Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 13HDC00259)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. In 2012, Ms A chose midwife Ms B to act as her Lead Maternity Carer (LMC). Ms A was a teenager who was pregnant with her first child. This report is primarily concerned with the events that took place in the four days leading up to the birth.

2. At 40 weeks and five days' gestation, Ms A was in text communication with Ms B. Ms A reported pain and cramping. That afternoon, Ms A attended a consultation with Ms B, who noted the fetal heart rate and that Ms A was "feeling good [fetal movements]".

3. In the evening at 40 weeks and seven days' gestation, Ms A was in further text communication with Ms B. She reported "really bad tummy pains" which were coming "every 15 minutes or so". Ms B advised Ms A by text message to take four Panadol at once. That night, Ms B decided to travel out of town the following day. She did not advise Ms A of her plans and did not document her communications with Ms A.

4. At 6.47am the following day, Ms B handed over Ms A's care to midwife Ms D by text message before travelling out of town for the day. Ms B did not inform Ms D about her communications with Ms A the previous evening.

5. From 10.51am that day, Ms A was in text communication with Ms B. Ms A reported that she was in a lot of pain. Ms B continued to advise Ms A, and did not inform her that she was off call until after 11.38am. Ms B was in text communication with Ms D throughout the morning but did not relay the information provided by Ms A to Ms D.

6. At approximately 1.10pm, Ms A presented to the maternity unit at the public hospital (the maternity unit) by ambulance. Staff were unable to find a fetal heartbeat. Sadly, Ms A's baby was stillborn with a true knot in the umbilical cord.

Findings

7. Ms B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[1] by failing to provide services to Ms A with reasonable care and skill, in that she failed to assess Ms A's condition and needs adequately, prescribed an inappropriate dosage of Panadol by text message and failed to make contact with Ms A in an appropriate manner.

8. Ms B breached Right 6(1) of the Code[2] by failing to provide Ms A with information that a reasonable consumer in her circumstances would expect to receive, in that she failed to inform Ms A that she was going off call and out of town or of the identity of her stand-in midwife in circumstances where Ms A was eight days overdue, in labour, and in regular text communication with Ms B.

[1] Right 4(1) of the Code provides that "[e]very consumer has the right to have services provided with reasonable care and skill".
[2] Right 6(1) of the Code provides that "[e]very consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive".

9. Ms B breached Right 4(5) of the Code[3] with regard to her handover to Ms D by failing to ensure the quality and continuity of services provided to Ms A, in that she did not advise Ms D of any of Ms A's concerns from the previous evening or as they were communicated to Ms B throughout the morning after she had gone off call.

10. Ms B breached Right 4(2) of the Code[4] by failing to provide care in accordance with professional standards, in that her record-keeping fell short of the requirements of Standards Three[5] and Four[6] of the *Standards of Midwifery Practice* (2008).

Complaint and investigation

11. HDC received a complaint from Ms A regarding services provided to her by a midwife, Ms B.

12. An investigation was commenced on 1 October 2013. The following issue was identified for investigation:

Whether midwife Ms B provided adequate care to Ms A.

13. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Ms B	Lead Maternity Carer (LMC) midwife

14. Information was received from both of the above parties, as well as from the following:

Ms D	Back-up midwife
Ms A's general practice clinic	
Midwifery Council of New Zealand	

15. Also mentioned in this report are:

Maternity unit/the public hospital
RN C, registered nurse

16. Independent expert advice was obtained from midwife Christine Griffiths (**Appendix A**).

[3] Right 4(5) of the Code provides that "[e]very consumer has the right to co-operation among providers to ensure quality and continuity of services".
[4] Right 4(2) of the Code provides that "[e]very consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards".
[5] Standard Three requires midwives to collate and document comprehensive assessments of the patient.
[6] Standard Four requires midwives to maintain purposeful, ongoing, updated records.

Information gathered during investigation

Background

Maternity services in New Zealand

17. Pregnant women in New Zealand are entitled to free maternity services from midwives or general practitioners to cover their pregnancy, birth and postnatal care. To access these services, the woman must choose an LMC, who is funded by the Ministry of Health to provide maternity services. LMC responsibilities are set out in the Primary Maternity Services Notice, issued pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 (the Section 88 Notice). The Section 88 Notice states that the LMC is responsible for the care provided to the woman throughout her pregnancy and in the postpartum period.

Text messaging

18. The Midwifery Council of New Zealand's Code of Conduct (December 2010) contains the following guideline statement:

> "Text messaging can be an unreliable method of communication, with message transmission delayed at times or messages open to misinterpretation. While women may use texting to contact a midwife, midwives must consider the appropriateness of using text communications and ensure that their communication with women occurs through reliable methods such as telephone. All communication with women should be appropriately documented."

Relevant factual background

19. In 2012, Ms A (a teenager) became pregnant with her first child. She met with and chose registered midwife Ms B to act as her LMC. Ms A told HDC that Ms B "was recommended to us by a friend of mine who had [Ms B] as her midwife for a home birth and she seemed good".

20. Ms B recorded in her notes a full-page summary of her initial consultation with Ms A. Ms B noted that, among other things, "when to call and how to contact" information was given to Ms A and discussed with her. The information sheet provided to Ms A recorded that Ms B offered a "24 hours LMC consultation service". It then listed a series of urgent matters for which Ms A was to call Ms B immediately, followed by a series of non-urgent matters for which Ms A was to call between 9am and 5pm. Non-urgent matters included mild abdominal pain, feeling unwell, and reduced fetal movements. Urgent matters included severe and constant abdominal pain, and strong, regular and painful contractions every five minutes.

21. Also at the initial consultation, Ms A and Ms B completed a number of registration and admission forms. Ms A signed an Admission Form dated that day, which records that she had a medical history of asthma and appendicitis. Ms B completed a Maternal Medical and Surgical History Form for Ms A, also dated that day, which records that Ms A had a history of "appendicitis surgery".

22. Ms A told HDC that she has nephrotic syndrome,[7] and that this information was "missed out" of Ms B's notes.[8] There is no reference in Ms B's notes to Ms A having nephrotic syndrome. The abovementioned forms both contained tick boxes pertaining to renal disorders, both of which were left blank.[9] None of the other tick boxes on those forms were filled in. Ms B told HDC that Ms A did not disclose any history of a kidney condition, either upon admission into Ms B's practice or subsequently.

23. Ms A attended 11 consultations with Ms B (including her initial consultation). Ms A told HDC that she had "no problems with [Ms B] until she [Ms A] hit 36 weeks".

24. Ms A said that at 36 weeks' gestation,[10] she experienced Braxton Hicks contractions[11] and asked Ms B whether she ought to go to hospital. Ms A reported that Ms B told her that there was no need to go to hospital, and that "since that time we've felt that [Ms B] has not listened to our concerns and has just blown us off".

25. At 36 weeks' gestation, Ms A self-presented to the maternity unit. Ms B recorded in her notes that Ms A received a "reassuring" cardiotocography[12] (CTG) result and that she was sent home as she was not in labour.

26. At 40 weeks and one day's gestation, Ms A was again assessed at the maternity unit. Ms B recorded in her notes that Ms A was "not getting lots of [fetal movements] lately", and that a CTG was obtained (the results of which were described by Ms B as "reassuring"). The plan documented in Ms B's notes was for Ms A to be referred to an obstetrician for a postdate pregnancy assessment after 40 weeks and six days' gestation.[13]

27. This report is primarily concerned with the events that then took place between Friday and Monday (40 weeks and five days gestation, and 41 weeks' gestation), the details of which are set out below.

