotomy,²¹ and appendicectomy²² on Mrs A, with no abnormal findings to explain her symptoms. After the operation, Mrs A was transferred to the Intensive Care Unit (ICU), where she was intubated. The following morning a diagnosis of puerperal sepsis was confirmed (Group A Streptococcal infection). Mrs A was transferred to the general surgery ward the next day (11 January 2008). She suffered complications after the operation, including a lower respiratory tract infection, lower limb oedema²³

¹⁸ The Clinic’s documentation policy contains the following statements: “The clinical/maternity notes are the only written record of the care provided during a client’s stay. Maternity notes are legal records and should accurately reflect the care given.” Included under the heading “Important Dos and Don’ts” are the following instructions: “Record findings and evaluations; Record client’s care and response to it; Document all changes in condition”.

¹⁹ There is clearly some discrepancy between the time Ms B believes Mrs A departed the Clinic (approximately midday) and the time Mrs A is recorded as arriving at the assessment unit.

²⁰ This procedure uses an instrument similar to a miniature telescope to look at the peritoneal cavity, ovaries, outside the tubes and uterus.

²¹ This involves making a surgical incision into the abdominal cavity to examine the abdominal organs and aid in diagnosis of abdominal pain.

²² Surgical removal of the appendix. Mrs A’s appendix was found to be normal but was removed.

²³ Abnormal accumulation of fluid beneath the skin.

secondary to hypoalbuminemia,²⁴ and persistent diarrhoea, and remained in hospital until 22 January 2008.

Ms E's ongoing clinical responsibility

According to the Referral Guidelines, where there has been a level 3 referral, the decision regarding ongoing clinical roles/responsibilities must involve a three-way discussion between the specialist, the LMC, and the woman. It goes on to say that:

“[i]n most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.”

While both the public hospital clinical record and Ms E's records show that Ms E continued to be active in caring for Mrs A and her baby, there was no record of any formal discussions she had with Mrs A or staff at the public hospital about her ongoing role and responsibility for Mrs A once Mrs A's care had been transferred to the public hospital.

Ms E advised HDC that:

“[i]n Mrs A's case it was clear that when [Mrs A] was admitted to the Women's Assessment Unit, she was in secondary care and the hospital staff looked after her and took full responsibility [for] her care [in] ICU, HDU, [the] postnatal ward, until Mrs A was well enough to be handed back to my care”.

Ms E also advised:

“I was in constant communication with [Mrs A] before, during and after the events in question. In co-ordination of care I did everything possible within my scope of practice to ensure that [Mrs A] received appropriate care. It was a three way process between [Mrs A], the LMC and [the] Hospital.

...

I was in constant communication with [Mrs A] and also the [public] Hospital staff. This may not have been clearly documented by me ... I continued to visit baby, a boarder baby, [on the Ward] and facilitated the baby's care plan in discussion with staff midwives/co-ordinator postnatal ward and [Mrs A].

...

The transfer back to the LMC will be negotiated at the appropriate stage ... On [Mrs A's] transfer back to my care; the hospital midwife contacted me when they determined that she was ready to discharge her to primary care (LMC). This was standard procedure.”

²⁴ A medical condition where the levels of albumin (a major protein) in blood serum are abnormally low.

Ms E also pointed to another part of the Referral Guidelines (Part DA8), where it states that, if a woman's care is transferred to secondary maternity services, the clinical responsibility for the woman and baby transfers until there is a transfer of care back to the LMC. Ms E also referred to the Hospital Maternity Transfer Guidelines, and advised that she understood that a transfer of care meant a transfer of clinical responsibility for decision-making regarding the woman's care from primary-based LMC to secondary/tertiary care specialist.

Complaint

Mrs A wrote to the Clinic (the letter was undated) expressing her concern about the care she received and seeking answers to some questions in relation to that care. On 4 April 2008, Ms B responded to Mrs A's letter (this was resent to Mrs A on 3 June 2008 when the Clinic became aware that Mrs A's address had changed). Ms B expressed empathy for Mrs A's experience, noting that it must have been very upsetting for her and her family. She then answered some of Mrs A's questions about the Clinic's procedures in certain circumstances, noting that:

“[c]are provided at a primary birth centre is decided in a three-way process involving the patient, her LMC and the staff midwife ... The LMC is involved in the overall direction of the care plan and is referred to if any event arises. The client can also directly raise any concerns with the LMC herself.

In answer to your questions on procedures at the [Clinic], we follow the standard procedures of observe, record and inform the LMC if considered necessary. Some of the events you refer to are very general and appropriate actions would be case dependent.”

Mrs A was dissatisfied with the response. In a letter dated 18 June 2008, she advised the Clinic that she did not believe it had answered her questions, and she was not reassured that the Clinic had adequate protocols and procedures in place to deal with situations like hers. On 23 July 2008 the Clinic responded:

“We have no further comments to add to those in [our] letter of 4th April 2008, apart from to confirm that [the Clinic] has full certification under the Health and Disability Sector Standards as a maternity facility. As such all appropriate procedures and protocols are in place and are reviewed regularly.”

Code of Health and Disability Services Consumers' Rights and other relevant standards

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.

Other relevant standards are attached as **Appendix B**.

Preliminary comments

Mrs A, Ms E, and the staff of the Clinic have given different accounts of the events during Mrs A's time at the birthing unit, and her transfer to the public hospital. I have carefully considered all the information provided by Mrs A and the providers, including the documentation.

What we do know from the documentation is that Mrs A was showing signs that she was not well from the early hours of 9 January 2008. She had a raised temperature, she reported feeling sick, and she felt exhausted. At 9am, she was described as dizzy but hungry. At around 10.45am, she phoned Ms E and, as a result of this call, Ms E referred her to the public hospital. At 11am, Ms D recorded in the notes that Mrs A "had rung [Ms E] for a referral to hospital doctors as she is feeling very unwell."

At midday, Mrs A arrived at the public hospital, where she was described in the clinical record as being "very unwell on arrival" and her symptoms were listed as "faint, abdominal cramps, fever, [low] blood pressure 70/50".

The clinical manager of the Clinic, Ms B, told my Office that all the staff involved in Mrs A's care "remember her as well". However, the documentation does not support this conclusion, and I therefore prefer the account of the events as provided by Mrs A.

In particular, I accept that Mrs A was feeling very unwell on the morning of 9 January, and that is why she contacted Ms E.

Even if Mrs A's strong character masked to some extent the degree of discomfort she was in, I consider that more should have been done, in particular by Ms D and Ms E, to ensure continuity and quality of care was provided to Mrs A. After the events documented overnight, Mrs A ought to have been assessed, and there should have been communication between her LMC and the Clinic, before she left with her husband to go to the hospital. These issues are discussed more fully below.

Opinion: Breach — Ms E

As Mrs A's LMC, Ms E was responsible for all aspects of Mrs A's care throughout her pregnancy and the postpartum period, including co-ordinating the transfer of Mrs A's care to specialist services. Ms E was also responsible for keeping clear and accurate records about the care she provided Mrs A, and of any discussions she had with other practitioners involved with Mrs A's care.

8 January 2008

My independent expert, Nimisha Waller, considers that Ms E's visit to Mrs A at the Clinic on 8 January was appropriate, and I accept this advice.

9 January 2008 — transfer to hospital

The next contact Ms E had with Mrs A was at 10.45am on 9 January when Mrs A phoned her to advise that her temperature had been up to 38°C twice during the night. Ms E recognised this as "a clear case of level three referral" and advised HDC that her only option was to refer Mrs A as soon as possible to the public hospital for assessment by a doctor.

Ms E states that she suggested Mrs A go to the hospital by ambulance, but Mrs A was "adamant" that her husband would take her. Mrs A denies that an ambulance was ever offered, and recalls being surprised that Ms E did not offer her one given her state of health and social circumstances. As noted earlier, it is not possible to determine what exactly was said by the parties regarding transport options; however, as noted by Ms Waller, if Mrs A was unwell, an ambulance would have been a better option.

Ms Waller advised HDC that Ms E's actions, after receiving Mrs A's phone call at 10.45am, were appropriate. It was reasonable for Ms E to assume from the information she was given that this was a level three referral (the midwife must recommend to the woman that the responsibility for her care be transferred to a specialist). According to the Referral Guidelines, puerperal sepsis (temperature over 37.6°C and maternal tachycardia) is a level three referral. Although it was unknown

whether Mrs A had tachycardia,²⁵ her temperature was over 37.6°C, she was feeling very unwell, and was noted to be “very unwell” on her arrival at the public hospital.

Ms Waller also advised that it was reasonable for Ms E to leave the women’s assessment unit prior to Mrs A’s arrival, in order for her to undertake other duties at the hospital. Ms Waller notes that Ms E had ensured that the co-ordinator of the assessment unit was aware that Mrs A was arriving with pyrexia and needed reassessment.

While I accept the clinical aspects of Ms Waller’s advice (that Ms E’s clinical decisions were appropriate), I am concerned about the failure of Ms E to communicate directly with the Clinic staff on the morning of 9 January.

When Mrs A telephoned Ms E on the morning of 9 January, Mrs A was still under the direct care of the Clinic’s midwives, who had the most up-to-date clinical information about Mrs A. Ms E did not contact the Clinic in order to obtain their perspective on Mrs A’s clinical history and situation, and to assess the appropriateness of Mrs A’s mode of transport to the public hospital. Rather, she relied entirely on Mrs A’s account of her health in making her assessment that a referral to a specialist was warranted. As Mrs A’s LMC, Ms E had a responsibility to co-ordinate Mrs A’s care to ensure she received continuity of care from providers. In my view, best practice indicates that Ms E needed to obtain a full and accurate account of Mrs A’s recent history and current health status from the midwives at the Clinic. This would then have enabled Ms E to pass on any relevant information to the public hospital, assess the appropriateness of Mrs A’s mode of transport to the public hospital, and ensure that Mrs A’s needs were being attended to at the Clinic in the meantime.

