Postnatal care of woman with perineal tear
16HDC00911, 22 June 2018

Obstetric consultant ~ Midwife ~ District health board ~ Perineal tear ~ Faecal leakage ~ Right 4(1)

At approximately 9am, a woman arrived at the delivery unit at a public hospital in established labour at term. She was cared for by her midwife lead maternity carer (LMC).

At 1.20pm, owing to a lack of progress, maternal tiring, and fetal distress in the second stage, a registrar recommended an instrumental delivery. The obstetric consultant agreed with the recommendation. The registrar documented that at 2pm, after performing a pudendal block and an episiotomy, the obstetric consultant carried out a ventouse extraction. It took three pulls to deliver the head, and there was moderate shoulder dystocia.

Immediately following the delivery, the obstetric consultant left the room to attend to another patient. The registrar remained in the room and began to repair the perineal tear. The registrar queried the tear as being a fourth-degree tear and discussed her concerns with a senior registrar. The senior registrar then examined the woman, decided that the tear was second degree only, and began repairing it. The senior registrar cannot recall whether she had closed the vaginal mucosa in its entirety when she became concerned that "the tear to the skin possibly involved the anal mucosa". The senior registrar said that she left the room and discussed her concerns with the obstetric consultant, and then left the repair as she had to go to theatre to attend to another patient.

The obstetric consultant documented that she examined the woman in the lithotomy position and repaired the episiotomy tear. The obstetric consultant recorded that the tear was to the anal margin but did not involve the sphincter, and that the per rectum examination post-suturing was normal with no sutures felt.

The following day, the LMC midwife visited the woman and documented that the woman had not opened her bowels, and that her perineum was "normal" but tender. The midwife did not view the woman's perineum.

The midwife carried out a second postnatal visit to the woman and her baby in the neonatal intensive care unit. The woman advised the midwife that she had faecal discharge at the front of her underwear. The midwife considered the minor faecal leakage reported by the woman to be normal in the immediate postnatal period and she did not consider that a physical examination was indicated at that time.

At six days post-partum, the midwife carried out a third postnatal visit at the neonatal intensive care unit. The woman told HDC she again reported faecal discharge on the front of her underwear. However, the midwife told HDC that the woman did not report any faecal leakage on that occasion, but did report loose bowel motions.

At 10 days post-partum, another midwife visited the woman and documented that the woman reported that the "perineal pain" was improving and that "no physical concerns were voiced". The second midwife recorded that the woman reported that her bowels and perineum were normal.

The LMC midwife carried out another postnatal visit at 16 days post-partum. The woman reported pain and faecal discharge, and the midwife examined the woman's perineum. The midwife documented that the woman had had light faecal leakage after bowel motions for the past 10 days. The midwife queried an infected perineum and requested an obstetric registrar review.

Findings

Criticism was made that, considering the concerns raised by two registrars, the obstetric consultant did not identify that the tear was more significant. Accordingly, the obstetric consultant did not provide the woman with an appropriate standard of care and breached Right 4(1).

It was accepted that the policies relevant to the care provided by the obstetric consultant to the woman were adequate, and that the district health board (DHB) had taken reasonably practicable steps to prevent the error from occurring. Accordingly, the DHB was found not to be vicariously liable for the obstetric consultant's breach of the Code.

It was found that the LMC midwife's failure to carry out a visual perineal examination earlier was unacceptable. Accordingly, the midwife did not provide the woman with an appropriate standard of care and breached Right 4(1).

Recommendations

The following recommendations were made:

- The LMC midwife to provide a written apology to the woman, and provide evidence to HDC confirming attendance or enrolment at a course relating to perineal tears.
- The obstetric consultant to provide a written apology to the woman. It was also recommended that the obstetric consultant audit the outcome of deliveries in which she had been involved over the previous three months, and provide HDC with a copy of the audit report.
- The Midwifery Council of New Zealand to consider undertaking a review of the midwife's competence.
- The Medical Council of New Zealand to review HDC's report of this case.