



# Taranaki District Health Board

## MATERNITY

## ANNUAL REPORT

1 July 2014 - 30 June 2015

TARANAKI TOGETHER, A HEALTHY COMMUNITY  
TARANAKI WHANUI HE ROHE ORANGA

Taranaki District Health Board  
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Taranaki, NEW ZEALAND



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Report prepared and written by Belinda Chapman Associate Director of Midwifery/Maternity Quality & Safety Coordinator

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## **Message from Dr Jeremy Smith, Head of Department – Obstetric and Gynaecology; Belinda Chapman – Associate Director of Midwifery; and Leigh Cleland – Clinical Services Manager, Child & Maternal Health**

The recent announcement that the national Maternity Quality & Safety Programme (MQSP) is to be funded for a further three years is welcomed as it supports the District Health Board (DHB) to move quality and safety in maternity to become “business as usual”. Taranaki DHB is committed to this programme, its benefits and the significant improvements it has achieved for the maternity services, consumers, families/whanau, practitioners and stakeholders within the Taranaki region. It is recognised as a valuable and important programme which has become embedded into the Taranaki DHB wider Quality Committee which it reports to annually as well as to the Ministry of Health (MoH) and to the Taranaki DHB Clinical board.

The Maternity Quality Committee (MQC) was established in 2012 and has continued to meet on a monthly basis. It has wide representation from maternity practitioners, managers, consumers and stakeholders of maternity care. The Committee has continued to progress and review the work plan set out for 2013/14. It has also enhanced stronger relationships with other services associated with this Committee such as quality and risk, maternal mental health services, operating theatres, smoke free coordinator, child protection and family violence coordinators and stakeholders of maternity care both in the hospital and community.

The Taranaki DHB consumer role is seen as a vital role, which has evolved and matured from this programme, bringing the consumer view and link between the community, hospital practitioner and stakeholder services, so much so that a second consumer position will be considered in this next year.

Taranaki DHB has seen an improvement in the ability to recruit midwives to both the self-employed and employed workforces across the region. We are however cautious as this has been an area of risk and has not always been sustained in the past. A group of senior midwives, managers and unions are currently reviewing how Taranaki DHB is best to manage staffing in the peaks and troughs of the day to day variance of patient numbers and acuity in the maternity units. This is a difficulty that other units of a similar size face and finding a solution that is viable and meets the needs of the services and staff work-life balance is proving difficult.

Taranaki DHB is now staffed with four senior medical officers. Having a full complement of experienced and capable obstetricians enables us to provide an excellent service to women and families of Taranaki as well as support teaching and development of our staff.

Service progress has been guided by the Maternity Quality Committee, which has given some clarity about where we wish to head and areas that the team needs to focus on. This has resulted in recognition of national issues such as prevention and management of haemorrhage, also local issues such as obstetric outcomes and the Taranaki caesarean rate for first baby.

Dr Jeremy Smith, Mrs Belinda Chapman and Mrs Leigh Cleland

## Message from the Chair, Midland Maternity Action Group

The Midland Maternity Action Group (MMAG) was established in 2011, the group includes stakeholders from across the five Midland DHBs. The current membership of MMAG is:

- **BOP DHB:** Matthais Siedel (SMO rep), Thabani Sibanda (SMO rep), Marg Norris (Midwifery Leader), Karen Palmer (Senior Lactation Consultant; Chair, Breastfeeding/ Baby Friendly Hospital Initiative (BFHI) Sub-Group), Sachit Gagneja Maternity Quality and Safety Programme (MQSP Project Manager)
- **Lakes DHB:** Simon Ewen (O&G HOD), Sue Finch (Clinical Midwife Manager/MQSP)
- **Tairāwhiti DHB:** William Wiederman (SMO rep), Mary-Clare Reilly (Midwifery Leader/MQSP), Liz Lee-Taylor (Maternity Educator ex officio)
- **Taranaki DHB:** Anene Chukwujama (SMO rep), Belinda Chapman (Associate Director of Midwifery (ADOM)/MQSP), Sharon Howe (MQSP/Maternity Educator)
- **Waikato DHB:** Penelope Makepeace (Clinical Director - Obstetrics), Corli Roodt (Clinical Midwife Director; MMAG Chair), Pip Wright (Maternity Educator; Chair, Maternity Educators, Clinical Midwife Managers, & Midwifery Leaders Sub-Group), Ruth Galvin (MQSP Project Manager; Chair, Midland MQSP Sub-Group)
- **Chief Operating Officer rep:** Vacant
- **Director, Nursing/Midwifery rep:** Sue Hayward (Waikato DHB)
- **Maori Health rep:** Jade Chase (Waikato DHB)
- **Planning & Funding rep:** Jenny James (Taranaki DHB)
- **Communications rep:** Mary-Anne Gill (Waikato DHB)
- **HealthShare Ltd:** Suzanne Andrew (Project Manager)

The primary purpose of the group is to lead regional maternity activity, including the implementation of maternity actions on behalf of the Midland DHBs, with a focus on sustainable service delivery through quality improvement and workforce development activities. The outcome of this regional approach is to facilitate improved coordination and responsiveness of services for women and their families requiring maternity services, with a vision to improve equity of access and health outcomes for Midland communities.

MMAG has focused on educational and quality activities to improve access to education for the region's maternity workforce, and supporting a standardised approach to the delivery of maternity services through improving communication, sharing of resources, reducing duplication, and developing initiatives that when done collaboratively, will improve efficiency and effectiveness across the five Midland DHBs. An example of this regional collaboration is MMAG's development of the Midland Maternity Transfer and Repatriation Standards which will ensure a consistent system for maternity transfers and repatriations across Midland and beyond.

MMAG looks forward to continuing its work and collectively facing the challenges associated in identifying opportunities to continue to provide sustainable quality maternity services to the Midland region.

