unexpected outcome?

INFORMATION FOR MIDWIVES

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

Contents

Introduction

As a midwife you may be involved in a case which results in an unexpected outcome for the woman and her baby. This may or may not lead to a consumer complaint or a complaint from another health provider about the care that you provided. You may have had a lead role in the woman's care or a support role. You may have been the woman's LMC or a core midwife involved in her care. Regardless of your involvement and what eventuates from this case, this booklet:

- outlines some of the immediate actions you should take as a midwife who was involved,
- offers some advice as to how to access necessary support and assistance,
- provides an overview of the forums in which you may be held to account for your practice in relation to the case.

The New Zealand College of Midwives (the College) provides professional indemnity insurance cover for all its midwife members. All legal cases are managed through the College member's Legal Advisor (the Legal Advisor). If you are called to account for your practice in relation to the case, the Legal Advisor can be contacted via New Zealand College of Midwives National Office and they offer legal support and representation on a one-to-one basis. The legal service works for the individual midwife and is discrete and separate from other services provided by the College's National Office staff, who are not privy to your personal information. Your communications with the Legal Advisor are subject to legal privilege.

To ensure you meet the terms and conditions of your indemnity insurance and obtain your full entitlement to the College's legal service benefits you must:

- contact the Legal Advisor as soon as possible after an event;
- ensure your membership fees were paid up to date at the time of the event and when the claim came to your attention for the correct practice category;
- abide by the terms and conditions of all legal case management processes and protocols, as advised to you;
- unless you are permanently retired from midwifery practice, ensure your membership remains active for the duration of the case.

I've been involved in a case which may result in a complaint – what should I do?

Midwifery care records

When writing your midwifery care records, whether in hard copy or electronically, it is important to be as comprehensive, accurate and detailed as possible. You should always enter the date and time of your entry and record the time of your actions, using only accepted abbreviations. You should also record your discussions and information shared with the woman, her family and other health providers, and decisions made about interventions. Your signature should always be legible. You should document your rationale for decisions, including options considered and discussed with the woman.

Midwifery care records are vitally important in relation to any case. It is essential that you review the midwifery care records that you wrote at the time of the event to identify any areas where their meaning, your actions, or the course of events is unclear. You should do this as soon as possible after the event has occurred. You may need to make an additional entry in the records. However you must note it as retrospective documentation with the date and time that you made the entry. Asking a midwifery colleague to review your midwifery care records to give you their opinion as to their comprehensiveness and clarity may be helpful.

Take a photocopy of the midwifery care records and any other relevant documentation such as a CTG, medication chart or partogram preferably before you leave the clinical setting. If you have not done this, obtain a copy as soon as possible.

Your reflections

If you are called to account for your practice in relation to this case, it may be many months later or even years. It is therefore important that you write two separate documents on the incident in a separate private record as soon as possible after the event while the details are fresh in your memory.

1. A detailed chronological factual report
2. A reflection (thoughts)

In the reflection be as detailed as possible, noting down what your thoughts were while you were providing the woman's care, what led you to make the decisions you did, and why you did or didn't undertake certain actions, and the context in which these occurred.

You should sign and date this record and keep it in a safe place for future reference along with copies of the case notes. You should not share this record with anyone until legal advice has been sought and obtained. This personal record will assist you to present this case at a Midwifery Standards Review, a Special Review or if you are held to account for your practice. In the meantime it may also help you to identify gaps in your knowledge or practice which you can address regardless of any other processes you may be involved in.

Organise a Special Review

A Midwifery Standards Special Review is available to you to reflect on a specific case. A Special Review allows you to reflect on your practice using the framework of the College's Philosophy, Code of Ethics and Standards of Practice alongside the Midwifery Council's Scope of Practice and Competencies for Entry to the Register of Midwives. This is an opportunity to look at a particular case study in the context of your whole practice.

After completing the Review you will receive a Certificate of Participation and a Professional Development Plan. Undergoing this process may assist you to identify and process any issues that arise for you from the case in relation to your practice. The Professional Development Plan identifies aspects which the Review committee agreed with you would be useful to address. It may be things such as completing some ongoing education, or dealing with communication and handover issues.

TO ORGANISE A SPECIAL REVIEW, CONTACT THE MIDWIFERY STANDARDS REVIEW ADMINISTRATOR AT THE COLLEGE'S NATIONAL OFFICE ON (03) 377-2732.

