Midwife, Ms B

A Report by the

Health and Disability Commissioner

(Case 13HDC00952)

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Executive summary

1. In 2012, Mrs A became pregnant with her first child. Mrs A arranged for midwife Ms B to be her Lead Maternity Carer.

2. Mrs A attended antenatal consultations with Ms B during her pregnancy. Ms B did not weigh Mrs A or test her urine at any of the antenatal appointments, and kept minimal records. Mrs A felt that her appointments with Ms B were rushed, and she felt unable to ask questions.

3. When Mrs A was 38 weeks' pregnant, she had an appointment with Ms B, during which a student midwife was present. The student took Mrs A's blood pressure and informed Ms B that it was elevated. Ms B did not document rechecking the high blood pressure reading or any further action.

4. Mrs A recalls that Ms B informed her that the student would be present at the birth. Mrs A was concerned at this, so she emailed Ms B explaining that she and her husband would prefer not to have the student there. Ms B responded to the email explaining that the student would be a great support, and stated: "Think it is not a wise decision."

5. A week later, Mrs A had a further appointment with Ms B. The student midwife was again present, and again took Mrs A's blood pressure, which was not checked by Ms B and was recorded as normal.

6. Mrs A called Ms B late the following afternoon advising that she had eaten fried chicken an hour previously, and had pain in her mid chest. Ms B suggested that Mrs A rest, as the pain could have been caused by the fatty food. Ms B said that if the pain did not subside, Mrs A might have food poisoning or a gall bladder problem. However, if her condition worsened, she would need to seek medical help.

7. Mrs A did not call Ms B back. At 10.13pm that night, Mrs A presented at an emergency department with epigastric pain and high blood pressure. Mrs A was diagnosed with severe pre-eclampsia[1] and HELLP syndrome.[2]

8. Mrs A underwent an emergency Caesarean section, and her baby boy was delivered at 1.38am. Subsequently he progressed well.

9. Following the Caesarean section, Mrs A was transferred to intensive care. Her recovery was complicated by a large subcapsular haematoma (bleeding in the liver), and she required transfer to another hospital for ongoing care. She remained in hospital for a month.

[1] Pre-eclampsia is a disorder of pregnancy characterised by high blood pressure and large amounts of protein in the urine. If left untreated, pre-eclampsia can develop into eclampsia, the life-threatening occurrence of seizures during pregnancy.
[2] HELLP syndrome is a life-threatening obstetric complication usually considered to be a variant or complication of pre-eclampsia.

Findings

10. Ms B's antenatal care of Mrs A was suboptimal. She did not establish Mrs A's relevant medical history, failed to monitor Mrs A appropriately by urinalysis, and appeared not to elicit from Mrs A that she had oedema and there had been a reduction in fetal movement. Further, Ms B failed to respond to Mrs A's high blood pressure appropriately at 38 weeks' gestation by rechecking the reading and by undertaking urinalysis at that point. A week later, Ms B did not assess Mrs A's blood pressure herself despite the high reading the previous week. Accordingly, Ms B failed to provide services with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[3]

11. Ms B's email response to Mrs A in relation to the student's presence at the birth was inappropriate and disrespectful, and therefore Ms B breached Right 1(1) of the Code.[4]

12. Ms B's inadequate documentation amounts to a failure to comply with professional standards and, accordingly, Ms B breached Right 4(2) of the Code.[5]

Complaint and investigation

13. The Commissioner received a complaint from Mrs A regarding the services provided to her by midwife Ms B.

14. The following issue was identified for investigation:

Whether midwife Ms B provided appropriate care to Mrs A.

15. An investigation was commenced on 25 February 2014.

16. The parties directly involved in the investigation were:

Mrs A	Consumer
Mr A	Consumer's husband
Consumer's father	
Ms B	Midwife/provider
District health board	Provider

Also mentioned in this report:

Ms C	Student midwife

17. Independent expert advice was obtained from midwife Bridget Kerkin (**Appendix A**).

[3] Right 4(1) states that every consumer has the right to have services provided with reasonable care and skill.
[4] Right 1(1) states that every consumer has the right to be treated with respect.
[5] Right 4(2) states that every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Information gathered during investigation

Background

18. 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 a lead maternity carer (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.

19. In 2012, Mrs A, then aged 34 years, became pregnant with her first child. Mrs A arranged for self-employed, community-based midwife Ms B to be her LMC.

Ms B

20. Ms B advised that she has been a practising midwife for over 30 years, and that her midwifery expertise comprises over 15 years' overseas and nearly 20 years' experience in New Zealand.

Antenatal records

21. Mrs A provided HDC with her antenatal booklet (the booklet), which contains Ms B's handwritten notes from the appointments. Ms B provided HDC with the notes she recorded on her computer following the appointments (the electronic record).

Midwifery appointments

22. Ms B advised that Mrs A came to her clinic when she was at nine weeks and two days' gestation. In response to my provisional opinion, Ms B told HDC that this booking visit always takes "a good hour with every client", and that it was not rushed. She said she explained to Mrs A that if she was unhappy, she could terminate the partnership at any time. At the initial consultation with Ms B, Mrs A completed the Maternity Facility Registration form (the registration form). Ms B recorded on the registration form that Mrs A's medical history and family history were "nil of note". Ms B confirmed to HDC that she would have written that after asking questions relating to prior hospital admissions, family history, and surgical history.

23. Ms B told HDC:

> "I sat with [Mrs A] and asked her history as per [the] history form [the registration form] that is required to book women into hospital. From that history I load information onto my computer. She was clearly asked if she had any Medical/surgical … or mental health issues in the past. She was asked about her family history, medications and allergies. All was documented on the [registration] form as information she had given to me."

24. Ms B told HDC that she was not advised of some of Mrs A's medical history. Ms B stated that had she been aware of this history at the time, she would have taken liver function tests during the pregnancy and referred Mrs A to the obstetrics team.

25. Ms B stated that she asked Mrs A to read, complete and sign the registration form. Mrs A's signature is on the form.

26. Mrs A does not remember the first appointment in detail, but she recalls the discussion about her medical history, and says that she told Ms B that her father had had renal failure and a kidney transplant. In response to my provisional opinion, Ms B stated that Mrs A did not give her this history.

Health questionnaire

27. Ms B provided Mrs A with the booklet, which contained (among other things) a detailed health questionnaire. Ms B said that she asked Mrs A to complete the forms in the booklet, including the detailed health questionnaire. Ms B stated: "I did not complete the history in her book as at that time there is a triplication of entries, the [registration form], my computer and her notes." Ms B stated that Mrs A gave her no history that would alert her to risk problems.

28. In contrast, Mrs A told HDC that she does not recall Ms B drawing her attention to the health questionnaire or asking her to complete it. Mrs A's husband, Mr A, who attended most appointments, also does not recall any discussion of the questionnaire.

29. Ms B told HDC that she did not follow up with Mrs A about the questionnaire.

Assessments of urine and weight

30. At the booking appointment, Ms B recorded in the electronic record that Mrs A's weight was 65kg, her body mass index was 25, and her blood pressure was 100/60mmHg.[6] This information was not recorded in the booklet. Mrs A stated that Ms B never weighed her or tested her urine at any of the antenatal appointments.

31. There is no record of Mrs A's weight gain throughout her pregnancy. However, Ms B advised that Mrs A had normal weight gain during her pregnancy. Ms B stated: "I do not recall discussing [Mrs A's] weight with her as she appeared to be well and her baby was growing well." She also said that she did not weigh Mrs A throughout her pregnancy.

32. Ms B told HDC that the best indication of progress is the clinical findings and physical clinical observations of the woman. Ms B further stated that often she gets women to weigh themselves on their own scales, because frequently the midwives' scales are faulty, and she feels women are more comfortable weighing themselves at home. She stated that she told Mrs A to weigh herself, but could not recall whether they discussed her weight at the appointments. Mrs A told HDC that Ms B never asked her to weigh herself at home, nor did she discuss Mrs A's weight at any of the appointments.

33. Ms B stated that at that time, she did not do urine dipstick testing of pregnant women because the dipstick tests are not totally accurate.

[6] Normal blood pressure in pregnancy is generally 90/60 to 120/80mmHg. Blood pressure is considered low if it falls below 90/60mmHg or high if it exceeds 140/90mmHg.