**Corli Roodt, Clinical Midwife Director, Waikato DHB**  
**Chair, Midland Maternity Action Group**

## **Taranaki District Health Board : Our Vision**

### **Our Shared Vision - Te Matakite**

Taranaki Together, A Healthy Community  
Taranaki Whanui He Rohe Oranga

### **Our Mission – Te Kaupapa**

Improving, promoting, protecting and caring for the health and wellbeing of the people of Taranaki

### **Our Aims**

- To promote healthy lifestyles and self-responsibility
- To have the people and infrastructure to meet changing health needs
- To have people as healthy as they can be through promotion, prevention, early intervention and rehabilitation
- To have services that are people-centred and accessible where the health sector works as one
- To have a multi-agency approach to health
- To improve the health of Maori and groups with poor health status
- To lead and support the health and disability sector and provide stability throughout change
- To make the best use of the resources available

### **Our Values**

How We Work Together With Others – Ngā Tikanga

The actions and behaviours described below are how we aim to contribute to all our relationships including those with our patients, clients, Whānau, funded agencies, staff and members of the public. Therefore, we will work together by:

- Treating people with trust, respect and compassion
- Communicating openly, honestly and acting with integrity
- Enabling professional and organisational standards to be met
- Supporting achievement and acknowledging successes
- Creating healthy and safe environments
- Welcoming new ideas

## **Taranaki District Health Board : Maternity Services Vision**

Taranaki Together, committed to caring in pregnancy, birth and beyond, for a Healthy Community:

HE URUNGA WHENUA

HE URUNGA TANGATA

HE URUNGA OHI

HE URUNGA TARANAKITANGA

KI TE TAIAO

MAU TONU





## Purpose

This Annual Report covers the outcomes of Taranaki DHB's MQSP in 2014/15, as required under section 2.2c of the MQSP Crown Funding Agreement (CFA) Variation (Schedule B42).

This Annual Report:

- demonstrates Taranaki DHB's delivery of the expected outputs as set out in Section 2 of the MQSP CFA Variation
- outlines progress towards Taranaki DHB's MQSP Strategic Plan deliverables in 2014/15
- describes Taranaki DHB's activities undertaken in 2014/15 and those intended to be undertaken to improve the quality and safety of its maternity services in 2015/16

## Background and Summary of the Taranaki MQSP

### Alignment with New Zealand Maternity Standards

This Annual Report has been developed to meet the expectations of the New Zealand Maternity Standards (as set out below).

Expectations of the New Zealand Maternity Standards		
<b>Standard One:</b> Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies		
8.2	Report on implementation of findings and recommendations from multidisciplinary (MDT) meetings including access holders.	√
		Appendix 1
8.4	Produce an annual maternity report.	√
8.5	Demonstrate that consumer representatives are involved in the audit of maternity services at Taranaki DHB.	√
		Page 55
9.1	Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Taranaki region.	√
		Appendix 1 and Page 84
9.2	Identify and report on the groups of women within their population who are accessing maternity services, and whether they have additional health and social needs.	√
9.4	The proportion of women with additional health and social needs receive continuity of midwifery care.	√
10.1	Clinical audit demonstrates effective communication among maternity providers.	Monitored
10.2	The number of sentinel and serious events in which poor communication is identified is monitored and decreases over time.	Monitored
11.1	National evidence informed clinical guidelines are implemented. (National PPH and observation of the mother and newborn implemented, working forwards with implementation of the GDM guidelines).	√
21.1	100% maternity service specifications are implemented in each funded DHB-funded maternity service.	√
<b>Standard Two:</b> Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage		
16.1	Taranaki DHB provides access to pregnancy, childbirth and parenting information and education services.	Contracted and to be reviewed



17.2	Demonstrate in the annual maternity report how Taranaki DHB have responded to consumer feedback on whether services are culturally safe and appropriate.	√
18.1 18.2	Consumer feedback demonstrates that consumers consider the services to be culturally safe and appropriate. Taranaki DHB to report on how they have responded to consumer feedback.	√
19.1 19.2	Taranaki DHB provides information about local maternity facilities and services and facilitates women's contact with Lead Maternity Carers (LMC) and primary care. Taranaki DHB report on the proportion of women accessing continuity of care from an LMC for primary maternity care.	√
<b>Standard Three:</b> All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriately to ensure there are no financial barriers to access for eligible women		
22.1	Local services are consistent with the national and regional plans and are accessible and appropriate for the local population.	√
23.1	Clinical audit demonstrates women and babies have access to levels of care that are clinically indicated.	2015/16
24.1	Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility (reported in 2012/13 annual report).	√
24.2	Clinical audit demonstrates effective linkages between services.	√
		Appendix 1
25.1	Report on local and regional maternity and neonatal emergency response plans.	√
25.3	Clinical audit demonstrates effective communication among maternity providers in cases of clinical emergency.	Monitored
26.1	Taranaki DHB provide a model of continuity of midwifery and obstetric care when secondary services are responsible for the woman's care.	√
26.2	Consumer feedback shows that women requiring secondary level care are satisfied with the continuity of midwifery and obstetric care received.	√

## Summary of the Taranaki Maternity Service and MQSP 2014/15

- Taranaki DHB has an established consumer who has undergone training and is contracted to Taranaki DHB to provide consumer advice and direction on our maternity services. She assists in identifying positive changes conducive to our consumers by being engaged and supported to survey our consumers. Additionally she obtains feedback on Taranaki DHB primary and secondary maternity services by reaching consumers via multimedia/Taranaki Maternity Quality & Safety Facebook page, and face-to-face meetings. She has also participated in the national consumer face-to-face meetings and the national MQSP evaluation programme.
- Local, regional and national maternity data has been utilised to inform practitioners and the public. This has been reported via dashboards, MQC newsletter and reports. It has also assisted in prioritising local audit and implementation of changes to improve practices and outcomes.
- MQC/governance was established in December 2012. MQC meets monthly and is represented by maternity practitioners, stakeholders, consumers and a member of the Taranaki DHB quality team. This Committee reports and presents to the Taranaki DHB Clinical Board annually on its work plan, audits, progress, quality improvements and priorities. MQC has developed stronger relationships with the DHB quality teams, primary care/stakeholders that are linked to the maternity services through this Committee.
- MQC can demonstrate quality reporting and audit processes and improvements that have been implemented as a result of this for the services to women and their families.
- Taranaki DHB participates and collaborates with the four other Midland Regional DHBs through the MMAG, Midland Midwifery Leaders Group and the Midland Regional Educators Sub-Group, the Midland MQSP Sub-Group and the Midland Breastfeeding Sub-Group. MMAG work together to share education sessions and templates, protocols and other strategies including benchmarking and provision of data to reduce duplication, workloads and increase efficiency and networking. This has been a most valuable program and has seen progress with local and regional quality improvement initiatives.
- MQC has submitted a maternity report annually that has been endorsed by consumers and clinical leaders both locally and regionally since 2012/13. It is available to the public, maternity practitioners and stakeholders on the Taranaki DHB internet site. Additionally MQC promotes alliance with local primary care providers, stakeholders and practitioners of maternity care and circulates an MQC newsletter to update on its progress, dashboards and new initiatives. A directory of Taranaki DHB maternity stakeholders and vulnerable services is updated quarterly and circulated to advise of contacts and services available in Taranaki.
- The future of the local MQSP will be to continue to report annually to the Taranaki DHB Clinical Board on its planned activities, audits, achievements and outcomes with planned measures to track progress.