Friday

Text message communication between Ms A and Ms B

28. On Friday at 7.43am, Ms A texted Ms B advising that she would be unable to attend her appointment that day as her brother, on whom she was relying for transport, had been called into work.[14] Ms A told HDC that Ms B "expected [her] to go to [the clinic] for all the appointments", and that this was difficult for her as she had no transport and all of her family members worked. Ms B told HDC that "at no time did

[7] A kidney disorder that causes the body to excrete too much protein into the urine.
[8] Clinical documentation provided to HDC by Ms A's medical centre confirms that Ms A has a history of recurrent nephrotic syndrome.
[9] The Admission Form completed by Ms A contained a tickbox alongside "UTI/Renal". The Maternal Medical and Surgery History Form completed by Ms B contained a tickbox alongside "Renal/Urinary tract disorder".
[10] The age of the fetus. The normal period of gestation is 40 weeks.
[11] Sporadic uterine contractions, also known as prodromal labour or practice contractions.
[12] A recording of the fetal heartbeat and uterine contractions during pregnancy.
[13] Postdate pregnancy is a prolonged pregnancy of more than 42 completed weeks.
[14] Ms A was 40 weeks and five days' gestation.

[Ms A] voice concern about attending appointments at [her] clinic nor did [Ms A] request that visits occur in her home".

29. At 11.39am, Ms B responded: "ok all good?". At 11.41am, Ms A replied: "yea. are we able to bring [the baby] along as im been having alot of pains". At 11.44am, Ms B texted Ms A asking whether she was contracting. Ms A responded at 11.45am that she did not think so but that she "had a few tummy cramps but they aren't close or anything, and i've had a sore lower back".

30. At 11.47am, Ms B advised Ms A to "try to go swim or exercise". At 11.48am, Ms A responded that she had been "doing heaps of walking and its not helping". At 11.51am, Ms B texted Ms A asking "is baby active?", to which Ms A responded at 11.52am: "kind of".

31. At 12.02pm, Ms A texted Ms B advising that her brother could take her to see Ms B in around two hours' time. Ms B responded that that would be "perfect".

Consultation with Ms B

32. At approximately 2.30pm, Ms A attended a consultation with Ms B, who recorded in her notes that Ms A was now "feeling good [fetal movements]" and was not in labour. Ms B also recorded her examination of Ms A, noting that Ms A's blood pressure was 105/50mmHg[15] and that her urinalysis showed "protein ++" and negative glucose.[16] Ms B further noted that the fetal heart rate was 150 beats per minute (bpm)[17] and that Ms A's baby had moved into a posterior position.[18]

33. Ms A told HDC:

> "I tried to talk to [Ms B] about a 'really big feeling at the front of my stomach which felt really hard' and she said this was normal and didn't explain anything. I was concerned as it was just like a ball, a little bit of stomach really hard, [Ms B] did take the baby's heartbeat and we found out the baby was back to back. She touched my stomach lightly but did not investigate this further."

34. Ms B told HDC that she does not recall Ms A raising any complaints at this appointment.

Saturday

35. On Saturday, the maternity unit received an Internal Referral Form from Ms B, which requested a postdate pregnancy assessment of Ms A by an obstetrician on Monday. Ms B told HDC that Ms A was scheduled to attend an appointment at the maternity unit at 1pm on Monday.

36. Ms A said that during the day she "went swimming and did work on [her] hands and knees as [Ms B] said that this would help".

[15] Normal blood pressure typically ranges between 120/80mmHg and 90/60mmHg.
[16] Increased levels of protein in urine during pregnancy can be an indicator of urinary tract infection and of pre-eclampsia. The presence of glucose can indicate gestational diabetes.
[17] Normal fetal heart rate at term is 110–160bpm.
[18] Posterior fetal position is when the baby's head is positioned against the mother's back.

Sunday

37. Ms A told HDC that on Sunday, she began to have "really bad pains at night". At 9.51pm, Ms A texted Ms B stating:

> "i'm getting really bad lower tummy pains and back the ones in my tummy last up to 40 seconds to over a minute they that bad I've been crying and when they not there it still gets painful just not as bad can we do something this pain is like unbareable, i just want her out."

38. Ms B told HDC that Ms A was "counselled concerning comfort measures and advised to use Panadol, not to exceed established dosing guidelines".

39. Telephone records provided to HDC by Ms A show that at 9.53pm, Ms B texted: "take 2 panadol every 4 to 6 hours". Ms A responded at 9.54pm: "pandaol hasn't helped". At 9.55pm, Ms B then texted Ms A: "okay you can take 4 at once". Ms B then texted Ms A at 9.56pm, asking how often the pain was coming and going. At 9.56pm, Ms A responded: "every 15 minutes or so". At 9.58pm, Ms B responded by text message: "will be a long night for you. well help yourself".

40. Telephone records provided by Ms B also show that these text messages were exchanged on Sunday (although the specific times are not recorded).

41. Ms B did not document the above communications with Ms A in her notes. She and Ms A did not exchange any further communications (either by text message or telephone) that night.

Monday

Handover to LMC Ms D

42. Ms B told HDC that she went off call at 8.00am on Monday morning, at which time she handed over the coverage of her practice to LMC Ms D (who was at the maternity unit that day). Ms B explained to HDC that she had decided late the previous night to travel out of town. Ms B is unable to recall whether she made that decision before or after her text message communications with Ms A on Sunday night.

43. Ms B explained that the policy in her practice was to "transfer care via direct verbal, telephonic or confirmed receipt, text message communication with a summary of cases in labour, en route to hospital or those whose labour was imminent". Ms B advised:

> "[I was] in communication with my covering midwife, [Ms D], on [Monday] at 06:47AM when I advised her via a text message (receipt of which was acknowledged by [Ms D]) that [Ms A] was scheduled for assessment during post dates clinic that afternoon."

44. Ms B told HDC that Ms D was "made aware that [Ms A] and another of my clients were in prodromal labour[19] and were likely to require hospital services that day".[20]

[19] Prodromal labour is an early phase of labour before uterine contractions become forceful and frequent enough to result in progressive dilation of the uterine cervix.

Telephone records provided to HDC by Ms B indicate that she texted Ms D at 6.47am advising that Ms A (and another client) were "overdue, primips[21] & referred to postdates clinic for today". Those records also show that Ms D responded: "Absolutely going to [maternity unit] this morning so will do. Don't worry [Ms B]. U do what u hve to do. If anyone goes into labour no probs. enjoy yr trip ;))".

45. Ms D told HDC that Ms B asked her to go on call on Monday and that:

> "[Ms B] unfortunately did not relay to me that [Ms A] had been in distress throughout the night and had been requesting to come into [the maternity unit] for assessment. I had been texted by [Ms B] that morning. The only information I received regarding her clients that morning was that her clients were all well and two of her postdates were being assessed in [the maternity unit] that afternoon."

46. Telephone records provided by Ms B to HDC indicate that she and Ms D then exchanged a series of text messages before Ms B boarded her plane.

47. There is no documentation in Ms A's notes of Ms B's handover to Ms D. Ms B told HDC that she did not document her transfer of care to Ms D as she did not have access to her notes at the time, and was reluctant to make any retrospective entries "given [her] concern for the integrity of the record as well as the unfortunate pregnancy outcome".

