Registered Midwife, RM B

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC00503)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 1
Information gathered during investigation 2
Opinion: RM B — breach 10
Changes to practice 16
Recommendations 17
Follow-up actions 17
Appendix A: Independent clinical advice to Commissioner 18
Appendix B: Relevant standards 28

Executive summary

1. This report concerns postnatal care provided to a woman by a midwife, and the importance of ensuring good record-keeping and communication.

Findings

2. The Deputy Commissioner found that the midwife breached Right 4(1) of the Code for failing to store her patient notes adequately, failing to provide the adequate number of postnatal visits to the woman, failing to assess and manage the baby's reflux and colic adequately, failing to assess the woman's breast lumps adequately before prescribing antibiotics, and failing to discharge or refer the woman to appropriate services at the end of the postnatal period.

Recommendations

3. The Deputy Commissioner recommended that the midwife provide a written apology to the woman, provide a written statement that details the steps she would take if a client lives outside her catchment area during the postnatal period, and provide evidence of her attendance at an NZCOM record-keeping course.

4. The Deputy Commissioner also recommended that the midwife conduct an audit of her last ten clients outlining the dates on which the postnatal visits were completed; whether a comprehensive end-point assessment was completed; and the completion of a referral to a "well child" provider.

5. The Deputy Commissioner recommended that the Midwifery Council of New Zealand consider whether a review of the midwife's competence is warranted.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the care provided to her by Registered Midwife (RM) RM B. The following issue was identified for investigation:

- *Whether RM B provided Mrs A with an appropriate standard of care in 2017.*

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

8. The parties directly involved in the investigation were:

Mrs A	Consumer
RM B	Provider/self-employed registered midwife

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.

9. Further information was received from:

Birthing clinic
Midwifery Council of New Zealand
Pharmacy

10. Independent advice was obtained from RM Nicholette Emerson (Appendix A).

Information gathered during investigation

Introduction

11. Mrs A (in her twenties at the time of these events) became pregnant with her first child. She engaged a self-employed registered midwife, RM B, as her lead maternity carer (LMC).

12. This report focuses on the postnatal care RM B provided to Mrs A in 2017, in particular the number of home visits undertaken, the management of mastitis,[1] and the storage of patient notes. In providing the postnatal care, RM B was working beyond her normal geographical catchment area.

Maternity records

13. RM B was not able to provide HDC with the clinical notes relating to the care she provided to Mrs A. At the time of events (2017), RM B stored patient clinical notes in boxes in her garage.[2] RM B told HDC that the box in which she kept Mrs A's notes was eaten by mice, and therefore she no longer holds any clinical notes for the care she provided to Mrs A.

14. RM B kept brief electronic records, which were used for claiming payment from the Ministry of Health (MOH).[3] These electronic records record the date, place, and type of communication, but do not contain any clinical information. The information outlined below is primarily the recollections of the parties, with dates from the electronic records, text messages, and Mrs A's son's Well Child book.[4]

Antenatal care and delivery — Month1[5]

Catchment area

15. Since 2017, RM B had worked as an LMC. At the time of engaging RM B as her LMC, Mrs A lived in her parents' house, an hour's drive from the main centre. RM B told HDC that she

[1] Inflammation of breast tissue that may involve an infection.
[2] The Midwifery Council of New Zealand "Be Safe. Documentation and record keeping" (March 2018) outlines that midwives should retain maternity records for a minimum of ten years following the date of the last entry, and stored in an easy and accessible filing system that is lockable and that protects the records from intruders and destructive forces, eg, fire, water, earthquake.
[3] The electronic notes provided to HDC were a four-page document entitled "postnatal visits" and a one-page document entitled "front page summary visits".
[4] The Well Child Health Book is a parent information, health, and immunisation record for a child.
[5] Relevant months are referred to as Months 1-3 to protect privacy.

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.

agreed to provide LMC care to Mrs A because Mrs A was moving to a town closer to the main centre when the baby arrived, which meant that RM B would be attending postnatal visits in her normal geographical catchment area.

16. In response to the provisional opinion, Mrs A told HDC that the settlement of her new house was planned to take place on 17 Month2, and her due date was 28 Month1, and therefore when RM B agreed to be her LMC there was always going to be one or more postnatal visits to Mrs A's parents' house. Mrs A stated that RM B knew these dates and agreed to be her LMC.

Antenatal care[6]

17. Mrs A told HDC that she was happy with the care RM B provided in the antenatal period of her pregnancy. However, she said that RM B did not discuss the use of contraception following birth.

18. RM B told HDC that she discusses contraception with a mother in the antenatal period. She said that she informs the woman about what contraception she is able to provide, and what can be provided by a general practitioner (GP) and by Family Planning. RM B told HDC that if a mother outlines what contraception she wants, she waits for the woman to follow up with her about accessing it. RM B told the Midwifery Council[7] that she did not follow up with Mrs A about contraception because she had discussed it in the antenatal period and at the public hospital.

Delivery

19. On 9 Month2, Mrs A gave birth to her baby by emergency Caesarean section (C-section) at the public hospital. Mrs A told HDC that she spent approximately two and a half weeks at her parents' home after delivery, and then moved to her new home on 28 Month2.

Postnatal care — 10 Month2–21 Month3

20. This section outlines RM B's and Mrs A's recollections of the number of home visits RM B carried out postnatally over the six-week period following her C-section, and the discussions regarding Mrs A's C-section wound and Baby A's feeding and sleeping issues. This section also outlines the discussions that occurred, primarily by text message, regarding Baby A's colic and Mrs A developing mastitis.

Public hospital and birthing clinic 10–14 Month2

21. Mrs A told HDC that she was at the public hospital following delivery, and transferred to the birthing clinic for postnatal care on 12 Month2. Mrs A recalls RM B visiting her once at the birthing clinic.

---

[6] Specific dates of antenatal care have not been provided.

[7] RM B provided a response to the Midwifery Council dated 4 February 2020 in relation to the concerns raised by, and care provided to, Mrs A, which was provided to HDC.

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.

22. RM B's electronic records document that on 10 and 13 Month2 she made telephone calls, but her records do not outline who she called or the content of the conversation. RM B's electronic records document that on 11 and 12 Month2 she visited Mrs A in person.

Home visits by RM B on 15 Month2 and 22 Month2

23. RM B's electronic records document that she visited Mrs A at home on 15 and 22 Month2. The electronic notes state "HOME [main centre]" and contain no other information. On 15[8] and 22[9] Month2, RM B made notes in the Well Child book for Baby A. Mrs A told HDC that on both of these visits RM B promptly asked for the Well Child book when she arrived and made notes in it.

24. RM B has not provided HDC with her recollections of what took place or was discussed at each individual home visit, but has provided a more general account of what was discussed at the visits overall. RM B told HDC that during two of the home visits, she assessed Mrs A's C-section wound. RM B said that she recalls discussing wound care with Mrs A, including showering, using a sanitary pad for comfort and wound protection, and using Vitamin E oil and micro-tape for approximately six months to minimise the appearance of the scar. RM B told HDC that she recalls telling Mrs A that if she developed any lumps or infections, to telephone her. Mrs A agrees that she discussed her C-section wound with RM B both times she saw her.

25. RM B told HDC that when a woman lives a long way from the main centre (as Mrs A did), she asks for photos of the C-section wound, but she did not receive any from Mrs A. Mrs A disagrees that RM B asked her to send her photos of her C-section wound.