A summary of meeting initiatives, changes in clinical practice and quality improvements that have been driven by MQSP in 2014/2015 can be seen in Appendix 1.

Progress on the planned service deliverables are tabled on page 15. The proposed work plan for 2015/16 is tabled on page 75.

**Summary of Maternity Services Provided in Taranaki**  
**(see Appendix 1 for more detail)**

<b>Taranaki Base</b> <b>Primary Care plus Secondary Care</b>	<b>Hawera DHB</b> <b>Primary Facility</b>
<ul style="list-style-type: none"> <li>• Normal delivery</li> <li>• Inpatient postnatal care</li> <li>• Outpatient specialist consultation and secondary antenatal clinics</li> <li>• Orthopaedic hip checks</li> <li>• Ultrasound</li> <li>• Caesarean Section</li> <li>• Complex delivery</li> <li>• Lactation consultant services</li> <li>• Fetal day assessment unit (FAU)</li> <li>• Inpatient antenatal care</li> <li>• Management of miscarriage</li> <li>• Support for private obstetrician LMC (labour and birth)</li> <li>• Newborn hearing screening</li> <li>• Level 2A neonatal services</li> </ul>	<ul style="list-style-type: none"> <li>• Normal delivery</li> <li>• Inpatient primary postnatal care</li> <li>• Outpatient specialist consultation and secondary clinic</li> <li>• Orthopaedic hip checks</li> <li>• Lactation consultant services</li> <li>• Newborn hearing screening</li> </ul>

Home birth services by Midwife LMCs are available in Central, North and South Taranaki.



## MQSP Governance and Operations

### Taranaki DHB MQSP Governance Structure and Purpose

The MQSP Governance Group is known as the MQC and is chaired by the ADOM/MQSP Project Coordinator. It meets monthly to support the Taranaki maternity services, the Taranaki DHB Clinical Board and maternity related multidisciplinary clinical teams to monitor and manage standards of clinical care to ensure they are of a high quality.

Its main functions are to:

- Monitor and oversee regional and local activities associated with:
  - The National MQSP
  - The National Maternity Standards
  - Maternity Service Specifications
  - The Universal Newborn Hearing Screening Programme

An example of priorities for the MQC is to review, monitor and recommend improvements for:

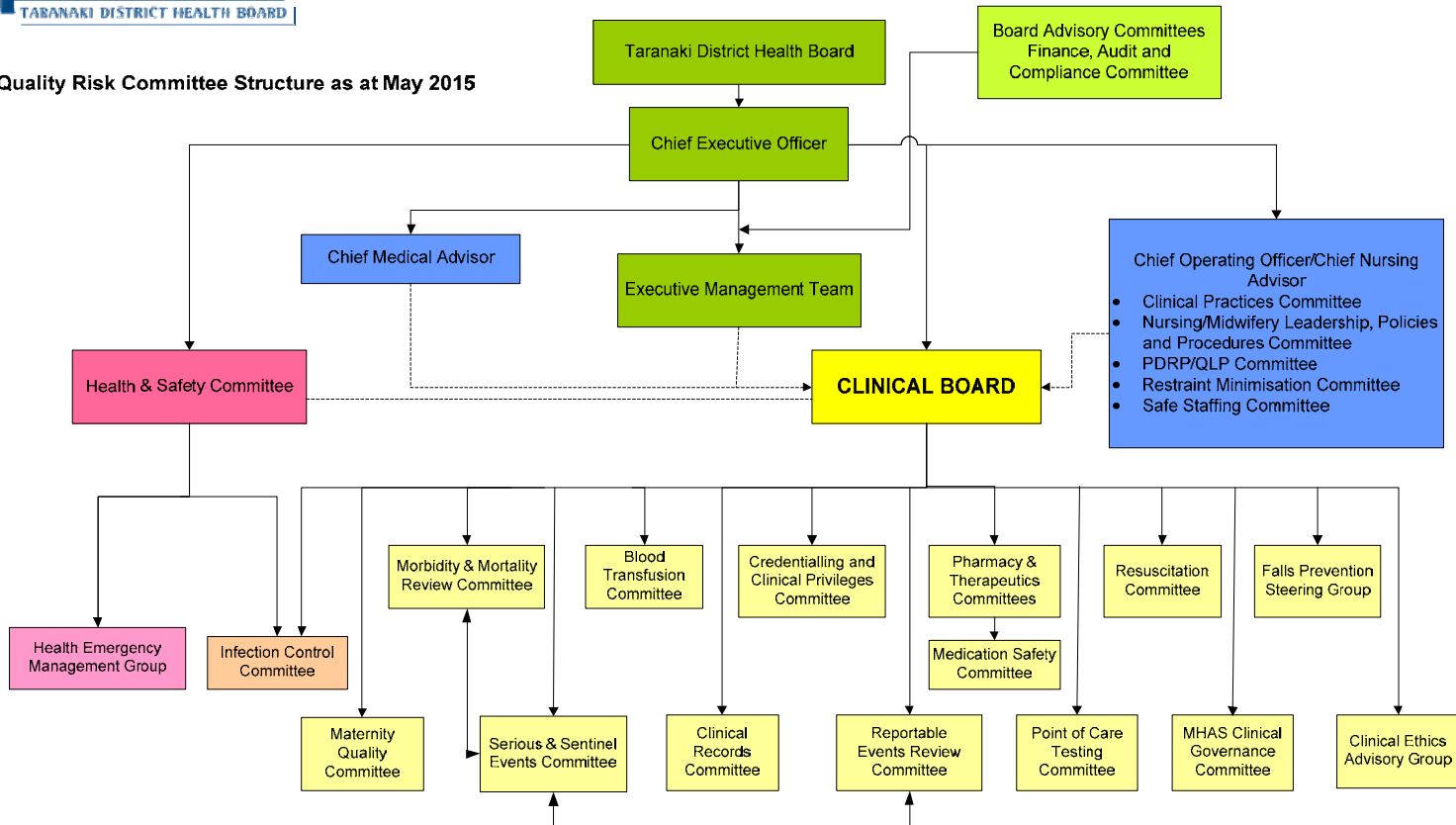
- Actions and themes arising from adverse events submitted to the Serious & Sentinel Events Committee (SSEC), Reportable Events Committee (REC) and the Perinatal Mortality & Morbidity reviews
- Clinical Indicator Reviews
- Actions and themes arising from complaints submitted to Customer Services and the REC
- The National MQSP
- The National Maternity Standards
- Maternity service specifications
- Actions and themes arising from Newborn Hearing Screening audits
- Overseeing quality improvement, quality assurance and risk management activities within the maternity services and Newborn Hearing Screening.
- To provide a forum in which decision making and responsibilities for the quality of maternity care are shared between clinicians and managers in consultation with consumers and stakeholders.
- To report these activities to the Taranaki DHB Clinical Board.
- To manage obstetric clinical risk.
- Membership consists of:
  - Clinical Directors or their representative: O&G and Paediatrics
  - ADOM
  - Clinical Midwifery Manager (CMM)
  - Four stakeholders:
    - Clinical Nurse Manager, Neonatal Unit
    - Maternal & Child Health Social Worker
    - Maternal Mental Health Intake Coordinator
    - Clinical Nurse Specialist (CNS) - Infection Control & Quality and Risk
  - Clinical Services Manager for Maternal & Child Health (CSM,M&CH)
  - Quality Improvement and Effectiveness Coordinator
  - Midwife Educator (ME)/Quality Risk delegate