Text communication between Ms B and Ms A

48. At 10.46am, Ms A texted Ms B: "im in a lot of pain and cant get rid of it, they coming like every 5 or so minutes". At 10.49am, Ms B responded "u r doing well" and asked whether she had been taking Panadol regularly. At 10.50am, Ms A responded that she had but that it was not easing the pain.

49. At 10.51am, Ms B texted Ms A: "it works & u just to be patient". Ms A responded: "okay". At 11.38am, Ms A texted Ms B: "I've just thrown up".

Telephone conversation with Ms B

50. Ms A told HDC that, having heard nothing back from Ms B after her text at 11.38am, her mother:

> "… phoned [Ms B] to say that I wanted to be seen by [Ms B] and [Ms B] told her to get in contact with this other person as she was not available to see me. We still did not know she was [out of town], she hadn't told us this or discussed who would be there for me while she was away. So I was referred to [Ms D], who was just great."

51. Ms B told HDC that she "did follow up [her] texting with a phone call to the patient at 11.38am on [Monday]". Ms B said that she advised Ms A to go to the maternity unit

[20] Ms B initially advised that this communication took place at 7.47am. She subsequently clarified that this was a typographical error in her written response, and that handover to Ms D took place at 6.47am.
[21] A female during her first pregnancy.

for evaluation, and that Ms D would be seeing her as Ms B was no longer on call. Ms B subsequently told HDC that she may have spoken with Ms A's mother, as opposed to directly with Ms A.

52. Ms B again advised that she did not document this conversation because she did not have access to her notes at the time and was reluctant to make any retrospective entries.

Communication between Ms B and Ms D

53. Telephone records provided to HDC by Ms B indicate that she texted Ms D at 11am advising that she had arrived safely. The text message makes no reference to her communications with Ms A between 10.46am and 10.51am.

54. Ms B told HDC that she communicated with Ms D at 12.09pm and advised her of Ms A's expected arrival. Ms B further advised that "[Ms D] was physically in hospital and awaiting [Ms A's] arrival". Telephone records provided to HDC by Ms B indicate that she texted Ms D at 12.09am, stating: "[Ms A] is going to call you."

55. Telephone records provided to HDC by Ms B show that she and Ms D then exchanged a series of text messages (although the precise timing is not recorded for each message). Ms B advised Ms D by text message that Ms A had had a "false labour" four weeks earlier. Ms B did not convey any further information about Ms A's condition by text message.

56. Maternity unit notes indicate that at 12.45pm, registered nurse RN C received a telephone call from Ms A's mother, who advised that Ms A was "having painful contractions 1 minute apart and LMC [Ms B] was unavailable". Ms A's mother asked to speak with Ms D. RN C recorded in the notes that she "advised that [Ms D] was in the unit and to come in for assessment".

57. Ms D told HDC that she received a call from RN C advising that one of Ms B's clients was coming into hospital by ambulance in strong labour.[22] Ms D advised that she was "surprised by this as I had no information on [Ms A] as [Ms B] had not mentioned about one of her clients in labour or that she had been niggling throughout the night". Ms D recalls: "I was not happy about [Ms B] not informing me of her client being in labour and distressed as I had a very hectic day ahead and if I had known I would have arranged my day around her client in labour." Ms D further recalls that she then "dashed down" to the delivery suite, where she waited for Ms A's arrival.

Presentation to maternity unit

58. At approximately 1.10pm, Ms A presented to the maternity unit by ambulance. She was accompanied by her mother. The ambulance service's patient report form recorded that Ms A was experiencing pain in her lower abdomen, and pain radiating around her waist. The form also recorded that Ms A had a history of nephrotic syndrome.

[22] Notes taken by RN C record that this telephone call was made at 12.50pm.

59. Ms D told HDC that she "attempted to auscultate the fetal heart rate but unfortunately I could not obtain the heart rate. I used the CTG machine and then the sonacaid.[23] I realised at [that] point that the baby was dead." Ms D reports that she was "in shock with this finding".

60. Labour notes record that an ultrasound was performed at 1.45pm, which confirmed intrauterine fetal demise. At 4.24pm, Ms A's baby was stillborn with a "true knot" in the umbilical cord.[24] Subsequent testing showed a normal fetus with no chromosomal abnormalities.

61. Ms B's notes for Monday record that "[Ms A] delivered [her baby] today". No further details are recorded.

Subsequent events

62. On 8 January 2013, Ms B visited Ms A in the maternity unit. Her notes record that she was "so sorry for [Ms A's] loss" and that funeral arrangements were discussed. Ms A's care was then transferred from Ms B to Ms D.

63. Ms A told HDC:

> "We asked for [Ms D] to do the after birth care, not [Ms B], and have had no further contact with her. We then found out that [Ms B] had been [out of town] from 6.00am–8.00pm on [Monday], we were never told this or given any contacts for [Ms D] or any other midwives while she was away."

Changes made by Ms B

64. Ms B told HDC that she has made a number of changes to her practice since this incident. In particular:

- Ms B now "strongly discourage[s] the use of texting as a means of communication with [her] clients and strive[s] to follow up any text communication with clients telephonically". Ms B has updated the information sheet provided to her clients, which now includes a note that "telephone texting message is strongly discouraged".

- Ms B has incorporated a telephone conversation documentation checklist into her practice.

- Ms B now ensures that patient handovers to covering midwives occur telephonically or personally. Ms B also now transfers all patient calls and continuing care to the covering midwife when she is not on call.

65. Ms B also told HDC that she agrees that "it would have been more optimal to have personal contact with the patient at 21.51 on [Sunday] relative to contractions and the

[23] A fetal heart monitor.
[24] A "true knot" denotes an intertwining of a segment of umbilical cord, usually without obstructing circulation, commonly formed by the fetus slipping through a loop of the cord. Consequences hinge on the tightness of the knot. A tight knot can cause fetal demise.

use of over the counter medications for management of associated discomfort". Ms B further advised that she agrees that she "should have made [Ms A] aware that [she] was going off call" and that her communications with [Ms A] and [Ms D] between [Sunday and Monday] ought to have been documented.

66. The Midwifery Council of New Zealand told HDC that in April 2013, Ms B commenced a competency programme, which was satisfactorily completed in November 2013.

67. In response to my provisional opinion, Ms B stated that she has "learned tremendously from this case and has taken to heart the findings".

Relevant standards

68. The *Standards of Midwifery Practice* (2008) provides:

> "**Standard Three**
> The midwife collates and documents comprehensive assessments of the woman and/or baby's health and other relevant persons.
>
> **Standard Four**
> The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons."

Opinion: Ms B

69. Ms A came under Ms B's care in 2012. Her pregnancy proceeded largely without incident until Ms A reached 36 weeks' gestation. This report is specifically concerned with the events that took place over the four days leading up to the birth and, in particular, during the 24 hours before the tragic stillbirth of Ms A's baby, who was found to have a "true knot" in the umbilical cord. It is important to note that my role does not extend to determining the cause of the baby's death. I am primarily concerned with the standard of care provided by Ms B to Ms A.

Ms A's medical history — No breach

70. At the initial consultation, Ms A and Ms B completed a number of registration and admission forms. Ms A signed an Admission Form dated that day, which recorded that she had a medical history of asthma and appendicitis. Ms B completed a Maternal Medical and Surgical History Form for Ms A, also dated that day, which recorded that Ms A had a history of "appendicitis surgery".

71. Ms A told HDC that she has nephrotic syndrome, and that this information was "missed out" of Ms B's notes. There is no reference in Ms B's notes to Ms A having

nephrotic syndrome. The abovementioned forms both contained tick boxes pertaining to renal disorders, which were left blank. Ms B told HDC that Ms A did not disclose any history of a kidney condition either upon admission into Ms B's practice or subsequently.