Seek support from those around you

Most midwives will find being involved in an unexpected outcome to be a stressful and difficult time for themselves, personally and professionally. Natural responses can be fear, shame, grief, anger and/or anxiety. You may not want to tell anyone what has happened for fear that you will be blamed for the outcome. However, your colleagues, family and friends are there to support you during this time so it is important to seek their help. It is also important any discussions about the case take place confidentially.

Make sure that you ask for the support that you need, including time off and additional support in your practice or employment setting if you need it. You may want to seek counselling to assist you to deal with issues and emotions which arise for you in relation to the case. The College has a free counselling service available to its self employed members who have experienced a tragic or unexpected outcome and are requiring the support of the Legal Advisor. This service is provided by the Employee Assistance Programme (EAP). Please speak to the Legal Advisor to find out how to access this free and confidential service.

If you are an employed midwife you will be able to access a similar service through your place of work. It is for this reason that the College funds this service for self employed members only.

You may also wish to engage the support of a midwife mentor to assist you to reflect on events. If you would like to be put in touch with a mentor, the College's National Office has a list of midwives who have undergone the College's mentor education and who can provide you with that support. It is important to remember that confidentiality is vital when you are discussing issues surrounding the case with others who are not protected by legal or confidentiality privileges. The Legal Advisor can guide you in how to conduct these conversations.

Sometimes it may be a friendly face or someone to accompany you to a meeting where the case is discussed. The regional Chairperson of the College in your area can help access this level of support.

Ensure the woman receives ongoing midwifery care

The woman involved in the case is still entitled to midwifery care. If you are the LMC it is important that you ensure that this happens. Where possible, provide the care yourself. Families will often be experiencing a range of grief related emotions including anger, shock and disbelief. Providing care can be difficult for midwives who are experiencing similar emotions and questioning their role in relation to the case. Seek the support of your colleagues.

Allow the family the opportunity to discuss aspects of care, raise questions with you and seek your explanations about the course of events. Going over the midwifery and other health care records with them provides a basis for discussion and helps place the context of events for the woman and her family. Midwives must also inform consumers of other avenues that may assist in addressing their concerns, including the College's Resolutions process and the office of the Health and Disability Commissioner.

Sometimes women may request that a different midwife provides ongoing care. This can be a normal reaction for families as they come to terms with events. Try not to take this personally but accept that this is what this family needs to do at this point in time. Be open and available to the family if they wish to talk to you at a later date. Remember that it may take time before the family is ready to explore aspects of what has happened.

Remember to document in the maternity notes that the woman has requested a different midwife and that you are still available if the family wishes to discuss any aspects of care or go over the clinical notes with you.

New Zealand College of Midwives Resolutions process

The College's Resolutions process is available to support the woman where she has concerns about care provided by her midwife. It is a good idea to encourage the woman to use this process if they want to meet with you to discuss things at a later date. It provides them with consumer-focused support to assist them to seek resolution for any outstanding issues they may have. The opportunity to receive a detailed explanation of what occurred, complete a consumer feedback form which then goes to the Midwifery Standards Review panel, or a letter of explanation from the midwife, sometimes helps a family to move on from an event. The Resolutions Committee is there to support the woman through the process and assist them to resolve outstanding issues and meets LMC requirements under the Consumer Code of Rights.

What can happen if I am held accountable for my practice?

You may be held to account for your practice in one or several different forums. Exactly which one(s) or how many depend on the nature of the case and the wishes of the woman.

The different forums may be:

- Directly with the woman and/or her family;
- A District Health Board (DHB) case review (eg a Perinatal Mortality Review, or a Reportable or Sentinel Events process);
- The Accident Compensation Corporation (ACC);
- The Health and Disability Commissioner (HDC);
- A Coroner's or Police investigation;
- The Privacy Commission;
- The Human Rights Review Tribunal;
- The Midwifery Council or;
- The Health Practitioners Disciplinary Tribunal.

It is important to understand that each investigation or review of the case is independent from the other and you may be required to present written or verbal statements to different forums as each has a different focus on the case. Written submissions and statement preparation can take several weeks or more for final drafts to be developed especially if expert opinions are required. It is therefore important to inform the Legal Advisor promptly when you receive a request from one of these forums so that they can assist you to meet the deadlines.

District Health Board Serious and Sentinal Event Reviews

District Health Boards (DHBs) Serious and Sentinal Event (SSE) Reviews will generally conduct their own investigation or review into a specific case if it took place in one of their facilities against the Ministry of Health framework for SSE Review. Always talk with the Legal Advisor about how these reviews operate in your DHB so you know what to expect and how to participate. Seek the support of your local College representative or your practice colleagues to attend with you for any review meetings. It is essential that you don't go alone.

