Midwives Protection Program

Special Delivery

Volume 2, Issue 1 **Spring/Summer 2010**

A Risk Management Newsletter for Midwives' Protection Program Members

In this Issue:

Please feel free to copy and distribute as necessary.

If you would like to receive an electronic version of this publication just drop us a line at MPP@gov.bc.ca and we will add you to our distribution list.

Welcome to Special Delivery

Welcome to the Spring/Summer 2010 Edition of *Special Delivery*. George Bernard Shaw said that *"the single biggest problem in communication is the illusion that it has taken place"*. Effective communication can be challenging in many health care settings, including obstetrical departments. In this edition of *Special Delivery,* Grant Warrington, a Senior Claims Examiner/Legal Counsel, draws on his experience to explore ways registered nurses and midwives can communicate more effectively.

Next, staff at the Midwives Protection Program (MPP) recognize that sometimes registered midwives with hospital privileges have difficulty accessing their client and infant health records. We were able to liaise with risk management leaders at all Health Authorities to make them aware of this issue. We've shared a risk management document that was created to provide guidance to Health Records staff as to when and how midwives can access their client and infant records.

Finally, our Risk Answers responds to a common question as to why insurance coverage beyond MPP is necessary to properly protect a midwife from third party liability exposures.

We hope you enjoy this issue of Special Delivery and find the articles helpful in your practice. As always, we welcome feedback or suggestions for future editions. Please contact us at MPP@gov.bc.ca.

Correction - Complaints to the College

In the Fall/Winter edition of Special Delivery, the article Midwifery Discipline Process incorrectly stated the number of complaints made to the BC College of Midwives. Since midwives became self-regulated in 1998, the College has received thirty-seven complaints involving a total of thirty-seven midwives: six were from physicians, twenty were directly from clients of midwives, one was from the family of a client, one from a midwife, one from both a midwife and a physician, one from both a client and a physician, and seven were from hospitals.

We apologize for this error and any confusion caused.

EFFECTIVE COMMUNICATION BETWEEN NURSES AND MIDWIVES

Effective communication is a constant challenge for all of us. What I have learned from our experience with cases reported to both the Health Care Protection Program and the Midwives Protection Program is that certain communication patterns or problems seem to repeat themselves in obstetrical settings.

In this article I will try to set out a few of those examples to illustrate how effective communication and preparation can assist both nurses and midwives. Of course the same principles and considerations will apply to relations with other health care providers but the focus of this article is on the dynamics between nurses and midwives in a hospital setting.

One of my frequent observations is that for nurses and midwives who have practiced in other jurisdictions, or for midwives who have recently acquired privileges in a new hospital, it is imperative that the nurse or midwife familiarize him/herself with the procedures and guidelines of the new setting(s). It is unsafe to assume that the rules of engagement are the same between one country or province and another and in many respects the same consideration must apply as between hospitals, particularly between health authorities but also for different hospitals within the same health authority.

Both nurses and midwives frequently acknowledge in investigations that they have not taken the time or effort to familiarize themselves with a new work environment. In some instances nursing orientations have been lacking. In other instances policies and procedures that differ as between health authorities, or are inconsistent or unevenly applied in different hospitals within the same health authority, have made the health care providers' lives more difficult than need be. Midwives must pay particular attention when they are serving clients who may end up in an unfamiliar hospital due to lack of choice, urgency or timing. Clearly not all planned homebirths will remain at home and once they move to hospital, often at short notice, there is little time to learn the environment, meet staff or read critical policy or procedure. Prepare for these contingencies ahead of time, where reasonably possible, and give nursing staff sufficient information to assist you so that they too can provide the best care possible.

An essential part of the midwife's client preparation and birth plan is to ensure that the client's transfer and transition to hospital care is as seamless as possible. This includes knowing the culture of the facility and being as familiar as possible with the expectations, the guidelines and local policies and procedures: some of which may differ from practice in other facilities.

Conflict or misunderstanding over local policies can lead to significant problems for all care givers and leave clients and families wondering if they are in safe hands: especially so where tension or dispute arises in their midst.

Knowing local procedures and, where possible, the expertise, expectations and limitations of nursing and other health care providers ahead of time can make a sudden change in condition or transfer of an at-home client to hospital less stressful for all concerned. For the registered midwife this may mean taking the time to visit the facility ahead of time and introducing yourself to the staff. For the registered nurse on duty when a midwife is providing care this may mean stepping forward and stating your level of experience and/or ability to provide care given other patient demands and/or staffing levels.

It is important to try to know and understand each others' skills and limitations. Equally, if not more, important is to know your own skills and limitations and to be able to state those clearly. This is especially important between the primary care giver and the second attendant, be that second another midwife or a nurse. I am aware of many examples where nursing staff did not fully understand the midwife's role or did not agree with a particular assessment. Conversely the midwife may have had a different expectation of the nursing staff or second attendant's role(s) in a particular delivery or a different assessment of the urgency or condition of a client or infant. Where arrangements are with a second attendant at another practice or at some distance consider whether that distance or means of transport will, given changing weather conditions, be appropriate for your client's needs.

Obviously not all nurses and not all midwives working in an obstetrical setting will have the same level of experience, confidence, expertise or

(Continued on page 3)

(Continued from page 2)

specialized training. Uncertainty about who can, or who is willing and/or able to do what has led or contributed to some unfortunate outcomes or close calls for clients and their families and for the nurses and midwives providing care. By knowing strengths AND your own limitations, which can change from one birth to another or even during the course of a difficult labour and delivery, you are better serving your client, your profession and your relationship with other health care providers.