- Two LMC Representatives
  - Rural
  - Urban
- Maori Health representative
- Consumer representative
- Core midwife/ New Zealand College of Midwives (NZCOM) representative
- Planning & Funding Maternity Portfolio Manager

### Taranaki DHB MQSP Governance Accountability within the wider Taranaki DHB Governance



Quality Risk Committee Structure as at May 2015



The MQC oversees quality improvement, quality assurance and risk management activities within the primary and secondary maternity services

Priorities for the MQC are to review, monitor and recommend improvements for:

- Actions and themes arising from adverse events submitted to the SSEC and REC, and the Perinatal Mortality & Morbidity reviews
- Clinical Indicator Reviews
- Actions and themes arising from complaints submitted to Customer Services and the REC
- The National MQSP
- The National Maternity Standards
- Maternity Service Specifications

The MQC evaluates service improvements as a result of the Committees' recommendations:

- To set audit priorities, schedules and review audit outcomes and to endorse and monitor implementation of audit recommendations.

- To monitor retrospective clinical record reviews with feedback to individual practitioners by nominated lead reviewers.

Recommendations and actions from the MQC are forwarded to the CSM, M&CH and CMM or other relevant units:

- The activities/minutes are submitted monthly to the Chief Operating Officer/Chief Nursing Advisor and Quality & Risk Manager

Information and direction is communicated to multidisciplinary clinical teams, including LMCs and stakeholders through relevant members of the MQC.

### **Consumer Representation on Taranaki DHB MQC**

Taranaki DHB MQC has a consumer group representative who is a mother of two young children who were born in Taranaki Base Hospital. She has a letter of appointment and has signed an agreement of confidentiality and the Taranaki DHB Code of Conduct. She has completed Taranaki DHB training in confidentiality and consumer service and is remunerated for her attendance at meetings.

The representative is an active advocate for empowered birthing and informed consent, and brings an open minded and honest view/approach to maternity services in Taranaki. She is an active member of community maternity consumer groups Active Birth Taranaki and La Leche League.

### **Community Practitioner Representation on Taranaki MQC MQSP**

Please see membership above for stakeholder and LMC representation.

There are no GP representatives however GP liaison representatives are notified of any pertinent information relevant to them and maternity quality and safety within Taranaki DHB so the information can be shared within their group meetings. Additionally GPs are sent a copy of the MQC newsletter.

### **Perspectives of Maori, Pacific and Other Groups (as appropriate) represented on Taranaki MQC**

The population of Taranaki is predominately Maori and New Zealand European. The Maori Health Services have a Maori health worker who is a representative and consultant to this Committee.



## Progress Report of MQSP Strategic Plan Deliverables for Taranaki DHB and the Midland Region

### Progress of List of Priorities, Deliverables and Planned Actions for 2012/13/14/15

Note : Some quality improvement initiatives may be developed at the regional level for local delivery

Governance				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Ensure cultural responsiveness of all MMAG related activities - delivery on the RSP Māori accountability framework	<ul style="list-style-type: none"> <li>Ethnicity data in each initiative/ programme of work will be captured</li> <li>All regional planning documents are reviewed against the HEAT tool</li> </ul>	Improved responsiveness to vulnerable population	MQC and MMAG has a Maori representative responsible to communicate and input into MMAG and MQC related activities	<ul style="list-style-type: none"> <li>MMAG/Maori health project manager/Pepi-Pod and SUDI/oral health projects.</li> <li>Baby summary form now captures ethnicity of mother and baby to ensure Maori Health support if required.</li> <li>Maori representation on MQC.</li> <li>Local education delivered by Te Hapu Ora on safe sleep, smoking cessation support, SUDI, Pepi-Pod distribution and breastfeeding delivered.</li> </ul>
Inclusion of consumers in maternity decision making groups – ensure consumer input is established at all levels of maternity services	<ul style="list-style-type: none"> <li>An agreed regional framework exists relating to consumer involvement, (inclusive of payment, job descriptions, contracts)</li> <li>Implement the Consumer Framework in all DHBs in the Midland Region, at the local governance level</li> </ul>	Decisions made inclusive of consumer view	Consumers involved in each DHB's MQ&SP activities and MMAG	<ul style="list-style-type: none"> <li>Consumer framework has been developed and implemented in Taranaki DHB. Consumer rep and ADOM for Taranaki DHB MQC has developed a closed Facebook page and a media/communications policy has been published; regional consumer framework is complete and published on MQSP national group site.</li> <li>Taranaki DHB consumer completed training in confidentiality and conducting face to face consumer feedback surveys which have commenced.</li> </ul>
Administration and community consumer liaison support	Implement set administration and community consumer liaison position in Taranaki DHB	Administration support in place and improved responsiveness to consumers	Evidence of consumer liaison meetings and admin support	Consumer has taken on role to take draft minutes at meetings. Other Taranaki DHB admin support available when required.
Quality & Safety				
Improve LMC registration - increase number of women registering with an LMC in their first trimester	<ul style="list-style-type: none"> <li>DHB data regarding number of women who register by end of first trimester with an LMC is available and monitored regionally</li> <li>Enhance GP proficiency in first trimester screening and expedite booking with an LMC</li> </ul>	<ul style="list-style-type: none"> <li>Improved access to care.</li> <li>Early uptake of first trimester screening</li> <li>Increased number of women booking with an LMC by end of the first trimester</li> </ul>	MMAG and Taranaki DHB developing regional and local strategies to encourage consumers to register with an LMC early in the first trimester; increase number of women in Taranaki registering before the end of the first trimester to 77% 2016	<ul style="list-style-type: none"> <li>Taranaki DHB Email and send newsletters to GP Liaison to encourage GPs to use the <a href="http://www.findyourmidwife.co.nz">www.findyourmidwife.co.nz</a> site and the Taranaki DHB information link; refer to ADOM if unable to access maternity care.</li> <li>MQC stakeholder newsletter circulated three times per year.</li> <li>Social Media campaign.</li> <li>Top 5 Things to do before 10 weeks of pregnancy.</li> <li>4000 posters, rack cards have been developed and circulated to GP practices, schools, pharmacies supermarkets in Taranaki in August 2014. See page 35. Additionally 3 iron in pregnancy posters distributed.</li> </ul>