Antenatal visits

34. The electronic record shows that during her pregnancy, Mrs A attended 10 consultations with Ms B. However, the booklet records only six visits.[7] In response to my provisional opinion, Mrs A told HDC that she attended fewer than 10 appointments with Ms B, "as [Ms B] was away quite a lot and had to re-schedule [her] appointments a few times". Ms B said that there were 10 consultations, and stated that Mrs A did not bring her booklet to some of the visits, which causes the discrepancy. Ms B also said that when her computer crashed she did not transfer the electronic record to the booklet.

35. Ms B stated that Mrs A did not complain of being unwell during her pregnancy, and never called her or left a message for her. Mrs A stated that she telephoned Ms B two to three times during the course of her pregnancy. Mrs A recalls that on one occasion she did so because she had experienced some bleeding, and said that "the other times … it might have been about appointments". In response to my provisional opinion, Ms B said that Mrs A did not complain of any bleeding and, if she had done so, it would have been documented and acted upon.

36. Ms B told HDC that the only concern during Mrs A's pregnancy was Mrs A's elevated polycose, and that she therefore had "lengthy discussions" with Mrs A about eating a healthy diet and avoiding fast and refined foods. Ms B stated: "We discussed diet at every visit … This was a very healthy woman who was cheerful and confident the whole pregnancy. She looked radiant and very healthy especially after we had discussed her diet and polycose[8] results. There was not history to make me think otherwise."

37. In her complaint, Mrs A stated that Ms B recorded her blood pressure every now and then, but was mostly concerned about the food Mrs A was eating. Mrs A stated: "[M]ore often than not, [Ms B] put my symptoms down to nutritional issues." Mrs A said that although she had regular visits with Ms B, she felt "rushed and somewhat 'brushed off'". Mrs A felt unable to ask questions, and stated that she felt she never had the time to confide in Ms B.

38. Mr A stated that he attended most appointments, and they were short and lasted only 5–10 minutes. Mrs A said that the appointments were never longer than 10 minutes, apart from the appointment at 36 weeks' gestation.[9] Ms B stated that her antenatal visit clinic times have half-hourly slots, but if a student midwife is present the appointments can take longer. Ms B said that she went out of her way to meet Mrs A for visits at 7.45am, 45 minutes before the next appointment, or on Saturdays. She also said that Mrs A had her contact details and knew she could contact her any time.

[7] Ms B's diary records show that seven appointments were scheduled.

[8] A 50g glucose tolerance test (the polycose test) is used to screen for gestational diabetes. In New Zealand, it is recommended that testing for gestational diabetes occurs for all women between 26 and 28 weeks' of gestation. Women with an elevated result should be followed up with a 75g oral glucose tolerance test.

[9] Discussed below at paragraph 41.

39. When Mrs A was 28 weeks' pregnant, Ms B advised Mrs A that she was travelling overseas on holiday, and would not be available again for six weeks. Ms B said that she advised Mr and Mrs A that they should see her backup midwife in two weeks' time. Mrs A told HDC that Ms B did not tell her she would need an antenatal check while Ms B was away, and because she was a first-time mother she was not aware that she needed one. Mrs A said that if she had been informed she definitely would have arranged an appointment. Mrs A did not contact the backup midwife to make an appointment in Ms B's absence, and so did not have an antenatal check for six weeks. Mrs A's blood pressure at 28 weeks' gestation was recorded in the electronic record as 100/60mmHg. However, there is no record of this appointment in the booklet.

40. Ms B stated that on her return she had a busy clinic because she had been away for six weeks; however, she discussed the birth plan with Mrs A and told her what to read regarding birth. Ms B said that they would have an in-depth discussion about the birth at the next visit. Mrs A's blood pressure is recorded in the booklet as 100/60mmHg; it is not recorded in the electronic record.

41. When Mrs A was 36 weeks' gestation, Ms B met Mr and Mrs A at the hospital at 9.30am and spent 45 minutes talking to them about the birth. Ms B took them around the garden and showed Mrs A's husband how to manage the labour, and undertook the usual antenatal check. Ms B recorded in the electronic record that Mrs A's blood pressure was 110/60mmHg, and that Mrs A declined routine antenatal blood tests. The electronic record states: "[D]eclined 36 [week] bloods as healthy well diet discussed." There is no record of any discussion about blood tests in the booklet record of this appointment, and the blood pressure is recorded there as 110/70mmHg.

42. Mrs A attended another appointment at 37 weeks' gestation. There is no record of this visit in the booklet. The blood pressure is recorded in the electronic record, but the only comment recorded is: "[N]o book present."

Appointment 38 weeks' gestation

43. Ms B stated that she had scheduled Mrs A's appointment at 7.45am, but Mr and Mrs A were late. However, Mrs A stated that her husband was not present with her at that appointment. Ms B told HDC that a student midwife, Ms C, was working with her that day. Ms B recalls that she introduced Ms C to Mrs A and asked whether she minded Ms C being present for the consultation.

44. Ms B stated that Mrs A "verbally consented to [Ms C] being present", and that she allowed Ms C to palpate her abdomen. Mrs A stated that Ms B did not ask her whether she agreed to the student being present at the appointment, but did ask whether it was "OK" for the student to touch her stomach. Mrs A told HDC that Ms B asked her in front of the student, and she felt she had to say "yes" even though she had not met Ms C previously. The discussion and consent are not documented in Ms B's notes. In response to my provisional opinion, Ms B stated: "[I]t is not usual practice to document student's consent in the notes." However, she told HDC that she now does this.

45. Mrs A stated that Ms B said: "Oh, this is a student … she is going to be at your delivery." Mrs A had not met the student previously, and did not know that the

student would be present at the appointment. Mrs A said that she felt quite overwhelmed because the student was there and Ms B was telling her, in front of the student, that the student would be at her delivery. In response to my provisional opinion, Ms B stated that she did not tell Mrs A that the student was going to be present at the delivery at that stage.

46. Mrs A said that by that stage she had an itchy stomach and legs, her feet were swollen, and the baby was not moving as much as previously. She said she felt unable to discuss her concerns with Ms B because the appointments were so rushed. Mrs A stated that when Ms C touched her stomach it was quite painful, but Ms B said: "[T]hat's OK, she is just a student." Ms B said that Mrs A did not complain that her stomach hurt on palpation. Ms B also said that Mrs A did not complain of an itchy stomach, and her feet were not swollen, and had she presented with any of those symptoms Ms B would have documented it and performed the necessary investigations. There is no reference to the presence or absence of oedema at any time, in either the booklet or the electronic record.

47. There is no record in the booklet that Mrs A was asked about the baby's movements at any time. The word "norm" is repeated for every appointment in the electronic record under the heading "movements". In response to my provisional opinion, Ms B told HDC that she routinely asks every patient about movements and kicks, and that Mrs A did not complain of reduced fetal movement. She said that she would have taken Mrs A to hospital and performed a CTG if she had had concerns about reduced fetal movement. Mrs A said that Ms B did not ask her about kicks or movements, but that she would occasionally report this information to Ms B.

48. Ms C took Mrs A's blood pressure and informed Ms B that it was elevated at 150/80mmHg. Mrs A told HDC that Ms B stated: "Oh, that is quite high," and asked whether it was because Mrs A had rushed to the appointment. Mrs A recalls that Ms B told her that she (Ms B) was not concerned about the blood pressure reading.

49. Ms B recorded the blood pressure reading in her electronic notes and in the booklet. She recorded in the electronic notes that Mrs A was "stressed", and that she had advised Mrs A to "visit in one week to check and if any symptoms to call me".[10] Ms B stated that this refers to her advice to Mrs A that raised blood pressure is a matter to be aware of and, if she noticed any symptoms of oedema, epigastric pain, headaches or visual disturbances,[11] Mrs A was to let her know. In response to my provisional opinion, Ms B stated that she asked Mrs A to come to the hospital for a check on the Saturday after this appointment, but she did not do so. This request is not recorded.

50. In contrast, Mrs A does not recall any advice being given. She said that Ms B did not seem to be concerned about the high blood pressure reading, and just said to come in again the following week. Mrs A said that Ms B did not treat it as a big issue or something she needed to look into further. Mrs A told HDC that Ms B did not discuss

[10] At this stage of pregnancy antenatal assessments are routinely carried out weekly.