I accept Ms E’s point that it would have made no difference to the outcome for Mrs A if she (Ms E) had discussed Mrs A with the Clinic midwives prior to referring Mrs A to the public hospital. However, there may be instances where the Clinic midwives do have information that could make a difference to the client’s outcome, and it is just as much the LMC’s responsibility to request this information, as it is the Clinic’s responsibility to offer it.

I do not accept Ms E’s submission that the urgency of the situation prevented her from doing so in this case. Ms E could still have arranged for Mrs A’s urgent transfer to the public hospital based on the information provided to her by Mrs A, and then spoken to a Clinic midwife to obtain any other relevant information, and ensure Mrs A’s immediate needs were being attended to.

While I am concerned by Ms E’s failure to contact the Clinic, there were mitigating factors which, in my view, reduce the seriousness of the omission. Ms E knew Mrs A was a nurse and an experienced mother, and that she would soon be thoroughly assessed at the public hospital. In these circumstances, I consider that Ms E’s failure to contact the Clinic for any further information does not warrant a breach finding, as it was likely that all the necessary information would be conveyed to the public

²⁵ Mrs A’s pulse was last taken at midnight on the night of 8 January (her pulse was normal at this time).

hospital staff (by Mrs A and Ms E), and if anything was missed, it would most likely have been discovered during her assessment at the public hospital.

Documentation/care plans

I note that the Primary Maternity Services Notice (2007) requires the LMC to review and update the woman's care plan²⁶ and ensure that the respective responsibilities of the LMC and the maternity facility are clearly documented in the care plan.²⁷ The LMC is also required to ensure that the postnatal maternity facility has a copy of the care plan.²⁸ I also note that the Clinic's documentation policy requires the woman's LMC to document a postnatal care plan prior to handing the woman over to a staff midwife.

Ms E does not appear to have documented a care plan for Mrs A's postnatal care or made any formalised arrangements with the Clinic regarding the circumstances in which she should be contacted. However, I acknowledge that both Ms E and the Clinic accept that the Clinic staff are responsible for informing the LMC about any concerns about the women in their care.

Ms Waller has also commented on the lack of any documented plan as to who would be responsible for reviewing and discharging Mrs A from the Clinic on 9 January (Ms E or the Clinic midwives).

However, in view of the "collegiality and collaboration" between the LMC and the Clinic regarding discharge (as described by Ms E), Ms Waller considers it was reasonable for Ms E to simply document that Mrs A's discharge on 9 January would be "reviewed".

It was inadequate, however, for Ms E not to document evidence of any discussion or agreement reached between herself and the public hospital about her role as the primary practitioner once Mrs A was readmitted to the public hospital (required pursuant to the Referral Guidelines and the New Zealand College of Midwives Transfer Guidelines).

It is accepted that the care provided to Mrs A while she was in HDU and ICU at the public hospital was outside Ms E's scope of practice, and that responsibility for her clinical care had transferred to the public hospital. However, Ms E was still required to discuss with Mrs A and the public hospital any ongoing responsibility and role she would have in Mrs A's care, including a discussion about the timing of Mrs A's transfer back to her. While this discussion may have occurred, and it is clear from the clinical records that Ms E was involved in Mrs A's on-going care, it was not formally documented. I agree with Ms Waller's advice that:

“[c]lear documentation of ongoing clinical responsibility and role of the primary practitioner ensures seamless transition of care for women accessing maternity care”.

²⁶ DA29 (1)(a), Primary Maternity Services Notice (2007).

²⁷ DA29 (3)(b), Primary Maternity Services Notice (2007).

²⁸ DA29 (3)(b), Primary Maternity Services Notice (2007).

Ms Waller has also pointed out that Ms E's documentation did not always include the time she wrote the entry. I am particularly concerned about Ms E's entry on 9 January regarding Mrs A's transfer from the Clinic to the public hospital, which is untimed and appears to have been written retrospectively. Ms Waller has commented:

“[Ms E's] documentation lacks the inclusion of time at every episode of care. The need for transfer is an important clinical decision and a thorough documentation needs to occur regarding the discussion and the decisions made in relation to transfer. It is unclear whether some of the documentation by [Ms E] is in retrospect. This is appropriate but needs to be stated as being retrospective.”

Ms Waller further advised:

“Though lack of inclusion of time would not have any impact on care provided to [Mrs A], it has a potential to raise doubt on whether the documentation by [Ms E] was contemporaneous. Best practice is to ensure that such doubts do not arise regarding provision of care. Retrospective documentation is appropriate but this should include the time when it is being written with rationale for why it is being documented retrospectively.”

Summary

I am satisfied that Ms E provided Mrs A with an appropriate standard of care in terms of communication and co-ordination of care. While I consider it would be best practice for an LMC to obtain a full and accurate account of their client's recent history and current health status from the staff midwives when arranging a client's transfer from a maternity centre to hospital, I do not consider Ms E's failure to do so amounts to a breach of the Code, especially in light of the fact that Ms E knew Mrs A had been a nurse, and was an experienced mother. In these circumstances, I consider that Ms E responded appropriately.

However, I am not satisfied that Ms E's documentation was adequate. She did not document a care plan for Mrs A's postnatal care, nor the arrangements she put in place with the public hospital regarding various roles and responsibilities. She also failed to record the time when documenting the care she provided Mrs A. These omissions amount to a departure from professional standards. Accordingly, Ms E breached Right 4(2) of the Code.

Opinion: Breach — Ms D

As a midwife, Ms D is required to provide care with reasonable care and skill. This includes collating and documenting comprehensive assessments of the woman's health and well-being,²⁹ and ensuring that no action or omission on her part places the woman at risk.³⁰

Ms Waller is critical of the failure to undertake full maternal assessments³¹ on Mrs A on the morning of 9 January. Ms Waller noted two occasions in particular (both during Ms D's shift) where it would have been appropriate to carry these out. The first occasion was at 9am, when Mrs A complained of feeling dizzy. Ms Waller considers that it would have been appropriate to have taken Mrs A's vital signs at this stage, especially in light of Mrs A's history of pyrexia. The second occasion was at 11am when Mrs A was noted to be feeling "very unwell".

Ms Waller has considered Ms D's explanation that she did not think it was necessary to take Mrs A's vital signs or carry out a maternal assessment as Mrs A "appeared to be coping well, she was up and about, chatting and feeding her baby with ease, and happy waiting for her husband to pick her up, there was no urgency and she walked out with her family".

If this was the case, and Mrs A did not appear unwell, then Ms Waller advises that it was reasonable for Ms D not to have undertaken maternal assessments during her shift on 9 January. However, if Mrs A was unwell then Ms D had a responsibility to undertake a full assessment of Mrs A prior to her transfer to the public hospital, unless it was such an emergency that there was not time to carry out such an assessment.

Unfortunately, Ms D has documented only Mrs A's comments (that she felt "very unwell"), not her own observations. This is in contravention of the Clinic's documentation policy, and a good example of why it is so important to keep full records and document not only what is said by the patient, but also what is seen by the practitioner.

While it is impossible to know definitively what Mrs A's condition was prior to leaving the Clinic, I am assisted by observations made by DHB staff on Mrs A's arrival at the public hospital at midday, shortly after her departure from the Clinic ("Very unwell on arrival ... [low] blood pressure"), and her presenting symptoms of faintness, abdominal cramps, and fever. As Ms Waller has commented, this, together with the lack of clear documentation from the Clinic about Mrs A's condition, does create "some doubt regarding how well Mrs A was on 9th January when she left [the Clinic] for assessment at the public hospital". I am also assisted by Ms D's notes that Mrs A felt very unwell, and Mr A's recollection of his wife's condition when he arrived at the Clinic to pick her up (that she was moving very slowly and was the weakest he had ever seen her).

²⁹ New Zealand College of Midwives Standards of Practice.

³⁰ New Zealand College of Midwives Code of Ethics.

³¹ Ms Waller advised that a full maternal assessment includes a "top to toe" assessment, which is undertaken to exclude causes of pyrexia.

I also note that Ms D's recollection of seeing Mrs A walk out of the Clinic with her family is at odds with Ms B's advice (that staff were not aware of Mrs A's departure). While this is not evidence that Ms D's recollection is incorrect, it does cause me to question the accuracy of information provided about Mrs A's well-being on her departure.

Taking all of the above into account, I am of the opinion that Mrs A was not well prior to her departure and, accordingly, it was unreasonable for Ms D not to have carried out a maternal assessment on Mrs A.

While the assessment would not have changed the overall outcome for Mrs A (as she had already arranged transfer to the public hospital, where she would undergo a thorough review), an abnormal finding would have enabled staff to discuss again with Mrs A her mode of transport to the public hospital by private vehicle. Alternatively, if the assessment had found no abnormalities, it would have reassured staff that it was appropriate for Mrs A to go to hospital in her own transport.

In any event, regardless of Mrs A's state of well-being when leaving the Clinic, Ms D was required to recommend to Mrs A (in accordance with the Clinic's "Transfers Out" policy) that she go by ambulance to the public hospital. Ms D should have documented this recommendation, together with Mrs A's decision to go by private vehicle, and her reasons why. However, the only documentation regarding Mrs A's transport to the public hospital was Ms D's comment that Mrs A was "[a]waiting husband to pick her up".