Quality & Safety cont'd				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Improve patient care quality and safety through establishing a robust transfer system - implement consistent system for maternity transfers across Midland and beyond	<ul style="list-style-type: none"> <li>Regional maternity patient flow policy with sign off by Chief Operating Officers</li> <li>Capability of each hospital is agreed so safe repatriations can occur, maternity transfer guidelines in place</li> <li>Quality indicators for maternity transfers developed, standards for midwifery coordination developed and implemented to underpin transfers</li> </ul>	<ul style="list-style-type: none"> <li>Expedient transfers to place of definitive care</li> <li>Reduced number of women experiencing compromised care</li> <li>Improved communication between midwifery coordinators</li> </ul>	<ul style="list-style-type: none"> <li>Evidence of MMAG revised inter facility referral, transfer and repatriation processes, guidelines and standards</li> <li>All cases transferred are reviewed against the guidelines and outcomes</li> <li>Number of transfers that were appropriate re criteria as a proportion of all transfers; aim = 100%</li> </ul>	<ul style="list-style-type: none"> <li>GP and practice nurse meeting with ADOM/Clinical Director (CD) Obstetrics and ANC coordinator to promote early engagement with an LMC, ideas on how to assist finding an LMC and update/Information on early pregnancy assessment and screening held in 2014.</li> <li>MMAG have completed this guideline and it has been endorsed by Taranaki DHB.</li> <li>100% transfers have been reviewed at case review sessions, all deemed appropriate.</li> <li>Revised flowchart and process for Taranaki DHB emergency Neonatal response team devised to assist in improving the timing and retrieving of Neonatal cases in the rural unit in 2014/15 (see page 49).</li> </ul>
Implement Perinatal Mental Health (PMH) Pathways to improve processes for identification referral and treatment of perinatal mental health illness	<ul style="list-style-type: none"> <li>Consultation with all practitioners involved with maternity cases up to one year post delivery</li> <li>Launch of the pathway, referral process and education on diagnostic tools and processes</li> <li></li> </ul>	All practitioners are educated and provided with the information to confidently screen and refer cases early if concern for PMH	<ul style="list-style-type: none"> <li>Number of cases of PMH screened and referred correctly over the total number of cases</li> </ul>	<ul style="list-style-type: none"> <li>PNMH are currently auditing the pathway to ensure 100% of cases are screened correctly using EPNDS and timely consultations are offered.</li> <li>In-service education has been offered to all maternity and neonatal practitioners on the referral pathway and EPDNS screening tool, this is on going.</li> <li>Monthly MMH/MDT/ Maternal and Infant health liaison meetings have been implemented.</li> <li>May 2015 an Acute perinatal-Infant Mental Health Nurse has been appointed to ensure PNMH referrals are prioritised, assessed and actioned for pregnant women and new mothers over and above the standard adult.</li> <li>Regional map of medicine can be seen in Appendix 4.</li> </ul>
Strengthen consistency of practices through shared educational activities - maximise collaboration between Midland Regional midwifery educators	<ul style="list-style-type: none"> <li>E-learning modules are developed in collaboration with GMs HR and e-learning facilitator</li> <li>Regional education plan is developed and activities are prioritised annually</li> </ul>	<ul style="list-style-type: none"> <li>Consistent and supported maternity education delivered across region</li> <li>Midland maternity educators group are sharing resources, training calendars, and assisting with training regionally</li> <li>Regional support for identified items of maternity education and training equipment</li> </ul>	<ul style="list-style-type: none"> <li>Number of staff completing Midland shared education modules over the number of practitioners in Taranaki DHB; aim is 30% by June 2014</li> </ul>	<ul style="list-style-type: none"> <li>MMAG/Taranaki DHB educator and ADOM responsibility.</li> <li>Shared template has been developed and approved by MCNZ for compulsory annual emergency and practice days. 98% Taranaki DHB midwives have attended a Midland emergency or practice day when due.</li> <li>Midland water birth and breastfeeding study day held for Taranaki DHB practitioners to attend.</li> <li>Taranaki DHB education calendar (Appendix 5) and Midland education calendar have been published.</li> </ul>