[11] Epigastric pain is pain that is localised to the region of the upper abdomen immediately below the ribs, and can be a symptom of pre-eclampsia. Headaches and visual disturbances may also be signs of pre-eclampsia. Ms B noted that epigastric pain can also be a sign of liver conditions or gallstones.

with her the consequences of raised blood pressure, so she (Mrs A) was not concerned about it.

51. Ms B stated that she rechecked the blood pressure after half an hour, and it was then 120/70mmHg, but she failed to document a second recording in the electronic record or the booklet. She said: "I was satisfied on that day the blood pressure was normal on the second check." She stated:

> "[Mrs A] was in a hurry to get out the door and she took the antenatal record with her which is my only explanation for not recording the second reading. I expect I attended to the next matter in my busy day and overlooked recording it in the electronic notes."

52. Ms B told HDC that if the blood pressure had remained elevated, it would have been accompanied with routine screening for pre-eclampsia, and that she told Mrs A that if her blood pressure became elevated it would be necessary to do further investigations.

53. Mrs A stated that Ms B did not check the reading taken by Ms C. Mrs A said that she was not there for half an hour, and that it was a short appointment because there were other clients waiting to see Ms B. Ms C does not recall whether Ms B rechecked the reading. Mrs A stated that when she returned home from the visit, she told her father that her blood pressure was high, and he tried to check her blood pressure using a digital machine. She said that "it was just going up and up and up" and her veins were popping out, so they thought they should be using different equipment to test her blood pressure.

Email exchange regarding student presence at the birth

54. Mrs A said that she was concerned about the suggestion of the student midwife being present at the birth so she emailed Ms B stating:

> "[Mr A] and I had a talk this weekend about the possibility of having a student at the birth of our first child … we both would prefer not to have one as we are both quite nervous already. I am sorry but I hope you understand. [Mrs A] and [Mr A]."

55. Ms B replied:

> "Actually [Ms C] is working with me and she will be a great support, she will actually support both of you all the decisions and examinations will be by myself. The student midwife is trained to support both of you you will have two people supporting you. [Ms C] is allocated to my practice and in order for your children to have good midwives when I am long gone I need to show them my experience. Think it is not a wise decision and her being there will be a tremendous support for the anxious husband."

56. Ms B accepts that by her email, Mrs A had declined the presence of a student at the birth. Ms B said that her email in reply was not intended to be read as stating that a student midwife would be at the birth contrary to Mrs A's wishes. Ms B stated that her intention was to provide another viewpoint to ensure Mrs A had "sufficient opportunity for informed consent to decline having the value of a student involved".

Appointment 39 weeks' gestation

57. Mrs A had a further appointment with Ms B. Mrs A stated that she felt uneasy about going to the appointment, and that at the appointment it was "almost like that email didn't happen", as Ms C was again present. In response to my provisional opinion, Ms B submitted that she had not seen Mrs A's email at the time of the appointment and, if she had, she would not have allowed Ms C to be present. Mrs A could not specifically recall whether she had received Ms B's email response before the appointment.

58. Mrs A was then at 39 weeks' gestation. Her blood pressure was taken by Ms C. Ms B stated that Ms C said that the reading was 120/70mmHg (Mrs A's electronic records state 120/70mmHg, whereas the booklet states 100/70mmHg).[12] Ms B said that she was in the room and supervising indirectly, but did not observe Ms C taking the blood pressure because she was confident Ms C was competent to do it. Mrs A also stated that Ms B did not check Ms C's reading of her blood pressure. Ms B said that she did not consider it was necessary to re-check the blood pressure because she "had directly supervised [Ms C] in relation to previous [blood pressure] measurements and by this time had confidence in her [blood pressure] reading ability". Ms B stated that Ms C had been taking blood pressures in the hospital environment. Ms C stated that she was in her first year of midwifery training. Ms C does not recall this appointment.

59. Ms B stated that she palpated Mrs A's abdomen, and Mrs A had no abdominal discomfort evident. Ms B stated that Mrs A was well and healthy. Mrs A said again that she did not discuss her concerns about the itchiness of her stomach because the appointment was so rushed, and because she thought her itchiness and swollen feet were normal in pregnancy. In response to my provisional opinion, Ms B said: "I had explained the symptoms of GPH [pre-eclampsia] and oedema to her. I could not provide care if I was not informed of her symptoms and she didn't show any signs of oedema or itchiness."

60. Mrs A stated that she did not want to discuss her concerns about the presence of the student at the birth in front of Ms C. At the end of the visit, Mrs A privately reiterated to Ms B that she and her husband did not wish to have a student present at the birth.

61. Ms C recalls that Mrs A was not happy to have her present at the birth. Ms C told HDC that she heard this from Ms B, but does not remember a conversation between Mrs A and Ms B regarding her presence at the birth.

The following day

62. Mrs A called Ms B late the following afternoon, advising that she had eaten fried chicken an hour previously, and had pain in her mid chest. Ms B stated that this is a common complaint from eating very fatty foods, and she suggested that Mrs A rest, as the pain could have been caused by the food. Ms B told Mrs A that if the pain did not subside, Mrs A might have food poisoning or a gall bladder problem, and that Mrs A should call her and let her know how she was doing and, if her condition got worse, they would need to seek medical help. Ms B stated that Mrs A did not call her back.

[12] Ms B explained that this was an error that must have occurred when she entered the information onto her computer.

63. At 10.13pm Mrs A went to the Emergency Department (ED) because the pain was so intense. The admitting doctor in the ED documented possible eclampsia, but could not rule out gall bladder or liver problems.[13]

64. At that stage, Mrs A was at 39 weeks plus three days' gestation. She was experiencing epigastric pain and vomiting, and was hypertensive[14] with a blood pressure of 180/116mmHg. Mrs A was seen by the obstetrician on call who treated her high blood pressure with nifedipine[15] and transferred her to the maternity ward.

65. Mrs A was noted to have protein in her urine, and her blood tests showed a low platelet count of 133[16] and abnormal liver function. She was diagnosed with severe pre-eclampsia[17] and HELLP syndrome.[18] Magnesium sulphate was commenced to reduce the risk of seizures, and Mrs A was transferred to Hospital 2 for delivery and ongoing care.

66. Ms B stated that she was at Hospital 1 because she had just delivered a baby and, by chance, she was in the ED at 11pm when Mrs A was there. Ms B said that she and a hospital midwife travelled in the ambulance to Hospital 2 with Mrs A. Ms B stated that Mrs A was in a lot of pain, and her eyes were rolling back. Ms B stated that the pains were wave-like, similar to gall bladder pain, and that in her experience it did not resemble eclampsia alone.

Birth of the baby

67. Mrs A underwent an emergency Caesarean section, and her baby boy was delivered at 1.38am. Ms B remained with Mrs A while she was in theatre. Ms C was not present at the birth. Initially the baby had difficulty breathing and was transferred to the special baby unit for observation. He weighed 2.4kg at birth, and subsequently progressed well.

Post partum events

68. Following the Caesarean section, Mrs A was transferred to the intensive care unit (ICU). Her post partum course was complicated by increasingly abnormal liver function tests and a drop in haemoglobin.[19]

69. After the delivery, a computed tomography (CT) scan was performed, which demonstrated a large subcapsular haematoma (bleeding in the liver).[20] Mrs A required

[13] Ms B provided HDC with information about other conditions that can mimic eclampsia, such as acute fatty liver of pregnancy and gallstones.
[14] Hypertension is a chronic medical condition in which the blood pressure in the arteries is elevated. Hypertension puts strain on the heart.
[15] Nifedipine is used to treat high blood pressure and to control angina (chest pain).
[16] Normal platelet counts are in the range of 150–400 x 10^9 per litre of blood.
[17] Pre-eclampsia is a disorder of pregnancy characterised by high blood pressure and large amounts of protein in the urine. It involves many body systems, and evidence of associated organ dysfunction may be used to make the diagnosis when hypertension is present. This includes the presence of a low blood platelet count, impaired liver function, and/or visual disturbances. If left untreated, pre-eclampsia can develop into eclampsia, the life-threatening occurrence of seizures during pregnancy.
[18] HELLP syndrome is a life-threatening obstetric complication usually considered to be a variant or complication of pre-eclampsia.
[19] Haemoglobin is a protein in blood. It carries oxygen from the lungs to the rest of the body.

transfusion with platelets and red blood cells, and was transferred to Hospital 3 for on-going care. She remained in hospital for a month.

