Midwives Protection Program

SPECIAL DELIVERY

Volume 1, Issue 1 Spring/Summer 2009

A Risk Management Newsletter for Midwives' Protection Program Members

In this Issue:

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Welcome to Special Delivery

Welcome to ***Special Delivery*** the first edition of the **Midwives Protection Program** Newsletter.

If you are a member of the Midwives Association of BC (MABC) and you are in good standing with the College of Midwives and are current in your premium payments then the Midwives Protection Program (MPP) covers your professional practice liability concerns.

What is the Midwives Protection Program?

Up to November 2000 midwives in BC had coverage under a commercial insurance plan. Under that plan midwives paid up to 8 times their current premium for less than half the coverage.

Because the cost had become prohibitive and there were concerns that coverage was insufficient in the event of a significant claim, MABC and the Ministry of Health approached the Risk Management Branch of the Ministry of Finance for assistance.

In January 2001, the Midwives Protection Program (MPP) was created to better serve BC midwives.

How much do I pay for MPP and what do I get in return?

The current annual contribution of each midwife to MPP is $2000. In return, each midwife receives risk management advice (provided through MABC) and claims services provided directly by MPP. Claims services include coverage for claims made against you for allegations of negligent acts, errors or omissions while acting within your scope of practice and any complaints of professional misconduct, incompetence or incapacity taken before the College of Midwives. Coverage also includes legal expenses.

For further details contact Sharon White at 250-952-0850 or sharon.p.white@gov.bc.ca

To report a potential claim call 250-952-0836 or fax a copy of the MPP Incident Reporting Form to 250-356-0661 and a Claims Examiner or Legal Counsel will call you.

(For urgent only after hours concerns call 250-356-1794).

We are here to help.

MPP Incident Reporting Guidelines and Incident Reporting Form

In this edition of ***Special Delivery*** we are including copies of the MPP Incident Reporting Guidelines and the MPP Incident Reporting Form. We'd like your feedback on whether or not the guidelines and the form are/will be helpful to you when considering whether or not to report an incident to MPP.

Please let us know what you think by emailing MPP@gov.bc.ca
or you can write to us at:
Midwives Protection Program
PO Box 3586, Victoria BC V8W 3W6

Shared Learnings

Watch for SHARED LEARNINGS which will be a regular feature in *Special Delivery*

SHARED LEARNINGS are case summaries or abstracts of cases, combined with risk management tips gleaned from a variety of sources, intended to inform midwives about current issues or trends and cases of concern or interest. The midwifery community is a relatively small community in BC, so if you think you recognize your own practice concerns or someone else's in one of the Shared Learnings don't despair. Remember we can all learn from one another.

MPP will make every effort to de-identify or change facts to be sensitive to your right to privacy, while at the same time provide current examples of real issues that may assist you in reducing risk to your clients and to your own exposure to a complaint or malpractice claim. By sharing these learnings it is our hope that all midwives will benefit.

In this edition of ***Special Delivery*** we discuss two common practice concerns: Meconium Aspiration and Hyperbilirubinemia.

Meconium Aspiration

Midwives may note the presence of meconium with or without aspiration during labour and delivery. It is appropriate to report poor or questionable outcome where there has been meconium in the fluid or where meconium has been aspirated.

As you know, Meconium Aspiration Syndrome (MAS) is a serious condition in which a newborn breathes a mixture of meconium and amniotic fluid into the lungs around the time of delivery. MAS is a leading cause of severe illness and death in the newborn. The possibility of inhaling meconium occurs in about 5-10% of births. It typically occurs when the foetus is stressed during labour, especially when the infant is past its due date.

Risk factors include: foetal distress, decreased oxygen to the infant while in the uterus; diabetes in the pregnant mother; difficult delivery; and high blood pressure in the pregnant mother.

The midwife should identify risk factors as early as possible and consider them in her care plan.

For example the expectant mother should be made aware ahead of time that if her water breaks at home, she needs to tell the midwife whether the fluid is clear or stained.

The presence of meconium may help the midwife decide if monitoring should be started so that signs of foetal distress can be recognized early on and appropriate interventions can take place. Follow CMBC guidelines for consulting a colleague or physician or for arranging delivery in hospital where indicated, unless of course delivery at home is imminent and transfer would be unsafe.

Failure to plan for and consider presence of meconium puts you at increased risk of a complaint or malpractice claim concerning your care in the event of an adverse outcome, particularly where meconium is aspirated. Make sure you chart your actions to plan for and respond to the presence of meconium and include any instructions that you have left with your client.