26. RM B told HDC that she remembers giving Mrs A some expressing tips and feeding tips to manage her breast lumps, and taking a breast pump with her when she visited Mrs A, but she cannot recall whether she left a breast pump with her. In response to the provisional opinion, Mrs A told HDC that RM B did not explain how to express or show her how to use a breast pump, and that she learnt these things with her second child.

27. RM B said that she discussed safe sleep at length with Mrs A. RM B recalls the basinet Baby A slept in, and that she had no concerns about his sleeping environment. RM B recalls that when Baby A was showing signs of colic and reflux (discussed further below), she advised Mrs A to raise the bed and make it safely so that Baby A could not wiggle under the blankets.

28. Mrs A agrees with RM B's recollection that they discussed safe sleep, but disagrees with RM B that there were no concerns about Baby A's sleeping environment. Mrs A recalls that Baby A was having difficulty sleeping on his back, and RM B provided advice on the risks of Baby A sleeping on his front. Mrs A disputes that RM B had a discussion with her about raising the bed, and told HDC that her mother had told her to do that.

---

[8] Documented weight, weight loss, head circumference and length, hearing screen/assessment, physical assessment.

[9] Made handwritten note of weight and skin assessment, and documented: "Breastfeeding brilliantly. Noisy feeding, lots of appreciation for mum's milk. Great work."

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.

29. Mrs A stated that when she raised feeding issues during these appointments, RM B told her that the noise Baby A made when he was feeding was appreciation for her milk, and not to be concerned. Mrs A told HDC that when she raised her concerns about Baby A's colic and reflux, and the noise and fuss he made whilst feeding, RM B led her to believe that Baby A was fine and there was nothing to worry about. Mrs A said that she felt that RM B did not take her concerns seriously, and it is untrue that RM B provided her with support about these issues.

30. Mrs A told HDC that after the first couple of visits, there was almost no communication from RM B except for when Mrs A initiated the communication.

Communication regarding mastitis 17–29 Month2

31. On 17 Month2, Mrs A sent RM B a text message explaining that Baby A had fed only once or twice in the night and her left breast was full and "crazy sore". She explained that she could feel a small, very tender lump in her breast and that she wanted to check about mastitis.

32. RM B's electronic records document "Home [main centre] Text" on 17 Month2. RM B told HDC that she believes this indicated that she sent a text message to Mrs A. RM B has not provided HDC with a copy of a text message she sent to Mrs A on 17 Month2.

33. RM B's electronic records also document contact with Mrs A on 20 Month2, but do not outline the nature of the contact. RM B told HDC that she does not recall the nature of the contact on this date. There is no record of a text message sent on 20 Month2, and the text message chain provided by RM B shows the text message sent on 17 Month2 by Mrs A, and the next text message sent on 22 Month2 (see below).

34. RM B told HDC that she remembers having some phone and text conversations about Mrs A's sore breasts and lumps, but has not provided the dates on which these phone calls took place or any detail of what was discussed.

35. On 22 Month2, RM B sent Mrs A a text message asking her where she was. Mrs A responded that she was at her parents' house, and said "see you later".

36. On 29 Month2, Mrs A sent a text message to RM B stating that she felt like she was getting sick and her skin was "tingling", which is a usual sign for her that she is becoming unwell.

37. RM B responded by text message and advised Mrs A that she might be experiencing the start of mastitis. RM B told Mrs A to take anti-inflammatory medication such as ibuprofen, and to pump or hand express and breastfeed until the lump in her breast reduced. RM B told Mrs A to let her know if the lump remained there, and she would send a prescription for antibiotics to a pharmacy by the end of the day. Mrs A responded that she had some antibiotics from the hospital, and asked if she could take them. RM B confirmed that Mrs A should take those antibiotics. Mrs A responded that she would be in touch if anything got worse.

38. RM B did not document a phone call taking place on 29 Month2, and cannot recall whether this occurred, due to the passage of time. Mrs A cannot remember any conversations over

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.

the phone about Baby A or his feeding, and told HDC that all telephone conversations she had with RM B postnatally were about scheduling an appointment.

Disputed third home visit

39. RM B's electronic records documented "HOME [main centre] visit" on 30 Month2. The electronic records do not record any observations or clinical assessments during this visit, nor was the visit recorded in the Well Child book. RM B told HDC that she believes that the Well Child book was not made available to her that day, and that it is her standard practice to complete the Well Child book when it is available. RM B stated that she did not check Mrs A's C-section wound on 30 Month2 as it had healed.

40. RM B said that she specifically recalls a third visit occurring, as she remembers parking in three different spots (for each visit) in Mrs A's car parking area at her parents' house, and that Mrs A's dog knew her. RM B told HDC that she gave Mrs A some expressing and feeding tips to manage her lumps, but she has not told HDC when she provided this information to Mrs A.

41. Mrs A is certain that RM B did not visit her on 30 Month2. Mrs A told HDC that she had moved into her new home two days previously (on 28 Month2), and she is certain that RM B did not visit her new house.

42. RM B agreed that she did not visit Mrs A's new home. However, she stated that this does not prove that she did not carry out a third visit, and she noted that after 28 Month2, Mrs A was still visiting her parents' house after the move (as evidenced by the text message Mrs A sent on 4 Month3 (see paragraph 56), and the third visit would have occurred in Mrs A's parents' house.

43. At 7.41pm on 30 Month2, RM B sent a text message to Mrs A asking how she had been over the last 24 hours, and whether anything had improved or "got worse". Mrs A responded that her breast was less painful but she could still feel a lump.

Cancelled appointment and feeding assessment 3 Month3

44. RM B was scheduled to visit Mrs A on Monday 3 Month3.

45. Mrs A sent a text message to RM B asking for advice and any good tips for upset babies, as Baby A had been unsettled for the past few days and was waking himself up and remaining awake for six hours at a time. At 8.35am, RM B sent a text message to Mrs A explaining that she might have to postpone the appointment for that day until Friday, as she had had an injury. RM B told HDC that also on that day her daughter had injured herself.

46. In response by text message, Mrs A expressed her understanding that RM B was unable to see her that day, and explained that she had a sore lump in her breast and her skin was red. RM B responded at 10.07am and asked Mrs A whether she felt as if she was getting the flu, as that was a classic sign of mastitis.

47. At 12.00pm, RM B sent Mrs A a text message asking whether Baby A was having regular bowel movements, was crying after feeding, and whether he was squirming and showing

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.

signs that he could not get comfortable. RM B sent a further text message at 12.01pm stating: "[S]orry I would love to come but I'm having to wait for d[octor]s until 3.15pm today for any diagnosis."

48. At 12.08pm, Mrs A replied stating "yes" and that he could not get comfortable. Mrs A explained issues with Baby A's bowel movements and said that he brought up a lot of milk often, and asked RM B if there was anything she could do to help him. Mrs A asked: "Will we hopefully see you Wednesday[10]?"

49. It is apparent (from subsequent messages received) that there were text messages in between the text message at 12.08pm and the text message sent at 7.06pm, but RM B has not provided HDC with a copy of these.