Consultation with LMC — transfer to the public hospital

Ms B explained that care provided at a primary birth centre is decided in a three-way process involving the patient, her LMC, and the staff midwife. However, as Ms Waller noted, this was not evident on the morning of 9 January when Mrs A transferred to the public hospital.

While it is unclear whether Mrs A called Ms E at 10.45am on 9 January because she chose to do so, or because she was told she should by Ms D, the fact remains that the decision for Mrs A to be discharged from the Clinic and transferred to the public hospital for further assessment was a decision made between Mrs A and Ms E, without any input from Ms D.

While it is accepted that the LMC has primary responsibility to co-ordinate the woman's care, and that women can raise any concerns directly with their LMC, Ms D was also responsible for Mrs A, and had a duty to ensure that Mrs A received continuity of care.

Accordingly, Ms D had a responsibility to contact Ms E at 11am (once it became apparent that Mrs A had consulted Ms E and arranged transfer to the public hospital) and discuss Mrs A's transfer to the public hospital. This would have enabled important information to be conveyed to Ms E, including Ms D's perspective on Mrs A's clinical history and condition, and the appropriateness of transport to hospital by private vehicle. Such consultation ensures that everyone is "on the same page" so to speak, and allows for a "seamless transition of care" between the Clinic and the LMC.

Summary

Ms D did not provide Mrs A with an appropriate standard of care. By failing to monitor and assess Mrs A during her shift, failing to consult Ms E about Mrs A's transfer to the public hospital, and failing to keep detailed and accurate notes (about Mrs A's condition and discussions around transport arrangements) her services did not meet professional standards or ensure continuity of care for Mrs A. Accordingly, Ms D breached Rights 4(1), 4(2) and 4(5) of the Code.

Opinion: Breach — the Clinic

Mrs A had the right to expect that the Clinic and its staff would provide reasonable care in accordance with professional standards. She had the right to expect that she would be monitored and assessed appropriately, and that her LMC would be kept informed, and consulted if required. This was not the case, and the Clinic must also take responsibility for this.

7 January 2008–8 January 2008

Mrs A was noted to be suffering from “afterpains”, and Synflex was charted to be taken every six hours to relieve her pain. There is no record of Mrs A complaining of stomach pain. However, Ms Waller has advised that even if Mrs A was suffering from stomach pain, the management would have been the same in this early post-partum stage,³² unless the pain was agonising and there was no relief from Synflex.

Mrs A alleges that the pain was “agonising” and she was not getting relief from the Synflex; however, this is not reflected in her clinical notes. Ms F noted that it was “effective”.

Ms Waller explained that she could only comment on what is documented, and she considers that, from the documentation available, the care provided by staff at the Clinic from 7 January 2008 to midnight on the night of 8 January 2008 was appropriate. I accept this advice.

9 January 2008 — management of pyrexia

At 12.30am on 9 January, Mrs A had an elevated temperature (38.6°C), and had earlier (midnight) been complaining of feeling “hot and cold, shivers ++”. The Clinic protocols at the time did not call for any further investigations or action to be taken in response to these symptoms. Further investigations would be required only if Mrs A's temperature was above 38°C “on any two consecutive days of the first 10 days post-partum”, or above 38.6°C in the first 24 hours post-partum. According to Ms B, she had planned to observe Mrs A closely over the next hour.

³² Although the management for stomach and uterine pain is the same in the early post-partum stage, Ms Waller advised that it is still necessary to differentiate stomach pain from uterine or abdominal pain.

Mrs A's temperature was taken again at 1.20am (37.8°C) and, after having a discussion with Mrs A, Ms C assumed that the elevated temperature was due to Mrs A's milk coming in. Ms C took Mrs A's temperature again at 4.40am (37.7°C) and 5.15am (36.6°C). Given the continued reduction in temperature, and the fact that it had returned to normal by 5.15am, Ms Waller has commented that these readings "would have reassured staff that the pyrexia was due to milk coming in rather than infection". I note, however, that Mrs A was also given various medications during this time (Panadol at 12am, a sleeping tablet at 2am, Synflex at 4.40am, and Panadol at 5.15am), and the Synflex and Panadol could potentially have helped to bring down her temperature and could have masked an infection. There is no evidence that this was considered.

Referral Guidelines

While Ms B and Ms C correctly followed the Clinic's protocol in response to Mrs A's elevated temperature, the protocol was not in line with the national Referral Guidelines. The Clinic is directly liable for failing to have a protocol for dealing with elevated temperatures/pyrexia that was consistent with national Referral Guidelines.

The Referral Guidelines recommend a level two referral (the LMC must recommend to the woman that a consultation with a specialist is warranted) where the woman has "pyrexia of unknown origin with rigors or shock" or where the woman's temperature is greater than 37.5°C — both of which Mrs A had.

The Referral Guidelines also required the staff at the Clinic to discuss with Mrs A why a decision not to consult a specialist was made in these circumstances. There is no evidence that any of the staff at the Clinic gave any consideration as to whether consultation with a specialist was warranted in these circumstances (let alone discussed with Mrs A their reasons for deciding not to consult).

It is clear that the protocol for pyrexia that was being followed by the Clinic's staff at the time was out of line with the Referral Guidelines. Ms B advised HDC that at the time of these events she was not aware of this; however, she would consult with the DHB to bring the Clinic's protocols in line with the Referral Guidelines.

Consultation with LMC — pyrexia

The Clinic advised HDC that "[c]are provided at a primary birth centre is decided in a three-way process involving the patient, her LMC and the staff midwife". Yet, the only communication by the Clinic with Mrs A's LMC was on 8 January, when Ms E asked the staff whether Mrs A would be ready for discharge the following day.

Ms B explained to HDC that Ms E was not notified about Mrs A's pyrexia at the time (12.30am) as "staff might decide not to wake up an already overtired LMC to inform her about her client's health status unless the condition is serious".

I agree with Ms Waller that this practice is "reasonable and supportive of LMC practitioners". Accordingly, the decision not to contact Ms E at 12.30am about Mrs A's elevated temperature was appropriate. However, it was important that Ms E was notified about the raised temperature at some stage later that morning, even though

Mrs A's temperature had stabilised. This has been acknowledged and accepted by both Ms B and Ms C.

As discussed earlier, there was a failure by Ms D to consult Ms E about Mrs A's discharge from the Clinic and transfer to the public hospital on 9 January. I agree with Ms Waller's advice that the Clinic needs to review its guidelines to staff regarding circumstances when communication with LMCs needs to take place.

Transport to hospital

Both Mr and Mrs A recall being surprised that an ambulance was not offered to transport Mrs A from the Clinic to the public hospital. However, Ms E and the Clinic advised that while an ambulance was offered, Mrs A was adamant that her husband would pick her up. There is no documentation about this issue in Mrs A's notes from the Clinic. While Ms E's notes do confirm that she offered Mrs A the option of an ambulance, these notes appear to have been written retrospectively (but not annotated as such).

It is not possible to make a clear determination on this. I do note, however, Ms Waller's advice that an ambulance "would have been a better option if Mrs A was unwell" and, as I have previously indicated, I am persuaded by the evidence that Mrs A was not well at that time.

Breastfeeding

Mrs A claims that Ms B and another midwife were "trying desperately to latch the baby on my breast while I was having rigors". Ms B denies that she, nor any of the midwives, tried to latch the baby onto Mrs A's breast. She advised HDC that the decisions surrounding feeding the baby are discussed and agreed to between the mother and the midwife. She also notes that there was only one midwife caring for Mrs A at a time.

There is insufficient evidence on this point. Ms Waller notes that there is no record in Mrs A's notes of staff assisting Mrs A with breastfeeding. However, if this occurred, it would have needed to happen with Mrs A's consent. She advised that breastfeeding is not contraindicated in the presence of fever and rigors, and the encouragement of breastfeeding was appropriate.

Presence during departure

It is unclear from the conflicting information received whether anyone witnessed Mrs A depart the Clinic. However, Ms Waller has noted that Mrs A's departure from the Clinic was recorded as 12pm, yet her arrival at the public hospital is also recorded as midday.

I agree with Ms Waller's advice that:

"[t]hough staff may not always be aware of the exact departure time of each woman leaving the Clinic, when the woman appears unwell, it may be in the Clinic's best interest to be present when the woman departs from the facility".

Summary

Mrs A did not receive an appropriate standard of care from the Clinic. In particular, the Clinic is directly liable for failing to have a policy for managing elevated postnatal maternal temperatures in a manner consistent with national guidelines. It is also directly liable for not having clear policies about communication between LMCs and the Clinic staff midwives.

The Clinic is vicariously liable for the actions of its staff in failing to adequately consider, and discuss with Mrs A and her LMC, referral to specialist services, as it failed to take reasonable steps to ensure that an adequate policy was in place for staff to follow.

Accordingly, the Clinic breached Rights 4(1) and 4(2) of the Code.

Action taken

The Clinic

On 23 May 2010, the Clinic's CEO wrote a letter of apology to Mrs A. He apologised for breaching the Code of Rights and for not taking her concerns seriously. He advised Mrs A that the Clinic's policies and protocols had been reviewed and amended where necessary, and that staff training had been undertaken to ensure the policies are followed.