DHB SSE Reviews look at their role in the case and determine what, if any, systems or service changes can improve services and avoid similar cases occurring. DHB Reviews may also consider individual practitioner competence. There is an expectation of a 'no blame' culture and all parties working together to reduce the likelihood of a similar event.

Some general points to remember:

- It should not be necessary for you to provide the DHB with anything more than the clinical records already available to them, unless the Legal Advisor advises otherwise.
- Assume whatever is said by you is not confidential unless the Legal Advisor informs you otherwise.
- Find out the Terms of Reference of the DHB's review process. Discuss these with the Legal Advisor.
- Find out who will be present at any meeting and the purpose and agenda of the meeting.
- You are entitled to take a support person/people such as a local College representative and/or practice colleague to the meeting.
- Take your own minutes of the meeting.
- DHBs will usually produce a written report at the end of their review process. Make sure you have the opportunity to review and feedback on any reports while in draft form before they are finalised, and that you agree with the final content of the report and any of the recommendations that are made that relate to you.
- Find out who the DHB intends to circulate the report to and if, or how, they are intending to feedback to the family.
- If employed by the DHB you have a right to expect respect and support from the DHB in any investigation forum.

CONTACT THE LEGAL ADVISOR FOR MORE ADVICE IF YOU DISAGREE WITH THE CONTENT OF THE REPORT.

DHBs are not disciplinary bodies but they do have a mandate to ensure public safety within their facilities. Working collaboratively with the DHB will assist them to complete their review process in a timely manner and this in turn may assist families to come to terms with the events. Follow up on any recommendations which come out of the review that are relevant to you.

Local Perinatal and Maternal Mortality Review Committee Case Review

If the case has resulted in the death of mother or baby - the DHB PMMRC is required to review the case. Although the PMMRC is not a forum in which midwives can be held to account for their practice, they may be required to provide information to these committees.

The PMMRC is a statutory committee whose role is to examine perinatal and maternal mortality with a view to reducing avoidable deaths.

Local DHB PMMRC co-ordinators are required to collate detailed information about the case, which is then presented at the legal committee meeting. Perinatal deaths are then classified according to Perinatal Society of Australia and New Zealand classification and contributing factors and potentially avoidable features are identified.

PMMRC processes are ***strictly*** confidential. Any information shared by midwives for this purpose cannot be used in other forms or investigations. It is a legal requirement to share information about the case upon the request of the PMMRC.

If you have concerns about requests for information from your DHB PMMRC co-ordinator or the PMMRC process, please contact the Legal Advisor.

Accident Compensation Corporation (ACC)

ACC's role is to provide compensation for individuals or families who have experienced 'treatment injury'.

TREATMENT INJURY IS DEFINED AS 'A PERSONAL INJURY RESULTING FROM TREATMENT GIVEN BY OR AT THE DIRECTION OF ONE OR MORE REGISTERED HEALTH PROFESSIONALS. IT ALSO INCLUDES THOSE SITUATIONS WHERE INJURY ARISES FROM LACK OF TREATMENT'.

(Ref. Injury Prevention, Rehabilitation and Compensation Act 2001)

Families or individuals can apply to ACC for compensation for ongoing medical costs related to the treatment injury or for expenses such as funerals. ACC is not a disciplinary body, and has no powers over health professionals. They are not required to find fault with a health professional in order to provide cover for the injury but instead their focus is on the outcome for the individual applying.

However if ACC determines that there is a risk of public harm in relation to the compensation claim, they are required to report the event to the relevant authority. In a midwifery related claim, this would be the Midwifery Council. This is only for events which are consistent with the Ministry of Health's definition of a Serious or Sentinel event. (See the Ministry of Health's website www.moh.govt.nz for a definition of a Serious or Sentinel event.) ACC will require information about the case that the family has applied for in order to make a decision about compensation.

CONTACT THE LEGAL ADVISOR BEFORE YOU PUT ANYTHING IN WRITING FOR ACC NO MATTER HOW SMALL OR INSIGNIFICANT YOU THINK THE CASE MAY BE.

Once ACC receives the information it requires, the assessment process may take several weeks or longer depending on the nature of the application. If it is a more complex claim, ACC may seek external expert midwifery advice about the case before they make a decision.

ACC is not required to notify the health professional of the outcome of the claim, however you can request information relating to any reports regarding the care you provided. If a claim is rejected by ACC the claimant has the right to apply for a review of the decision within three months, in which case a review hearing may take place. You may be required to attend the review hearing. The Legal Advisor will support you in this process.