50. At 6.27pm, RM B sent a text message suggesting that Mrs A drink peppermint tea or give Baby A gripe water.

51. At 7.06pm, Mrs A sent a further text message saying that she had given Baby A gripe water[11] and asking RM B if the dosage was right. RM B responded at 7.25pm and explained that it was okay and that Mrs A could find guidance on the packet.

52. At 8.27pm, Mrs A asked whether she could go to her doctor for the reflux issues Baby A was experiencing. At 9.08pm, RM B responded that Mrs A could go to the doctor and that it would be good for the doctor to meet Baby A and follow his progress.

Telephone assessment on 3 Month3

53. RM B's electronic records document "Phone contact" on 3 Month3. RM B told HDC that she cannot recall what was discussed on this date.

Reflux and colic diagnosis

54. Mrs A told HDC that in early Month3, she attended the Family Centre. Baby A was diagnosed with reflux and colic, and it was confirmed that Mrs A was not producing any milk. RM B told HDC that she had suggested that Mrs A attend the Family Centre, as staff have the ability to watch patterns of feeding when a mother is struggling. Mrs A disputes that RM B suggested this, and told HDC that the suggestion to attend the Family Centre was made by her cousin.

55. Mrs A told HDC that in early Month3 she also contacted a Plunket[12] nurse herself, to ask for her visits to begin early.

Final communications for postnatal care

Attempts to arrange appointment — 4 Month3

56. At 7.35pm on 4 Month3, Mrs A sent a text message to RM B outlining that she would be in her new home until 11.30am and then at her parents' house from 12pm the following day. RM B responded between 7.35pm and 7.42pm saying that she was unsure whether she

[10] Wednesday 5 Month3.
[11] A remedy used to soothe symptoms of colic.
[12] Aotearoa's largest support service for the health and wellbeing of under-five tamariki and their whānau.

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.

would have time for a round trip to Mrs A's parents' house, but she would try to work something out. RM B said that she had two C-sections booked in the morning, and also had a woman who was at 34 weeks' gestation whose waters had broken, and she was waiting to see what was happening with that woman.

57. Mrs A responded asking RM B to let her know when she would see her next. RM B responded saying that she would try to "sort something" as she would really like to catch up.

58. Mrs A responded that she had been rather stressed over the past few days and had gone to the Family Centre, which had helped her. Mrs A told RM B that she was going back to the Family Centre for the day on Friday, so that staff could watch her baby feeding and sleeping. RM B responded: "ok awesome. They are very good. [Staff member] has been there many years. I saw them with my [child]."

59. On an unknown date,[13] Mrs A sent a text message to RM B asking whether anybody else could visit her and explaining that Baby A needed to be weighed and to have a check-up.

Arranging antibiotics — 21 Month3

60. On 21 Month3, Mrs A sent a text message to RM B asking whether a prescription for antibiotics could be sent to a pharmacy in her new hometown. Mrs A explained to RM B that she had stopped breast-feeding as her milk had dried up, and that she had mastitis again and had not fed Baby A in over a week.

61. At 3.59pm, RM B sent a text message saying "sent now", and at 4.03pm she sent a further text message explaining that she was having some difficulty faxing the prescription request. Mrs A spoke to the pharmacy and arranged that RM B could call the pharmacy. RM B arranged for a prescription of antibiotics to be picked up from Mrs A's local pharmacy. Only part of RM B's text message response to Mrs A has been provided to HDC, which stated: "… fax a script where you would like".

62. RM B told the Midwifery Council that she arranged the prescription "after a discussion of symptoms". RM B did not provide any further information about what symptoms were discussed during this phone call. Nor did she document a phone call in her electronic notes. In response to the provisional opinion, Mrs A told HDC that RM B did not telephone her, and that communication was done by text message.

63. RM B explained that she cannot always see clients, especially when they live as far out of town as Mrs A did. RM B said that Mrs A had had mastitis previously, and they were both happy with a prescription being sent for her partner or family to pick up. There is no evidence that RM B followed up with Mrs A to ascertain whether the antibiotics had worked, and RM B told HDC that she cannot recall speaking to Mrs A's GP.

[13] RM B provided HDC with an undated text message that was in a chain of text messages, and the next message in the chain is dated 21 Month3.

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.

64. Mrs A told HDC that after this she did not hear from RM B again. RM B did not see Mrs A in person for a review on this date.

65. RM B told the Midwifery Council that she offered Mrs A final visits by asking her when she was going to the Family Centre, and saying that she would "pop in" or get a colleague to see her there. RM B said that following this offer, Mrs A did not make contact, and neither did she. There is no contemporaneous evidence of RM B making this offer to Mrs A. In response to the provisional opinion, Mrs A told HDC that RM B did not offer her final visits. She said that Baby A was four weeks old when she visited the Family Centre, and that RM B should have visited her after this, and she should not have had to ask for these visits.

66. RM B did not refer Mrs A to a "well child" provider or GP at the end of the postnatal period. RM B told HDC that she did not send an update or referral to Plunket because she did not see Mrs A in the last two weeks of Mrs A's postnatal period. Mrs A told HDC that RM B did not hand over her care, and did not ask who she would like to have involved going forward.

Further information

Mrs A

67. Mrs A told HDC that after her first child, she suffered with anxiety and she blocked out a lot of what happened after the birth, as it was too traumatic. Mrs A said that when she found out she was having her second child, she reflected on what had happened with RM B.

68. Mrs A also recalled that discussions about contraception did not occur in the postnatal period (as outlined in paragraphs 17–18).

69. Mrs A stated that her difficulties would have been less stressful if RM B had seen her regularly and listened when she raised concerns. Mrs A said that RM B added to her stress and anxiety, and she felt completely alone.

70. Mrs A told HDC that even though she lived a one-hour drive away from the main centre, she would have driven there to attend appointments if RM B had provided the option.

RM B

71. RM B told HDC that she accepts that she did not give Mrs A and Baby A physical postnatal visits after the fourth postnatal week, and said that she would be willing to apologise for this. RM B said that she was aware that Mrs A was going to the Family Centre after the fourth postnatal week, and that it is usual for midwives to discharge patients at 28 days because the "well child" provider (Plunket) commences at five weeks. RM B stated that she explains to mothers that she is available for prescriptions.

72. In response to the provisional opinion, Mrs A noted (as outlined above at paragraphs 55 and 66) that RM B did not contact Plunket on her behalf, and questioned RM B's statement that Plunket would take over at five weeks when RM B had not contacted Plunket to provide a handover.

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.

Responses to provisional opinion

73. Mrs A was given an opportunity to respond to the "information gathered" section of the provisional opinion. Where relevant, her responses have been incorporated into this report. Mrs A told HDC that it was an incredibly difficult time for her and her partner, and that the postnatal care they received after the birth of their second child was completely different. She stated that she hoped RM B has learnt from her mistakes.

74. RM B was given an opportunity to respond to the provisional opinion, and advised that she had no comment to make.

Opinion: RM B — breach

Introduction

75. Notwithstanding the challenge of providing midwifery care to a woman domiciled some distance away, and beyond her normal geographical catchment area, RM B had undertaken to act as Mrs A's LMC. As such, RM B had a responsibility for ensuring Mrs A received the primary maternity care she was entitled. She also had a responsibility for ensuring it was provided with reasonable care and skill. I have significant concerns about aspects of the care RM B provided to Mrs A, as outlined below.

Documentation

76. RM B kept paper clinical records and stored these in boxes in her garage. RM B told HDC that the clinical notes relating to Mrs A were eaten by mice.