On 27 May 2010 the CEO provided HDC with information about the steps taken by the Clinic to improve its service in light of this complaint:

- The Clinic's protocol on puerperal infection was revised in May 2010 and is now in line with, and specifically refers to, the Referral Guidelines.³³ The revised protocol has been placed in the protocol folder and communication book, and LMCs have been informed about the changes in the LMC newsletter.
- In April 2010 the Clinic developed "Protocol Review Procedures". The purpose of this protocol is "to ensure that the organization operates and complies with legislation and best practice standards". It requires the Clinic's clinical protocols to be reviewed three yearly (or as soon as possible where legislative or best practice changes have occurred) to ensure clinical protocols comply with best practice and are in line with the Ministry of Health Referral Guidelines and, where appropriate, DHB protocols.

³³ The revised protocol states that the diagnostic criteria for puerperal infection is where the woman has an elevated temperature (over 37.6°C) and maternal tachycardia (referral guideline level 3) or an elevated temperature of unknown origin with rigors or shock (referral guideline level 2). The woman's temperature is to be taken hourly and, if it remains over 37.6°C on two occasions (without tachycardia or rigors) or if the woman is deteriorating, the staff member is to contact the woman's LMC and/or consult with the DHB, and arrange transfer to hospital if necessary.

- In April 2010 the Clinic developed a “Compliance Audit Plan”, which requires three types of compliance audits to be carried out (clinical, environmental, and service). The clinical compliance audit requires samples of 50–100 clinical notes to be audited every six months. The types of notes that will be audited include care plans, signatures, allergies, and drug charts.
- In August 2008 the Clinic amended its Admissions protocol, and staff/LMC manuals to clearly reflect the requirement for a three-way consultation to take place between the woman, the LMC, and the Clinic staff midwife when making decisions about the woman’s and baby’s care.
- At the next monthly meeting, staff will be reminded of the importance of keeping accurate and up-to-date documentation.

Ms E

On 20 June 2010 Ms E sent Mrs A a letter of apology. Ms E apologised to Mrs A and her family if the care she provided “fell short of [Mrs A’s] expectations”. Ms E wished Mrs A all the best for the future.

Ms E accepted, in her response to HDC’s provisional report, that she had “faulted in [her] documentation”. She advised that she now ensures that all her documentation “is done properly and accurately especially with the inclusion of times”. She also included with her response a certificate for attending a technical skills workshop in April 2010 covering the following topics: referral and consultations, documentation, legislation/standards and competencies, and assessment of labour.

Ms D

On 19 June 2010 Ms D sent Mrs A a letter of apology. Ms D apologised to Mrs A for not meeting professional standards, and for any delay in treatment that may have been caused by her omissions.

Ms D also advised that she is undertaking further education on documentation and record-keeping, and is attending an education session on the Code of Rights, Advocacy, and Informed Consent.³⁴

³⁴ Ms D enclosed copies of the following documents with her letter of apology: Certificate of Attendance (HDC workshop on informed consent, advocacy, and the Code of Rights); and details of the documentation workshop she will be attending.

Recommendations

The actions taken by the Clinic, Ms E, and Ms D have addressed many of the issues identified by this complaint. However, some issues remain outstanding. Accordingly I recommend that the Clinic:

- review its protocols to ensure staff are appropriately guided in the assessments and monitoring needed when there has been a deviation from normal in the woman's condition;
- ensure that a midwife is present on a woman's departure if she appears unwell or is thought to be unwell.

The Clinic is to report back to HDC by **8 October 2010** about the steps it has taken (with evidence where applicable) to meet the above recommendations.

I recommend that Ms D:

- review her practice in light of these findings, in particular her responsibility to monitor and assess women in her care.

Ms D is to report back to HDC by **8 October 2010** about the steps she has taken (with supporting evidence where applicable) to improve these aspects of her service.

Follow-up actions

- A copy of this report will be sent to the Midwifery Council of New Zealand and the Accident Compensation Corporation.
- A copy of this report, with details identifying the parties removed except the name of the Clinic and the expert who advised on this case, will be sent to the DHB.
- A copy of this report, with details identifying the parties removed except the expert who advised on this case, will be sent to the New Zealand College of Midwives, the Maternity Services Consumer Council, and the Federation of Women's Health Councils Aotearoa, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Expert advice from registered midwife Nimisha Waller

The following expert advice was obtained from registered midwife Nimisha Waller:

“I have been asked to provide an opinion to the Commissioner on case number 08/18402, and that I have read and agree to follow the Commissioner’s guidelines for Independent Advisors.

My qualifications are RN (includes General and Obstetrics), RM, ADM, Dip Ed (UK) and Master in Midwifery (VUW, 2006). I have been a midwife for 25 years, the last 13 years in New Zealand. I have worked in community and hospital tertiary settings as well as in education both here and in the UK. I am currently a Senior Lecturer in Midwifery at Auckland University of Technology, Midwifery Coordinator of the NZCOM Auckland Midwifery Resource Centre and take a small caseload of women as a Lead Maternity Carer. My caseload includes women who reside in the City, in semi rural areas and occasionally in rural areas.

The following sources of supporting information that were sent have been reviewed prior to the advice being given:

- Letter of complaint from [Mrs A], dated 4th November 2008. (Appendix A; pages 1–8)
- Information received from Midwife [Ms E]. (Appendix B; pages 9–36)
- Information received from [the Clinic]. (Appendix C; pages 37–58)
- Letter from [Mrs A] (replying to Providers’ responses) dated 2nd February 2009. (Appendix D; pages 59–69)
- Copy of clinical notes from [the] District Health Board, from 7–22 January 2008. (Appendix E; pages 70–149)

[At this point in her advice Ms Waller sets out the questions she has been asked to answer, and the background facts. I have omitted this information for the purpose of brevity.]

My response to the advice required is as follows:

Midwife [Ms E]

1) *Please comment generally on the standard of LMC care provided by [Ms E] to [Mrs A] from 7th January to 9th January 2008.*

[Mrs A’s] previous four pregnancies had been in [another country] with the first pregnancy in 1995 being a miscarriage at 12 weeks gestation. This was [Mrs A’s] fifth pregnancy and she gave birth to her fourth baby on 7th January 2008 at 2.51am at [the public hospital]. The expert advice is required on [Mrs A’s] care from 7th January once she returned to [the Clinic] following the birth of her baby to her re-admission at the public hospital on 9th January feeling unwell.

Following [Mrs A's] admission back to [the Clinic] on the 7th January 2008 at 4.40am, [Ms E] visited [Mrs A] on the 8th January 2008 for a postnatal visit. There is no time documented of the visit but it must have been before 12pm as other practitioners have documented after 12pm. During this visit by the LMC [Ms E], [Mrs A] was thinking of giving the baby formula. [Mrs A] was reassured that breast feeding is best. The documentation states that [Mrs A] knows this as an experienced mother but she is too sore and has had lack of sleep etc. Obstetrically and postnatally [Mrs A] was well. The baby was slightly jaundiced and [Mrs A] was advised to 'sun' the baby and breast feed 3 hourly. It is documented that the baby was active and alert.

[Mrs A] at this time also made a request to the LMC a wish to go home after lunch in the morning of the 9th January. This was discussed by the LMC with staff midwife on the floor and the decision was to review next morning as [Mrs A] had not slept well the night of the 7th January due to the baby being unsettled and she required pain relief frequently. [Ms E's] visit on the 8th January was appropriate.

There is no documented plan of who would be responsible for reviewing and discharging [Mrs A] on the morning of the 9th January — whether this would be the LMC or the midwives at [the Clinic]. In the documentation there also appears to be no plan of when the LMC should be contacted by [the Clinic] or [Mrs A] if there was concern about [Mrs A] or her baby. Formulation of such plan can enable a seamless service for the woman when accessing care from the LMC as well as the facility. Such plan may have been in place between [Ms E] and the facility but since [the Clinic] did not contact the LMC on the 9th January it leaves one wondering if it existed.

The next contact [Ms E] had with [Mrs A] appears to be a phone call from [Mrs A] at 10.45 on the morning of the 9th January 2008. She was informed by [Mrs A] that her temperature had been up to 38 degrees Celsius twice in the night. [Ms E] suggested that [Mrs A] required a review by the team at the public hospital. At this time [Ms E] was on [a] ward at the public hospital. [Mrs A] was informed by [Ms E] that she would contact her once she had liaised with the doctor.

[Mrs A] states that she was asked by [Ms E] to inform her husband to bring her to the hospital. However, [Ms E] (page 9) states that she mentioned to [Mrs A] that she would ask [the Clinic] staff to call an ambulance to transport her to Women's Assessment Unit (WAU) in the delivery suite but [Mrs A] responded that she wanted [her husband] to bring her over to the delivery suite at the public hospital. [Ms E] then tried to liaise with the registrar who was in theatre and therefore consulted with the coordinator of the WAU and informed her to expect [Mrs A] who was two days postnatal and had a temperature of over 38 degrees Celsius. At 12.10pm [Ms E] rang [the Clinic] to ask for [Mrs A]. A staff midwife informed her that [Mrs A] had left [the Clinic] and was on her way to the public hospital. [Ms E] then rang [Mrs A's] cell phone but did

not get a response. [Ms E] apparently waited in WAU till 12.10hrs. When [Mrs A] did not arrive she went to do her work.

[Ms E] states “this was a clear case of Level 3 referral and there wasn’t much she could do other than refer her as soon as possible to the delivery suite. It was outside my scope of practice”.

The MOH (2007) Referral guidelines state: ‘Puerperal sepsis temp >37.6, maternal tachycardia’ (Code 7006) as a Level 3 referral. This means that the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist given that her labour and birth may be affected by the outcome. The decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the LMC and the woman concerned. In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner (LMC) will be agreed between those involved. This should include discussion about timing of transfer back to the LMC.