Quality & Safety cont'd				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
	<ul style="list-style-type: none"> <li>• Monitor and evaluate underlying reasons for and the number (% of total) of preterm births</li> <li>• Investigate any improvements that can be made to prevent preterm births</li> </ul>	<ul style="list-style-type: none"> <li>• Data captured to benchmark regionally and nationally.</li> <li>• Identify areas for improvement: <ul style="list-style-type: none"> <li>• Early enrolment with an LMC</li> <li>• Healthy women and healthy babies</li> </ul> </li> <li>• Reduce the numbers of preterm births/admissions to Neonatal unit</li> <li>• Keeping mothers and babies together; plan for co-location of Maternity, Neonatal and Child Health Services</li> <li>• Identify areas for improvement in the care of the late preterm infant so that mother and baby can remain together in the postnatal ward</li> </ul>	<ul style="list-style-type: none"> <li>• Number of Neonatal unit admissions for preterm and late preterm births are reduced</li> </ul>	<ul style="list-style-type: none"> <li>• Midland/HealthShare decision to progress e-learning modules regionally and be accessed through the Moodle site for all five Midland DHBs.</li> <li>• Training equipment received so all Midland DHBs have equity in access: PROMPT trainer, suturing trainer, hip check doll, MAMA Natalie, breastfeeding talk cards, revised PROMPT manuals.</li> <li>• Data captured and reported to MQC.</li> <li>• 2014/15 audit on preterm births under 36+6 weeks' gestation commenced. Actions to be developed on findings of audit and benchmarking of data in 2015/16 work plan.</li> <li>• See audit page 38.</li> <li>• Postnatal ward introduced nominated rooms for late preterm mother and babies requiring tube feeds/secondary care.</li> <li>• Neonatal and Maternity study day held to promote care of the late preterm baby in the post natal ward; to include casual staff too.</li> <li>• Exploring and introducing Neonatal staff support to postnatal ward when a late preterm infant remains with his/her mother. Meetings commenced 29th May 2014 and are ongoing.</li> </ul>
Neonatal Admissions term births	<ul style="list-style-type: none"> <li>• Continue to monitor numbers of term admissions to NNU</li> <li>• Identify reasons for admission</li> <li>• Monitor length of stay</li> <li>• Explore reasons for admission</li> </ul>	<ul style="list-style-type: none"> <li>• Benchmarking – regionally and nationally</li> <li>• Identifying areas for improvement in care in pregnancy and labour to reduce the number of term births admitted to NNU</li> </ul>	<ul style="list-style-type: none"> <li>• Number of term babies admitted to NNU are reduced</li> </ul>	<ul style="list-style-type: none"> <li>• Care of the jaundiced baby protocol has been completed and signed off, with ongoing education of staff.</li> <li>• Weekly case reviews discuss unexpected admissions to NNU and actions where appropriate to provide improvements in care.</li> </ul>
Reduce the smoking and SUDI rates - support the reduction of SUDI rates and numbers of women who smoke in pregnancy across Midland	<ul style="list-style-type: none"> <li>• All maternity providers have access to education around smokefree pregnancy</li> <li>• Progress towards 90% of all pregnant women entering into LMC/obstetric care are assessed using the MoH ABC programme</li> <li>• All providers of maternity services are trained in promoting safe sleeping messages</li> </ul>	<ul style="list-style-type: none"> <li>• Increased focus on smoking cessation and SUDI prevention with decreased morbidity of infants</li> <li>• Increased numbers of pregnant women accessing quit smoking programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Aim 100% smoke screening questions and referral process completed on admission to Taranaki DHB</li> <li>• All maternity providers have access to education around smokefree pregnancies</li> </ul>	<ul style="list-style-type: none"> <li>• Achieving 95% smoking screening and referral on admission</li> <li>• Midland Health Network: <ul style="list-style-type: none"> <li>- ABC approach</li> </ul> </li> <li>• Taranaki DHB secondary care (Hawera and Base Hospitals) <ul style="list-style-type: none"> <li>- ABC approach</li> </ul> </li> <li>• Aukati Kaipapa Service (Tui Ora Ltd) <ul style="list-style-type: none"> <li>- Intervention</li> <li>- Group Session</li> </ul> </li> </ul>

Quality & Safety cont'd				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• All Midland DHBs have a safe sleep policy in place; a regional safe sleep policy is developed and in place</li> <li>• Midland Regional support through the purchase of Pepi-Pod safe sleep devices</li> <li>• Number of Pepi-Pods distributed over the number of births</li> </ul>	<ul style="list-style-type: none"> <li>• Aukati Kaipapa Service (Ruanui Health Centre) <ul style="list-style-type: none"> <li>- Intervention</li> <li>- Group Session</li> </ul> </li> <li>• Quitline <ul style="list-style-type: none"> <li>- Quit Coach</li> <li>- Txt2Quit</li> <li>- Quit Blog</li> </ul> </li> <li>• Wero (Auckland UniServices) <ul style="list-style-type: none"> <li>- National - Group Stop Smoking Competition / local contact Jason Mathews Public Health Unit</li> </ul> </li> <li>• National Heart Foundation <ul style="list-style-type: none"> <li>- Smoking Cessation Training</li> <li>- Specialist Training</li> </ul> </li> <li>• Combined smoking cessation, safe sleep and breastfeeding education has been implemented locally and through MMAG in November 2013 and has continued through Te Hapu Ora (see education calendar Appendix 5).</li> <li>• Pepi-Pod data in Safe Sleep section; \$10,000 Taranaki DHB received funding from local sponsorship to purchase more Pepi-Pods. Regional safe sleep policy implemented, audit indicates more education required to comply with safe sleep assessment.</li> </ul>
Implement individualised antenatal and postnatal care plans based on the goals and desired outcomes of the consumer (CAR)	<ul style="list-style-type: none"> <li>• Draft care plans for mother and baby devised and piloted, sent out for consultation, amended where appropriate and implemented.</li> <li>• Care plans passed by Clinical Records Committee</li> </ul>	Individualised antenatal and postnatal care plans are implemented to guide and evaluate care in consultation with the woman, LMC and maternity care practitioners.	100% mothers and babies have a care plan that is completed and based on the desired outcomes of the consumer	100% mothers and babies have care plans (implemented in November 2014).
Information and Communication Systems				
Strengthen communication linkages across the DHB	Further investigate and implement audio visual tools to support rural practitioners attendance at meetings and forums	Increase in attendance of rural practitioners at meetings, forums, case reviews and education sessions	Number of meetings where Video Conference (VC)/ teleconference is available over number of meetings	VC facility now in Maternity Meeting room in Ward 15. Meetings, debrief and education sessions to include invites via VC for rural practitioners.
Antenatal clinic data collection	Collection of data to ascertain reasons for consultation and transfer of clinical responsibility align with the referral guidelines	Antenatal clinic midwifery FTE hours reflect antenatal clinic appointment preparation and care schedules	Number of antenatal clinic appointments over hours of midwifery hours available	<ul style="list-style-type: none"> <li>• 2014/15 Ward Clerk hours increased to 1.4fte to provide services to support the antenatal clinic coordinator, secondary clinics and FAU.</li> <li>• 2014/15 Hawera Hospital have an appointed 0.2FTE secondary antenatal clinic midwife to provide services for secondary outpatient antenatal clients and support the obstetrician for outpatient secondary consultations.</li> </ul>

