

Delayed notification of pregnancy ultrasound results breaches the Code 21HDC00168

According to a report released today, the rights of a woman and her stillborn baby were breached under the Code of Health and Disability Services Consumers' Rights (the Code).

Deputy Commissioner Rose Wall found Pacific Radiology and a registered midwife failed to deliver an appropriate standard of care.

At just over 41 weeks of pregnancy, the woman was referred by her midwife to Pacific Radiology for a post-dates ultrasound scan. The scan noted low amniotic fluid and a drop in the estimated fetal weight, however, the woman was reassured that it was 'quite normal' for her stage, and that her results would be sent to her midwife.

After experiencing bleeding and reduced fetal movements, the woman informed her midwife, who contacted Pacific Radiology and discovered that a coding error had prevented the midwife from receiving the scan results. At that stage, the midwife referred the woman to hospital where the baby was induced and stillborn.

The findings of the post-dates scan were significant and required priority communication to the midwife. However, the coding error meant the findings were not sent.

Pacific Radiology also lacked adequate systems to verify the successful delivery of the scan report and did not follow up with a phone call, as might have been expected.

Ms Wall emphasized that the responsibility for communicating clinical findings rests with the health service provider, not the patient, and she said it was crucial that health service providers have systems in place to support such a responsibility.

Accordingly, she found Pacific Radiology breached the Code for failing to provide services of an appropriate standard.

"I am highly critical that Pacific Radiology was aware that it was using an IT system that held 'empty' codes, which, if selected, would result in the report in question going 'nowhere', Ms Wall said.

"I am also critical that it appears that no checking systems or policies were in place for such cases...whether that be within the system itself, and/or follow-up by frontline staff."

Ms Wall also found the registered midwife breached the Code for failing to provide services of an appropriate standard.

While the midwife did not receive the results, due to the coding error, Ms Wall said the midwife held the ultimate responsibility, as the requestor, to be proactive about following up on scan results promptly. Failure to do so contributed to the delay in care for the woman and her unborn baby.

Ms Wall also made an adverse comment about the radiologist who reported the ultrasound for not ensuring the scan report was successfully communicated to the registered midwife.

"I am critical that he did not take further steps to fulfil his duty as a radiologist, subject to the Communication of Critical/Actionable Results Policy, for ensuring that the results of the report were communicated successfully," she said.

Pacific Radiology and the midwife have made changes in response to these events. Ms Wall made several further recommendations, outlined in the report.

18 November 2024

Editor's note

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's '<u>Latest Decisions</u>'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website <a href="https://example.com/here-name="https://example.com/here-n

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an <u>animated video</u> to help them understand their health and disability service rights under the Code.

Read our latest Annual Report 2023

Learn more: Education Publications

For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709