[Mrs A’s] temperature was over 37.6 degrees Celsius however there was no monitoring of maternal pulse apart from the initial one at midnight which was 88bpm. It was therefore not evident whether [Mrs A] had tachycardia. However, it was reasonable to assume that this was a Level 3 referral. [Mrs A] was feeling unwell that morning and collapsed on her admission to the public hospital. There is no documentation by [Ms E] of the discussion of the role of the primary practitioner in caring for [Mrs A] once she was readmitted to the public hospital. [Ms E] states that the care of [Mrs A] was outside her scope of practice as [Mrs A] required care in HDU and ICU; this is true. Once [Mrs A] was out of HDU and ICU care, midwifery care could be transferred to the LMC following a three way discussion between the specialist, the woman and the LMC.

The public hospital documentation shows that [Mrs A] arrived in Woman’s Assessment Unit (WAU) on 9th January at 12pm. [Mrs A] appeared to be very unwell on arrival. Her blood pressure on admission was 70/50. There were no abdominal cramps, fainting or fever. [Ms Waller later amended this statement — please see annexure at end of advice.] The history given by [Mrs A] at the time of admission was of abdominal pain for a couple of days, diarrhoea for one day, vomiting for one day and fever for one day — there has been no documentation of diarrhoea and vomiting in [the Clinic] notes. Bloods were taken following insertion of the luer. The diagnosis from blood cultures done showed Group A Streptococcal infection.

The public hospital clinical records show that at 4.20pm [Ms E] received a call from WAU that [Mrs A] had been admitted and was unwell. The doctors were assessing her at this point. [Ms E] then looked after [Mrs A’s] three children under five years old until she handed over their care to [the staff nurse] who was to look after them before [Mrs A’s husband] arrived. [Ms E] continued to visit [Mrs A] at the public hospital following this admission.

Should [Ms E] have stayed in WAU until [Mrs A's] arrival?

[Ms E] left WAU at 12pm. [Ms E] and [Mrs A], who arrived at WAU at 12pm, must have just missed each other. [Ms E] had co-ordinated the care and ensured that the Co-ordinator of the WAU was aware that [Mrs A] was going to arrive with pyrexia and needed reassessment. [Ms E] therefore leaving WAU to undertake her other commitments is reasonable. Ideally there should be a three way discussion between the woman, the LMC and secondary care regarding ongoing clinical responsibility and care and this should be clearly documented in clinical records. The secondary service would then contact the LMC to inform her of the admission. This is what occurred when the public hospital contacted [Ms E] at 4.20pm.

If not covered above, please answer the following questions:

- 1) *Did [Ms E] respond appropriately to the information she received from [Mrs A], about her medical condition?***

[Ms E's] plan to have [Mrs A] reassessed at the public hospital was appropriate.

- 2) *Was [Ms E] correct in her assertion that 'This was a clear case of level three referral and there wasn't much I could do other than refer her as soon as possible to the Delivery Suite'.***

See above.

[The Clinic]

- 1) *Please comment generally on the standard of care provided by [the Clinic] to [Mrs A] from 7th January to 9th January 2008.***

[At this point in her advice Ms Waller sets out background facts. This information has been omitted for the purpose of brevity.]

The development of the temperature from midnight on 9th January 2008 was assumed by staff at [the Clinic] to be from the milk coming in and by [Mrs A] from exhaustion. When the temperature had increased from 37.6 degrees Celsius (midnight) to 38.6 degrees Celsius (12.30am) the plan was to observe [Mrs A] closely over the next hour. Her temperature an hour later did reduce to 37.8 degrees Celsius and remained at similar level at 4.40am (37.7 degrees Celsius) finally returning to normal at 5.15am (36.6 degrees Celsius). This would have reassured the staff that the pyrexia was due to milk coming in rather than infection.

The maternal pulse had been taken at midnight (88bpm — which is normal) but there was no follow up on maternal pulse subsequently. The rise or fall in the maternal pulse is of great importance as it indicates excitement, anxiety, fatigue, excessive blood loss, infection or underlying cardiac problems. As maternal pulse was not assessed following an initial assessment at midnight it

could be interpreted as lack of full maternal assessment in presence of unknown pyrexia.

[Mrs A] feeling sick, having uterine cramps and having a bowel motion has been documented at 5.15am. The uterus was palpated and was found to be well contracted. The vaginal loss was normal. The maternal temperature was 36.6 degrees Celsius. This would have reassured the staff that [Mrs A's] condition was improving though she was exhausted from lack of sleep. Though uterine cramps and having a bowel motion on 3rd day postpartum could be seen as normal there appears to be a lack of fuller documentation around [Mrs A's] complaint of feeling sick and the subsequent plan relating to this. If [Mrs A] did request for her bowel motion to be seen as she was concerned, then this needed to be documented.

[Mrs A] called the staff at 9am feeling dizzy but hungry so breakfast was given. This was an opportunity to undertake a full assessment of [Mrs A] as she was feeling dizzy and had pyrexia overnight. At 11am it is charted that "has contacted [x] for referral to hospital doctors as she is feeling very unwell". Baby was just waking and [Mrs A] was helped by [Ms D] to a shower. Following shower [Mrs A] fed the baby and was awaiting her husband to pick her up.

I am not sure what "[x]" means or if this is the other name for [Ms E] as [Mrs A] had called [Ms E]. As it is documented that [Mrs A] was feeling very unwell a full maternal assessment needed to occur including the monitoring of the vital signs that is temperature, pulse and blood pressure. The findings from this assessment would have enabled the staff to re-discuss [Mrs A's] decision to go to the public hospital in her own transport. The maternal assessment findings may have been normal at this stage but undertaking them would have reassured [Mrs A] that staff at [the Clinic] had not been complacent. It would have also reassured the staff that [Mrs A's] plan to go in her own transport was appropriate. [The Clinic] was still responsible for providing midwifery care to [Mrs A] as the LMC was on [a] Ward of the public hospital.

The care provided to [Mrs A] from midnight on 9th January to her discharge approximately before 12pm to go to the public hospital is not reasonable. Not undertaking full maternal assessments during the night and particularly prior to discharge to the public hospital for reassessment when [Mrs A] was pyrexial overnight and was still feeling dizzy and unwell can be viewed by peers with moderate disapproval.

The MOH (2007) Referral guidelines state: 'Pyrexia of unknown origin with rigors or shock' (Code 7007) as a Level 2 referral. This means that the LMC must recommend to the woman (or parents in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should

include discussion on any need for and timing of specialist review. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.

Since [Mrs A] was at [the Clinic], the staff needed to discuss with [Mrs A] or the LMC why a decision not to consult regarding her pyrexia was made. The LMC [Ms E] also needed to be informed of [Mrs A's] pyrexia at the earliest opportunity that had been negotiated between the LMC and the facility.

If not answered above, please answer the following questions:

1) Did staff at [the Clinic] appropriately monitor [Mrs A's] clinical signs?

Though the temperature was monitored regularly there was lack of monitoring of the maternal pulse after midnight on 9th January 2008. There was no monitoring of the vital signs or full assessment of [Mrs A] when she was feeling dizzy as well as unwell prior to her discharge and reassessment of pyrexia at the public hospital.

2) Did staff at [the Clinic] appropriately monitor and manage [Mrs A's] pain?

With hindsight it is easy to say that the pain [Mrs A] was having required further evaluation. However, the diagnosis of Group A Streptococcal infection was not evident between 7th January and 9th January 2008 while [Mrs A] was at [the Clinic]. Group A Streptococcal infection is not a common infection postpartum though I understand it is on the increase. The pain was also being described as being uterine and uterine cramps are common in women who have second and subsequent babies. There are comments in the documentation that Synflex provided some relief. The management of pain is therefore reasonable.

The decision not to give [Mrs A] Apo-zopiclone 7.5mg until further reflection/discussion is appropriate.

3) Did staff at [the Clinic] conduct appropriate investigations into the cause of [Mrs A's] illness?

[Mrs A's] uterus was palpated to ensure it was well contracted and her vaginal loss was checked to ensure it was not offensive. There is no documentation of whether [Mrs A] was asked for any symptoms of urinary tract infections or other infections that could have contributed to her pyrexia. Usually a top to toe assessment is undertaken to exclude other causes of pyrexia. As the temperature was reducing this would have reassured the staff not to undertake a midstream urine sample, a high vaginal swab or consult with the team at the public hospital. Blood cultures are usually done in consultation with secondary/tertiary services, though [the Clinic] could have done them prior to transfer. However, [Mrs A's] temperature had earlier been normal at 36.6 degrees Celsius.

4) *Did staff at [the Clinic] communicate in an appropriate and timely way with [Mrs A's] LMC ([Ms E])?*

The only communication documented is when [Ms E] (LMC) asked the staff at [the Clinic] on 8th January whether [Mrs A] would be ready for discharge on the morning of the 9th January 2008.

There has been no documentation of any other communication between [the Clinic] and [Ms E]. As [Mrs A's] temperature was high in the early morning of the 9th January one would have expected [the Clinic] staff to inform the LMC [Ms E] of this occurrence at the earliest opportunity so that the LMC could come and review [Mrs A] and develop an appropriate plan of care.

[Mrs A] called her midwife as she was told by [the Clinic] staff to contact the LMC when she had asked to see her GP. The process of the communication that needs to occur between the facility and LMC appears to be unclear from this documentation.

