Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Taranaki DHB breaches Code for failing to provide appropriate standard of service to a pregnant woman with diabetes

20HDC00772

Taranaki District Health Board (DHB) (now Te Whatu Ora Taranaki) has breached the Code of Health & Disability Services Consumer's Rights (the Code) for failing to provide an appropriate standard of care to a pregnant woman with diabetes.

The woman, in her twenties at the time of events, had several existing conditions, including type 1 diabetes. The care provided by Te Whatu Ora Taranaki did not support the woman to adequately manage her diabetes throughout her pregnancy. Sadly, the woman miscarried at eight months.

Deputy Commissioner Rose Wall said her role is not to determine what caused the death of the woman's baby, but to determine whether the care provided to the woman was reasonable in the circumstances and consistent with the accepted standard of care.

The report did not identify any concerns with the midwifery and obstetrics care provided to the woman. The focus of the report is limited to the Taranaki DHB endocrinology service's management of the woman's diabetes during her pregnancy.

At the time of these events, Taranaki DHB did not have an established antenatal diabetes multidisciplinary team (MDT) (which enables input from a diabetes midwife, an obstetrician, an endocrinologist, a diabetes clinical nurse specialist, and a dietitian). As a result, the obstetrics team and diabetes team were providing the woman with care from separate clinics.

Ms Wall said this resulted in a clear disconnect between the two specialties and did not enable effective coordination of clinical care. She found that Te Whatu Ora Taranaki failed to provide the woman with an appropriate standard of care in the following ways:

- She was not seen for an initial consultation with the diabetes service in a timely manner due to an administrative error.
- A dietician review was not arranged in a timely manner, owing to the referral not being marked as 'urgent' for the medical typists.
- A clinical nurse specialist review was not undertaken regularly, resulting in the woman being seen by the diabetes clinical nurse specialist on only four occasions throughout her pregnancy.
- Care between the diabetes and antenatal services was not coordinated effectively.

Ms Wall said, "I consider that the failings in this case indicate systems issues… In my view, the failure to coordinate the woman's care effectively resulted in her not receiving services of an appropriate standard throughout her pregnancy."

Ms Wall found Taranaki DHB in breach of Right 4(1) which states that every consumer has the right to services provided with reasonable care and skill, and also Right 4(5) of the Code, which states that every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Since these events, Taranaki DHB sought an external review of the care provided to the woman and has told HDC it has made a number of changes as a result of the complaint, including the following:

- A multidisciplinary Team (MDT) clinic has been set up to coordinate the care of women with diabetes during pregnancy. The team includes a consultant obstetrician, a consultant endocrinologist, a diabetes nurse specialist, and an antenatal clinic coordinator.

- The Dietitian Department has commenced recruitment for two full-time dietitians who focus solely on diabetes. One will be required to attend the MDT meetings.

- Two further staffing resources have been employed specifically to support Māori patients with the diabetes service (Kaitautoko).

- Diabetes MDT meetings are held fortnightly, with the 'Diabetes in Pregnancy Management' guidelines being progressed as part of the MDT meetings with medical leadership.

In light of the changes already made Ms Wall recommended that Taranaki DHB:

- Provide a written apology to the woman for the issues identified in the report.
- Provide an update on the progress of actions taken in response to the recommendations made in the internal review.
- Provide results of the documentation audit that was conducted, and the changes that have been implemented to address any concerns raised by the audit.
- Use this case (anonymised) as a case study for the maternity/diabetes service multidisciplinary team, to highlight the importance of careful planning and management of women with diabetes during pregnancy.

7 August 2023

ENDS

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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