Service Delivery					
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress	
Improve attendance at pregnancy and parenting (P+P) classes especially for rural and Māori pregnant women - increase number of pregnant women who enrol in pregnancy and parenting (P+P) /antenatal classes, especially in rural areas	<ul style="list-style-type: none"> <li>Identify existing classes available, costs, attendance and location</li> <li>Information from the Hapu Wananga Evaluation is utilised as basis for action plan to increase attendance rates for Māori women</li> <li>Implement recommendations from consumer group surveys in rural areas of identified low attendance to determine barriers to attendance and develop plan to improve this</li> </ul>	Information to direct recommendations about how many/what sort and where P+P classes need to be held	Evidence of initiatives being undertaken to meet identified needs in pregnancy and parenting/antenatal classes of vulnerable pregnant women	<ul style="list-style-type: none"> <li>To develop Wahakura weaving sessions and incorporate antenatal education into weaving sessions.</li> <li>Investigate Mama, Pepi, Tamariki contract.</li> <li>Maori health services/planning and funding/ MMAG/Consumer rep.</li> <li>May 2015 Hui with Hapu Wananga to explore the future provision of P+P in the Taranaki region.</li> </ul>	
Support framework for young vulnerable women who are pregnant - develop a regional programme to address identified issues and provide relevant support	<ul style="list-style-type: none"> <li>Work collaboratively with primary providers, including Maori health providers, and PHOs to identify the issues and support systems</li> <li>Commence the development with relevant stakeholders and primary providers to develop a regional programme that will wrap support around young vulnerable women who are pregnant, including smoking cessation and substance abuse</li> </ul>	Young vulnerable women who are pregnant have improved access to information, support and quit smoking programmes	Collaborative work with primary providers and PHOs towards developing a regional programme for young vulnerable women who are pregnant	<ul style="list-style-type: none"> <li>MMAG/Maori Health project manager/CMM/ADOM/ Paed developed and published local directory of services for vulnerable women. Distributed and updated to maternity stakeholder and practitioners to help guide referral pathways to support agencies for Mama and Pepi at risk (see Appendix 3).</li> <li>Paediatric liaison meeting includes CMM to discuss any cases re child protection/concerns. National Maternity Care, Well being and Child Protection (MCWCP) toolkit received and currently localising, meeting with stakeholders and practitioners on implementation of Multi agency Group (MAG) meetings in 2015/16.</li> <li>Access to Family Violence Intervention Training (FVIP) well attended by core staff and available for SEMs to attend. NZCOM provided a free education session for SEMs in 2014.</li> <li>Screening for FV in maternity audit shows 99% maternity staff are trained. Please see page 47 for FVIP screening data.</li> </ul>	
Improve access to local Nuchal Translucency (NT) services when the private obstetrician is on leave	Investigate possibility of locum services to cover Taranaki DHB to offer this service when the private obstetrician is on leave	NT services are available locally to all women that choose this screening	Number of days NT scanning was not available in Taranaki	2015 NT services are now available at alternative sites. A free service is available provided by a local GP who is accredited and Wanganui also offers these services for free which is utilised by South Taranaki clients.	
Caesarean Section (C/S) <ul style="list-style-type: none"> <li>Improve timing from phone call of decision to birth of baby for Level 1 C/S</li> <li>Decrease General Anaesthesia (GA) in emergency C/S</li> </ul>	Investigate an area that maternity and neonatal unit can be accommodated near to the new hospital building and operating theatres	<ul style="list-style-type: none"> <li>Area is secured for maternity and neonatal services nearer to the hospital operating theatres; plans in place for commissioning and moving to new location</li> <li>Decrease in GA for Level 1 C/S</li> </ul>	<ul style="list-style-type: none"> <li>GA C/S rates performed under GA over all Level 1 C/S</li> <li>Number of Level 1 cases not reaching the recommended time from phone call (decision) to birth of baby over all Level 1 C/S</li> </ul>	<ul style="list-style-type: none"> <li>Please see page 42 for GA C/S and timings of Level 1; this is an ongoing project to try to improve timings and relocate the maternity unit to an area closer to the main operating theatres. All Level 1 caesareans are audited and reviewed.</li> <li>Carry forward to 2015/16.</li> </ul>	



Service Delivery cont'd				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Investigate rising C/S rate	Conduct an audit on the C/S rate to assist in identifying the reasons for the increasing rates and help plan actions to reduce help reduce rates	<ul style="list-style-type: none"> <li>Improved timing for decision to birth of Level 1 C/S</li> <li>Improved rates of C/S in line with the national rate</li> </ul>	Number of C/S performed in line with RANZCOG guidelines over the number that did not align with the guidelines	<ul style="list-style-type: none"> <li>The purchase of a portable CTG monitor in August 2013 was aimed at reducing the GA C/S rates and has shown signs of a reduction; the portable monitor reassuring the clinicians there is time to insert spinal anaesthesia in some cases. Additionally the purchase of new delivery beds in 2014 with battery backup has assisted in achieving decision to delivery time earlier as shown in the data. New operator call out list for 777 Obstetric calls implemented.</li> <li>A C/S audit has been completed in April 2015, this will be presented to practitioners and education plans made to try and improve rates. See response to the National Maternity Monitoring Group (NMMG) and audit page 43.</li> <li>All elective C/S are monitored and are questioned if performed prior to 39+0 weeks' gestation unless medically indicated. If medically indicated less than 39 weeks' gestation the mother is administered antenatal steroids.</li> </ul>
Investigate an area in Taranaki Base hospital where co-location of Maternity (antenatal/postnatal/labour) and neonatal services (to be nearer to the child health services and operating theatres)	Explore what the future maternity services will look like in Taranaki DHB including location of primary maternity units and integration/co location of the secondary maternity and neonatal unit services being closer situated to Taranaki base operating theatres	<ul style="list-style-type: none"> <li>Integrated Antenatal / Postnatal/Labour and birth services with Neonatal unit adjacent to improve continuity, effectiveness and efficient use of staff and equipment in Base Hospital</li> <li>Staff skill mix and environment meets the needs of the maternity services</li> <li>Security to the existing areas is implemented with video surveillance and remote access</li> <li>Primary maternity facilities are utilised and located to meet the needs of the birthing population</li> </ul>	<ul style="list-style-type: none"> <li>Client and staff satisfaction</li> <li>Number of security incidents</li> </ul>	<ul style="list-style-type: none"> <li>November 2014 security wiring completed. Cameras and security access system fully operational in April 2015 now recording.</li> <li>Wireless in place March 2015 (still areas of PN this cannot be obtained due to building). Midwife in charge now has a wireless phone to carry to improve communication.</li> <li>Hawera Hospital undertaking security assessment.</li> </ul>