77. The Midwifery Council of New Zealand *Competencies for Entry to the Register of Midwives* (the Midwifery Competencies) outlines that midwives should provide accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided.[14]

78. My independent advisor, RM Nicholette Emerson, advised that RM B did not store records in line with accepted midwifery practice, and that the storage of Mrs A's midwifery records represents a severe departure from accepted midwifery standards.

79. I agree with this advice. Women who receive midwifery care should feel confident that the care they receive will be documented and their maternity records stored safely, should they need to be accessed in the future. RM B had an obligation to store her midwifery records in a safe manner, and she did not do so. As a result, there is scant contemporaneous documentation of the care she provided to Mrs A. This has made it challenging to assess the care RM B provided to Mrs A.

---

[14] Midwifery Council Competency Standard 2.16.

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.

Number of postnatal home visits

80. There is contention between RM B and Mrs A regarding the number of home visits RM B made postnatally. Both parties agree that the first and second home visits occurred but RM B's electronic records document a third visit on 30 Month2, but there is no record of the visit in the Well Child book. Mrs A disagrees that a visit took place on 30 Month2, and said that RM B always asked for the Well Child book promptly when she visited, and made notes in it. RM B told HDC that she did not make notes in the Well Child book on 30 Month2 because it was not made available to her.

81. RM B recalls parking in three different spots at Mrs A's parents' home, which she says proves that she made three visits. RM B also said that she checked Mrs A's C-section wound twice, and she did not check Mrs A's C-section wound on 30 Month2 because it had healed. At 7.41pm on 30 Month2, RM B sent Mrs A a text message and asked how she had been over the last 24 hours, and whether anything had improved or become worse.

82. Mrs A told HDC that she moved to her new house on 28 Month2, and both RM B and Mrs A agree that RM B did not go to Mrs A's new house. RM B told HDC that Mrs A moved between her parents' house and the new house after she had relocated, and that this is evidenced by a text message Mrs A sent on 4 Month3 stating that she would be at her parents' house.

83. In order to make a factual finding, I must be satisfied that it is more likely than not that the fact at issue occurred. I have considered the evidence carefully. The evidence that supports that a visit took place on 30 Month2 are RM B's contemporaneous electronic notes, her memory of parking in three different parking spots, and evidence that Mrs A was at her parents' house after 28 Month2. The evidence in favour of the view that a visit did not take place is the lack of midwifery notes in the Well Child book on 30 Month2, and the text message sent by RM B on the same day asking Mrs A how she had been over the last 24 hours.

84. Taking all the evidence into account, including the contemporaneous documentation of a home visit on 30 Month2 and that Mrs A was at her parents' house after 28 Month2, I am satisfied that it is more likely than not that RM B undertook three home visits.

85. Regardless of whether RM B undertook two or three home visits, the MOH guidelines[15] state that a midwife should visit the mother and baby at home at least five times after birth. MOH funding (via the section 88 Maternity Notice) is based on completion of a minimum of five home visits and an additional two visits that may occur prior to discharge from a hospital or birthing unit.

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

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.

86. The Midwifery Competencies outline that a midwife:

> "2.10 regularly and appropriately assesses the health and well-being of the baby/tamaiti and initiates necessary screening, consultation, and/or referral throughout the postnatal period
>
> …
>
> 2.12 assesses the health and well-being of the woman/wāhine and baby/tamaiti throughout the postnatal period and identifies factors which indicate the necessity for consultation with or referral to another midwife, medical practitioner, or other health practitioner
>
> 2.13 demonstrates the ability to prescribe, supply and administer medicine, vaccines and immunoglobulins safely and appropriately within the midwife's scope of practice and the relevant legislation"

87. RM Emerson advised that in the context of a first-time mother requiring support and assessment of her C-section wound healing, support to breastfeed, including clinical assessment of mastitis, and ongoing assessment of her new baby, three home visits in the postnatal period represents a moderate departure from accepted midwifery practice.

88. I agree with this advice. This was Mrs A's first baby, and she required assistance and guidance from her LMC during this period. RM B provided minimal assistance to Mrs A. I acknowledge the time it took RM B to travel to Mrs A's home, but I consider that this does not excuse her from failing to attend the required number of home visits (i.e., at least five) or, if this was not possible, to make alternative arrangements (see discussion below).

Catchment area

89. RM B told HDC that she agreed to provide LMC care to Mrs A because Mrs A was planning to move closer to the main centre when her baby arrived, which meant that RM B would be attending postnatal visits in her normal geographical area. In the first two and a half weeks, Mrs A resided one hour's drive from the main centre, and then moved at the end of Month2. As noted above, Mrs A told HDC that even though initially she lived an hour's drive from the main centre, she would have travelled there to attend appointments if RM B had provided the option.

90. RM Emerson stated that in some cases, it is not possible to continue care if a woman moves from a catchment area. RM Emerson said that if it is accepted that moving from the catchment area prevented realistic postnatal care, then RM B should have formally discussed this with Mrs A and an alternative plan could have been arranged. RM Emerson advised that if some of the care is provided following movement from the catchment area, then a robust back up plan should be arranged if RM B was unable to commit to further home visits.

91. RM B visited Mrs A at home on three occasions, and had planned a fourth visit for 3 Month3. RM B stated that after this visit had to be cancelled, she told Mrs A that she would "pop in"

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.

to the Family Centre or arrange for a colleague to see Mrs A. However, this did not happen, and RM B made no further attempts to make an appointment with Mrs A, despite Mrs A informing her when she was available and when she was closer to the main centre. If RM B was unable to provide appropriate ongoing postnatal care to Mrs A, she should have discussed this and made an alternative plan with Mrs A. By not taking such action, RM B left Mrs A without adequate postnatal support.

Clinical assessment of mastitis

92. In her postnatal period, Mrs A reported mastitis symptoms to RM B on 17 and 29 Month2 and 3 and 21 Month3. During this time, RM B communicated with Mrs A via text messages, phone calls, and home visits.

93. The Midwifery Council's "Statement on text communication" (2016) acknowledges text messages as a form of communication. However, the statement comments that a midwife cannot undertake clinical assessments by text message and, if a woman raises a question about a clinical concern, the midwife should have a telephone conversation with her or arrange an appointment for a further assessment.

94. RM Emerson advised that accepted midwifery practice is to assess the affected breast/s and maternal symptoms and vital signs, in particular temperature. Additionally, if possible, observation and assessment of baby latch and feeding is useful, and if antibiotics are prescribed, flucloxacillin is the accepted course of treatment.

95. RM Emerson advised that it is also accepted that there may be circumstances where following a discussion with a woman, clinical assessment is not possible immediately (e.g., the midwife may be at a birth), and pre-emptive antibiotics are commenced, and assessment occurs later that day or the following day. Alternatively, if the midwife is unable to attend immediately, she may advise the woman to go to her GP for assessment of whether antibiotics are needed.

96. On 29 Month2, by way of text message, Mrs A told RM B that she was feeling unwell and her skin was tingling. RM B responded by text message that Mrs A might be experiencing the start of mastitis, and advised her to take anti-inflammatory medication and to pump, hand express, and breastfeed until the lump on her breast reduced. RM B also told Mrs A to let her know if the lump remained, and she would arrange for a prescription of antibiotics to be sent to a pharmacy by the end of the day. Mrs A responded that she had some antibiotics from the hospital, and asked whether she could take them. RM B confirmed that she could.

