Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC02303)

Introduction 1
Background 1
Opinion: RM B — breach 3
Changes made since events 5
Recommendations 5
Follow-up actions 6
Appendix A: In-house clinical advice to Commissioner 7

Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the postnatal care provided to Ms A by Registered Midwife (RM) B.[1]

3. The following issue was identified for investigation:

- *Whether RM B provided Ms A with an appropriate standard of care in 2020.*

Background

4. In 2020, Ms A (aged in her twenties at the time of events) was pregnant with her first child and booked RM B to be her midwife (her lead maternity carer (LMC)). Ms A had a family history of pre-eclampsia[2] in pregnancy.

[1] Concerns raised by Ms A about the antenatal care provided to her by RM B have been addressed separately from this report.
[2] A potentially dangerous pregnancy complication characterised by high blood pressure.

Names have been removed (except the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. On 5 Month1, Ms A was admitted to the public hospital with pre-eclampsia and underwent an emergency Caesarean section on 7 Month1 due to fetal distress indicated on a CTG,[3] and failure to progress in labour.

6. Ms A and her baby were discharged from the public hospital two days later, on 9 Month1 (a Friday), with medication for her high blood pressure and a plan for her 'midwife to please monitor blood pressure'. RM B was aware of this plan.

7. Ms A told HDC that she was told that she would be seen by her midwife every day in the first week post-birth, to ensure that both she and her baby were doing well at home. However, Ms A was not seen by RM B until four days post-discharge, as RM B had the weekend off and was busy on the Monday.[4]

8. Overall, RM B saw Ms A and her baby three times postnatally, on 13, 22 and 29 Month1, within a period of three weeks after the birth. RM B told HDC that at these appointments she monitored Ms A's blood pressure (which was stable), and that she was happy with how well Ms A and her partner had transitioned to parenting.

9. RM B told HDC that it is not her normal practice to see consumers every day in the first week post-birth. The letter provided to Ms A upon booking RM B as her midwife stated:

> 'Once you go home from hospital your midwife will visit you regularly for between four and six weeks depending on your needs. Your midwife will generally do your first home visit the date after you go home from hospital or birthing unit, after that first visit, they will visit again when your baby is one week old …'

10. RM B told HDC that she tries to see women routinely and discharge them from her care at around four weeks, or 28 days post-birth. She stated that during this period, she sends Plunket a referral to ensure that it has enough time to arrange an appointment with the woman at around five weeks' post-birth, and that she discussed this at the 29 Month1 visit. RM B told HDC that she was planning to see Ms A the following week for her discharge visit but was unable to, as Ms A was out of town.

11. Ms A texted RM B on 9 Month2, stating that she was going to be back in town that evening, but RM B did not arrange another appointment to see her.

12. On 20 Month2, a Plunket nurse visited Ms A's house to let her know that she had been referred by RM B. That same day Ms A sent a text message to RM B to ask whether she was still under her care, but RM B did not respond.

13. Ms A told HDC:

> 'We were never discharged from our midwife care, nor were we seen the amount of times we were told. We were kept majorly in the dark. This was hugely disappointing,

[3] Cardiotocograph — a machine used to monitor the fetal heartbeat.
[4] RM B had an elective Caesarean section and an induction of labour for other clients, followed by her usual Monday clinic, which ran from 11.30am until 6pm.

Names have been removed (except the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

as we continuously kept the midwife in the loop and as first time parents, we definitely did not feel supported as we should have.'

14. RM B acknowledged that she did not respond to Ms A's last text message and told HDC: 'I cannot explain as to why I did not receive and reply to her last message, but I do admit that it was a complete oversight on my part.'

15. RM B expressed her apologies to Ms A for this oversight, and for Ms A feeling unsupported during this period.

Opinion: RM B — breach

Timing and frequency of postnatal visits

16. After giving birth to her baby via emergency Caesarean section on 7 Month1, Ms A and baby were discharged from the public hospital on 9 Month1. RM B's first postnatal visit to Ms A was four days later, on 13 Month1, as RM B was unavailable until then. RM B provided Ms A and her baby with three postnatal visits in total, with the last being around three weeks post-birth. This report concerns the frequency of RM B's visits, rather than the quality of care provided to Ms A.

17. My in-house midwifery advisor, RM Isabelle Eadie, noted that while there is no expectation that a midwife would visit daily post-birth (as Ms A was expecting), there is an expectation (from the Ministry of Health standards[5]) that the midwife will make a minimum of seven postnatal visits in total. In addition, it is expected that there will be a home visit within 24 hours of discharge from the maternity unit. I note that the letter provided to Ms A upon booking RM B as her midwife did not set the expectation for Ms A to be seen every day in the first week post-birth, but it was clear that she could expect to have her first home visit on the day after returning home from the hospital. The letter also noted that visits would be regular for between four and six weeks.

18. Noting that Ms A was not seen for her first visit until four days after discharge from hospital, RM Eadie stated:

> 'In itself this contravenes expectations, but in addition, [Ms A] had pre-eclampsia, that was medicated and had had a [Caesarean section], so she had considerable risk factors that would warrant an early post-natal review.'