72. Both forms contain written comments pertaining to asthma and appendicitis, which indicates that Ms A's medical history was discussed at least to that extent. Given that the other tick boxes in the forms were also left blank, it is difficult to determine conclusively whether Ms B discussed these particular conditions with Ms A. I am unable to make a finding as to whether Ms B was advised of Ms A's history of nephrotic syndrome. I note the comments made by my independent expert adviser, midwife Ms Christine Griffiths, that Ms B should make it clear in her documentation whether she has asked about the conditions set out in those forms.

Consultation on Friday — Adverse comment

73. As of 40 weeks and five days' gestation, Ms A was five days overdue. She and Ms B exchanged a number of text messages throughout the morning. Ms A initially contacted Ms B at 7.43am to advise that she would be unable to attend her appointment that day as her brother had been called into work. Some four hours later, at 11.39am, Ms B responded: "ok all good?". Ms A responded two minutes later that she had "been having a lot of pains".

74. Ms B then asked Ms A by text message whether she was contracting. Ms A responded that she did not think so but that she "had a few tummy cramps" and "a sore lower back". Ms B advised Ms A to "try to go swim or exercise". Ms A responded that she had been "doing heaps of walking and its not helping". At 11.51am, Ms B texted Ms A: "is baby active?". Ms A responded at 11.52am: "kind of".

75. Ms B did not respond to that text message. However, 10 minutes later at 12.02pm, Ms A texted Ms B again, advising that her brother could take her to see Ms B in around two hours' time.

76. At approximately 2.30pm, Ms A attended a consultation with Ms B, who recorded in her notes that Ms A was now "feeling good [fetal movements]" and was not in labour. An appointment was made for a postdate pregnancy assessment with an obstetrician for the following Monday, which Ms Griffiths advised me demonstrates reasonable care by Ms B.

77. Ms B also recorded her examination of Ms A, noting that Ms A's blood pressure was 105/50mmHg and that her urinalysis showed "protein ++" and negative glucose. Ms Griffiths stated:

> "Given [Ms A's] blood pressure was low, rather than high, the proteinuria[25] was more likely to be a sign of a urinary tract infection than preeclampsia developing, however it may have been prudent to recommend blood tests to exclude preeclampsia."

[25] The presence of excess protein in the urine.

78. I agree that, in the circumstances, it would have been sensible for Ms B to have done so. I am also critical of Ms B's communication with Ms A in the lead-up to this consultation. In particular, I am concerned that, after exchanging a number of text messages with Ms A between 11.39am and 11.51am, which indicated that Ms A had been experiencing pain and cramping, Ms B did not respond to Ms A's text message of 11.52am advising that the fetus was "kind of" active. I acknowledge that Ms A contacted Ms B 10 minutes later to arrange a consultation later that afternoon. However, in my view, it would have been preferable for Ms B to have initiated direct contact with Ms A by proactively following up Ms A's text message of 11.52am (such as with a telephone call).

Advice by text message and failure to assess properly — Breach

Use of Panadol

79. On Sunday at 9.51pm, Ms A texted Ms B stating that she was experiencing "really bad lower tummy pains", which were lasting up to over a minute and that she had been crying. Ms B told HDC that Ms A was "counselled concerning comfort measures and advised to use Panadol, not to exceed established dosing guidelines".

80. Telephone records provided to HDC by Ms A show that at 9.53pm, Ms B texted: "take 2 panadol every 4 to 6 hours" and that Ms A responded at 9.54pm: "pandaol hasn't helped". Those records further indicate that at 9.55pm, Ms B texted Ms A: "okay you can take 4 at once". Telephone records provided to HDC by Ms B also indicate that these text messages were exchanged on Sunday.

81. The evidence indicates that Ms B advised Ms A to take four Panadol at once. However, the recommended dosage of Panadol is one to two 500mg tablets every four to six hours with a maximum of eight tablets in 24 hours (Medsafe 2013). Ms B's advice to take four at once was clearly inappropriate.

82. Similarly, I agree with Ms Griffith's advice that prescribing medication by way of a text conversation is inappropriate when the woman has not had an assessment by her midwife. I am particularly concerned that Ms B did not enquire further about Ms A's condition before directing her to take Panadol. I therefore have serious concerns as to the standard of care provided by Ms B to Ms A in this regard.

Failure to assess properly — 6 January

83. At 9.56pm on 6 January, Ms B asked Ms A by text message how often the pain was coming and going. At 9.56pm, Ms A responded: "every 15 minutes or so". At 9.58pm, Ms B responded by text message: "will be a long night for you. well help yourself". She and Ms A did not exchange any further communications (either by text message or telephone) that night. Ms Griffiths advised:

> "Undertaking a text conversation in this way is not an appropriate way to communicate with women, or to accurately assess the condition of a woman, or to plan ongoing care in partnership with her. At the minimum, [Ms B] should have rung [Ms A] and talked with her. There is no mention of any assessment being undertaken apart from [Ms B] asking how often the pains were coming. […] Other information it would have been helpful to know includes the woman's general state and how she was coping, how long the contractions had been coming for,

> enquiring about any vaginal loss e.g. liquor, show or blood, asking about fetal movements and asking about support people present."

84. The Midwifery Council of New Zealand's Code of Conduct (December 2010) notes the unreliability of text message communication and provides that midwives must "ensure that their communication with women occurs through reliable methods such as telephone". As I have previously stated:[26]

> "The provision of midwifery advice by text message must be done cautiously. Text message communication does not allow a midwife to properly assess a woman's level of concern, or allow the midwife to be sure that the woman has received the advice and interpreted it as intended. Phoning the woman allows the midwife to better assess any concern that has been expressed and determine whether a physical consultation is necessary."

85. I am concerned about the nature of Ms B's response to Ms A's communications on Sunday evening. I agree with my advisor that undertaking a text conversation with Ms A in this way did not enable Ms B to assess Ms A accurately. This was inadequate care. I note that Ms B agrees that "it would have been more optimal to have personal contact with the patient at 21.51 on [Sunday] relative to contractions and the use of over the counter medications for management of associated discomfort".

Failure to assess properly — Monday

86. At 10.46am on Monday, Ms A texted Ms B: "I'm in a lot of pain and can't get rid of it, they coming every 5 or so minutes." At 10.49am, Ms B responded "you are doing well" and asked whether she had been taking Panadol regularly. At 10.50am, Ms A responded that she had but that it was not easing the pain. At 10.51am, Ms B texted Ms A "it works and you just to be patient", to which Ms A responded "okay".

87. Ms Griffiths advised me that "[t]hese details should lead a midwife to consider whether [Ms A] was in labour given her gestation at this point". Ms Griffiths noted that Ms A was a teenager, pregnant with her first child, and eight days overdue. In her view:

> "[Ms B] did not respond appropriately to the many texts that she received from [Ms A] on [Monday] which clearly indicated [Ms A] was in labour and requiring midwifery care and support. Not responding appropriately by arranging to meet with [Ms A] to assess her condition fully represents, in my opinion, a moderate departure from the standard expected of reasonable care."

88. I agree with my advisor that Ms B did not respond appropriately to Ms A's text messages on Monday. In my view, Ms B should have arranged an assessment for Ms A on Monday morning (either with herself or with her back-up midwife, Ms D).