97. RM Emerson advised that if RM B assessed Mrs A at her home on 30 Month2 and considered that antibiotics were not necessary, then there would be no departure from accepted practice on this occasion.

98. As outlined above, I have accepted that a home visit took place on 30 Month2. However, there is no contemporaneous record of what assessment occurred during the visit. RM B told HDC that she recalls giving Mrs A advice on expressing and feeding to manage the

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.

lumps, but RM B has not been specific about when this took place (in spite of HDC's request for an account of what happened during this consultation). Due to the lack of evidence, I cannot make a finding of fact regarding what occurred during this visit. However, I acknowledge that as Mrs A had reported mastitis symptoms the previous day, it is likely that this was discussed at the visit.

99. On 3 Month3, Mrs A told RM B (by text message) about a further lump in her breast, and that her skin was red. RM B's electronic notes document a telephone call on 3 Month3. RM B told HDC that she does not recall the content of this call owing to the passage of time. Mrs A told HDC that any phone calls between herself and RM B related to arranging appointments, not clinical care. Whilst I am satisfied that RM B did telephone Mrs A on 3 Month3, due to the lack of documentation I cannot make a factual finding regarding what was discussed during the call.

100. On 21 Month3, Mrs A sent a text message to RM B asking whether a prescription for antibiotics could be sent to a pharmacist in her new hometown. Mrs A explained that she had stopped breastfeeding as her milk had dried up, and she had mastitis again. On the same day, RM B sent a text message saying "sent now", and sent a further text message explaining that she was having some difficulty faxing the prescription request. RM B stated that in addition to these text messages, she discussed Mrs A's symptoms during a telephone call on the same day. However, there is no contemporaneous record of this call and, as such, I am unable to make a factual finding as to whether this conversation occurred.

101. RM Emerson advised that if following the home visit on 30 Month2, the recurrence of a breast lump, redness, and flu-like symptoms were not fully assessed by RM B, a midwifery colleague, or a GP, then this would be a moderate departure from accepted practice. As stated above, RM Emerson explained that such an assessment would include the affected breasts and vital signs, including temperature, and, if possible, observation of the baby latching and feeding.

102. RM Emerson advised that in her opinion, the extenuating circumstances of RM B having an injury, a demanding case load, and a daughter with an injury, should not have prevented RM B recommending to Mrs A that a GP assess her breast. RM Emerson said that whilst it may be reasonable to diagnose recurring mastitis, it is also reasonable to do further assessment to rule out the formation of a breast abscess.

103. I accept RM Emerson's advice that Mrs A should have been assessed in person by either RM B, a colleague, or a GP after she reported further issues including a reoccurrence of a breast lump and redness. I am critical that RM B failed to either conduct an in-person assessment or recommend to Mrs A that she be assessed by another midwife or a GP. I am also critical that RM B proceeded to prescribe antibiotics without conducting such an assessment.

Assessment of colic and reflux

104. On 3 Month3, Mrs A informed RM B that Baby A had been upset and unsettled, and that she had given him gripe water. Mrs A also asked RM B whether she could take Baby A to see the doctor for reflux issues, to which RM B agreed that she should.

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.

105. RM B did not review Mrs A or Baby A in person in Month3, and documented that a telephone call took place on 3 Month3. Mrs A's recollection is that when she raised her concerns about Baby A's colic and reflux during the home visits in Month2, RM B led her to believe that Baby A was fine and there was nothing to worry about. When Mrs A attended the Family Centre in Month3, Baby A was diagnosed with reflux and colic, and it was identified that Mrs A was not producing milk.

106. As noted above, the Midwifery Competencies outline that midwives should assess the health and wellbeing of the baby/tamaiti regularly and appropriately, and should initiate any necessary screening, consultation, and/or referral throughout the postnatal period.[16]

107. Whilst there is a contemporaneous electronic record documenting that a telephone call occurred on 3 Month3, there is no further contemporaneous information about what was discussed during the conversation. Accordingly, I am unable to make a factual finding about the extent to which an assessment of Baby A's colic and reflux issues occurred during the call. I am critical of RM B's poor standard of record-keeping and storage of clinical notes.

Discharge of Mrs A

108. RM B last saw Mrs A for review on 30 Month2, and did not see Mrs A in person for the final two weeks of the six-week postnatal period (which would have ended on approximately 21 Month3). RM B's last communication with Mrs A was on 21 Month3.

109. Between 4 and 21 Month3, RM B did not initiate any communication with Mrs A to enquire how she was or to arrange an appointment, despite the last communication being around Baby A's reflux and colic diagnoses and Mrs A expressing that she was feeling stressed. Mrs A requested a prescription for antibiotics on 21 Month3, and RM B did not follow up with Mrs A to ascertain whether the antibiotics had worked.

110. RM B told the Midwifery Council that she offered Mrs A final visits by asking her when she would be going to the Family Centre so that she could "pop in" or ask a colleague to see her there. RM B said that following this offer, Mrs A did not make contact and neither did she. There is no contemporaneous evidence of RM B having made this offer to Mrs A.

111. RM B did not refer Mrs A to a "well child" provider or a GP at the end of the postnatal period. RM B told HDC that she did not send an update or referral to Plunket because she did not see Mrs A in the last two weeks of her postnatal period. Mrs A stated that RM B did not hand over her care, and did not ask who she would like to have involved going forward.

112. RM B told the Midwifery Council[17] that she did not follow up with Mrs A about contraception because she had discussed it in the antenatal period and at the public hospital. Mrs A told HDC that contraception was not discussed in the antenatal period.

[16] Midwifery Council Competency Standard 2.10.

[17] RM B provided a response to the Midwifery Council dated 4 February 2020 in relation to the concerns raised by, and care provided to, Mrs A, which was provided to HDC.

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.

113. Midwifery Competencies outline that midwives should perform a comprehensive end-point assessment of the woman/wahine and her baby/tamaiti within the six-week postnatal period, and this should include the provision of contraceptive advice, and information about, and referral to, "well woman" and "well child" services, and available breastfeeding support and immunisation advice.[18] RM Emerson noted that there is no evidence that RM B discharged Mrs A to a "well child" provider or a GP, and advised that this continuity of care was particularly important for a first-time mother who had struggled in the postnatal period. I agree, and am critical that RM B failed to make the appropriate referrals.

114. It is outlined clearly in the above competency that a midwife should perform a comprehensive end-point assessment of the woman/wahine and her baby/tamaiti within the six-week postnatal period. RM B did not do so, and, as a result, Mrs A was not referred to the appropriate services, and had to seek assistance herself from the Family Centre and Plunket. Mrs A also did not receive the full six weeks of postnatal care from RM B as expected.

Conclusion

115. In conclusion, I am concerned about the following deficiencies in the postnatal care RM B provided to Mrs A following her emergency C-section:

- Inadequate documentation storage;
- Poor management of postnatal care, including an inadequate number of postnatal visits;
- Inadequate assessment and management of Baby A's reflux and colic;
- Inadequate assessment of Mrs A's breast lumps before prescribing antibiotics; and
- No discharge or referral to appropriate services at the end of the postnatal period.