70. Ms B stated that she did not visit Mrs A while she was in Hospital 3 because she did not have an access agreement at Hospital 3. Ms B told HDC that her colleague, a midwife, visited Mrs A while she was in Hospital 3 and relayed her progress to Ms B. Ms B went to Mrs A's home to check the baby, who was discharged after two weeks. Mrs A told HDC that Ms B could have visited her in Hospital 3 as a member of the public if she did not have an access agreement. Mrs A considered that if Ms B had visited her while she was in hospital, she could have helped her to understand what had happened to her. Mrs A stated:

> "I was devastated after finding out what had happened to me and how concerned my family were and [Ms B] could have psychologically helped me understand what had happened to me if she had visited me in hospital. She was the only health expert I had relied on during my pregnancy and yet when I was fighting for my life in hospital she had disappeared."

71. Ms B said that she asked the family to let her know when Mrs A was discharged, but they did not do so. Ms B said that she visited the house but no one answered the door, so she telephoned Mrs A and left a message. Ms B asked the backup midwife to visit Mrs A, but this was declined as Mrs A was tired. Ms B had no further contact with Mrs A. Ms B told HDC that at this stage she had discharged the baby to Plunket, and Mrs A was still under the care of the hospital, receiving community nursing for dressing changes.

Response to provisional opinion

72. In response to the "information gathered" section of my provisional opinion, Mrs A stated that she fully trusted and valued Ms B's advice and expertise, and believed she was being provided with the necessary support, care and advice. Mrs A is upset that Ms B did not provide thorough care or carry out relevant tests required to keep her and her baby safe.

73. Ms B informed HDC that she is prepared to accept that she was in breach of the Code and to apologise to Mrs A. Ms B told HDC: "I can clearly see … through this complaint my deviations of practice." Ms B accepted that her documentation was suboptimal.

74. Ms B advised that she has satisfactorily completed a Voluntary Competence Programme set by the Midwifery Council of New Zealand (Midwifery Council) to address the issues raised by this case. Part of the Competence Programme was submitting a reflection to the Midwifery Council. Ms B also had a professional conversation with the Midwifery Council chair, which covered the following points:

[20] A rare complication of pre-eclampsia.

- Informed consent process, particularly in relation to the involvement of student midwives in women's care.
- Communication with the woman — including Ms B's processes used to ensure women's rights are upheld.
- The nature of evidence based practice and how evidence informs midwifery practice.
- Professional conduct within the midwifery partnership with women and as an experienced midwife working with students, new graduate midwives and within the education arena.
- Ms B's expectations and understanding of responsibilities and accountability within the midwifery practice partnership.

75. On 17 March 2015, the Midwifery Council confirmed that it had received the reassurance it needed regarding Ms B's competence to practise, and closed the matter.

76. On 11 May 2015, Ms B underwent her two-yearly Midwifery Standards Review, which is a compulsory component of the recertification programme. This case was discussed at the review, including matters of respect, documentation, communication, and further continuing professional development. Ms B agreed to have her next review in 12 months' time rather than 24, to ensure that the professional development and learnings from this case stay at the forefront of her professional development. She also said that she now makes personal telephone calls to women in the weeks between their visits to ask about their pregnancy. She said that she documents the telephone calls and retains all text messages.

77. Ms B told HDC that she has made improvements to the way she keeps client records, and a new computer system enables her to enter the antenatal visit information at the time and print it off on the day for the woman's file. She told HDC that she has completed a course on documentation, communication and the law.

78. Ms B told HDC that she now conducts dipstick urine analysis on clients despite its inaccuracies, and she follows the New Zealand College of Midwives *Handbook for Practice* (detailed below). She also told HDC that she follows recommendations from Action on Pre-eclampsia (APEC) and the Society of Obstetric Medicine of Australia and New Zealand (SOMANZ).

79. Ms B told HDC that she now discusses student involvement with women at their booking visit and provides women with a contract defining the student involvement and responsibilities of each party during the partnership. She said that she asks the woman for consent to student involvement in her care at that time. Ms B provided HDC with evidence that she has undertaken further education about pre-eclampsia.

Relevant standards

80. The New Zealand College of Midwives (NZCOM) *Code of Ethics* provides:

> "**Responsibilities to the woman:**
> …
> Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience."

81. The NZCOM *Handbook for Practice* (the NZCOM Handbook) provides:

> "Standard 3: The midwife collates and documents comprehensive assessments of the woman and/or baby's wellbeing.
>
> Standard 4: The midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons."

82. The NZCOM Handbook sets out decision points for midwifery care:

> "**The first decision point in pregnancy within the first 16 weeks of pregnancy**
> This timing allows for a comprehensive health assessment to be made …
>
> *Information shared*
> - Review of midwifery, medical, obstetric, social and psychiatric history to identify altering factors
> - Review of current and past health status (physical, mental, emotional, spiritual, cultural) …
>
> *From examination*
> - Review physical health status. This should include a blood pressure check, weight and height
> - Assessment of uterine size …
>
> *From tests …*
> - Urinalysis …
>
> **The second decision point in pregnancy — 24 weeks**
> This timing provides for assessment of the health and wellbeing of the woman and her baby ...
>
> *Information shared*
> *From examination*
> - Blood pressure …
>
> *From tests*
> - Urinalysis for proteinuria, glycosuria …"

The NZCOM Handbook states that at the third, fourth and fifth decision points in pregnancy (at 30, 36 and 38 weeks respectively) the following information should be shared:

"*From history*
- Woman's wellbeing
- Baby's movements

From examination
- Blood pressure

From tests
- Urinalysis for proteinuria …"

83. The Midwifery Council *Competencies for the Entry to the Registry of Midwives (2007)* provides:

"**The midwife**:

…

2.16 Provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided."

84. The Ministry of Health 2012 *Guidelines for Consultation with Obstetric and Related Medical Services* (Referral Guidelines) state that the requirements for transfer to a specialist in relation to pre-eclampsia are:

"[Blood pressure] of ≥ 140/90 and/or relative rise of > 30/15 mmHg from booking [blood pressure] and any of:

1. proteinuria > 0.3g/24 hours; or protein/creatinine ratio ≥.3, or 2+ protein on dipstick testing
2. platelets < 150 x 10/9/l
3. abnormal renal or liver function
4. imminent eclampsia."

The Referral Guidelines provide:

"Transfer: The LMC must recommend to the woman (or parent(s) in the case of the baby) that the responsibility for her care be transferred to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition.

The decision regarding ongoing clinical roles/responsibilities must involve three-way conversation between the specialist, the LMC and the woman.

The specialist will assume ongoing clinical responsibility and the role of the LMC from that point on will be agreed between those involved. This should include discussion about timing of transfer of clinical responsibility back to the LMC when the condition improves. Decisions on transfer should be documented in the woman's records."

Opinion: Ms B — Breach

Introduction

85. Ms B was responsible for the care provided to Mrs A throughout her pregnancy until her admission to Hospital 1 with pre-eclampsia. I am concerned about the quality of the services Ms B provided to Mrs A in a number of respects, as follows.

Antenatal care

86. Ms B did not weigh Mrs A at any antenatal appointment. While a booking weight and BMI are recorded in the electronic record, Ms B stated that her opinion is that the best indication of maternal well-being is the clinical findings in relation to the woman. However, despite not weighing Mrs A, Ms B stated that Mrs A had normal weight gain during her pregnancy.

87. Ms B did not conduct routine urinalysis for proteinuria during the pregnancy, and did not check Mrs A's blood pressure at each appointment. Ms B stated that at that time, she did not do urine dipstick testing of pregnant women because the dipstick tests are not totally accurate. My expert advisor, midwife Bridget Kerkin, advised that routine screening undertaken by midwives during the antenatal period includes assessment for pre-eclampsia. She stated that it is usual practice for midwives to check a woman's blood pressure at each antenatal visit and undertake urinalysis for the presence of protein. She noted that pre-eclampsia is an unpredictable disease that can develop and deteriorate rapidly. The NZCOM Handbook also provides that the midwife undertake urinalysis at the first five decision points of pregnancy.