Conclusion

89. I note that Ms B now strongly discourages the use of text message communication in her practice. Nonetheless, I consider that Ms B breached Right 4(1) of the Code by

[26] 11HDC00596 (21 February 2013) and 11HDC00771 (26 June 2013), available at www.hdc.org.nz.

failing to provide services to Ms A with reasonable care and skill, in that she failed to assess Ms A's condition and needs adequately, prescribed an inappropriate dosage of Panadol by text message, and failed to make contact with Ms A in an appropriate manner. I am particularly concerned that Ms B did not consider attending and providing reassurance and support to Ms A, particularly given Ms A's age and circumstances (being overdue, in labour and in distress). In my view, these failings are unacceptable.

Handover to LMC Ms D — Breach

90. Ms B told HDC that she went off call on Monday morning, at which time she handed over the coverage of her practice to midwife Ms D (who was at the maternity unit that day). Ms B explained to HDC that she had decided late the previous night to travel out of town.

Communication with Ms A

91. As set out above, Ms A had been in communication with Ms B during Sunday night and again on Monday morning (when Ms B was no longer on call).

92. At 11.38am on Monday, Ms A texted Ms B: "I've just thrown up." Ms A told HDC that, having heard nothing back from Ms B after her text at 11.38am, her mother telephoned Ms B. Ms B told HDC that she "did follow up [her] texting with a phone call to the patient at 11.38am on [Monday]". Ms B told HDC that she advised Ms A to go to the maternity unit for evaluation, and that Ms D would be seeing her as Ms B was no longer on call. Ms B subsequently clarified that she spoke with Ms A's mother rather than directly with Ms A. In any event, she did not document the conversation.

93. I am satisfied that Ms A was not advised until after 11.38am on Monday that Ms B had gone off call that day and that Ms A's care had been transferred to Ms D. Ms B acknowledged to HDC that she "should have made [Ms A] aware that [she] was going off call".

94. By Monday, Ms A was eight days overdue. She had been distressed and in regular text communication with Ms B since the previous night. Ms A had advised Ms B that she was in pain and that Panadol was not working. Ms B did not inform Ms A on Sunday night either that she was going off call the following morning or who Ms A's stand-in LMC would be if required. I note that Ms B is unable to recall whether she decided to travel out of town before or after her text communications with Ms A.

95. In any event, Ms B continued to be in regular text communication with Ms A the following morning (including after Ms B had gone off call). It was not until after 11.38am, some three hours and 40 minutes after Ms B went off call, that Ms A was made aware that Ms B was unavailable.

96. Right 6(1) of the Code provides that every consumer has the right to information that a reasonable consumer, in that consumer's circumstances, would expect to receive. Ms A was eight days overdue and in labour. She had been in contact with her LMC since the previous night regarding her progress. The fact that her chosen LMC was off call and out of town, and the identity of her stand-in LMC, is plainly information that

a reasonable consumer in Ms A's circumstances would expect to receive. In my view, Ms B had ample opportunity to provide this information to Ms A but failed to do so.

97. I therefore consider that Ms B breached Right 6(1) of the Code by failing to provide to Ms A information that a reasonable consumer in her circumstances would expect to receive.

Communication with Ms D

98. Ms B told HDC that the policy in her practice at the time was to "transfer care via direct verbal, telephonic or confirmed receipt, text message communication with a summary of cases in labour, en route to hospital or those whose labour was imminent". Ms B told HDC that Ms D was "made aware that [Ms A] and another of my clients were in prodromal labour and were likely to require hospital services that day". By contrast, telephone records provided to HDC by Ms B show that she advised Ms D by text message that Ms A (and another client) were "overdue, primips and referred to postdates clinic for today".

99. Ms D told HDC that Ms B had texted her on Monday morning but "unfortunately did not relay to me that [Ms A] had been in distress throughout the night". Ms D recalls that the only information she received regarding Ms B's clients that morning was that her clients were "all well and two of her postdates were being assessed in [the maternity unit] that afternoon".

100. It is agreed that Ms B advised Ms D at handover that Ms A was scheduled for a postdate pregnancy assessment at the maternity unit on Monday. However, it appears to me from the information available that Ms B did not advise Ms D at handover that Ms A was in prodromal labour or that she was likely to require hospital services (as initially submitted by Ms B). I do not accept that Ms D was advised of Ms A's complaints from the previous evening. This was important clinical information that ought to have been conveyed to Ms D at the outset.

101. Ms B initially told HDC that she contacted Ms D at 12.09pm to advise her of Ms A's expected arrival at hospital. However, telephone records provided by Ms B indicate that she simply texted: "[Ms A] is going to call u." This does not convey any of the information regarding Ms A's condition which had been communicated by Ms A to Ms B over the course of that morning. In particular, it does not convey that Ms A was in a lot of pain, contracting "every 5 or so minutes" and had "just thrown up". It also does not convey that Ms A would be coming into hospital (as initially submitted by Ms B).

102. I am particularly concerned by this, given that Ms B and Ms D then exchanged a series of text messages. In those messages, Ms B advised that Ms A had had a "false labour" four weeks earlier. However, she made no reference to Ms A's discomfort over the previous 24 hours. In my view, this was a missed opportunity for Ms B to pass on significant clinical information regarding Ms A's condition.

103. Ms D told HDC that she was advised by RN C that Ms A was coming into hospital and that she was "surprised by this as I had no information on [Ms A] as [Ms B] had not mentioned about one of her clients in labour or that she had been niggling

throughout the night". Hospital notes indicate that at 12.45pm, RN C received a phone call from Ms A's mother, who advised that Ms A was "having painful contractions 1 minute apart and LMC [Ms B] was unavailable", and that RN C then contacted Ms D at 12.50pm. Ms D recalls that she "was not happy about [Ms B] not informing me of her client being in labour and distressed as I had a very hectic day ahead and if I had known I would have arranged my day around her client in labour".

104. I consider it more likely than not that Ms B did not inform Ms D of Ms A's expected arrival at hospital. Furthermore, Ms B did not advise Ms D of any of Ms A's concerns from Sunday evening or as they were communicated to Ms B throughout Monday morning after she had gone off call. As a result, I consider that Ms B breached Right 4(5) of the Code with regard to her handover to Ms D by failing to ensure the quality and continuity of services provided to Ms A.

Documentation — Breach

105. Ms B did not document in her notes any of her text communications with Ms A on Sunday or Monday. Ms B also did not document her handover of care to Ms D on Monday. The *Standards of Midwifery Practice* (2008) requires midwives to collate and document comprehensive assessments of the patient (Standard Three) and to maintain purposeful, ongoing, updated records (Standard Four).

106. The text messages exchanged between Ms B and Ms A on Sunday and Monday contained important clinical information regarding Ms A's condition. This information needed to be documented in Ms A's clinical record for her future care. This documentation was particularly important in these circumstances where Ms B was going off call and handing over Ms A's care to another midwife.

107. Ms B told HDC that she did not document her transfer of care to Ms D or her communications with Ms A on Monday as she did not have access to her notes at the time and was reluctant to make any retrospective entries "given [her] concern for the integrity of the record as well as the unfortunate pregnancy outcome". I do not consider this to be an adequate explanation for Ms B's failure to document these communications fully.

108. In my view, Ms B's record-keeping fell short of the requirements of Standards Three and Four. I consider that Ms B breach Right 4(2) of the Code by failing to provide care in accordance with professional standards.

Recommendations

109. I recommend that Ms B:

- Provide a written apology to Ms A for her breaches of the Code. The apology is to be sent to HDC within three weeks of this report being issued, for forwarding to Ms A.