116. Accordingly, I find that RM 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).[19]

Changes to practice

117. Since the events in 2017, RM B has completed an NZCOM record-keeping course for midwives and made the following changes to her practice:

- She uses an electronic record-keeping system to record her clinical notes.
- She communicates to women that she cannot complete six-week postnatal visits if they reside further than the immediate area.

[18] Midwifery Council Competency 2.14.

[19] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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.

- She sends a follow-up referral to Plunket and asks Plunket to follow up with the woman.
- She asks women to follow up with her after the six-week postnatal period if they are not contacted by a "well child" provider.

Recommendations

118. I recommend that RM B:

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

b) Within three weeks of the date of this report, provide a written statement that details the steps she would take if a client lives outside her catchment area during the postnatal period.

c) Within three weeks of the date of this report, provide evidence of her attendance at the NZCOM Midwives record-keeping course.

d) Within three months of the date of this report, provide an audit of her last ten clients outlining:

    i. the dates on which the postnatal visits were completed;
    ii. whether a comprehensive end-point assessment was completed, including contraceptive advice, and information about, and referral to, "well woman" and "well child" services, including available breastfeeding support and immunisation advice; and
    iii. the completion of a referral to a "well child" provider.

119. I recommend that the Midwifery Council of New Zealand consider whether a review of RM B's competence is warranted.

Follow-up actions

120. 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 it will be advised of RM B's name.

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

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.

Appendix A: Independent clinical advice to Commissioner

The following independent clinical advice was obtained from RM Nicky Emerson (dated 3 September 2020):

"Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided by LMC [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

I have reviewed the documentation on file: Complaint from [Mrs A] 11 March 2020, Complaint response from [RM B] (not dated). Plunket booklet pages (photocopy).

Background: [Mrs A] has raised concerns about her Lead Maternity Carer, [RM B]. [Mrs A] said that [RM B] offered no advice or support to her following the birth of her baby. She claims [RM B] visited her only once at home after [Baby A] was born. [Mrs A] had mastitis and feeding issues with [Baby A] who had colic and reflux. [RM B] cancelled her postnatal visits twice and never rescheduled.

Advice Request: I have been asked to review the documentation supplied and advise whether I consider the care provided to [Mrs A] by [RM B] was reasonable in the circumstances and why.

In particular I have been asked:

Whether the care [RM B] provided to [Mrs A] was reasonable in the circumstances and in line with accepted practice.

The adequacy and appropriateness of the advice and follow-up plan given to [Mrs A] about her mastitis and [Baby A's] colic and reflux

Whether the number of postnatal visits by [RM B] is adequate and appropriate under the circumstances

[RM B's] method of note taking and storage at the time of events in question and the loss of [Mrs A's] clinical records as described in [RM B's] response

Any other matters in this case that I consider amount to a departure from accepted practice.

A. Whether the care [RM B] provided to [Mrs A] was reasonable in the circumstances and in line with accepted practice.

B. The adequacy and appropriateness of the advice and follow-up plan given to [Mrs A] about her mastitis and [Baby A's] colic and reflux

In her complaint [Mrs A] states that she was happy with the care she received in the antenatal period of the pregnancy, she says that the pre labour advice was good. She states that [RM B] was helpful and answered all of [Mrs A's] questions.

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.

[Mrs A’s] complaint is in regard to the lack of postnatal care received from [RM B].

- Documentation records two postnatal visits at home. MOH guidelines require at least five visits at home.
- There is no documented evidence that [RM B] discharged [Mrs A] to either Well Child services or to her GP. There is no documented record of advice regarding contraception, immunisation, safe sleep or smoke free environment.
- There is no documented evidence that [Mrs A] was appropriately assessed for her Mastitis including, physical assessment of vital signs, advice re management, follow up.
- There is no documented evidence that [Baby A] was assessed when [Mrs A] expressed concern regarding feeding.

Midwifery Council Competency 2

2.10 Regularly and appropriately assess the health and well-being of the baby/tamaiti and initiate necessary screening, consultation, and/or referral throughout the postnatal period.

2.12 assess the health and well-being of the woman/wahine and the baby/tamaiti throughout the postnatal period and identifies factors which indicate the necessity for consultation with or referral to another midwife, medical practitioner, or other health practitioner.

2.13 Demonstrates the ability to prescribe, supply, and administer medicine, vaccines and immunoglobulins safely and appropriately within the midwife’s scope of practice and the relevant legislation.

For the reasons above, in my opinion the care provided in the postnatal period (more detail in the following question) does not meet accepted midwifery standards.

C. Whether the number of postnatal visits by [RM B] is adequate and appropriate under the circumstances.

Ministry of Health (MOH) Guidelines state that a midwife will visit at home at least five times after the birth. MOH funding is based on the completion of a minimum of five home visits and an additional two visits that may occur prior to discharge from hospital/birthing unit.

Once home, your midwife or a midwife working on behalf of your specialist doctor will visit you regularly (at least five visits at home). These health visits are to support you and your breastfeeding and to check that you and baby are well.

Midwifery Council Competency two for entry to the register of midwives state the midwife

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.

2.10 regularly and appropriately assesses the health and wellbeing of the baby/tamaiti and initiates necessary screening, consultation and/or referral throughout the postnatal period;

2.11 proactively protects, promotes and supports breastfeeding, reflecting the WHO 'Ten steps to Successful Breastfeeding'

2.12 assesses the health and wellbeing of the woman/wahine and baby/tamaiti throughout the postnatal period and identifies factors which indicate the necessity for consultation with or referral to another midwife, medical practitioner, or other health practitioner;

2.14 performs a comprehensive end-point assessment of the woman/wahine and her baby/tamaiti within the six week postnatal period, including contraceptive advice and information about and referral into well woman and well child services, including available breastfeeding support and immunisation advice;

2.19 provides the woman/wahine with clear information about accessing community support agencies that are available to her during pregnancy and to her, the baby/tamaiti, and family/whānau when the midwifery partnership is concluded

In forming an opinion I have considered the following

- In the complaint, [Mrs A] states that she was seen once at home after leaving hospital. She had mastitis twice and on both occasions was assessed over the phone and prescribed antibiotics.
- Due to her family support [Mrs A] attended [the] Family Centre. [Baby A] was diagnosed there as having reflux and colic at 4 weeks old.
- Well Child record book records 2 visits at home. 1) First week assessment on 15 [Month2]. 2) second assessment 22 [Month2].
- In her complaint response [RM B] states that she is unable to provide clinical notes as they were eaten by mice in her garage. She recalls visiting [Mrs A] about 3 times in the postnatal period. [RM B] states that she was aware [Mrs A] was being seen at [the] Family Centre but does not offer this as an excuse for her not visiting.

In my opinion, [RM B] has documented 2 visits postnatally in the Well Child book. She has not met the MOH guidelines of a minimum of 5 visits or met the Midwifery competencies outlined above or documentation requirements (discussed further in this report).

[RM B] has provided antibiotics without assessment or follow up and has not been able to provide postnatal documentation of assessment of [Mrs A].

In the context of a first time mother requiring support and assessment of her C-section wound healing, support to breastfeed including clinical assessment of mastitis and

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.

ongoing assessment of her new baby; in my opinion 2 documented home visits in the postnatal period represent a severe departure from accepted Midwifery practice.

There is no evidence provided that [Mrs A] was referred to her GP for [Baby A's] immunisation or referred to a well child provider at discharge.