Health and Disability Commissioner (HDC)

The role of the Health and Disability Commissioner (HDC) is to assess complaints in relation to the Code of Health and Disability Services Consumers' Rights. Anyone can make a complaint to the Commissioner, including consumers, their families and support people or other third parties such as concerned staff members of a provider organisation.

When the Commissioner receives a complaint you will be notified and may be asked to provide some information.

YOU SHOULD CONTACT THE LEGAL ADVISOR AT THE NATIONAL OFFICE IF YOU RECEIVE NOTIFICATION OF A COMPLAINT, AND YOU WILL BE ASSISTED TO PREPARE YOUR WRITTEN RESPONSE.

The Commissioner will make a preliminary assessment of the complaint and decide whether to;

- Take no action,
- Refer the matter to the Health and Disability Advocacy service or the College's Resolution Committee or,
- Investigate the complaint, in which event the Midwifery Council of New Zealand will be notified.

If the Commissioner decides to investigate the complaint you will be asked to provide a written response. Again, the Legal Advisor at the College's National Office will assist you with this process.

The Commissioner will seek written information about the case such as clinical notes, correspondence, policy and practice manuals. An interview with the midwife may be requested. HDC may obtain an independent expert midwifery opinion regarding the standard of care provided by you in relation to the case.

The Commissioner makes an assessment in relation to the Code of Consumer Rights and determines whether there has been a breach of the Code in relation to the case. If the final finding is a breach of the Code, the Commissioner has a range of options to promote change, including making recommendations to you, the Midwifery Council, the Ministry of Health, the College or other professional colleges, DHBs etc. Recommendations may include a written apology to the consumer, reimbursement for costs, undertaking specific training or a Special Review.

In a small number of serious cases, the Commissioner can ask the Director of Proceedings to decide whether to take a case to the Human Rights Review Tribunal for monetary damages and/or to the Health Practitioners Disciplinary Tribunal for disciplinary action.

Coroner and Police Investigations

Certain types of death must be reported to the Coroner. This includes any death that occurred while the woman concerned was giving birth, or that appears to have been a result of that woman being pregnant or giving birth; and any death that appears to have resulted from any medical treatment or that occurred during a medical operation or procedure. Such deaths are initially reported to the police who then report it to the Coroner. The Coroner's Court is not a disciplinary process and the Coroner has no power over health professionals as such, except to issue a subpoena to give evidence or provide documents to the Court.

If you are involved in a case which involves a death, you may be approached to provide information to the police. The police may be investigating either as agents on behalf of the Coroner and/or with a view to whether criminal charges should be laid. You have the legal right not to provide any clinical information to the police unless certain formalities have been observed.

YOU HAVE THE LEGAL RIGHT BEFORE YOU DISCLOSE INFORMATION TO THE POLICE TO SEEK LEGAL ADVICE. YOU NEED TO CONTACT THE LEGAL ADVISOR IMMEDIATELY AND RECEIVE ADVICE ABOUT HOW TO PROCEED BEFORE YOU PROVIDE INFORMATION TO THE POLICE.

If the police contact you out of office hours contact the College after hours message service for the Legal Advisor's number. You should not hand over a copy of the clinical notes in the meantime unless a Search Warrant or Subpoena requires this.

A Coroner may make recommendations which are brought to the attention of the appropriate authorities, so that the chances of similar deaths occurring in the future are minimised. This may include recommendations to professional organisations such as the New Zealand College of Midwives, DHBs or the Ministry of Health. The Coroner's process may take over a year to be completed.

Child Youth & Family Services (CYFS); Ministry of Social Development (MSD); General Police Enquiries; other requests for information

You may be called to account for your midwifery practice in relation to care and protection issues for a baby. Alternatively you may be asked by CYFS or the Police to provide a statement about your observations of parenting for a family you have cared for. The MSD may investigate a family for benefit entitlement/fraud or the Police may approach you in relation to a criminal investigation concerning for instance, an assault. Other approaches for information may be for Family Court Proceedings or from the Perinatal and Maternal Mortality Review Committee.

Contact the Legal Advisor or National Office staff who can assist you before you provide any written or verbal information to ensure you comply with legal and ethical obligations.

Midwifery Council

The Midwifery Council of New Zealand has wide ranging responsibilities under the Health Practitioners Competence Assurance Act 2003. Among other things, the Council is responsible for public safety by ensuring that midwives are competent and fit to practise midwifery.