- Review her practice and provide HDC with a report outlining her learning about the Code and her learning from this complaint, within one month of this report being issued.

- Provide HDC with a progress report, including anonymised examples, on all changes made to her practice as outlined in her responses to this complaint, within one month of this report being issued.

Follow-up actions

110.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Midwifery Council of New Zealand and to the New Zealand College of Midwives, each of which will be advised of Ms B's name. I note that Ms B completed a competency programme in November 2013.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of Ms B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent midwifery advice to the Commissioner

The following expert advice was obtained from registered midwife Christine Griffiths:

"Report to the Health and Disability Commissioner: Case number C13HDC00259

My name is Christine Rae Griffiths.

I have been asked to provide expert advice to the Health and Disability Commissioner (HDC) on case number C13HDC00259, which is currently in the preliminary assessment stage.

I have worked full time since registering as a midwife in September 1985. Over this time I have worked as a core hospital midwife and as a community based case loading Lead Maternity Carer (LMC) midwife. I have also held several midwifery management positions. Currently I am a Senior Lecturer within the School of Midwifery at Otago Polytechnic, Dunedin, and the Bachelor of Midwifery Programme Coordinator, though I remain based in Whitby, Porirua, where I live. Up until August 2013 I continued to maintain a small community based case loading LMC midwifery practice. I have a position as a Midwife on the casual pool of the maternity unit at Hutt Hospital, Lower Hutt.

I am a founding member of the New Zealand College of Midwives (NZCOM) and a member of the NZCOM Wellington regional core management group. I have been a NZCOM ratified expert midwifery advisor since 2009. In this role I have been a member of a Midwifery Council of New Zealand (MCNZ) Professional Conduct Committee, a member of MCNZ Competence Review Panels, a MCNZ appointed supervisor, and given an expert midwifery opinion to the HDC and to a Coroner.

My professional qualifications are: Registered General and Obstetric Nurse 1980, Registered Midwife 1985, Advanced Diploma in Nursing 1989, Diploma in Social Sciences (Distinction) 1998, Master of Arts in Midwifery (1 class Hons) 2002, Graduate Certificate in Tertiary Learning and Teaching (Level 7) 2012. I am currently studying towards a PhD degree through AUT, Auckland.

I have read and understood the Guidelines for Independent Advisors previously provided by the HDC, and agree to follow these guidelines.

I have been asked to provide expert advice on [Ms A's] complaint about the care provided to her by midwife [Ms B], to enable the Commissioner to determine whether, from the information available, there are concerns about the care provided by [Ms B] which require formal investigation. I have been asked whether I consider the care provided to [Ms A] was reasonable in the circumstances. I have been asked to comment specifically on the text conversation between [Ms B] and [Ms A] in the 24 hours prior to [Ms A's] hospital admission. I have also been asked to comment on the manner in which the handover of care to [Ms D] was handled.

Supporting documentation: I have reviewed the documentation sent to me by [the] Complaints Assessor, HDC, consisting of: [Ms A's] complaint to the HDC office dated […] including a log of midwife text messages received between 1210pm [a

week before the birth] and 1138am [Monday], Letter from [the] CEO of MCNZ dated 25/2/13, response from [Ms B] dated 24 March 2013 to the MCNZ which HDC was copied into, response from [Ms D] to HDC, a copy of [Ms A's] clinical notes from hospital with MMPO notes attached, and a copy of [Ms A's] clinical notes from her GP.

Summary of events from midwifery notes received

[Ms A] was a [teenage] woman in her first pregnancy who met with [Ms B] for the first time [in 2012] at 6 + 5 weeks gestation (as confirmed by a dating scan [a few days later]). At this visit, a care plan was commenced in the MMPO notes. This is in accordance with the 'first decision point in pregnancy' outlined in the Midwives Handbook for Practice (NZCOM, 2008), which recommends that midwives begin discussion around the birth plan within the first 16 weeks of pregnancy. Commencing the birth plan at this visit, as [Ms B] did, demonstrates reasonable practice. I note however, that there is not further update to this birth plan after an entry [at 29+3] weeks pregnant. In the MMPO notes [Ms B] has documented this initial visit, including the information discussed with [Ms A] and the assessments requested. There is no mention of [Ms A] having Nephrotic Syndrome. The Maternal History Summary page of the MMPO notes gives a list of medical conditions commonly enquired about at some point early in pregnancy. The date that this history was completed is not documented, nor referred to in the midwifery notes MMPO pages. The tickbox for 'renal/urinary tract disorder' is blank, as are all the other boxes on this page. It is therefore not able to be stated whether [Ms B] asked [Ms A] about any personal history of renal/urinary conditions specifically. [Ms B] could be advised to make it clear in her documentation that she has asked about these conditions. In 'Past Medical History' on the second page of [Ms A's] Admission Form, [Ms A] has signed and dated the first page [date of initial consultation]. On the second page the tickbox for 'UTI/Renal' is blank.

From the MMPO notes (although some of the photocopied Antenatal record is hard to read), [Ms A's] pregnancy appears to have progressed normally. She was seen a further 11 times by a midwife antenatally, had two more scans — Nuchal translucency and Anatomy — various blood tests including 1 trimester serum screening and a glucose challenge. Blood tests show reduced Haemoglobin and Ferritin, and [Ms A] was given a script for Iron tablets. [Ms B] appears to have organised a scan at the hospital in response to [Ms A] stating she couldn't afford to pay for the Nuchal scan at the private radiology clinic. [Ms B] attended a CYF meeting on [date] as [Ms A] and her siblings had had ongoing involvement with CYF. [Ms B] has documented in the MMPO notes that she gave information on benefits, baby gear, community support groups such as Family Start and Plunket at various times throughout [Ms A's] pregnancy. [Ms B] appears to have addressed [Ms A's] maternity and social requirements during the antenatal period well. This demonstrates reasonable care. This is supported by [Ms A], who states in her letter to HDC that she had no problems with [Ms B] until she was 36 weeks pregnant.

[At] 36 weeks pregnant, it is documented in [Ms B's] notes that [Ms A] self-presented to [the maternity unit] (hospital), and had a reassuring cardiotocograph

(CTG) monitoring of the baby's heartbeat over a period of time. 'UA absent' is recorded on the MMPO Antenatal record. I do not know what this abbreviation means. Also recorded in the MMPO notes is 'Not in labour. Sent home'. The background to [Ms A] self-presenting at [the maternity unit] is not documented. [Ms A's] clinical notes record she was in hospital at 2215 that day, seen by her LMC at 2235 and then returned home.

[At] 40+1 weeks pregnant, [Ms A] was assessed at [the maternity unit] as she had not been getting lots of 'FMs' (fetal movements) recently. A CTG was reassuring. 'UA absent' is recorded in the MMPO notes. Again, I am not aware of what this abbreviation means. [Ms B] has documented this assessment, and the notes infer she undertook [Ms A's] assessment herself. The plan documented in the notes was for a referral after [41 weeks' gestation] for postdates. This is in accordance with Code 4024 of the 'Guidelines for consultation with Obstetric and related medical services (Referral Guidelines)' (New Zealand Government, 2012), which recommends referring for a consultation in a timely manner for planned induction by 42 weeks of pregnancy. This demonstrates reasonable care. A plan was made to 'otherwise follow-up at clinic on Friday' [with LMC midwife], again demonstrating reasonable care. No mention is made of whether the importance of ongoing monitoring of fetal movement or reporting a change in fetal movement was discussed at this assessment.

