Monitoring of woman with premature rupture of membranes
17HDC01030, 17 October 2019

District health board ~ Midwife ~ Monitoring ~
CTG ~ Fetal movements ~ Support ~ Escalation ~ Right 4(1)

A woman experienced premature rupture of membranes at 29 weeks' gestation and was admitted to hospital. Regular fetal monitoring was undertaken, and the woman and her baby's condition remained stable.

Subsequently the woman was transferred to the antenatal ward. While cardiotocograph (CTG) monitoring was reassuring, the woman had rising inflammatory markers and ongoing liquor discharge.

Two days later, the woman's liquor was noted to have changed in colour from pink and slightly blood-stained to "yellowish". The evening shift began at 3pm. Two midwives (one a new graduate) and a student midwife were working on the antenatal ward. The woman was allocated to the new graduate midwife as her patient. A registrar was allocated to the ward, a consultant was on site, and a further consultant was on call. The ward acuity was high, with nine high-risk patients, and it was a very busy shift.

At 5pm the woman was seen by the registrar, who signed off the CTG trace and documented: "Patient aware if any concerns re [fetal movements]/abdo pain/discharge, to alert staff. For Reg[istrar] review if any concerns."

At 6.30pm the midwife documented, "query lightly meconium stained", in relation to the woman's liquor. She did not advise the other midwife or the registrar of this finding. At 8.54pm, the student midwife commenced a further CTG but was unable to obtain a good trace. The first midwife reviewed the trace multiple times over the following hour and noted that a clear trace could not be obtained. While it is not documented, she acknowledged that the woman reported reduced fetal movements to her. The midwife stopped the CTG at 10.15pm.

At around 10.20pm, the midwife had concerns about the CTG, and consulted the second midwife. The two midwives have different accounts of what information and advice was exchanged between them, particularly regarding escalating the CTG to the obstetric team.

The midwife showed the CTG to a night staff midwife at 11pm. This midwife was very concerned by the trace and attended the woman's room to reattach the CTG. She was unable to obtain a trace, and could detect only a fleeting heartbeat. She pushed the emergency call bell, and the woman was taken to theatre for an emergency Caesarean section.

The baby was born in very poor condition. She suffered from stage 3 hypoxic ischaemic encephalopathy and continues to require a high level of care at home.

Findings

The district health board (DHB) did not have in place adequate systems to ensure that staff were supervised and supported in their decision-making, and its culture did not support staff to report concerns and ask for assistance. The care provided was considered to be seriously suboptimal and, accordingly, it was found that the DHB breached Right 4(1).

The midwife failed to recognise the deteriorating situation adequately, and failed to escalate this in a timely manner, and the Commissioner was critical that the more experienced midwife did not recognise that the CTG was significantly abnormal.

The DHB has since made a significant number of changes to its women's health service. It was noted that the changes are appropriate and necessary, and show a strong commitment by the DHB to improve the quality of its service.

Recommendations

It was recommended that the DHB (a) provide details of how it is ensuring that midwives in their first year of practice have unimpeded access to senior support; (b) develop a protocol for how staff should access obstetric care when rostered staff are unavailable; (c) facilitate interviews with remaining midwifery staff who were working at the hospital at the time to determine whether the changes made have improved the level of support they now experience; and (d) review adverse events involving a midwife in the first year of practice, to assess whether inadequate staffing or supervision was a contributing factor.

It was also recommended that the DHB and the midwife provide apologies, and that the Midwifery Council of New Zealand undertake a competency review of the first midwife's practice, and of the second midwife's practice should she re-apply for a practising certificate.