Note: See also question 11.

5) *Was it appropriate for staff at [the Clinic] to encourage breast feeding when [Mrs A] had a fever and rigors?*

Breast feeding is not contraindicated in presence of fever and rigors. However, if the woman is feeling unwell then breast milk can be expressed by use of breast pump. The baby can then be offered expressed breast milk while the mother recovers from fever and rigors. If the fever and rigors is due to milk coming in then breast feeding or expressing would enable the breast to empty and help to reduce the fever. Encouragement of breast feeding was appropriate unless the woman decides to formula feed or top the baby up with formula.

[Mrs A] states that [Ms B] and another midwife on duty that night were holding [Mrs A's] baby to the breast to latch on while [Mrs A] was shaking. [Mrs A] found this appalling as she felt it was impossible to breast feed under such distress. They finally offered baby formula. There is no documentation of assisting [Mrs A] with breast feeding. However, if this was the case then it needed to occur with [Mrs A's] consent.

6) *Was it appropriate for staff at [the Clinic] to allow [Mrs A] to transfer to [the public] Hospital in a private vehicle, with her husband?*

As it is documented at 11am on 9th January that [Mrs A] was very unwell then a review of the decision made by [Mrs A] to travel to the public hospital in her own transport needed to occur. Undertaking the assessment of [Mrs A] including the vital signs would have given an opportunity to re-discuss the mode of transport with [Mrs A]. If the observations were satisfactory then it would have reassured the staff that [Mrs A's] decision to use her own transport was appropriate. Ambulance would have been a better option if [Mrs A] was unwell.

7) ***Are there any aspects of the care provided by [the Clinic] or [Ms E] that you consider warrant additional comment?***

[Ms B] in her letter on 4th April 2008 (p49) states that “Care provided at primary birth centre is decided in three way process involving the patient, her LMC and the staff midwife”. This is evident in relation to [Mrs A] wanting to go home on morning of 9th January but not when [Mrs A] was unwell and was going to the public hospital for assessment.

Apparently [Mrs A] made a request to see her own doctor. However, she was informed that she needed to contact her midwife and inform her of her condition. [Mrs A] was surprised as she felt that there would be team work between her midwife and [the Clinic]. The seamless transition of care between [the Clinic] and the LMC were not evident within the documentation in this instance.

On Page 69 [Ms B] has commented that [Mrs A] left [the Clinic] at approximately 12pm. However, the public hospital clinical records state that [Mrs A] was admitted to the public hospital at 12pm. Though staff may not always be aware of the exact departure time of each woman leaving [the Clinic] when the woman appears unwell it may be in [the Clinic’s] best interest to be present when the woman departs from the facility.

[Ms E’s] documentation lacks the inclusion of time at every episode of care. The need for transfer is an important clinical decision and a thorough documentation needs to occur regarding the discussion and the decisions made in relation to transfer. It is unclear whether some of the documentation by [Ms E] is in retrospect. This is appropriate but needs to be stated as being retrospective.

Do you recommend that any changes be made to [Ms E’s] practice, or any improvements be made to [the Clinic’s] services, in light of this incident?

[Ms E] needs to ensure that a clear plan is in place of when the facility or the woman should contact her. For example would she have liked the facility to inform her of [Mrs A’s] pyrexia during the night or first thing the following morning? This may have been in place but was not evident within the documentation.

[The Clinic], with the LMCs that use their facility, needs to review when would be the appropriate time to contact the LMC to inform of any change in the woman or baby’s condition as well as who should contact the LMC. Ideally it should be [the Clinic] staff and not the woman when she is in the facility, unless the woman prefers to do this which is what is said by [the Clinic] staff.

[The Clinic] staff need to update and reflect on the appropriateness of full assessments that need to be undertaken when there is deviation from normal in the woman’s condition. These are basic assessments that should be part of the practitioner’s care.

References:

MOH (2007) *Guidelines for consultation with Obstetric and related specialist medical services (referral guidelines)*. Ministry of Health. July.

New Zealand College of Midwives (2005) *Handbook for Practice*. NZCOM. Christchurch.”

On 12 October 2009 Ms Waller provided the following further expert advice:

“I have been asked to provide further advice to the Commissioner on case number 08/18402. I have read and agree to follow the Commissioner’s guidelines for Independent Advisors.

[At this point in her advice Ms Waller sets out her qualifications and experience. This information has been omitted for the purpose of brevity.]

The following sources of further information that were emailed have been reviewed prior to the advice being given:

- Response from [Ms D] dated 13th September 2009
- Response from [Ms E] dated 15th September 2009
- Response from [Ms B] as clinical manager of [the Clinic] dated 10th September 2009
- Two responses from [Ms C] — one dated 13th September 2009 and other received at the HDC office on 17th September 2009.

Thank you for giving me the opportunity to comment further and my response to the advice required is as follows:

[Ms E]

1. No documented plan of who would be responsible for reviewing & discharging [Mrs A] on 9 January

[Ms E] states in her response of the 15th September 2009 that prior to this case there has been collegiality and collaboration between LMCs who have access to [the Clinic] and the staff of [the Clinic] regarding discharge at 48 hours from the facility or any concerns regarding the woman and her baby. In view of this, documenting that [Mrs A’s] discharge on the 9th January would be reviewed is reasonable. Either party i.e. [the Clinic] staff or the LMC in discussion with each other would have planned [Mrs A’s] discharge from the facility at 48 hours.

2. No documented plan of when the LMC should be contacted by [the Clinic] or [Mrs A] if concern about [Mrs A]/baby

The Clinical Manager [Ms B’s] response of the 10th September 2009 states that [the Clinic] staff may not disturb the LMC midwife in the night to inform her about the woman’s health status unless the condition is serious. This is reasonable and supportive of LMC practitioners that have access to the facility. Usually if the health status improves i.e. in this case the temperature returning to normal (36.6 degrees Celsius) the information is conveyed to the

LMC in the morning or when she next visits the woman (varies across primary units).

[Ms C] says in her response that it would have been appropriate to have done it in the morning (9th January) but not sure if this was discussed at the handover. This raises the question of what is standard practice regarding informing LMC of the change of health status of the woman or baby when in [the Clinic] and is this practice clear to all LMCs that have access to this facility and [the Clinic] staff? If this information is clear to all concerned then there was no need for the LMC to document a plan regarding when she should be contacted. Documentation of a plan or having a standard understanding of when each party should contact each other would help to reduce the perception that care was not collaborative/seamless.

3. *No documentation of discussion of the role of the primary practitioner in caring for [Mrs A] once she was readmitted to the public hospital*

MOH (2007) Section 88 states:

Level 3

‘The Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *The decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned.* In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.’

As stated in my initial report [Ms E], following a phone call from [Mrs A] had organised review of [Mrs A] at the public hospital with WAU Co-ordinator because of [Mrs A’s] high temperature. So there was a three way conversation between [Ms E], the secondary services and [Mrs A] regarding the admission.

On admission [Mrs A] collapsed and needed admission to HDU and ICU, so her care would have been considered to be a Level 3 referral as [Ms E] has stated. The discussion of the role of the primary practitioner does need to be agreed between the public hospital and the LMC. [Ms E] may have discussed the role of the primary practitioner when she organised [Mrs A’s] review with the WAU Co-ordinator but this is not documented. Though in most instances of Level 3 referral the specialist will assume ongoing responsibility, the role of the primary practitioner needs to be agreed and one can’t assume that secondary care has accepted that role/responsibility. Clear documentation of ongoing clinical responsibility and role of the primary practitioner ensures seamless transition of care for women accessing maternity care.

4. *No documentation of three way discussion between [Mrs A], [Ms E] and secondary care regarding ongoing clinical responsibility and care of [Mrs A]*

See above number 3.

5. *Lack of documentation of time in her notes*

[Ms E] has not commented in her response of 15th September 2009 on why she has not included/written the time when documenting the care provided to [Mrs A]. Though lack of inclusion of time would not have any impact on care provided to [Mrs A] it has a potential to raise doubt on whether the documentation by [Ms E] was contemporaneous. Best practice is to ensure that such doubts do not arise regarding provision of care. Retrospective documentation is appropriate but this should include the time when it is being written with rationale for why it is being documented retrospectively.

[The Clinic]

1. *Failure to assess maternal pulse after midnight on 9th January*

[Ms C's] response on 13th September 2009 states that she provided care to [Mrs A] from 1am to 7am on 9th January 2008.

[Ms C] further states that her normal practice is to take the maternal temperature and pulse at the same time and that she can provide no explanation of why she did not do this at the time of caring for [Mrs A]. She apologises in case this has delayed [Mrs A's] treatment in any way. It is debatable whether the knowledge of the maternal pulse may have altered the management of [Mrs A's] care at that time but it would have reassured [Mrs A] that the full assessment had been undertaken and the staff had not been complacent.

2. *Failure to undertake a full maternal assessment of [Mrs A] at 9am and 11am on 9 January*

See below re [Ms D's] response and my advice.

3. *Failure to discuss with [Mrs A] or [Ms E] why the decision was made not to discuss a specialist regarding her pyrexia*

The Clinical Manager [Ms B's] response of the 10th September 2009 states that their protocols are in line with [the] DHB which suggests referral when temperature is over 38 degrees Celsius. [Ms B] further comments that she had not realised that they were not in line with MOH guidelines and she will consult with the public hospital staff to bring protocols in line. My understanding is that there are practitioners and DHBs who feel there is a need to review the MOH (2007) referral guidelines however, at present these are the guidelines available for consultation with obstetrics and related medical specialist service until such time as when they are reviewed.

