Systemic failure to ensure appropriate standard of care to woman experiencing severe hyperemesis gravidarum

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This case concerns the care provided to a woman during her first pregnancy, when she was experiencing severe hyperemesis gravidarum (a condition characterised by severe nausea, vomiting, weight loss, and electrolyte disturbance during pregnancy).

Over the course of her pregnancy, the woman presented to Wairarapa Hospital (Health New Zealand|Te Whatu Ora (Health NZ) Wairarapa) Emergency Department (ED) five times with the condition. During her presentations to ED, the woman was given intravenous hydration and anti-nausea medication.

On her final presentation to ED, the woman was suffering from weakness, dehydration, and exhaustion and had suffered several episodes of fainting. Blood tests showed abnormal results, and she was admitted to the High Dependency Unit. The following day, the woman was transferred to another hospital because of abnormal electrolytes and renal function. Sadly, an ultrasound scan showed that the woman had suffered a septic miscarriage.

Findings

The Deputy Health and Disability Commissioner considered that Health NZ breached Right 4(5) of the Code of Health and Disability Services Consumers' Rights, which states that every consumer has the right to co-operation among providers to ensure quality and continuity of services. The Deputy Commissioner was critical of Health NZ for failing to manage the woman's ongoing and severe hyperemesis gravidarum appropriately and proactively and failing to monitor the health of her fetus appropriately.

The Deputy Commissioner found that because of a systems failure, the woman's care was not escalated to the obstetrics team, and therefore she did not receive appropriate scanning to check the health of her fetus when she presented to the ED five times with dehydration and nausea. In addition, the Deputy Commissioner found that Health NZ did not ensure that the woman was taking her anti-nausea medication effectively; did not have in place local guidelines for the management of severe hyperemesis gravidarum; did not provide adequate patient information; and did not coordinate with the woman's lead maternity carer (LMC) adequately in failing to ensure that the woman's discharge summaries were shared with her LMC.

Recommendations

The Deputy Commissioner recommended that Health NZ provide a written apology to the woman; provide evidence that an education session about new guidelines and patient information has been conducted with ED staff; and that Health NZ conduct an audit of a sample of discharge summaries to ensure that these have all been copied to LMCs.