There should be no shame for a midwife in asking an available obstetrician to take over suturing a client if the midwife is too tired or too adrenaline rushed to hold the needle steady, or if the tear is of questionable severity. A registered nurse should not hesitate to ask: "Do you need any help?" or "Do you need me to call the obstetrician or paediatrician or other back up?"

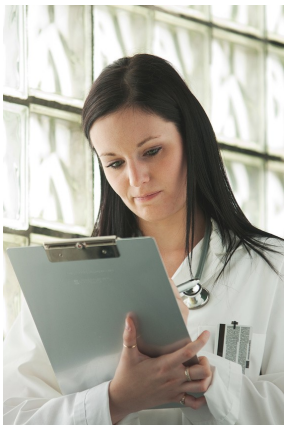
There should also be no hesitation in the midwife asking a nurse or her supervisor to ensure the midwife, as the most responsible health care provider, is given the same level of assistance and cooperation that a doctor delivering the infant would be able to count on. Registered nurses for their part need to understand what a midwife's expectations are and not, as has happened in some unfortunate cases, leave the midwife without the support or cooperation a doctor would receive.

Communication is not only the direct discussion, orders or casual banter that may occur during delivery, it includes how the record is recorded. It should be clear in any delivery who will be responsible for what observations or measures or actions are to be taken by whom. Effective communication includes who charts what, and where and when. Ideally all of this is clear to the relevant caregivers well ahead of time. If APGARS are going to be altered (a frequent problem) or if there are differences in interpretation of foetal monitoring (another frequent challenge) or if there is disagreement in any assessment, it is imperative that there either be some effort at accommodation or a common understanding, or, at a minimum, an explanation must be given in the record.

Where a client's care has been transferred to an obstetrician the continuing role of the registered midwife as support-only, if that is the case, must be made clear to everyone concerned. If care has been transferred back to the midwife, nursing staff need to be aware of that transfer, as does the client and her family. There have been several instances where confusion about who is responsible for providing care have left families feeling abandoned or wondering who is responsible for what and when.

Confusion of all kinds is to be avoided if nurses and midwives are to communicate effectively and ensure the kinds of positive outcomes we all want to enjoy for our clients, patients, families and ourselves as caring human beings.

Grant Warrington RPN LLB MA CRM



Midwives Access to Hospital Health Records

Here at the Midwives Protection Program we're aware that midwives with privileges in some facilities are having more difficulty than others in accessing their client and infant records and we wanted to do something about that. In an effort to promote more consistent practice amongst the gatekeepers or custodians of those hospital base records we have developed a Risk Note for distribution to all BC hospitals. The text of that Risk Note follows this introduction.

Please feel free to refer to this Risk Note when encountering any challenges in accessing client or infant records which you believe you should be entitled to.

For general questions or concerns about accessing records please contact the Midwives Association of BC and for any claims related concerns please contact Kim Oldham, Director Claims and Litigation Management or Grant Warrington, Legal Counsel.

RISK NOTE

SUBJECT: Registered Midwives with Hospital Privileges and Access to Health Records

This Risk Note is intended to provide guidance to Health Records staff when considering requests by registered midwives with hospital privileges seeking access to their client and infant records.

Registered midwives have a right to access a complete copy of the client and infant charts, including foetal monitoring strips and images:

- without the client's consent any time the midwife is treating the patient or infant
- if treatment is over, at any time the request meets the requirements of the Bylaws of the hospital regarding medical staff rules
- with the client's consent, at any time.

Registered midwives also have a right to be copied on consultation reports that arise as a result of transferring care in accordance with medical staff rules. These consultation reports are relevant for continuity of care purposes.

Registered midwives can also access and review paediatric reports without the client's consent at any time if the registered midwife is involved in the care of the child. If the registered midwife is not involved in the care of the child she still may have access to the paediatric report with the consent of a parent.

If named in litigation the registered midwife is entitled to relevant records and reports usually obtained through the lawyer acting for HCPP or in compliance with the hospital's medical staff rules.

Where a client has terminated her relationship with the registered midwife the midwife is still entitled, without the client's consent, to records created while the midwife was providing care.

If a registered midwife is being reviewed by a quality assurance committee, or an inquiry or disciplinary committee, the midwife is entitled to see whatever is put before such a committee that could be relevant to the care provided, including subsequent consultations and reports.

March 2010

Risk Answers

Why do I need to purchase commercial general liability coverage in addition to MPP?

The Midwives Protection Program provides only professional malpractice coverage for bodily injury arising from the practice of midwifery. Midwives have a broader liability exposure for third party injury or property damage arising from sources other than the provision of professional services. For example, a client may slip on the floor during an office visit, or a midwife may accidentally spill something on her client's carpet. Because MPP would not respond to these types of losses, midwives need to maintain a commercial general liability (CGL) policy to ensure these exposures are properly addressed. The Midwives Association of BC has a group policy available to its members which includes commercial general liability. While not required to utilize the group policy, midwives must ensure that CGL coverage is in place to meet the underwriting requirements of MPP.

The MPP Team

Linda Irvine, Director, Client Services – Health Programs

Grant Warrington, Senior Claims Examiner/Legal Counsel

Kim Oldham, Director Claims and Litigation Management

Sharon White, Senior Risk Management Consultant – Health Programs

Midwives Protection Program

FEEDBACK IS IMPORTANT TO US AT MPP

Please let us know what you think about **Special Delivery**.
Did you find the **Effective Communications** informative?
Will **Midwives Access to Hospital Health Records** make any difference to your practice?
Are there any topics you would like us to cover in **Special Delivery?**
Do you have any questions **f**or the **Risk Answers** section?

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

It should be clearly understood that this document and the information contained within is not legal advice and is provided for guidance from a risk management perspective only. It is not intended as a comprehensive or exhaustive review of the law and readers are advised to seek independent legal advice where appropriate.