19. RM Eadie advised that if RM B had a weekend off, it would be expected that she would arrange for her midwifery partner to visit Ms A. RM Eadie considers that the failure to see

[5] Section 88 of the New Zealand Public Health and Disability Act 2000 Primary Maternity Services Notice 2007 Clause DA29: Services following birth DA29 Service specification: services following birth — 'a LMC is responsible for ensuring that all of the following services are provided for both the mother and baby … post-natal visits to assess and care for the mother and baby in a maternity facility and at home until six weeks after the birth, including between five and ten home visits by a midwife (and more if clinically needed) including one home visit within 24 hours of discharge from a maternity facility; and a minimum of 7 postnatal visits …'.

Names have been removed (except the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms A until four days post-discharge from the hospital reflects a 'moderate departure from expected practice'. I accept this advice.

20. In addition, I note that postnatally RM B visited Ms A only three times. While RM B told HDC that Ms A was doing well at these appointments, this fell far short of the minimum of seven expected visits as set out by the Ministry of Health guidelines.

21. As noted by RM Eadie, Ms A had risk factors that made early postnatal review even more warranted. I am critical of the delay in RM B visiting Ms A for her first postnatal visit and consider that RM B also fell short in what was expected of her, and what was communicated to Ms A by RM B's booking sheet in terms of the timing and frequency of postnatal review of Ms A and her baby.

Discharge from care

22. RM B's final visit to see Ms A and her baby was on 29 Month1. RM B told HDC that she was planning to see Ms A the following week, but Ms A was out of town. RM B said that she made a referral to Plunket so that care could continue, and Plunket saw Ms A for her first visit on 20 Month2. RM B did not contact Ms A, either in person or by telephone, to discharge Ms A and her baby from her care after the 29 Month1 visit.

23. RM Eadie noted that it is appropriate for midwives to discharge women to the care of Plunket between four to six weeks postnatally. However, RM Eadie advised that in the midwifery standards (New Zealand College of Midwives 2019[6]) that underlie midwifery practice, standard 9 states that '[t]he midwife negotiates the completion of the midwifery partnership with the woman'. Accepting that extenuating circumstances (Ms A being out of Auckland) may have arisen, RM Eadie was 'mildly critical' that RM B did not meet with Ms A personally, or contact her by telephone, to discharge her from her care postnatally.

24. I acknowledge that RM B intended to see Ms A for a discharge visit in the week following 29 Month1 (three weeks after the birth), but Ms A was unavailable. However, Ms A sent RM B a text message on 9 Month2 advising that she would be back in town, and another appointment was not arranged. In addition, when asked directly via text message on 20 Month2 whether Ms A and her baby were still under RM B's care, RM B did not respond. As such, I am not persuaded that Ms A being unavailable initially mitigates the lack of any further contact, and I am critical of RM B's failure to negotiate the completion of the midwifery partnership with Ms A. Instead, RM B left Ms A in the dark about where her care stood, and left her feeling unsupported, as noted in Ms A's complaint to this Office.

Conclusion

25. The main goal of postnatal care is to maintain and promote the safety and wellbeing of mothers and their newborns. It also promotes continuity of care to ensure that mothers receive the ongoing support they require after birth. In my opinion, it was the responsibility of RM B to ensure that safety-netting measures appropriate to the circumstances were followed. This was particularly important in the case of a first-time mother who had had an

[6] https://www.midwife.org.nz/midwives/professional-practice/standards-of-practice/.

Names have been removed (except the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

unexpected and likely distressing birthing journey, and it was crucial that Ms A felt supported and received postnatal care at a frequency that met accepted standards and addressed her needs. Ms A had added risk factors due to her pre-eclampsia (for which the hospital had asked RM B to monitor Ms A's blood pressure postnatally) and her emergency Caesarean section. In addition, RM B's own information sheet that was provided to Ms A at the time of her booking set an expectation that Ms A would have her first home visit on the day after she returned home from the hospital, and that she would be seen for four to six weeks after the birth of her baby.

26. I am critical that RM B failed to visit Ms A and her baby within 24 hours after discharge from hospital, that RM B undertook only three postnatal visits in total instead of the expected minimum of seven, and that she failed to negotiate the completion of the midwifery partnership with Ms A. I consider that these omissions meant that the ongoing safety and wellbeing of Ms A and her baby had the potential to be compromised in this postnatal period.

27. As such, for failing to adhere to the Ministry of Health and New Zealand College of Midwives standards when providing postnatal care to Ms A, I find that RM B breached Right 4(2) of the Code.[7]

Changes made since events

28. Since these events, RM B has worked in a partnership of four (as opposed to having only one backup midwife) so that she can have a first and second midwife on call to assist if required over a weekend. In addition, RM B told HDC that she now makes a habit of sitting down as soon as she arrives home from work, and she scrolls through her messages received throughout the day to ensure that none have been missed.