Hyperbilirubinemia

It is estimated that about 60% of newborns are jaundiced. Jaundice is caused by a high level of bilirubin in the blood and tissues. Hyperbilirubinemia can be treated. Norms for bilirubin are based on the age in hours after birth. Factors such as prematurity, blood group incompatibilities between mother and infant including Rh and ABO blood types and bruising, especially cephalohematomas and caputs, can increase bilirubin production and lead to excessive jaundice.

Infants with high bilirubin levels can be effectively treated and phototherapy, if instigated promptly, is usually very effective. Untreated such infants can develop kernicterus with resulting hearing loss, paralysis of upward gaze and severe permanent mental and physical disability.

There have been a number of instances where at-risk infants have been discharged early from hospital and follow-up in the community has not occurred in a timely fashion. Given the trend to early discharge from hospital this is an issue of concern to all care providers. Adherence to CMBC guidelines for early discharge (e.g. infant weight criteria) is essential to an effective risk management strategy.

Early discharge (sometimes at the patient's insistence) combined with inadequate follow-up can lead to serious complications for the infant. As noted above infants with prolonged hyperbilirubinemia may suffer permanent disabilities and have extensive care needs. Legal claims brought on behalf of such infants may amount to several million dollars, including significant costs associated with cochlear implants and additional therapies for hearing loss.

Midwives who are responsible for follow-up should ensure that the patient receives sufficient instructions with respect to at risk infants. Parents need to know that they must get help ASAP if the baby turns yellow at home or develops feeding problems. They also need to understand that your follow up visits are very important.

A history of hyperbilirubinemia for older siblings, especially where a sibling required phototherapy, must be noted and considered in your care plan. Remember, some parents may be lulled in to thinking a treatment as "simple" as phototherapy for a prior child means the jaundice is not necessarily very serious and thus not consider it to be relevant when providing history. It is good to ask.

At-risk infants must be followed promptly upon discharge; delays of even two to three days may be unacceptable. Follow-up may need to include a prompt home visit. Where an infant is identified as at-risk, efforts to follow-up must be reasonable in the circumstances and be well documented.

The midwife may need to consider engaging the family physician or public health nurse in earlier follow up. Informational handouts and specific client teaching can also be useful. Where in doubt about what follow up may be required in a particular situation consult CMBC.

Delays in follow-up can lead to complaints that may result in disciplinary proceedings against the midwife. In addition, inadequate follow up can increase the potential for a claim in negligence being brought by the family when they begin to appreciate the costs associated with meeting their child's care needs where an infant has suffered permanent damage. Such a claim may not arise until the child has reached school age, or even adulthood. These time frames underscore the need for good documentation of the care plan and all steps taken to ensure adequate follow up takes place.

Risk Answers

"I am in a shared practice with other midwives. Whose obligation is it to report an incident to MPP?"

The attending midwife should be the one reporting an incident to MPP however if you are aware that your partner has been unable to report or has not yet reported, it is appropriate for you to encourage your colleague to report. Any midwife involved in care can report and the midwife reporting should also let her colleagues know about the report to MPP.

"**When should I report to MPP? Should I complete a Reporting Form and if so how much detail should I include? When should I use the After Hours contact?"**

MPP reporting guidelines are attached to this Newsletter. If in doubt seek advice on whether or not to report.

Midwives who have come to BC from other jurisdictions may have different notions of what to report in writing. MPP would like to see sufficient information to evaluate a potential claim so, at a minimum, include any critical findings or results and make sure that you include your contact information. The FAX claim form is received at a confidential dedicated number. If a situation is urgent it is appropriate to call MPP and common sense should apply to the use of after hours telephone calls.

"What is prompt reporting and how might late reporting impact my coverage?"

What is prompt? As soon as the necessary care has been provided to the patient contact MPP where a reportable incident has occurred. One or two hours or the next morning is normally satisfactory. A day or two over a weekend is certainly acceptable. After that for a serious incident this is no longer considered prompt reporting.

Of course you may not become aware of a potential claim until the parents or a lawyer request a copy of the records or the parents give some indication that they are dissatisfied with care or concerned about their infant's progress. In these situations your obligation is simply to report as soon as you receive such information, even if some time after your care has ended.

Where a serious incident is not reported and subsequent investigations reveal late or absent notification has seriously compromised the defence of a claim brought against you, you may also be in breach of your policy and be responsible for your own legal defence costs and any damages. Any limitations on coverage would be decided on a case by case basis.