D. [RM B's] method of note taking and storage at the time of events in question and the loss of [Mrs A's] clinical records as described in [RM B's] response

Midwifery Council Competencies for entry to the register include the following

1.13 formulates and documents the care plan in partnership with the woman/wahine.

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 of all decisions made and midwifery care offered and provided.

According to the Midwifery Council Guideline (March 2018)

Non electronic notes (paper) should be stored in an easy and accessible filing system that is lockable and protects the records from intruders and destructive sources.

I note here that the guideline above was produced after 2017; however the legislation informing the guideline historically informed accepted Midwifery practice prior to the guideline.

New Zealand College of Midwives (NZCOM) Handbook for practice

Midwifery Standard Three

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

Midwifery Standard Four

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

- Ensures confidentiality of information and stores records in line with current legislation.

I note here that current legislation (also relevant in 2017) requires 'an accurate summary to be retained for a minimum of 10 years from the last entry'.

In my opinion records have not been stored in line with accepted Midwifery practice for the reasons outlined above. I cannot make a comment about the documentation entries meeting standards as there is no documentation to review.

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.

In my opinion, the storage of [Mrs A's] midwifery records represents a severe departure from accepted midwifery standards.

E. Any other matters in this case that I consider amount to a departure from accepted practice.

I have reviewed the file as requested and in my opinion [RM B] has severely departed from accepted midwifery practice in the postnatal period. There is no documentation to support more than two visits at home. There is no documentation to support appropriate discharge to Well Child and GP. There is no documentation to support advice given to [Mrs A] in the postnatal period including assessment of her Mastitis and Caesarean wound or breastfeeding support. For the questions raised, in my opinion [RM B] has severely departed from accepted midwifery practice in the care that she provided to [Mrs A] in the postnatal period.

I note that since 2017 [RM B] has attended NZCOM's documentation workshop and now stores her records electronically.

Finally, I wish [Mr and Mrs A] the best in the ongoing care of their precious family.

Nicky Emerson BHSc — Midwifery"

The following further advice was obtained from RM Nicky Emerson (dated 11 March 2021):

"1. Thank you for the request that I review my clinical advice in relation to the complaint from [Mrs A] about the care provided by LMC [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **I have reviewed the documentation on file:** My report 3 September 2020, Response to advice from [RM B] 4 February 2021, Response to [RM B] from [Mrs A] 22 February 2021.

3. **Background:** [Mrs A] has raised concerns about her Lead Maternity Carer, [RM B]. [Mrs A] said that [RM B] offered no advice or support to her following the birth of her baby. She claims [RM B] visited her only once at home after [Baby A] was born. [Mrs A] had mastitis and feeding issues with [Baby A] who had colic and reflux. [RM B] cancelled her postnatal visits twice and never rescheduled.

4. **Advice Request:** Noting the two versions of events I have been asked to explain for each version of events whether there is a departure from the accepted standard of care.

I have reviewed the above documentation and I am unable to comment further as there is no documentation in this case to verify what took place. [RM B] states that mice destroyed her documents which were stored in her garage.

It is agreed that two postnatal visits were undertaken. This does not meet the requirements of a minimum of 5 postnatal visits. It is agreed that [Mrs A] was not

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.

referred to a well child provider. It is agreed that the documentation was not stored in line with legislation at the time.

Nicky Emerson BHSc — Midwifery"

The following further advice was obtained from RM Nicky Emerson (dated 8 July 2021):

"Thank you for the request that I provide additional clinical advice in relation to the complaint from [Mrs A] about the care provided by LMC [RM B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the additional documentation supplied. Further response from [RM B] via New Zealand College of Midwives (including text records and Midwifery claim summary) 6 April 2021, Email to HDC from [the birthing clinic] 8 July 2021.

3. Background: [Mrs A] has raised concerns about her Lead Maternity Carer, [RM B]. [Mrs A] said that [RM B] offered no advice or support to her following the birth of her baby. She claims [RM B] visited her only once at home after [Baby A] was born. [Mrs A] had mastitis and feeding issues with [Baby A] who had colic and reflux. [RM B] cancelled her postnatal visits twice and never rescheduled.

4. Advice Request: I have been asked to review the additional documentation listed above and advise whether I consider the care provided to [Mrs A] by [RM B] was reasonable in the circumstances and why.

In particular I have been asked to comment on the following.

What actions you would expect from an LMC prior to arranging the prescription of antibiotics for mastitis?

In forming an opinion regarding the prescribing of antibiotics for mastitis I have considered the following. According to the Ministry of Health https://www.health.govt.nz/our-work/life-stages/breastfeeding/health-practitioners/mastitis-and-breast-abscesses the clinical definition of infective mastitis is:

- Tender hot swollen wedge-shaped area of breast
- Temperature of 38.5°C or over
- Chills
- Headache
- Flu-like symptoms
- Systemic illness

Further advice states:

- If symptoms of mastitis have not improved within 24 hours or if the woman is feeling ill, antibiotic treatment should be started.

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.

- Staphylococcus Aureus and coagulase-negative staphylococci are the most common pathogens and flucloxacillin 500 mg QID (four times a day) is usually given.
- Treatment duration of 10–14 days is recommended by clinical practitioners although there have been no clinical trials.

Following anonymised discussion with midwifery colleagues and in consideration of accepted midwifery actions, the above recommendations are in line with accepted midwifery practice, noting that not all mastitis is infective or requires antibiotics.

- In my opinion, it is accepted Midwifery practice to assess the affected breast/s including assessment of maternal symptoms and vital signs, temperature in particular. Additionally, if possible, observation and assessment of baby latch and feeding is useful. If antibiotics are prescribed flucloxacillin is the accepted course of treatment.
- Following an anonymised discussion with midwifery colleagues, it is also accepted that there may be circumstances where following a discussion with a woman, clinical assessment is not possible immediately (e.g., the midwife may be at a birth), and pre-emptive antibiotics are commenced, assessment occurs later that day or the following day. Alternatively, if the midwife is unable to attend immediately, she may advise that a woman attends her GP for assessment and evaluation of whether antibiotics are needed.

In this case, actions are difficult to determine due to the destruction of clinical notes by mice. Text records provide some evidence of text conversation however not all texts supplied are dated.

- 29 [Month2] — conversation suggests anti-inflammatory medication and advice to *'get back to me'* if symptoms continue during the day so a prescription for antibiotics can be written at the end of the day.
- 30 [Month2] — Visit at home. There is no documentation, I am unable to ascertain if a full clinical evaluation of [Mrs A], and feeding occurred.
- Unknown date: 9.44am — [Mrs A] advises her breast is sore again and she has a lump, redness, and flu-like symptoms.
- 3 [Month3] — postnatal visit planned however midwife's daughter has [injured herself], plan to visit 5 [Month3].
- 4 [Month3] [Mrs A] advises where she will be for a postnatal visit the following day. The visit does not occur.
- [Mrs A] advises she will be at [the] family centre 7 [Month3]. Visit does not occur.
- Phone prescription for antibiotics provided six weeks postnatally for mastitis.

My assessment and opinion are hampered by lack of documentation and dates on only some text messages. There has been no submission of phone records.

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.

A) If it is accepted that [RM B] provided an assessment of [Mrs A] at home on 30 [Month2] (following conversation 29 [Month2]) and considered that antibiotics were not necessary, then there is no departure from accepted practice on the first occasion.