88. At 38 weeks' gestation, Mrs A's blood pressure was elevated at 150/80mmHg. Ms Kerkin advised me: "In this circumstance, urinalysis and a repeat blood pressure several hours after the first recording would be the minimum expected assessment." She stated that the lack of urinalysis for proteinuria in this circumstance would be considered a significant omission in care.

89. The Referral Guidelines are mandatory legislative guidelines. In relation to the risk of pre-eclampsia, the Referral Guidelines provide that a rise from booking blood pressure of 30/15mmHg, in addition to the presence of proteinuria (2+ protein on dipstick testing), requires the transfer of the woman's care to a specialist. Mrs A's blood pressure at 150/80mmHg had risen by 50/20mmHg from her booking blood pressure of 100/60mmHg. However, Ms B failed to respond to Mrs A's high blood pressure by undertaking urinalysis. This meant that Ms B did not have the information to enable her to comply with the Referral Guidelines, which may have required transfer to a specialist for treatment of pre-eclampsia depending on the urinalysis result.

90. Ms B stated that she rechecked Mrs A's blood pressure half an hour after Ms C reported it to be 150/80mmHg and, at that time, it was 120/70mmHg. However, Ms B did not document a second recording in Mrs A's notes, and neither Ms C nor Mrs A recalls Ms B checking the reading taken by Ms C.

91. It is through the medical record that healthcare providers have the power to produce definitive proof of a particular matter. This Office has previously stated:[21]

> "In my view, this applies to all health professionals who are obliged to keep appropriate patient records. Health professionals whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted."

92. Given that Mrs A's evidence is that she does not recall Ms B rechecking her blood pressure at 38 weeks' gestation, there is no record of her doing so, and Ms C does not recall it, I find that Ms B did not repeat the blood pressure measurement at this appointment.

93. Furthermore, Ms B did not assess Mrs A adequately. Mrs A stated that at that stage she had an itchy stomach and legs, her feet were swollen, and the baby was not moving as much as previously. There is no record in the booklet that Mrs A was asked about the baby's movements, and Ms B appeared not to elicit from Mrs A that there had been a reduction in fetal movement, or that Mrs A was concerned about her itchy stomach and legs and swollen feet. While Ms B said that Mrs A never raised these concerns with her, Mrs A said that she felt unable to discuss her concerns because the visits were so rushed.

94. Ms B recorded in the electronic record for this visit: "[S]tressed advised visit in one week to check and if any symptoms to call me." Ms B stated that this refers to her having advised Mrs A that if she noticed any symptoms of oedema, epigastric pain, headaches or visual disturbances she was to let Ms B know. However, there is no record of the symptoms being discussed, and Mrs A does not recall any advice being given. Mrs A said that Ms B did not seem to be concerned about the high blood pressure reading, and just said that Mrs A was to come in again the following week. Mrs A said that Ms B did not treat it as a big issue or something she needed to look into further.

95. At 39 weeks' gestation, Mrs A had a further appointment with Ms B. Mrs A's blood pressure was again taken by Ms C. Ms B said that Ms C told her that Mrs A's blood pressure was 120/70mmHg. Although the electronic records state "120/70mmHg", in the booklet Mrs A's blood pressure was recorded as 100/70mmHg. Ms B said that she was in the room and supervising Ms C indirectly, but did not observe her taking the blood pressure because she was confident Ms C was competent to do it. Ms C does not recall this appointment.

96. Ms Kerkin advised that although Ms B was satisfied that Ms C was competent to check blood pressure, it would have been prudent for Ms B to assess Mrs A's blood pressure herself, and that to fail to do so was a departure from accepted standards of care. Again at that appointment, Ms B did not ask Mrs A about other symptoms, and Mrs A said that she did not discuss her concerns about the itchiness of her stomach and her swollen feet because the appointment was so rushed and she thought her symptoms were normal.

[21] Opinion 08HDC10236, 28 November 2008 at page 11; see also Opinion 13HDC00031 at page 8.

Medical history

97. The detailed health questionnaire in Mrs A's antenatal notes was not completed. Mrs A told HDC that she does not recall Ms B drawing her attention to the health questionnaire form or asking her to complete it. Ms B acknowledged that she did not follow up with Mrs A about completing the health questionnaire. In addition, Ms B did not establish some of Mrs A's medical history. As a consequence, Ms B had limited knowledge about Mrs A's health status.

Conclusions

98. Overall, in my view Ms B's antenatal care of Mrs A was suboptimal. She did not establish Mrs A's relevant medical history, failed to monitor Mrs A appropriately by urinalysis, and appeared not to elicit from Mrs A that she had oedema and there had been a reduction in fetal movement. Further, Ms B failed to respond appropriately to Mrs A's high blood pressure by rechecking the reading and by undertaking urinalysis at that point. Ms B did not assess Mrs A's blood pressure herself despite the high reading the previous week. Accordingly, I find that Ms B failed to provide services with reasonable care and skill and breached Right 4(1) of the Code.

Respect

Email exchange regarding student presence at birth

99. Ms B stated that Ms C began working with her on when Mrs A was 38 weeks' gestation. Ms B said that Mrs A agreed to Ms C's presence at her consultation that day, and allowed Ms C to palpate her abdomen. However, no discussion about the involvement of the student is documented in Mrs A's notes.

100. Mrs A stated that Ms B said: "[O]h this is a student … she is going to be at your delivery." Mrs A said that she felt quite overwhelmed because Ms C was there and Ms B was telling her in front of Ms C that Ms C would be present at her delivery.

101. Mrs A was concerned about Ms C being present at the birth of her baby, so she emailed Ms B saying that she and her husband would prefer not to have a student present at the birth of their first child.

102. Ms B replied:

> "[A]ctually [Ms C] is working with me and she will be a great support, she will actually support both of you all the decisions and examinations will be by myself. [T]he student midwife is trained to support both of you you will have two people supporting you. [She] is allocated to my practice and in order for your children to have good midwives when I am long gone I need to show them my experience. Think it is not a wise decision and her being there will be a tremendous support for the anxious husband."

103. Consent for the involvement of a student midwife should be sought and documented if a student is to be involved at any stage during a woman's midwifery care. The NZCOM *Code of Ethics* provides: "Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience." I am concerned that Mrs A felt she had to accede to Ms C's presence at two consultations, and very

concerned at Ms B's response to Mrs A's email declining Ms C's involvement during her birth.

104. Ms Kerkin said that, in her view, Ms B's response to Mrs A's email did not indicate respectful acceptance of Mrs A's decision not to have a student present at the birth. I agree. While Ms C was not present at the birth, I consider that the email response from Ms B to Mrs A was inappropriate and disrespectful.

Conclusion

105. Right 1(1) of the Code provides that every consumer has the right to be treated with respect. In my view, Ms B's email response to Mrs A was inappropriate and disrespectful and a breach of Right 1(1) of the Code.

Record-keeping

106. Competency 2.16 of the *Competencies for the Entry to the Registry of Midwives (2007)* provides that the midwife keeps accurate and timely written progress notes and relevant documented evidence of decisions made and midwifery care offered and provided. The NZCOM Handbook also provides that the midwife collates and documents comprehensive assessments of the woman and/or baby's well-being, and the midwife maintains purposeful, ongoing, updated records and makes them available to the woman and other relevant persons.

107. Mrs A provided HDC with the booklet containing Ms B's handwritten notes from the appointments. Ms B also provided HDC with the electronic record she documented on her computer following her appointments with Mrs A. These records are very limited, and there are a number of occasions in which the electronic record and the booklet do not contain the same information.

108. Ms Kerkin advised that the lack of documentation throughout Mrs A's antenatal record makes it difficult to assess the adequacy of the information provided to Mrs A, and is an area of concern. Ms Kerkin advised that thorough contemporaneous documentation of assessments, results, conversations/advice and decisions throughout the provision of midwifery care is a core midwifery competency.

109. Ms Kerkin stated that, generally, a midwife will use an antenatal checkbox page that summarises the basic assessments undertaken during each antenatal visit, alongside pages that hold the body of the notes. She said that these records should be updated at the time of every visit with the woman, to maintain currency of the clinical record. Ms Kerkin advised that the lack of contemporaneous verifiable documentation throughout Mrs A's antenatal record represents a moderate departure from accepted practice.