FEEDBACK IS IMPORTANT TO US AT MPP

Midwives Protection Program

Please let us know what you think about **Special Delivery**.
Did you find the **Shared Learnings** informative? Yes No
Will **Shared Learnings** make any difference to your practice? Yes No
Will you share this Newsletter with others? Yes No

Are there any topics you would like us to cover in **Shared Learnings** or in **Risk Answers**?

Write to us at MPP@gov.bc.ca or
Midwives Protection Program PO Box 3586, Victoria BC V8W 3W6

MPP Incident Reporting Guidelines

PO Box 3586 Victoria BC V8W 3W6
Telephone: (250) 952-0836 Claims Fax: (250) 356-0661

FOETAL/NEONATAL

- Low APGARS, in particular < 4 at 1 minute and <6 at 5 minutes, with other indicators
- Foetal scalp blood pH <7
- Umbilical artery blood pH <7 at birth
- Intrauterine acidosis e.g. base excess > -12
- Deep variable decelerations or late decelerations, with other indicators
- >4 minutes of positive pressure ventilation before sustained respiration
- Seizure after birth or other neurological signs
- Severe Hyperbilirubinaemia; Kernicterus
- Abnormal head imaging related to possible birth injury; abnormal EEG
- Prolapsed/severed/snapped cord/cord strangulation, with other infant sequelae
- Significant birth injury including:
  - Shoulder dystocia;
  - broken clavicle/ humerus; brachial plexus injury; head laceration;
  - forceps/instrument/vacuum injury
- Meconium aspiration pneumonia
- Pneumothorax
- Unanticipated lengthy course in NICU
- Significant infection
- Unplanned extubation
- Death/stillbirth

MATERNAL

- Significant tearing and/or episiotomy with other maternal sequelae
- Bladder laceration
- Uterine Rupture
- Significant haemorrhage (> 1000 ml and/or transfusion)
- Complicated or serious infection/ septicaemia
- Untreated maternal genital herpes, syphilis, HIV
- Significant post c-section complication
- Maternal ICU admission
- Maternal trauma/death
- Eclampsia seizures
- HELLP Syndrome
- Thrombo embolic event (DVT, PE)
- Disseminated Intravascular Coagulation

GENERAL

- Unplanned unattended home birth
- Unplanned/unexpected early discharge of non-compliant patient
- Problem with planned follow-up for at-risk infant/family
- Family raising credible concerns about care
- Complaint to CMBC
- Known breach of CMBC standard
- Any telephone or written complaint referencing law suit or compensation or complaint sent to Ombudsman, Minister etc.
- Any negative outcome complicated by inter-professional dispute over care
- Request for records by legal counsel specializing in obstetrical malpractice
- Request for records where reason indicated is “for litigation”
- Any other incident not listed here of concern and where advice may be sought

NB These are guidelines: they are not policy or regulation; common sense prevails. Whether or not the birth was planned/ unplanned, at home or in a hospital or other setting may be relevant to your reporting decision. Sources informing the Guidelines include: Health Care Protection Program and Midwives Protection Program claims history, BC Health Care Risk Management Society reporting guidelines, Society of Obstetricians and Gynaecologists of Canada guidelines, Canadian Patient Safety Institute, ECRI Institute, Health Insurance Reciprocal Of Canada (HIROC), Harvard Foundation publications and Canadian jurisprudence along with midwife, client, claims examiner and legal counsel feedback. If uncertain about whether or not to report, call us!

Midwives Protection Program

PO Box 3586, Victoria BC V8W 3W6
Ph (250) 952-0836 Fax (250) 356-0661
Email: MPP@gov.bc.ca

INCIDENT REPORTING FORM

Date of Report:

Primary Midwife: Registration #:

Address:

Telephone: Fax:

Email:

Secondary/Support Midwives:

Client/Claimant(s):

Address:

Telephone:

Date of Incident:

Description of Incident/Complaint/Problem **(FACTS ONLY):**
(If there is an injury to the infant or mother during birth the incident must be promptly reported either by fax or telephone)

Letter of complaint/Writ/Statement of Claim enclosed: ☐ Yes ☐ No

Has the Client/Claimant indicated concern? If so, please explain.

PLEASE NOTE:

Should you have any questions regarding your claims-made policy, please contact:
The Midwives Association of British Columbia at (604) 736-5976 or e-mail at mabc@telus.net.

Revised March 25, 2009