Postdates monitoring of pregnant woman
16HDC00188, 28 September 2018

Midwife ~District health board ~Monitoring ~ Postdates care ~Communication ~ Handover ~ Documentation ~ Rights 4(1), 4(2), 6(1), 7(1)

A woman pregnant with her first child engaged a midwife as her lead maternity carer (LMC). Previously, the woman had undergone high-frequency surgery on her cervix, and she had a history of urinary tract infections (UTIs). The *Guidelines for Consultation with Obstetric and Medical Related Services* (the *Referral Guidelines*) require an LMC to recommend to a woman that a referral for a consultation with a specialist is warranted if the woman has had cervical surgery without a subsequent term vaginal birth. There is no evidence that the midwife made such a recommendation.

The midwife advised the woman that as her pregnancy was normal and low risk, she could have her baby at home, and transfer to hospital only should anything go wrong. The midwife used landmarks to measure fetal growth, rather than measuring the fundal height. The pregnancy progressed uneventfully.

When the woman was 41 weeks' gestation by scan, she had an appointment with the midwife, who told her that the process was to wait until two weeks past her EDD, and then have a scan to assess whether her labour needed to be induced.

The *Referral Guidelines* require that the LMC recommend to the woman that a referral for a consultation with a specialist is warranted "in a timely manner for planned induction by 42 weeks". The woman said that she was never offered the option of consulting a specialist.

The woman began to experience contractions. She contacted the midwife by text and telephone. The midwife did not come to assess her, and said that someone would come in the morning.

At 6am, a second midwife arrived at the woman's house to carry out an assessment. The second midwife documented that contractions were coming at a rate of two every 10 minutes and lasting 60 seconds, and that the fetal heart rate (FHR) was 155 beats per minute (bpm). The woman's blood pressure (BP) was raised at 138/98mmHg. The second midwife informed the LMC of her assessment findings and then left.

At 7.15am, the LMC midwife arrived. She noted that the woman was experiencing "regular strong contractions" and was "breathing through quietly". The midwife performed observations and a urinalysis, which showed "protein ++".

At 10am, the midwife performed a further assessment. She documented that the cervix was fully effaced and 8–9cm dilated, the contractions had become "spaced out", and that she recommended that the woman try to get some sleep. The midwife noted: "[A]way to do a visit or two. Be back at 12. Call if needed sooner." The midwife then left.

Shortly before 11.45am, the woman contacted the midwife and said that her contractions had become more regular and strong again. The midwife then returned.

Labour progressed slowly. At 3pm, the midwife decided to transfer the woman to a local hospital for a CTG and assessment by another midwife. The results of the CTG were reassuring. The woman's BP was 143/96mmHg, and a urinalysis showed protein 2+.

At 4.30pm, the midwife contacted the on-call obstetric registrar at a main centre hospital to discuss transfer. The registrar recalls that the midwife was concerned because she had a term primiparous woman who was 9cm dilated, but had not progressed in the last hour. The registrar said that the midwife told her that it was difficult to ascertain the current vaginal examination findings, it was unclear whether the membranes were intact, and that the FHR monitoring was normal.

The registrar advised that the woman should be transferred to secondary care. The ambulance left at 6pm and arrived at the main centre hospital at approximately 8.30pm. The registrar and the on-call senior medical officer (SMO) assessed the woman and found the baby lying in an occiput posterior position. The SMO's plan was to insert an epidural and then attempt to rotate the baby manually with a possible vacuum delivery. The midwife returned home in the ambulance.

At approximately 9.15pm, staff had to attend theatre to undertake an emergency Caesarean section on another patient.

At 10.40pm, the core midwife administered the woman 25mg pethidine for pain relief. At around midnight, the anaesthetic registrar returned to the obstetric ward, reviewed the woman's history and blood results, and sited an epidural. The CTG was recommenced at 12.12am, and the FHR was monitored continuously until the birth.

The SMO attended at 12.20am, and the baby was manipulated manually to an occiput anterior position. The FHR showed decelerations during the rotation, but returned to the normal range between decelerations. During this time, intravenous fluids were increased, the woman was placed on her left-hand side, and BP recordings were performed at five-minute intervals.

At 12.31am, the SMO commenced an operative vaginal delivery using a vacuum cup. The SMO affected "gentle downward traction" with each contraction, and progress was noted with each pull. The SMO stated that the ventouse delivery was not prolonged, and that once the baby's head was crowning, the vacuum cup was removed.

The SMO said that although the CTG showed tachycardia with decelerations from 12.22am until 12.40am, she did not perform a Caesarean section because the fastest way to deliver the baby at that point was by an operative vaginal delivery. The baby was delivered at 12.51am, and required resuscitation. He was later diagnosed with stage 2 hypoxic ischaemic encephalopathy.

Findings

The midwife was found to have breached Right 4(1) as follows:

a) She failed to establish an agreed EDD and did not formulate a plan for postdates care.
b) She failed to measure the fundal height during the pregnancy.
c) She left the woman unattended for one hour and twenty-five minutes when she was in established late labour.
d) She failed to establish a baseline for maternal well-being and to follow up an elevated blood pressure recording, and during labour did not monitor the woman's maternal observations four hourly.
e) She failed to monitor the FHR every 15–30 minutes in the active phase of the first stage of labour, and between 10.00am and 11.45am was absent and did not monitor the FHR at all. She also did not monitor the FHR between 6.30pm and 8.30pm.

f) At 1.45pm, she failed to act on the clear indicators that labour was not progressing normally, and did not conclude that a consultation with a specialist was warranted.

The woman had the right to co-operation among providers to ensure quality and continuity of services. The midwife failed to hand over care adequately or supply the notes to the DHB team at the time of handover, and was found to have breached Right 4(5).

When the woman was in early labour, the midwife received and communicated clinical information by text, and did not document the text and telephone assessments, including whether or not the baby was active, and the advice given.

Furthermore, the midwife made multiple changes to the clinical records without dating the changes or noting that they were made retrospectively. The midwife's actions with regard to the clinical records were a serious breach of professional standards, and she was found to have breached Right 4(2).

The woman had the right to the information that a reasonable consumer in her circumstances would expect to receive. The midwife failed to provide such information, and so breached Right 6(1). It follows that the woman was not in a position to make informed choices about her pregnancy, labour, and the delivery of her baby, and the midwife was found to have breached Right 7(1).

Adverse comment was made that the core midwife acted outside the hospital guidelines by not having first consulted with the obstetric team before discontinuing continuous CTG monitoring, and not clearly documenting her rationale for her actions. She also did not record her 15-minute checks or record the FHR during those checks. In addition, staff failed to collect the cord blood following the baby's birth.

Recommendations

It was recommended that the DHB:

a) Review its processes in circumstances where two women with significant risk factors are in labour concurrently, and report to HDC on the outcome of its review and its improvement plan.
b) Conduct refresher training for its maternity staff on the RANZCOG guidelines, the DHB's guideline on the use of water in labour and birth, and its expected standards of record-keeping.
c) Provide an apology to the woman.

It was recommended that the Midwifery Council of New Zealand undertake a review of the LMC midwife's competence, should she make an application to return to midwifery practice, and that she provide an apology to the woman.

The LMC midwife was referred to the Director of Proceedings. The Director filed proceedings by consent against the midwife in the Human Rights Review Tribunal. The Tribunal issued a declaration that the midwife breached Rights 4(1), (2), and (5), 6(1), and 7(1) of the Code in relation to the care she provided.