110. I am very concerned at the inadequate documentation in this case. In my view, Ms B's suboptimal documentation amounts to a failure to comply with professional standards and, accordingly, Ms B breached Right 4(2) of the Code. I note that Ms B has accepted that her documentation was suboptimal.

Recommendations

111. I recommend that Ms B:

a) Apologise to Mrs A for her breaches of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.
b) Undertake further training with regard to antenatal assessments, informed consent, record-keeping, and communication with clients, and provide HDC with evidence of this training within three months of the date of this report.
c) Reflect on her failings in this case, and provide a written report to HDC within three months of the date of this report, on her reflections and the changes to her practice she has instigated as a result of this case.

112. In my provisional opinion, I recommended that Ms B organise a special midwifery standards review through NZCOM. However, Ms B provided HDC with evidence that she underwent her most recent midwifery standards review in May 2015, and advised that she has another review scheduled in one year's time (instead of the standard two years).

113. I recommend that the Midwifery Council of New Zealand consider whether a further review of Ms B's competence is warranted in light of this report, and report back to HDC with the findings of this review if it is undertaken.

Follow-up actions

114.
- 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 the relevant district health board, and they 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 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 — Independent midwifery advice to the Commissioner

The following expert advice was obtained from independent midwife Ms Bridget Kerkin:

"My name is Bridget Kerkin and I have been asked by the Health and Disability Commission (HDC) [Complaints Assessor] to provide advice regarding the above complaint. I have read, and agree to follow, the Commissioners Guidelines for Independent Advisors.

I registered as a midwife in 1998 and have worked primarily as a Lead Maternity Carer since then, with a focus on primary care in the community. I have provided care for women birthing at home and in primary and secondary care facilities. I have worked in rural, remote rural and urban environments. I am currently also employed as a Midwifery Lecturer at Otago Polytechnic. I am an active member of the New Zealand College of Midwives, having represented the Wellington Region as the Midwifery Resolutions Committee Midwife Representative for three years. I have a BSc in psychology, a BHSc in midwifery and have just completed my postgraduate certificate in midwifery.

I have reviewed the documents provided to me which include:

a. Complaint;
b. Notes taken by [Ms B] on [Mrs A's] admission to [Hospital 1];
c. Response from [Ms B], dated 23 August 2013;
d. Appendices to [Ms B's] response;
e. Clinical records from [Mrs A's] admission to [Hospital 1];
f. Comments from [the] District Health Board; and
g. Antenatal booklet, provided by [Mrs A].

As an addendum, [Ms B] has also provided digital records kept in her client database following query as to whether further antenatal records were available. Due to the digital nature of these records, the timing of the entries cannot be confirmed and some of the entries differ from those in the handwritten record held by [Mrs A]. I have considered the contemporaneously documented handwritten notes held by [Mrs A] to be the verifiable record.

Instructions from the Commissioner and advice requested:

1. *Should further investigation have been undertaken when [Mrs A's] blood pressure was measured as 150/80 [at 38 weeks' gestation]?*
2. *Was it appropriate for the student midwife to take [Mrs A's] blood pressure [at 39 weeks' gestation], and is this normal practice?*
3. *Do you consider [Ms B] provided an appropriate email response [at 39 weeks' gestation] when [Mrs A] and her husband advised they would prefer not to have a student midwife present at the birth?*
4. *Was the advice given by [Ms B] to [Mrs A], when she phoned her reporting chest pain [the following day], appropriate?*
5. *Were there any early indicators of pre-eclampsia that were not addressed by [Ms B]?*

6. *Is there evidence to support [Mrs A's] allegations that [Ms B] did not address her family's medical history, that her consultations were rushed, and that consent was not obtained for the student midwife to be present during consultations?*

*If there are areas of concern, please outline them and whether you consider any departures are **mild**, **moderate**, or **severe**. If you believe the care was appropriate, please say so, and explain your reasons.*

I declare that I have no conflict of interest.

Summary of events:

- [Ms B] provided care for [Mrs A] in her first pregnancy. It appears this relationship commenced [in 2012]. The written antenatal record is not dated but it seems [Ms B] booked [Mrs A] at 9 weeks and 2 days' gestation. *NB the digital record for this visit is dated at […]2012*
- [Mrs A's] pregnancy seems to have been straight forward although I note a positive glucose challenge test result [halfway through the pregnancy] with no clear documentation of a follow up glucose tolerance result. *Reference is made to a normal GTT result in the digital record.*
- In the handwritten notes, [Ms B] first recorded [Mrs A's] blood pressure to be 100/60 mmHg [at about 20 weeks' gestation]. *NB there are discrepancies between the digital records provided by [Ms B] and the written antenatal records provided by [Mrs A]*. [At 38 weeks' gestation] [Mrs A's] blood pressure reading was recorded as 150/80 mmHg.
- [Mrs A] emailed [Ms B] [to clarify] her choice to not have a student midwife present at her birth.
- [At 39 week's gestation] the student midwife working with [Ms B] undertook [Mrs A's] blood pressure assessment and found a result of 100/70 mmHg.
- [Mrs A] contacted [Ms B] with significant chest pain after eating takeaway food [the following day].
- [Mrs A] subsequently attended the Emergency department at [Hospital 1] and was transferred to [Hospital 2] for management of severe pre-eclampsia and HELLP syndrome.
  [The baby] was delivered by emergency LSCS [lower segment Caesarean section] and [Mrs A] was admitted to ICU following the LSCS. She has had on-going associated health concerns.

Commentary:

Antenatal assessment

Routine screening undertaken by midwives during the antenatal period includes assessment for pre-eclampsia. In New Zealand, it is usual practice for midwives to check a woman's blood pressure at each antenatal visit and also to undertake urinalysis for the presence of protein (NZCOM, 2008). Pre-eclampsia is an unpredictable disease which can develop and deteriorate rapidly (Chandiramani, Waugh and Shennan, 2007).

SOMANZ (2008) defines hypertension as a systolic of >140 mmHg and/or a diastolic of >90 mmHg. These Guidelines for the Management of Hypertension

Disorders of Pregnancy (SOMANZ, 2008) also recommend that 'closer monitoring of pregnant women with an increment in blood pressure of ≥30 mmHg systolic and/or 15 mmHg diastolic is appropriate' (p 3). The reading [Ms B] initially found [at 38 weeks' gestation] warranted further investigation. Although [Ms B] asserts that she took [Mrs A's] blood pressure a second time during the visit, there is no documentation of this. In addition, there is no contemporaneous documentation of urinalysis assessment being made, in the notes held by [Mrs A]. The blood pressure would have ideally been checked again, at least once, and at least an hour after the initial assessment.

As stated above, the decision points for midwifery care (NZCOM, 2008) recommend routine urinalysis for proteinuria at antenatal assessments. International guidelines also support regular assessment for proteinuria during pregnancy (National Institute for Health and Clinical Excellence [NICE], 2010). In the presence of a significant blood pressure change antenatally, it would be appropriate to undertake urinalysis (Grigg, 2010).

In addition, it would have been reasonable practice to offer to reassess the blood pressure within a couple of days to provide reassurance that it was not continuing to increase.

Given the unusual blood pressure result [at 38 weeks' gestation] (Grigg, 2010) it would be usual practice for the LMC to check the blood pressure herself at the next antenatal assessment, either before or after the student midwife.

Student Midwife

Consent for the involvement of a student midwife should be sought and documented if a student is to be involved at any stage during a woman's midwifery care (HDC, 2009). I have not been provided with documentation which clarifies whether consent was sought by [Ms B] for the presence of the student antenatally. [Mrs A] clearly declined the participation of the student midwife during her birth ([by email]). [Ms B's] response to this email did not indicate respectful acceptance of this decision. Her email is written in a way that suggests the student midwife would be in attendance regardless of [Mrs A's] refusal.

Midwifery Advice Provided

[Mrs A] made contact with [Ms B] [following the onset of chest pain] and according to [Ms B], [Ms B] advised [Mrs A] that she might have been experiencing a reaction to the fast food she ate for dinner and to make contact again if the symptoms did not improve. Contemporaneous documentation of this conversation has not been provided. It would be reasonable for a midwife to consider heartburn or cholecystitis as potential causes for the discomfort [Mrs A] was describing. If [Ms B] considered that [Mrs A] had contracted food poisoning (as suggested in [Mrs A's complaint]), or that she was suffering from cholecystitis, further immediate investigation would have been warranted.

