Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Failure to review and interpret CTG trace in a timely manner

20HDC00753

A report released today by Deputy Commissioner Rose Wall found Bay of Plenty District Health Board (DHB) (now Te Whatu Ora Hauora a Toi Bay of Plenty) breached the Code of Health and Disability Services Consumers Rights (the Code) for their care of a woman admitted with elevated blood pressure and in early labour with her first child.

The case highlights the importance of cardiotocography (CTG) traces being reviewed and interpreted in a timely manner.

A cardiotocography (CTG) trace, commenced in the early hours of the morning after the woman was admitted, should have been reviewed every 15-30 minutes. However, the CTG was not read and reviewed for nearly an hour, at which point an abnormal trace was identified. Following the abnormal trace, the baby was born in poor condition via caesarean section and required transfer to a tertiary hospital for specialist care for several weeks.

Ms Wall acknowledged the significant impact these events have had on the woman and her family. She also acknowledged the very difficult set of circumstances that presented that night when the acuity of the women being cared for on the labour ward was high, and staff were significantly affected by a clinical emergency earlier in the shift.

Despite the pressures on the ward, however, Ms Wall concluded that the woman had the right to services of an appropriate standard, as outlined in Right 4(1) of the Code. “In my view this standard was not met,” said Ms Wall.

Accordingly, she found Te Whatu Ora Hauora a Toi Bay of Plenty breached the Code for an unacceptable delay between commencing the CTG and reviewing the trace. Ms Wall concluded that the oversight was primarily a systems failure, relating to the allocation and pattern of work across the labour ward at the time.

Ms Wall was critical of the midwife who commenced the CTG at the request of a colleague. “I consider that the individual clinician who placed the CTG had the responsibility to check that it was not abnormal and document her findings before leaving the woman unattended.”

She was also critical of the midwife who requested the CTG. “I am concerned that the individual who asked her colleague to commence the CTG monitoring did not attend to assess the trace. If the midwife was unable to follow up with the woman,

my expectation is that this should have been handed over to another staff member to complete."

In addition, Ms Wall was critical of a midwife who did not did not bring an abnormal test result to the attention of the doctor caring for the woman overnight.

"Regardless of whether an elevated PCR (a screening test for protein in the urine) would have changed the plan of care, this was a medical decision, and clearly it is the standard of care for such results to be communicated to medical staff."

Te Whatu Ora Hauora a Toi Bay of Plenty has made a number of changes since this event relating to the monitoring of fetal wellbeing. The hospital has also put measures in place to better support staff when the labour ward is exceptionally busy.

In addition to the changes already made, Ms Wall outlined several recommendations for Whatu Ora Hauora a Toi Bay of Plenty, including:

- Providing the woman with a written apology for the failures identified in this report
- Reporting back to HDC on the impact the changes introduced have had on patient care.

9 October 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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