See also Number 2 under '[Ms E]'.

4. *Failure to advise [Ms E] at the earliest opportunity about [Mrs A's] pyrexia*

See above Number 3 and also Number 2 under '[Ms E]'.

5. Failure to document/ask [Mrs A] about other symptoms that may have contributed to her pyrexia

[Ms C] responds that [Mrs A's] explanation of the high temperature was related to her exhaustion and the milk coming in and she did not appear unwell. She did empty her breast by expressing and was not in respiratory distress at the time.

As stated in my initial report [Ms C] had checked the uterus to ensure it was well contracted and lochia to ensure that it was not offensive. [Mrs A] not appearing unwell and her explanation that her high temperature was related to her exhaustion and milk coming in (as this had apparently happened in her previous postpartum period) would have reassured [Ms C] that pyrexia was related to exhaustion and the milk coming in.

The maternal temperature decreasing would have further reassured [Ms C] not to undertake a midstream urine sample, a high vaginal swab or consult with the team at the public hospital. In view of [Mrs A] not appearing unwell the assessments undertaken by [Ms C] are reasonable.

6. Failure to take blood cultures prior to transfer to the public hospital

In my initial report I state that 'blood cultures are usually done in consultation with secondary/tertiary services, though [the Clinic] could have done them prior to transfer. However, [Mrs A's] temperature had earlier been normal at 36.6 degrees Celsius'.

The time to do the blood cultures was at 12.30am on 9th January 2008 when the temperature was 38.6 degrees Celsius. However, the plan was to monitor [Mrs A] over the next hour. An hour later the temperature had come down to 37.7 degrees Celsius. As the temperature was decreasing it was reasonable not to have taken blood cultures prior to transfer to the public hospital. From my memory of the Clinical records sent at the time of initial advice the public hospital did not undertake blood cultures when [Mrs A] was admitted as her temperature was normal but did take blood cultures once she became pyrexial again.

Further information

The investigator phoned midwife [Ms D] (midwife on duty at [the Clinic] from 7am on 9 January) to clarify her response and received the following information:

1. [Ms D] believes [Mrs A's] high temperature would have been discussed with her at handover, however she can not recall this.

[Mrs A's] clinical records do state high temperature (38.6 degrees Celsius) that was closely monitored and did return to normal at 5.15am so one would expect that it was discussed at handover. Handovers are usually verbal but should reflect what is documented in clinical records. However, [Ms D] may not recall as this.

[At this point in her advice, Ms Waller sets out further information provided by [Ms D]. This information has been omitted for the purpose of brevity.]

[Ms D's] response on the 13th September 2009 states that when she came on the duty on 9th January 2008 during her usual rounds she found a "Do not disturb" sign on the door of [Mrs A's] room and therefore left her undisturbed. This is reasonable as my understanding from previous information is that [Mrs A] was given a call bell to call if any concerns.

At 9am [Mrs A] rang the bell to ask for breakfast as she was hungry and feeling light headed. The staff support gave [Mrs A] breakfast. The feeling of being light headed in majority of postpartum cases can be attributed to being hungry, tired, exhausted or due to lack of sleep. However, in this instance [Mrs A] did have pyrexia of unknown origin which had resolved by 5.15am. There was therefore an opportunity to check [Mrs A's] vital signs and confirm that she was still afebrile. If there had been no history of pyrexia of unknown origin overnight and as [Ms D] states [Mrs A] looked well then it would be reasonable not to undertake [Mrs A's] assessment of vital signs.

I acknowledge that [Mrs A] stating that she was hungry would have reassured [Ms D] that the feeling of being light headed was related to her being hungry. It is debatable whether the checking the vital signs at this stage would have altered the plan of care for [Mrs A]. Ideally practitioners should have a low threshold for such assessments when there is a history that the health status had changed.

The next contact was at 11am when [Mrs A] informed [Ms D] that she had been in contact with her LMC and had organised a consultation with the doctors at the public hospital as [Mrs A] was not feeling well. [Ms D] states that as far as she can recall this was all arranged and she was not asked to do anything except that she helped [Mrs A] have a shower and helped her pack her belongings as she waited for her husband to pick her up.

[Ms D] responds that they do not routinely take temperatures on well women and that temperature taken on the early hours of the morning of the 9th January 2008 had stabilised. Maternal assessments were not undertaken on the 9th January 2008 due to 'Do not disturb sign' and that [Mrs A] had taken upon herself to initiate her own phone calls to the LMC with her concerns. [Mrs A] appeared to be coping well, she was up and about, chatting and feeding her baby with ease, and happy for her husband to pick her up, there was no urgency and she walked out with her family.

From my memory of the Clinical records sent for provision of initial advice this was not what was reflected in the documentation I was asked to review. The documentation stated that [Mrs A] looked very unwell. In my initial advice I have therefore commented:

'At 11.00hrs it is charted that "has contacted [x] for referral to hospital doctors as she is feeling very unwell". As it is documented that [Mrs A]

was feeling very unwell a full maternal assessment needed to occur including the monitoring of the vital signs that is temperature, pulse and blood pressure. The findings from this assessment would have enabled the staff to re-discuss [Mrs A's] decision to go to the public hospital in her own transport. The maternal assessment findings may have been normal at this stage but undertaking them would have reassured [Mrs A] that staff at [the Clinic] had not been complacent. It would have also reassured the staff that [Mrs A's] plan to go in her own transport was appropriate. [The Clinic] was still responsible for providing midwifery care to [Mrs A] as the LMC was on [a] Ward of the public hospital.'

[Ms D] in her response has presented a very different picture of [Mrs A] (being chatty etc) to what appears to have been documented in clinical records.

Additional Comment

[Ms B] in her response states that there was one midwife caring for [Mrs A]. I appreciate [Ms B's] clarification regarding this as in the Clinical records it is not clear whether it was one midwife caring for [Mrs A] on the early morning of 9th January 2008. When there is a change of practitioner, documenting 'Care taken over by... because of (e.g. meal break, change of shift etc)' would help make documentation clearer regarding who is responsible for provision of care at that given time.

Summary

The areas that need further reflections by the practitioners can be viewed by their peers with mild disapproval. However, if [Mrs A] appeared very unwell on the morning of the 9th January as she was waiting to go to the public hospital not undertaking the vital signs/assessments can be viewed with moderate disapproval.

References:

MOH (2007) *Guidelines for consultation with Obstetric and related specialist medical services (referral guidelines)*. Ministry of Health. July."

On 1 December 2009 Ms Waller provided the following further expert advice:

"I have been asked to provide further advice following [Ms D's] response of the 19th November 2009. I have read and agree to follow the Commissioner's guidelines for Independent Advisors.

[At this point in her advice Ms Waller sets out her qualifications and experience. This information has been omitted for the purpose of brevity.]

The following sources of supporting information that were sent have been reviewed prior to the advice being given:

- Letter to [Ms D] from HDC dated 3rd November 2009

- Response from [Ms D] to HDC dated 15th November 2009 and received by HDC on 19th November 2009.

My response to [Ms D's] response is as follows:

[Ms D] states that her documentation of [Mrs A] feeling unwell was based on what [Mrs A] had said to her. As she has stated in her previous response, in reality [Mrs A] appeared to be coping well, was up and about, chatting and feeding her baby with ease and there was no urgency and walked out with her family. If this was the case then there was no need for [Ms D] to undertake maternal assessment on the morning of the 9th January 2008. In such instances it is beneficial to ensure that the documentation is fuller and includes what is said by the woman as well as what is seen by the practitioner. My understanding from previous responses by staff at [the Clinic] was that nobody knew exactly when [Mrs A] left the facility.

[Ms D] on her response of 19th November 2009 states that she acknowledges that she could have done a maternal assessment on the morning of the 9th January 2008 but it would not have changed the already decided plan that [Mrs A] had actioned of transferring to the public hospital. I agree with [Ms D] that the plan of going to the public hospital would not have changed but the mode of transport i.e. of how [Mrs A] was going to the public hospital would have had to be reviewed if maternal assessments showed [Mrs A] was not well.

[Ms D] states that she was aware that [Mrs A] would be thoroughly assessed on arrival at the public hospital and that her LMC [Ms E] was planning on meeting her there also. If [Mrs A] appeared unwell then [Ms D] had the responsibility to undertake a full assessment irrespective of thorough assessment that may occur later unless it was such an emergency that there was no time to do such assessments at [the Clinic].

Summary

Not undertaking maternal assessments on the morning of 9th January 2008 is reasonable if [Mrs A] did not appear unwell. Ideally practitioners should document what is seen as well as what information is provided by the woman. Even if a thorough assessment is planned for later the practitioner has a responsibility to undertake an assessment in a facility prior to transfer if the woman is unwell. The plan of [Mrs A] going to the public hospital for assessment would not have changed by undertaking of maternal assessment. However, it would have enabled further discussion regarding mode of transport to the public hospital if the findings of the assessment were of concern.

SUBSEQUENT ADVICE

On 22 April 2010, Ms Waller clarified her advice as follows:

“As you mention the page 7 of my initial report of 1st August 2009 states the following:

*The public hospital documentation shows that [Mrs A] arrived in Woman's Assessment Unit (WAU) on 9th January at 12.00hrs. [Mrs A] appeared to be very unwell on arrival. Her blood pressure on admission was 70/50. **There were no abdominal cramps, fainting or fever.** The history given by [Mrs A] at the time of admission were of abdominal pain for couple of days, diarrhoea for one day, vomiting for a day and fever for a day — there has been no documentation of diarrhoea and vomiting in [the Clinic] notes. Blood were taken following insertion of the leur. The diagnosis from blood cultures done showed Group A Streptococcal infection.*

Looking at the Clinical notes forwarded I feel I erroneously interpreted what are bullet points as 'nil' so commented that these symptoms (abdominal cramps, fainting or fever) were not present on arrival at the public hospital when in-fact they are bullet points stating that these symptoms were actually present on admission. My apologies for this error.