B) If the above is accepted and recurrence of breast lump, redness and flu-like symptoms have not been fully assessed either by [RM B], a colleague or GP then this is a moderate departure from accepted practice. The extenuating circumstances of [RM B] having [an injury], a demanding case load and a daughter with [an injury], in my opinion should not have prevented recommendation for assessment of [Mrs A's] breast by a GP. Whilst it may be reasonable to diagnose recurring mastitis, it is also reasonable to discount the formation of a breast abscess by further assessment.

I am unable to clarify if there were phone calls supplementing text evaluation of clinical symptoms. [RM B] states in her response that supplementary phone calls did occur. If there were no phone calls providing clinical assessment this would be considered a moderate departure from accepted midwifery practice noting a clinical assessment cannot be carried out via text.

Midwifery Council statement on text communication 2016 acknowledges texting as a form of communication however the advice is as follows

' Set clear boundaries for use of texting Make sure you both have the same expectations about when and how to use text messages:

- *If she is worried about herself or her baby's condition, she should always telephone or arrange an appointment*
- ***If she texts a question about a clinical concern you will call her back or arrange an appointment to make a further assessment***
- *Any critical information about her care will be communicated by the phone or at the woman's next appointment — not via text*
- ***You cannot do clinical assessments by text****'*

- **Whether you would have expected any further actions from [RM B] in regards to the communication with [Mrs A] or the pharmacy.**

In my opinion the communication with the pharmacy does not depart from accepted Midwifery practice. Communication with [Mrs A] is only evidenced by text messages however [RM B] does state that there were phone conversations in addition which I am unable to verify. Following the prescription of antibiotics follow up assessment by [RM B] or recommendation to attend GP the following day would be accepted Midwifery practice.

What follow-up actions you would have expected from the LMC

Follow-up actions would include recommendation that the recurring mastitis is formally assessed by a GP if [RM B] were not available to provide this assessment. I am critical of the prescribing of antibiotics for mastitis without formal assessment however accept

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.

there are occasions where this may be pre-emptive. In these circumstances formal follow up of recurring mastitis should have been recommended. In my opinion, attendance in the family centre does not replace midwifery care but rather enhance or supplement midwifery support.

Communication

Please comment on the adequacy of [RM B's] communication

Comment on the communication is difficult due to the lack of clinical notes and unverified phone conversations.

Ending or transferring LMC care

Please outline whether you would have expected any further actions from an LMC when a patient moves out of the catchment area.

Women frequently move from a catchment area to access family support systems or to attend to a family death/crisis. In this case [RM B] states that on booking [Mrs A] had moved from [another region] and had family in [a town] (an hour from [a main centre]). [Mrs A] bought a house in [a town] which was closer for postnatal visits. The closer option of [the new town] was the reason [RM B] agreed to care for [Mrs A]. Postnatally [Mrs A] was [at her parents' house], and this is reported to be a 3-hour round trip if the visiting time is included.

In some cases, it is not possible to continue care if a woman moves from a catchment area. In this case, 3 postnatal visits were made to [Mrs A's parents' house] and there had been an intention to visit further however [RM B's] daughter [injured herself] on that day. [Mrs A] advised [RM B] on 2 occasions following this when she would be closer for further visits (at the family centre).

If it is accepted that moving from the catchment area prevented realistic postnatal care, then this should have been formally discussed and an alternative plan could have been arranged. It would appear that [RM B] had attempted to continue care but had difficulty doing so. In my opinion if some of the care is provided following movement from the catchment area then robust back up should be arranged if unable to commit to a 3-hour trip. It would appear that it was [Mrs A] who was advising her availability. There appears to be evidence of on-going text communication in the postnatal period however as stated in my previous report, this is not a substitute for clinical assessment.

In my opinion there were extenuating circumstances on the day that [RM B's] daughter [injured herself], however these circumstances did not prevent on-going postnatal care.

MOH recommendation for postnatal care 5–10 visits at home. [Mrs A] had 3 visits.

I have reviewed my previous advice and in light of an additional postnatal visit at home (3 not 2 in total) and text evidence of on-going discussion during the postnatal period I have revised my previous advice. I revise my opinion from severe to moderate departure from accepted midwifery practice. In my opinion, [RM B] has not met

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.

accepted midwifery standards in the care provided to [Mrs A] and does not appear to have discharged her to well child or GP. [The birthing clinic] has clarified 8 July 2021, that it is the role of the LMC to discharge to well child provider and GP at the end of the postnatal period. This continuity of care was particularly important for a first-time mother who had struggled in the postnatal period. The lack of documentation and dated text records in this case has hampered clarity of events and this departure from accepted Midwifery practice has been addressed in previous advice.

Nicky Emerson BHSc — Midwifery"

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.

Appendix B: Relevant standards

Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 Primary Maternity Services Notice 2007:

Clause DA29: *Services following birth*

"**DA29 Service specification: services following birth**

(1) A LMC is responsible for ensuring that all of the following services are provided for both the mother and baby:

…

b. postnatal visits to assess and care for the mother and baby in a maternity facility and at home until 6 weeks after the birth, including—

(i) a daily visit while the woman is receiving inpatient postnatal care, unless otherwise agreed by the woman and the maternity facility; and

(ii) between 5 and 10 home visits by a midwife (and more if clinically needed) including 1 home visit within 24 hours of discharge from a maternity facility; and

(iii) a minimum of 7 postnatal visits as an aggregate of DA29 (1) (b) (i) and (ii)"

Midwifery Council Competency 2

"2.10 regularly and appropriately assesses the health and well-being of the baby/tamaiti and initiates necessary screening, consultation, and/or referral throughout the postnatal period.

…

2.12 assesses the health and well-being of the woman/wāhine and the baby/tamaiti throughout the postnatal period and identifies factors which indicate the necessity for consultation with or referral to another midwife, medical practitioner, or other health practitioner.

2.13 demonstrates the ability to prescribe, supply, and administer medicine, vaccines and immunoglobulins safely and appropriately within the midwife's scope of practice and the relevant legislation.

2.14 performs a comprehensive end-point assessment of the woman/wāhine and her baby/tamaiti within the six week postnatal period, including contraceptive advice and information about and referral into well woman and well child services, including available breastfeeding support and immunisation advice.

2.15 shares decision making with the woman/wāhine and documents those decisions.

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.

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

…

2.19 provides the woman/wāhine with clear information about accessing community support agencies that are available to her during pregnancy and to her, the baby/tamaiti, and family/whānau when the midwifery partnership is concluded."

New Zealand College of Midwives (NZCOM) Handbook for practice

Midwifery Standard Three

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

Midwifery Standard Four

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

Ensures confidentiality of information and stores records in line with current legislation.

Midwifery Council Documentation and Record Keeping (Paper 4) March 2018

Maternity records must be retained for a minimum of 10 years following the date of the last entry.

Midwifery Council Paper 2 — Text messaging — April 2016

Set clear boundaries for use of texting

Make sure you both have the same expectations about when and how to use text messages:

- If she is worried about herself or her baby's condition, she should always telephone or arrange an appointment
- If she texts a question about a clinical concern you will call her back or arrange an appointment to make a further assessment
- Any critical information about her care will be communicated by the phone or at the woman's next appointment — not via text
- You cannot do clinical assessments by text.

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.