Summary of opinion:

1. It is my opinion that [Ms B] should have undertaken urinalysis at the visit [at 38 weeks' gestation] to assess for proteinuria. The blood pressure assessment should have been repeated at least once and these results should have been documented contemporaneously. In addition, it would have been advisable to reassess the blood pressure within a couple of days of this appointment, given the potentially unpredictable path of hypertension in pregnancy (Chandiramani, Waugh and Shennan, 2007). This represents a moderate departure from the expected standard of care.
2. [Ms B] should have assessed [Mrs A's] blood pressure herself at the visit [at 39 weeks' gestation], either before or after the student midwife had performed this assessment. Again this represents a moderate departure from the expected standard of care.
3. It is my opinion that [Ms B's response to Mrs A's email] was not appropriate. There was no indication in [Ms B's] email response that she acknowledged and supported [Mrs A's] choice.
4. It would appear that the initial advice provided by [Ms B] to [Mrs A] [the following day] was sound. Given that [Mrs A] had recently eaten fatty food, a midwife might reasonably conclude the chest pain related to heartburn. [Mrs A] chose to attend the Emergency Department when her symptoms did not improve. Contemporaneous documentation of the initial conversation between [Mrs A] and [Ms B] has not been provided, so I am unable to confirm the verbal advice provided by [Ms B] at this time.
5. [Mrs A's] increased blood pressure [at 38 weeks' gestation] may have been an early indicator of pre-eclampsia. A registered health professional did not assess her blood pressure again until [Mrs A's] admission to hospital [at 39 weeks' gestation]. In addition, other testing which might have clarified whether her blood pressure was a significant issue [at 38 weeks' gestation] was either not undertaken or was not documented.
6. I have not been provided with sufficient documentation to assess whether [Ms B] addressed the medical and family history appropriately, whether consultations were rushed and whether there was consent for the student midwife to be present antenatally.

References:

Chandiramani, M., Waugh, J. and Shennan, A. (2007). Management of hypertension and pre-eclampsia in pregnancy. *Trends in Urology Gynaecology & Sexual Health, 12*(3), 23–28.

Grigg, C. (2010). Working with women in pregnancy. In S. Pairman, S. Tracy, C. Thorogood, J. Pincombe. (Eds.) *Midwifery: Preparation for Practice.* pp 431–468. Sydney: Elsevier.

HDC (2009). Code of Health and Disability Services Consumers' Rights. Wellington, New Zealand: Author.

National Institute for Health and Clinical Excellence (2010). Antenatal care: NICE clinical guideline 62. Manchester, UK: Author

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

SOMANZ (2008). Guidelines for the management of hypertensive disorders of pregnancy. Retrieved from: http://www.somanz.org/guidelines.asp"

Further advice received 26 November 2014

"My name is Bridget Kerkin and I have been asked by the Health and Disability Commission (HDC) [Legal Investigator] to provide further advice regarding the above complaint. I have read, and agree to follow, the Commissioners Guidelines for Independent Advisors.

I registered as a midwife in 1998 and have worked primarily as a Lead Maternity Carer since then, with a focus on primary care in the community. I have provided care for women birthing at home and in primary and secondary care facilities. I have worked in rural, remote rural and urban environments. I am currently also employed as a Midwifery Lecturer at Otago Polytechnic. I am an active member of the New Zealand College of Midwives. I have a BSc in psychology, a BHSc in midwifery and completed my postgraduate certificate in midwifery in 2013.

Advice requested:
Please review the additional information provided and advise whether the responses received cause you to confirm, change, amend, add to, qualify or depart from your preliminary expert advice in any way. Please comment on all matters you consider to be relevant.

For each issue, it would be helpful if you would advise:

a) What is the standard of care/accepted practice?
b) If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?
c) How would it be viewed by your peers?

I have reviewed the additional documents provided to me which include:

1. HDC's letter dated 9 December 2013;
2. [Ms B's] written statement dated 18 December 2013;
3. My preliminary expert advice report;
4. HDC's notification letter dated 25 February 2014;
5. [Ms B's] response to notification dated 28 March 2014;
6. [Ms B's] further response dated 29 July 2014;
7. Interview transcript — [Ms B] (including [Ms B's] additional comments in red); and
8. Interview transcript — [Mrs A]

I declare that I have no conflict of interest.

Brief summary of events:

- [Ms B] provided care for [Mrs A] [in her first pregnancy].
- [Mrs A's] pregnancy appears to have been generally straight forward until 37 weeks gestation, with a booking blood pressure of 100/60.

- [At 38 weeks' gestation] [Mrs A's] blood pressure reading was recorded as 150/80 mmHg. No investigation of this elevation in blood pressure was recorded in either the woman-held antenatal record or the digital record held by [Ms B].
- [At 39 weeks' gestation] the student midwife working with [Ms B] undertook [Mrs A's] blood pressure assessment and found a result of 100/70 mmHg.
- [Mrs A] contacted [Ms B] with significant chest pain [after eating takeaway food].
- [Mrs A] subsequently attended the Emergency department at [Hospital 1] and was transferred to [Hospital 2] for management of severe pre-eclampsia and HELLP syndrome.
- [The baby] was delivered by emergency LSCS and [Mrs A] was admitted to ICU following the LSCS. She has had on-going associated health concerns.

Commentary relating to additional information provided:

Please note, in this provision of advice I have not restated information and opinions already addressed in my preliminary advice, dated 6 January 2014, unless I feel further discussion is required, or where revision of information is necessary. As requested, I have commented on all matters I consider to be relevant.

In her response letter dated 28 March 2014, point 12, [Ms B] discusses the debate concerning routine urinalysis for proteinuria during pregnancy. I would like to reiterate that current international and national guidelines recommend routine urinalysis for proteinuria at each antenatal assessment during pregnancy (National Institute for Health and Clinical Excellence [NICE], 2010; New Zealand College of Midwives [NZCOM], 2008). The 2014 article that [Ms B] refers to (Krogsboll, 2014) was not published at the time she provided care for [Mrs A] and does not specifically address urinalysis in pregnancy. In addition, the research of Alto (2005), to which [Ms B] also refers in point 12, supports the use of urinalysis for proteinuria in pregnant women with increased blood pressure (p 983 — 'Fast Track' comment). Further to this consideration, in point 11, [Ms B] refers to the summary given on the NZCOM website Guidelines page (NZCOM, n.d.) quoting 'in every given situation there must be an opportunity for midwives to use sound judgment, to act with sound rationale and acknowledge the context when making decisions.'

This statement is absolutely correct and, in the circumstance surrounding the assessment of [Mrs A's] blood pressure [at 38 weeks' gestation], the context dictated that further assessment was appropriate given the change in [Mrs A's] clinical presentation.

To address the requested advice:

a) What is the standard of care/accepted practice?

As stated above, usual midwifery practice in New Zealand (and internationally) currently includes urinalysis for the presence of protein at each antenatal visit (NICE, 2010; NZCOM, 2008). In this circumstance, urinalysis and a repeat blood pressure

several hours after the first recording would be the minimum expected assessment (SOMANZ, 2008).

b) if there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?

This constitutes a moderate departure from the expected standard of care.

c) How would it be viewed by your peers?

The lack of urinalysis for proteinuria in this circumstance would be considered a significant omission in care.

In this same letter, point 15, [Ms B] states that she rechecked [Mrs A's] blood pressure [at 38 weeks' gestation], half an hour after the student reported it to be 150/80, and this second result was 120/70. This is difficult to verify, given that it was not recorded in either the woman-held notes or [Ms B's] electronic record; or remembered by [Mrs A] (transcript dated 10 September 2014). Rechecking the blood pressure would be a reasonable response to the clinical picture, although SOMANZ (2008) recommends a larger interval, of several hours, between blood pressure assessments. The extent to which [Ms B] assessed [Mrs A's] symptoms of pre-eclampsia is also unclear from the documentation. She does not address oedema (a symptom of pre-eclampsia) in the antenatal record, although [Mrs A] refers to being oedematous at that time ('my feet were swollen', transcript dated 10 September 2014). The electronic record dated [38 weeks' gestation] states 'of any symptoms to call me' but does not define which symptoms of concern were discussed with [Mrs A].