However, at the next antenatal visit [on Friday] at 40+5 weeks pregnant, [Ms B] has documented that [Ms A] is 'feeling good FMs'. An appointment was made for a postdates assessment with the obstetric team for the following Monday. This demonstrates reasonable care, as per the Referral Guidelines mentioned above. The referral form for the postdates clinic is in [Ms A's] clinical notes. There is no mention of [Ms A] having a history of nephrotic syndrome on this referral form. At this visit ([Friday]) Protein ++ was found on testing [Ms A's] urine, and a mid stream urine test was requested. Given [Ms A's] blood pressure was low, rather than high, the proteinuria was more likely to be a sign of a urinary tract infection than preeclampsia developing, however it may have been prudent to recommend blood tests to exclude preeclampsia. There is no mention of whether [Ms B] assessed [Ms A] for other signs of preeclampsia developing. As there is no documentation here of [Ms A] having a history of nephrotic syndrome, it is unlikely that [Ms B] would have been linking the proteinuria to [Ms A's] previous history of nephrotic syndrome.

The next documentation in the MMPO notes by [Ms B], is on the [Monday] stating that [Ms A] had birthed her baby.

On [Monday] a retrospective entry written at 1350 in [Ms A's] clinical notes documents that at 1245 [Ms A's] mother contacted [the maternity unit] to report that her daughter was having painful contractions and that as [Ms B] was unavailable she was wanting to contact [Ms D]; [Ms B's] backup midwife [Ms D] was in [the maternity unit] at the time, so [Ms A's] mother was advised to bring [Ms A] into [the maternity unit] for assessment.

An ambulance report form dated [Monday] is in [Ms A's] clinical notes reporting a history of [Ms A] contracting every three minutes, lasting a minute, and having ambulance personnel with her from 1245. It is documented on this report form

that [Ms A] had felt the baby move around the night before. This report form also documents a past history of nephrotic syndrome, and that [Ms A] was not on any current medications.

It is documented in [Ms A's] clinical notes that the fetal heart beat was not heard on admission to [the maternity unit]. An obstetric doctor could not find the fetal heart on bedside scan and that [Ms A's] baby had died was then confirmed on scan by a Radiologist. Following an artificial rupture of membranes, [Ms A] had a normal birth of a stillborn [baby]. A true knot was noted in the two vessel cord. [Ms A] subsequently required manual removal of the placenta. This along with the suturing of a second degree tear was undertaken in main operating theatre.

[Ms B] has documented in [Ms A's] MMPO notes that she saw [Ms A] at 0130 on [Tuesday] in [the maternity unit], and again at 0815 that day. At 1045, [Ms B] has documented that [Ms A's] family 'wants to change LMC for postnatal care' and that [Ms D] was 'informed by phone call'. [Ms B] has documented that she 'will hand over to' [Ms D].

In [Ms A's] clinical notes it is documented on [Tuesday] that [Ms A's] family approached the Charge Midwife to request that [Ms A's] care be transferred from [Ms B] to another midwife. [Ms D] was contacted by hospital staff and was happy to take over [Ms A's] postnatal care.

At [Ms A's] follow up appointment with a Consultant at [the maternity unit] at six weeks postnatal, the baby's postmortem report was not available, however results of the culturing of three main chromosomes showed a normal baby. [Ms A] was advised that if the postmortem report showed no abnormality, the knot that was noted in the baby's cord at birth could be the reason for the baby dying in utero. [Ms A] was advised this was a rare event which should not occur in subsequent pregnancies.

Expert Advice required

I have been asked whether I consider the care provided to [Ms A] was reasonable in the circumstances.

I have been asked to comment specifically on the text conversation between [Ms B] and [Ms A] in the 24 hours prior to [Ms A's] hospital admission.

I have also been asked to comment on the manner in which the handover of care to [Ms D] was handled.

Text conversation between [Ms B] and [Ms A] in the 24 hours prior to [Ms A's] hospital admission:

The Standards of Midwifery Practice (NZCOM, 2008) provide a benchmark for the midwife's practice and the appropriate use of midwifery's body of knowledge, by identifying a series of actions that are essential to the development and maintenance of the midwifery partnership with women. The text conversation between [Ms B] and [Ms A] is not documented in [Ms A's] MMPO notes. This is a departure from several of The Standards of Midwifery Practice (NZCOM, 2008) and their specific criteria. These are; Standard Two: The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth

experience, specifically 'The midwife documents decisions and her professional actions' (NZCOM, 2008, p.16); Standard Three: The midwife collates and documents comprehensive assessments of the woman, specifically 'The midwife documents her assessments and uses them as the basis for on-going midwifery practice' (NZCOM, 2008, p.17); Standard Four: The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons, specifically 'The midwife reviews and updates records at each professional contact with the woman' (NZCOM, 2008, p.18); and Standard Seven: The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice, specifically 'The midwife clearly documents her decisions and professional actions' (NZCOM, 2008, p.21).

Every standard (NZCOM, 2008) can be linked to at least one of the Competencies for Entry to the Register of Midwives (MCNZ, 2007). These four competencies are the minimum competence standards expected of a registered midwife by the Midwifery Council of New Zealand. Therefore by departing from The Standards of Midwifery Practice (NZCOM, 2008) as above, [Ms B] has also departed from two of the competencies; Competency 1: 'The midwife works in partnership with women throughout the maternity experience' and Competency 2: 'The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care' (MCNZ, 2011). This lack of documentation demonstrates a moderate departure from the standard expected of reasonable care.

Undertaking a text conversation in this way is not an appropriate way to communicate with women, or to accurately assess the condition of a woman, or to plan ongoing care in partnership with her. At the minimum, [Ms B] should have rung [Ms A] and talked with her. There is no mention of any assessment being undertaken apart from [Ms B] asking how often the pains were coming. Although [Ms B's] letter to the HDC dated 24 March 2013 states that [Ms A] was 'counseled concerning comfort measures and advised to use Panadol, not to exceed established dosing guidelines', this is not evident in the text conversation [Ms A] has provided, nor is this text conversation documented in [Ms A's] MMPO notes. Other information it would have been helpful to know includes the woman's general state and how she was coping, how long the contractions had been coming for, enquiring about any vaginal loss e.g. liquor, show or blood, asking about fetal movements and asking about support people present. This information is required to negotiate joint decisions to be made between the midwife and the woman for planning ongoing management, as is clearly outlined in 'The first decision point in labour' (NZCOM, 2008), which is when the woman first contacts her midwife and lets her know she is in labour. [Ms A] text[ed] [Ms B] seven several times in the 14 hours preceding her hospital admission. This would indicate [Ms A] may have been wanting intermittent support from the midwife — The second decision point in labour — which is an opportunity for assessment of the laboring woman and for checking how the woman is feeling in labour and whether she wants ongoing support from her midwife (NZCOM, 2008).

Not facilitating open interactive communication and negotiating choices and decisions, is a departure from Standard One: The midwife works in partnership

with the woman (NZCOM, 2008). By not developing a plan for midwifery care together with the woman, there is a departure from Standard Two: The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience (NZCOM, 2008). By not acknowledging the individual nature of each woman's pregnancy in her assessments and documentation, there is a departure from Standard Three: The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing (NZCOM, 2008). These three standards can be linked with Competency l and Competency 2 as noted above (MCNZ, 2011). This demonstrates a moderate departure from reasonable care.