The Council sometimes receives notifications of concerns about a midwife's practice from consumers, other health professionals or provider organisations, or the Health and Disability Commissioner, or the ability of a midwife to practice may be questioned following concerns about the midwife's mental or physical capacity.

If concerns about your practice are notified to the Council, they will let you know the nature of the complaint.

YOU MUST CONTACT THE LEGAL ADVISOR AS SOON AS YOU ARE NOTIFIED OF THE COMPLAINT BY THE COUNCIL. THE LEGAL ADVISOR WILL ASSIST YOU TO PREPARE YOUR RESPONSE TO THE COUNCIL.

The standard that the Council assesses your practice against are the Competencies for Entry of the Register of Midwives. In addition, the Code of Ethics, and Guidelines in the College's Midwives Handbook for Practice, the College's Consensus Statements and other relevant legislation provide a framework for the Council's assessment.

The Council has a mandate for public safety. Its processes are guided by the HPCAA and they are designed to be educative for midwives and aimed at improving standards of practice. The Council has a range of options available to it including audit of Portfolios, requiring that a midwife undergo a Midwifery Standards Review or a Competence Review; suspension of a practising certificate and/or referral to a Health Committee of the Council. In some cases the Council may refer a midwife to the Council's Professional Conduct Committee and investigate whether disciplinary charges should be laid.

The Privacy Commissioner

Individuals may make a complaint against you in relation to the Privacy Code.

If you receive such a complaint contact the Legal Advisor who can assist you before you provide any written or verbal information.

In summary

The New Zealand College of Midwives' regional College Office bearers are available at any stage to assist and support you during what can be a very stressful time.

If you are involved in a case in which you may be held to account for your practice:

- Contact the Legal Advisor at the earliest possible opportunity and before you provide any written information to any agency.
- The clinical midwifery records are vitally important – review them and make additional notated retrospective entries if necessary. Always date and sign your entries. Ask your colleagues to review the records for you.
- Write down your detailed reflections (thoughts) and a separate factual report about the case as soon as possible after the case in separate private records. Sign and date the records and keep them in a safe place.
- Seek the support of your colleagues so you can take time out if you need to and have additional support in your practice for as long as you need it.
- Seek the support of your friends and family to make sure you get the necessary emotional support.
- Ensure that the woman and her baby receives ongoing midwifery care or are referred to the most appropriate obstetric service.
- Consider the College's Resolutions process if the family wants assistance to resolve any issues.
- The College provides a professional framework, systems and structures to support you.
- Consider undertaking a Special Review of the case.
- It may be some time (if at all) before you are held to account for your practice in relation to this case.

A note about Expert Advisors

An Expert Advisor is a midwife who is a member of the New Zealand College of Midwives and is appointed through a process of nomination and ratification. The midwife is endorsed by her peers to independently represent the midwifery profession as an Expert Advisor.

The Expert Advisor undergoes initial training and must attend the annual Expert Advisors education day run by the College.

Expert Advisors may be required to

- examine and evaluate case material and form an opinion;
- use their expertise to inform the agency, court or tribunal;
- communicate opinion to the requesting agency, court or tribunal;
- relate a midwife's practice to the framework provided by the Midwifery Council's Scope of Midwifery Practice and Competencies for Entry to the Register of Midwives; the New Zealand College of Midwives Philosophy, Code of Ethics, and Standards of Midwifery Practice;
- be an expert witness if requested.

They must maintain confidentiality while giving advice or an opinion.

Expert Advisors, who are registered midwives, are appointed because of the respect and credibility they have amongst their peers as well as their attributes and experience as a midwife.

The Expert Advisor is:

- an experienced midwifery practitioner of at least five years practice in New Zealand
- grounded in midwifery philosophy and practice
- knowledgeable about maternity services provision
- actively practising midwifery, or have done so within the year prior to appointment
- analytical with good assessment abilities
- confident, literate and articulate
- able to think and express herself rationally and with reasoned logic
- trustworthy, ethical and fair
- non-judgmental
- respectful of individuality, cultural diversity and privacy
- self reliant and diligent
- knowledgeable about the Treaty of Waitangi
- perceived by her peers to be clinically competent
- impartial and have integrity and good interpersonal skills
- committed to professional development and reflective practice
- well respected in her professional community

P O Box 21-106, Edgeware
Christchurch, 8143
Telephone 03 377 2732, Fax 03 377 5662
Email nzcom@nzcom.org.nz
www.midwife.org.nz
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