The initial report of the 1st August 2009 under point 9 (page 16) states 'As it is documented at 11.00hrs on 9th January that [Mrs A] was very unwell then a review of the decision made by [Mrs A] to travel to the public hospital in her own transport needed to occur'. [Ms D] has responded that this was based on what [Mrs A] said to her. My further advice on 1st December 2009 has stated that a fuller documentation needed to occur of what was said by [Mrs A] and what was observed by [Ms D]. This further advice also states that the responses from [the Clinic] show that nobody knew exactly when [Mrs A] left [the Clinic] to go to the public hospital. Unfortunately lack of clear ('[Mrs A] was very unwell') and fuller documentation does create some doubt regarding how well [Mrs A] was on 9th January when she left [the Clinic] for assessment at the public hospital.

Please do not hesitate to contact me if you require further clarification.

Nimisha Waller

Appendix B — Other Relevant Standards

Primary Maternity Services Notice (2007) issued pursuant to section 88 of the New Zealand Public Health and Disability Act 2000

“CB3 A maternity provider must ensure that primary maternity services that are provided by the maternity provider—

(a) are provided in a safe, timely, equitable, and efficient manner to meet the assessed needs of the person who is eligible for primary maternity services.

...

DA1 Aim of lead maternity care

(1) The aim of lead maternity care is to provide a woman with continuity of care throughout pregnancy, labour and birth, and the postnatal period.

(2) Lead maternity care is available to women, and their newborn babies.

...

DA6 General responsibilities of LMCs

(1) The LMC is responsible for—

(a) assessing the woman’s and baby’s needs; and

(b) planning the woman’s care with her and the care of the baby; and

(c) the care provided to the woman throughout her pregnancy and postpartum period, including—

(i) the management of labour and birth; and

(ii) ensuring that all the applicable primary maternity services are provided; and

(iii) ensuring all the applicable well child Tamariki/Ora services are provided to the baby.

(2) The LMC or a backup LMC will be available 24 hours a day, 7 days a week to provide phone advice to the woman and community or hospital based assessment for urgent problems, other than acute emergencies.

DA7 Continuity of care

- (1) From the time of registration of a woman, a LMC is responsible for co-ordinating for the woman all of the modules of lead maternity care in order to achieve continuity of care.
- (2) Subject to subclause (6), if a LMC is unavailable to provide an entire module of lead maternity care because of holiday leave, sick leave, bereavement leave, continuing professional education requirements or other exceptional circumstances, a back-up LMC may provide those services.
- (3) Subject to subclause (6), the LMC for a woman may, with the woman's consent, delegate to another midwife, general practitioner, or obstetrician the provision of part of a module, but not the entire module.
- (4) However, the responsibility for meeting the requirements of the module remain with the LMC.
- (5) The respective responsibilities of the LMC and the practitioner to whom aspects of a module have been delegated will be clearly documented in the care plan.
- (6) Despite subclauses (2) and (3), if, because of exceptional reasons, the LMC is unable to be responsible for the ongoing provision of lead maternity care to a woman, the maternity provider must ensure that the woman is registered with another LMC.
- (7) A LMC is responsible for ensuring that handover to primary care and well child services takes place.

DA8 Transfer of care to secondary maternity services, tertiary maternity services, and specialist neonatal services

- (1) If there is a transfer of care to secondary maternity services, tertiary maternity services, or specialist neonatal service, clinical responsibility for the woman and baby transfers, until there is a transfer of care back to the LMC.
- (2) Every transfer of care must be documented in the Clinical notes, including the date and time of transfer.
- (3) If responsibility for a woman's care transfers to a secondary maternity service or tertiary maternity service after established labour, the woman's LMC may continue to support the woman.

DA29 Service specification: services following birth

- (1) A LMC is responsible for ensuring that all of the following services are provided for both the mother and baby:
 - (a) reviewing and updating the care plan and document progress, care given and outcomes, and ensuring that the maternity facility has a copy of the care plan if the woman is receiving inpatient postnatal care:
 - (b) postnatal visits to assess and care for the mother and baby in a maternity facility and at home until 6 weeks after the birth, including—
 - (i) a daily visit while the woman is receiving inpatient postnatal care, unless otherwise agreed by the woman and the maternity facility; and
 - (ii) between 5 and 10 home visits by a midwife (and more if clinically needed) including 1 home visit within 24 hours of discharge from a maternity facility; and
 - (iii) a minimum of 7 postnatal visits as an aggregate of DA29 (1) (b) (i) and (ii):
 - (c) as a part of the visits in clause (b), examinations of the woman and baby including—
 - (i) a detailed clinical examination of the baby within the first 24 hours of birth; and
 - (ii) a detailed clinical examination of the baby within 7 days of birth; and
 - (iii) a detailed clinical examination of the baby as defined by the Well Child Tamariki Ora National Schedule before transfer to a well child provider; and
 - (iv) a postnatal examination of the woman at a clinically appropriate time and before transfer to the woman's primary care provider:
 - (d) as a part of the visits in clause (b), the provision of care and advice to the woman, including—
 - (i) assistance with and advice about breastfeeding and the nutritional needs of the woman and baby; and
 - (ii) assessment for risk of postnatal depression and/or family violence, with appropriate advice and referral; and

- (iii) provide appropriate information and education about screening; and
 - (iv) offer to provide or refer the baby for the appropriate screening tests specified by the Ministry of Health and receive and follow up the results of these tests as necessary;
 - (v) provision of Ministry of Health information on immunisation and the National Immunisation Register (NIR) and provision of any appropriate or scheduled immunisations consented to; and
 - (vi) provision of or access to services, as outlined in the Well Child Tamariki Ora National Schedule; and
 - (vii) advice regarding contraception; and
 - (viii) parenting advice and education.
- (2) If a birth has occurred in a maternity facility, the LMC, in discussion with the woman and the maternity facility, must determine when the woman is clinically ready for discharge.
- (3) If a general practitioner or obstetrician LMC uses hospital midwifery services, the LMC must—
- (a) make a prior agreement with the maternity facility on the use of the hospital midwifery services; and
 - (b) ensure that the respective responsibilities of the LMC and the hospital midwifery services are clearly documented in the care plan and that a copy of the care plan is given to the hospital midwifery services and to the woman; and
 - (c) be available to provide consultation and treatment on request.”

Guidelines for Consultation with Obstetric and Related Specialist Medical Services:

“1 Purpose of guidelines

This document provides guidelines for best practice in maternity care based on expert opinion and available evidence. It is the intention that the guidelines be used to facilitate consultation and integration of care, giving confidence to providers, women and their families.

For the purpose of these guidelines, referral to specialist services includes both referrals to Secondary Maternity or to a specialist, as defined in the Primary Maternity Services Notice 2007.

It is intended that these guidelines should be reviewed at two yearly intervals.

2 Circumstances where guidelines may be varied

The guidelines acknowledge that General Practitioners, General Practitioner Obstetricians and Midwives have a different range of skills. The guidelines are not intended to restrict good clinical practice. There may be some flexibility in the use of these guidelines:

- (a) The practitioner needs to make clinical judgements depending on each situation and some situations may require a course of action which differs from these guidelines. The practitioner will need to be able to justify her/his actions should s/he be required to do so by their professional body.

It is expected that the principles of informed consent will be followed with regard to these guidelines. If a woman elects not to follow the recommended course of action it is expected that the practitioner will take appropriate actions such as seeking advice, documenting discussions and exercising wise judgement as to the ongoing provision of care.

- (b) It is also recognised that there may be some circumstances where the requirement to recommend consultation places an unnecessary restriction on experienced practitioners, particularly where there is no immediate access to specialist services. The individual practitioner can come to an appropriate arrangement with the specialist.

It is agreed that, in accordance with good professional practice, a practitioner must record in the notes the reasons for the variation from the guidelines.

...

5 Levels of referral

These guidelines define three levels of referral and consequent action:

Level 1

The Lead Maternity Carer **may recommend** to the woman (or parents in the case of the baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should include discussion on any need for and timing of specialist review.* The specialist will not automatically assume

responsibility for ongoing care. This will depend on the Clinical situation and the wishes of the individual woman.

Level 2

The Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that a consultation with a specialist is warranted** given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *Where a consultation occurs, the decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned. This should include discussion on any need for and timing of specialist review.* The specialist will not automatically assume responsibility for ongoing care. This will depend on the Clinical situation and the wishes of the individual woman.

Level 3

The Lead Maternity Carer **must recommend** to the woman (or parents in the case of the baby) **that the responsibility for her care be transferred** to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. *The decision regarding ongoing clinical roles/responsibilities must involve a three way discussion between the specialist, the Lead Maternity Carer and the woman concerned.* In most circumstances the specialist will assume ongoing responsibility and the role of the primary practitioner will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.”

New Zealand College of Midwives Code of Ethics

“Midwives have a responsibility to ensure that no action or omission on their part places the woman at risk.”

New Zealand College of Midwives Standards for Practice

“Standard three: The midwife collates and documents comprehensive assessments of the woman and/or baby’s health and wellbeing.”