This lack of comprehensive documentation throughout [Mrs A's] antenatal record makes it difficult to assess the adequacy of the information provided by [Ms B] to [Mrs A] and constitutes another area of concern.

To address the requested advice:

a) What is the standard of care/accepted practice?

Thorough, contemporaneous documentation of assessments, results, conversations/advice and decisions throughout the provision of midwifery care is a core midwifery competency (Midwifery Council of New Zealand 2007; NZCOM, 2008).

From Competency Two of the 'Competencies for Entry to the Register of Midwives' (the Midwifery Council 2007):

The midwife:

2.15 shares decision making with the woman/wahine and documents those decisions;

2.16 provides accurate and timely written progress notes and relevant documented evidence decisions made and midwifery care offered and provided:

Generally, a midwife will use an antenatal 'check-box' page which summarises the basic assessments undertaken during each antenatal visit (as [Ms B] used with [Mrs A]), alongside pages which hold the 'body' of the notes — detailing significant results, assessments, conversations, advice and decisions. A blank example of such records is provided in Appendix One. These records are updated at the time of each and every visit with the woman, to maintain currency of the clinical record. Standards Three and Four of the Standards of Midwifery Practice (NZCOM, 2008) also specifically address the expectation of midwifery documentation. These can be found in Appendix Two.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider it is?

The lack of contemporaneous, verifiable documentation throughout [Mrs A's] antenatal record represents a moderate departure from expected practice.

c) How would it be viewed by your peers?

This absence of adequate documentation would be considered, by the midwifery community, to undermine [Ms B's] ability to communicate the effectiveness of her assessments of [Mrs A], advice to [Mrs A] and her family, and her support of the choices made by [Mrs A] whilst under [Ms B's] care.

In my preliminary advice (dated 6 January 2014) I advised that [Ms B] should have checked [Mrs A's] blood pressure [at 39 weeks' gestation], either before or after the student checked it. In her response letter, dated 28 March 2014 (point 19) [Ms B] describes the process she undertook to assess the student's competence to check blood pressure. She is correct in her assertion that midwives must make a professional assessment of a student's ability to perform any given task. Although I believe that it would have been prudent for [Ms B] to make this blood pressure assessment herself (alongside the assessment undertaken by the student), I have taken into account [Ms B's] perception of the student's ability. Therefore, I have revised my opinion to consider this was a minor departure from the expected standard of care.

Summary of opinion:

The additional information provided to me has led me to further discussion or amendment of some aspects of my original opinion. Please find my revised advice summarised below:

1. It is my opinion that [Ms B] should have undertaken urinalysis at the visit [at 38 weeks' gestation] to assess for proteinuria. The blood pressure assessment should have been repeated at least once several hours following this initial assessment and these results should have been documented contemporaneously. This represents a moderate departure from the expected standard of care.
2. [Ms B's] antenatal documentation does not provide sufficient detail to confirm the appropriateness of her actions in response to [Mrs A's] clinical circumstances [at 38 and 39 weeks' gestation]. This lack of a verifiable record represents a moderate departure from the expected standard of care.

3. [Ms B] would have been prudent to assess [Mrs A's] blood pressure, alongside the student's assessment [at 39 weeks' gestation]. This represents a minor departure from the expected standard of care.

References:

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National Institute for Health and Clinical Excellence (2010). Antenatal care: NICE clinical guideline 62. Manchester, UK: Author

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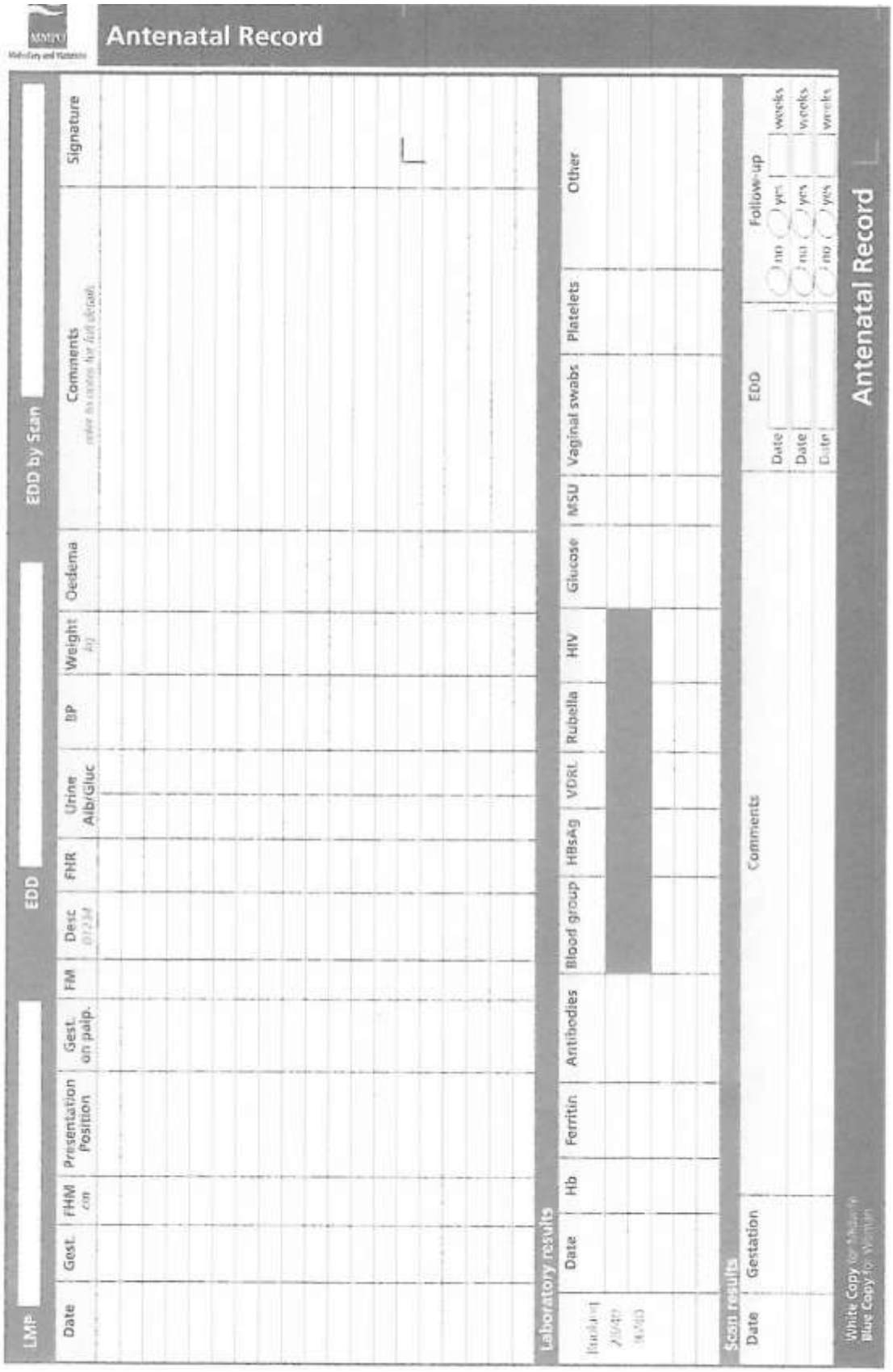
Appendix One



Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Maternity Notes

Date	Notes	Signature

Maternity Notes

Appendix Two

Standards of Midwifery Practice
Excerpt from Handbook for Practice (NZCOM, 2008, p17–18).

Standard Three

The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing.

Criteria
The midwife:

- Collects and compiles information from the first visit for antenatal care or at the first formal contact with the woman.
- Collects information using all sources in consultation with the woman.
- Collects information which includes:
- Personal and family/whanau details
- Physical, psychological, emotional wellbeing
- Cultural and spiritual dimensions
- Physical, social and cultural environment
- Acknowledges the Individual nature of each woman's pregnancy in her assessments and documentation.
- Documents her assessments and uses them as the basis for on-going midwifery practice.

Standard Four

The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons.

Criteria
The midwife:

- Reviews and updates records at each professional contact with the woman.
- Ensures Information is legible, signed and dated at each entry.
- Makes records accessible and available at all times to the woman and other relevant and appropriate persons with the woman's knowledge and consent
- Ensures confidentiality of information and stores records in line with current legislation."