Likewise, prescribing medication over a text conversation is inappropriate when the woman has not had an assessment by her midwife. In the NZCOM Consensus statement titled 'Prescribing Guidelines' (NZCOM, 2009), midwives are strongly discouraged from using analgesics during labour at home, as the necessity for this type of medication is an indication to transfer to hospital. Panadol is an analgesic indicated for fast effective temporary relief of pain and discomfort such as that associated with headache, muscular aches, period pain (Medsafe, 2013). The recommended dose of Panadol — the medication [Ms B] advised [Ms A] via a text conversation to take — is one to two 500mg tablets every four to six hours with a maximum of eight tablets in 24 hours (Medsafe 2013). Therefore the advice from [Ms B] via text at 2155 on [Sunday] for [Ms A] to take '4 at once' is clearly incorrect. This demonstrates a moderate departure from reasonable care.

According to [Ms A's] clinical notes from her GP (page dated 21/2/2011), [Ms A] has a history of recurrent nephrotic syndrome, for which she had been in remission since aged 8 and was not on any current medication for. Had [Ms B] been aware of [Ms A's] history of nephrotic syndrome, she may not have recommended taking Panadol, as Panadol is contraindicated in patients who have been diagnosed with kidney impairment, and such patients are advised to seek medical advice before taking this medication (Medsafe, 2013).

<u>The manner in which the handover of care to [Ms D] was handled</u>

[Ms B] did not inform [Ms A] that she was not available to provide midwifery care for most of [Monday], despite being in text contact with [Ms A] during the period [Sunday - Monday] so being aware that [Ms A] was in labour. Nor had [Ms B] documented in [Ms A's] MMPO notes that she would be away and the plans for her back up midwife to cover her practice for this time. Section DA7.2 of the Primary Maternity Services Notice (Ministry of Health (MoH), 2007) states that if the LMC is unavailable to provide care because of being away, a back-up LMC may provide those services. However, the woman must have consented to this, as stipulated in Section DA7.3 of the Primary Maternity Services Notice which notes that with the woman's consent the LMC may delegate to another midwife the provision of part of a module of care (MoH, 2007). Point 1.9 of Competency 1 (MCNZ, 2011) states that the midwife must communicate effectively with the woman/wahine and her family/whanau as defined by the woman (MCNZ, 2007). Competency 2.16 states that the midwife provides timely and accurate written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided. Standard 1 of the Standards of Midwifery

Practice states that the midwife works in partnership with women (NZCOM, 2008). Standard 5 states that midwifery care is planned with the woman (NZCOM, 2008). Not informing [Ms A] that she was to be unavailable to provide her care when [Ms A] contacted [Ms B] during the night of [Sunday-Monday], demonstrates a moderate departure from reasonable care by [Ms B].

[Ms D] had agreed to go on call for [Ms B] on [Monday] (not [incorrect date] as is written in [Ms D's] letter to HDC dated 16/5/13). While [Ms D] was aware that [Ms A] was booked for a day assessment on [Monday] due to being postmature, she states she was not aware that [Ms A] had been in touch with [Ms B] due to being distressed throughout the night of [Sunday-Monday]. In contrast in her letter to the HDC dated 24/3/13, [Ms B] states that she made [Ms D] aware during the 7.47am signoff on [Monday] that [Ms A] was in 'prodromal' labour and was likely to require hospital services that day. In her letter to HDC dated 24/3/13, [Ms B] also states that she updated [Ms D] on [Ms A's] status at 12.09pm on [Monday]. These details are not documented in [Ms A's] MMPO notes. Had [Ms D] been aware of the content of the texts [Ms B] had received, she may have instigated early contact with [Ms A] on [Monday morning].

Section DA7.5 of the Primary Services Notice (MoH, 2007) states that the respective responsibilities of the LMC and the practitioner to whom aspects of care have been delegated will be clearly documented in the care plan. Competency 4.13 (MCNZ, 2007) states that the midwife works collegially and communicates effectively with other midwives and health professionals. The NZCOM Consensus statement on Roles and Responsibilities in the Hospital Setting (NZCOM, 2001), states that the LMC is responsible for developing a plan of care with the woman. This care plan is to be documented and available for midwives who aren't the LMC to refer to, thus enabling them to work in cooperation with the woman and her chosen LMC (NZCOM, 2001). [Ms B's] actions regarding handover to [Ms D] represent a moderate departure from reasonable care.

In summary, it is my opinion that [Ms B] demonstrated care that was a moderate departure from the standard expected of reasonable care in regards to the text conversation with [Ms A] during the 24 hours prior to her admission, and in the manner in which the handover of care to [Ms D] was handled.

References

Medsafe. (2013). Panadol Tablets. Retrieved from www.medsafe.govt.nz

Midwifery Council of New Zealand. (2007). The competencies for entry to the register of midwives. Wellington, New Zealand: Midwifery Council of New Zealand.

Midwifery Council of New Zealand. (2011). Recertification programme: A summary for midwives. Wellington, New Zealand: Midwifery Council of New Zealand.

Ministry of Health. (2007). Primary maternity services notice 2007. Wellington, New Zealand: Department of Internal Affairs.

Ministry of Health. (2012). Guidelines for consultation with obstetric and related medical services (Referral Guidelines). Wellington, New Zealand: New Zealand Government.

New Zealand College of Midwives. (2008). Midwives handbook for practice. Christchurch, New Zealand: New Zealand College of Midwives.

New Zealand College of Midwives. (2001) Consensus statement: Roles and responsibilities in the hospital setting. Christchurch, New Zealand: New Zealand College of Midwives.

New Zealand College of Midwives. (2009). Consensus statement: Prescribing guidelines. Christchurch, New Zealand: New Zealand College of Midwives.

Christine Griffiths, 7 September 2013"

Further expert advice was obtained from Ms Griffiths as follows:

"I have been asked to provide further comment to the Commissioner on the appropriateness of the text conversation which took place between [Ms B] and [Ms A] during [Monday] morning. These conversations took place between 1046 and 1138 that morning. During this time [Ms A] text[ed] [Ms B] four times to advise she was in a lot of pain 'and can't get rid of it, they coming like every 5 or so minutes'. Her last text was to inform [Ms B] that she had vomited. These details should lead a midwife to consider whether [Ms A] was in labour given her gestation at this point. [Ms B] responded twice to the texts [Ms A] sent, texting that [Ms A] was doing well, asking if she was taking Panadol regularly and telling her that the Panadol works 'you just have to be patient'.

I have stated in my opinion of 7 September 2013 (pages 6–8) that [Ms B's] lack of documentation of these text conversations demonstrates a moderate departure from the standard expected of reasonable care. I have also stated that [Ms B] should have, at a minimum, rung [Ms A] and talked with her. No assessment of [Ms A] was undertaken apart from a previous text from [Ms B] asking how often the pains [Ms A] had been informing her about were coming. My opinion on prescribing Panadol via text is also documented. These points also demonstrate a moderate departure from the standard expected of reasonable care.

On [Monday] [Ms A], a [teenager] expecting her first baby, was 8 days overdue, so it would be expected she would labour at some point — which clearly the content of her text conversations to [Ms B] from the [Sunday-Monday] indicate she was. [Ms A] had contracted [Ms B] earlier in pregnancy to be her Lead Maternity Carer to provide her with midwifery care and support throughout her pregnancy and childbirth experience. [Ms B] did not respond appropriately to the many texts that she received from [Ms A] on [Monday] which clearly indicated [Ms A] was in labour and requiring midwifery care and support. Not responding appropriately by arranging to meet with [Ms A] to assess her condition fully represents, in my opinion, a moderate departure from the standard expected of reasonable care."