Recommendations

29. I recommend that RM B:

a) Within three months of the date of this report, provide HDC with an audit of her last 10 clients, outlining:

   i. the dates on which the postnatal visits were completed;

   ii. whether a comprehensive end-point assessment was completed, including the provision of contraceptive advice, and information about, and referral to, 'well woman' and 'well child' services, including available breastfeeding support and immunisation advice;

   iii. the information provided to her client/s about the discharge from midwifery care; and

   iv. the completion of a referral to a 'well child' provider.

[7] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

Names have been removed (except the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Where this audit does not show 100% compliance with the Ministry of Health and New Zealand College of Midwives standards for postnatal care, RM B is to report to HDC on how she intends to improve her practice to ensure that these standards are met going forward. In addition, a further audit is to be completed to ensure that compliance is being met after these improvements.

b) Provide Ms A and her family with a written apology for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding.

Follow-up actions

30. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Midwifery Council of New Zealand, and it will be advised of RM B's name.

31. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the New Zealand College of Midwives and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RM Isabelle Eadie:

'**C20HDC02303**

[Ms A]

…

<u>Postnatal care</u>

[RM B] has not provided the postnatal notes, however, [Ms A] has not complained about the quality of care she received from [RM B], but the frequency. [Ms A] states in her complaint that she was informed that [RM B] would visit her daily at home up for the first week and to continue to visit until 6 weeks postnatally. It is unfortunate that she was given this expectation because midwives are not expected to visit daily — rather there is an expectation they will make a minimum of 7 postnatal visits in total, of which 5–10 are home postnatal visits depending upon clinical need. In addition, it is expected that there will be a home visit within 24 hours of discharge from the maternity unit (Department of Internal Affairs 2007).

[Ms A] was discharged home from the hospital on 9th [Month1] and not seen until 13th [Month1]. In itself this contravenes expectations, but in addition, [Ms A] had pre-eclampsia, that was medicated and had had a CS, so she had considerable risk factors that would warrant an early postnatal review. In her response, [RM B] states that it was her weekend off and that she had other commitments on the Monday which is why she was unable to see [Ms A] until the Tuesday. [RM B] explained that she has antenatal clinics on Mondays and Wednesdays and does her postnatal visits on Tuesdays and Thursdays. It strikes me that there was an unwillingness to break her routine. If [RM B] had a weekend off, it would be expected that she would arrange for her midwifery partner to visit [Ms A]. [RM B] did write that her midwifery partner contacted [Ms A] during this time to check up on her, but does not provide an explanation as to why she was not visited in person. Failure to not see [Ms A] for 4 days post-discharge from the hospital (either [RM B] herself or another nominated midwife arranged by [RM B]) reflects a moderate departure from expected practice.

[RM B] then saw [Ms A] at home on the 22nd and 29th [Month1] and in her response she wrote that [Ms A] was recovering and transitioning to motherhood extremely well and that she did not have any concerns. During this visit on 29th [Month1], [RM B] wrote that she discussed referrals to Plunket and she made an appropriately timed referral to them. Section 88 requires midwives to make well child referrals before the 4th post-natal week (Department of Internal Affairs 2007).

[RM B] had planned to visit [Ms A] again the following week for the discharge visit; it is appropriate for midwives to discharge women to the care of Plunket and the GP between 4–6 weeks post-natally. Unfortunately though, this appointment did not take place because [Ms A] went [away], not returning until 8th [Month2]. Whilst she was

Names have been removed (except the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

[away], contact between [Ms A], [RM B] and her back up midwifery partner was maintained. In her response, [RM B] apologises profusely that she did not see [Ms A's] text messages regarding her anticipated return [home] and accepts responsibility for her failure to get in touch and formally conclude their relationship and discharge her from midwifery care.

Whilst [RM B] had arranged the transfer of care to Plunket, so care would continue, in the midwifery standards (NZCOM 2019) that underlie midwifery practice, standard 9 states that "The midwife negotiates the completion of the midwifery partnership with the woman". [RM B] failed to do this and this reflects a mild to moderate departure from expected practice.

Summary

I am not critical of [RM B's] "informal" consultation with the obstetrician but I am critical that [Ms A] did not receive a midwifery home visit until four days after being discharged from the hospital. I am mildly critical that [RM B] did not personally meet with [Ms A], or even contact her by phone to discharge her from her care post-natally, however, I do accept that extenuating circumstances ([Ms A] being out of [town]) may have got in the way and my perception is that [RM B] is extremely apologetic and accepts responsibility for this oversight.

References

Department of Internal Affairs. (2007). Maternity services notice pursuant to section 88 of the New Zealand public health and disability Act 2000. Wellington: Department of Internal Affairs.
https://www.midwife.org.nz/wp-content/uploads/2019/06/S88-Maternity-notice.pdf

Ministry of Health (2012). Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington: Ministry of Health.
https://www.health.govt.nz/system/files/documents/publications/referral-glines-jan12.pdf

New Zealand College of Midwives (2019). Standards of Practice for Midwives. In Midwives Handbook for Practice. Christchurch: New Zealand College of Midwives.
http://www.midwife.org.nz/midwives/professionsl-standards/standards-of-practice accessed 24/9/20'

Names have been removed (except the independent advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.