Research and Evaluation				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Regional and local data availability - comprehensive data collection systems to enable regional benchmarking and reporting	<ul style="list-style-type: none"> <li>Regional dashboard for maternity clinical indicators is developed and updated</li> <li>Accurate regional information is available which identifies issues, trends and enables focus for regional initiatives</li> <li>Local data examined on antenatal clinic consultations and transfers to secondary antenatal care</li> </ul>	<ul style="list-style-type: none"> <li>Current regional data is available to shape direction of care and action</li> <li>Sufficient FTE and support services to support Taranaki outpatient antenatal services.</li> <li>Appropriate management of consultation and transfer of care to and from primary LMC services</li> </ul>	<ul style="list-style-type: none"> <li>The availability of comprehensive regional data</li> <li>Audit results to ensure appropriate consultation and transfer of care antenatally and postnatally</li> </ul>	<ul style="list-style-type: none"> <li>MMAG provide regional data to allow benchmarking and reporting; local information is obtained from coders and local analysts.</li> <li>All antenatal clinical referrals are screened by the antenatal clinic coordinator and if considered not appropriate are discussed with referring practitioners.</li> <li>2015/16 work plan is to audit the guidelines for referral to ensure women have been appropriately referred/transfer of care to a specialist has taken place where indicated.</li> </ul>
Improving breastfeeding rates through use of agreed regional tools - regional agreement to the networking and sharing of resources throughout Midland regarding breastfeeding	<ul style="list-style-type: none"> <li>Identify breastfeeding rates in Midland using regional BFHI data</li> <li>Explore the development of the use of IT applications to improve access to information for Māori and disadvantaged mothers</li> </ul>	<ul style="list-style-type: none"> <li>Improved access to consistent breastfeeding information</li> <li>Enhanced availability of breastfeeding resources in the Midland Region and the sharing of initiatives and resources through the regional breastfeeding/BFHI support group</li> <li>Evidence of regional support for the purchase of Mama Aroha breastfeeding resources for each Midland DHB</li> </ul>	<p>Aim minimum 75% exclusive breastfeeding rates on discharge from Taranaki DHB facilities</p>	<ul style="list-style-type: none"> <li>Both Taranaki DHB facilities are monitored monthly on exclusive B/F discharge rates and are overall achieving minimum 75% (see page 64).</li> <li>MMAG Breastfeeding sub-group is established.</li> <li>Mama, Pepe Hauora project is established.</li> <li>Tamariki Ora and Tui Ora contracts &amp; Ngati Ruanui.</li> <li>Mama Aroha card education in Taranaki DHB by Te Hapu Ora and provision of MoH funded Mama Aroha to SEMs and PN services.</li> <li>4 Lactation Consultant (LC) scholarships have now become certified lactation consultants and community LC clinics are implemented around the province.</li> </ul>
Congenital Cardiac Heart Disease (CCHD) screening	Purchase of equipment and implementation of staff training and Taranaki DHB protocols are in place	Improved detection and treatment of CCHD	Number of cases detected prior to discharge from hospital over the total of cases detected in the first year of life	Decision for this not to proceed with CCHD screening until there is a national initiative in place to fund this.
Maternity Bariatric Guidelines	Maternity Bariatric Guidelines developed	Clear guidelines in place to inform clients and practitioners on bariatric cases	E learning package completed by staff; aim for 80% pass within one year of guidelines being implemented	Taranaki DHB Bariatric Guidelines implemented with maternity section; e-learning package has been implemented in 2014. MMAG looking at adopting this for regional use. An audit on care of pregnant bariatric women is currently underway.
Opportunistic immunisation for flu vaccine and Boostrix	Marketing and advertising the immunisation services	Increased uptake of flu and Boostrix immunisations for staff and clients; decrease in sick leave and hospital admission in relation to whooping cough and flu	Number of opportunistic & drop in pregnant women vaccinated	Taranaki DHB antenatal clinic and ward are offering free vaccinations in the flu season and Boostrix vaccination.
Hip Check services	Investigate hip check services for accessibility, timing and client satisfaction	Hip check services meet the needs of babies and families. Are provided in a timely and family friendly environment	<ul style="list-style-type: none"> <li>Number of hip check examinations performed prior to 1 week of age</li> <li>Client satisfaction</li> </ul>	This project has not commenced will be taken forward to 2015/16.

Research and Evaluation cont'd				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Access to Maternal Fetal Medicine (MFM) services	<ul style="list-style-type: none"> <li>Investigate whether MFM services can be provided by telemedicine where appropriate to reduce the number of visits to MFM centres</li> <li>Investigate if a visiting MFM specialist can be re implemented</li> </ul>	MFM services are accessed within seven working days of referral with a focus on consultation being provided where appropriate by telemedicine/local	Number of clients seen by 7 working days over total number of clients	Currently investigating if the local complex care meeting can video conference to MFM services Wellington to discuss complex/MFM clients to assist in care planning and decision making Carry forward to 2015/16.
<b>Enablers/Support</b>				
Workforce intelligence - plan for a sustainable maternity workforce (especially in rural areas)	<ul style="list-style-type: none"> <li>Head count to service current population vs workforce needed for future birthing trends is identified</li> <li>Areas of shortage are identified</li> <li>Identify rural midwives' issues and work towards regional solutions</li> <li>Trends in LMC and secondary/tertiary midwifery workforce numbers, distribution and forecasting are analysed by regional workforce group</li> </ul>	Understanding of current state and future state needs to achieve sustainability	Total FTE vacancies over total FTE	<ul style="list-style-type: none"> <li>Maori Health team are working with HR to develop new workforce initiatives to reduce inequalities.</li> <li>HWNZ funding for upskilling those that work with Maori; WRR is the Taranaki Maori workforce project being implemented (incubator and cadetships).</li> <li>Currently Taranaki DHB maternity Maori workforce has increased to around 21%.</li> <li>2015 No current vacancies/shortage of self employed midwives or core midwives in Base or Hawera. Training student midwives locally via AUT satellite training.</li> </ul>
Workforce utilisation - identify future maternity workforce requirements and develop plans to ensure appropriate maternity care provision continues	<p>Utility of existing workforce model critiqued against workforce forecasting</p> <p>Explore options to reduce ward acuity for routine admissions, prioritise cervical ripening admission for post dates cases</p>	<ul style="list-style-type: none"> <li>Accurate baseline data and engagement of service providers in developing innovation solutions</li> <li>Core midwifery predictable efficient workloads</li> <li>Improved interface relationships for cervical ripening admissions</li> <li>Improved core staffing and ward acuity by reducing numbers for this procedure during high acuity</li> </ul>	<p>Staff satisfaction and evaluation of trials</p> <p>Number of cervical ripening admissions reduction</p>	<ul style="list-style-type: none"> <li>2015 Trial underway to improve HCA job satisfaction and reduce turnover of staff.</li> <li>2015 Maternity staffing meetings ongoing with unions to explore ways to meet safe staffing levels in time of high and low acuity see page 73.</li> <li>2015 Stratford primary maternity unit has closed permanently due to the contractors being unable to sustain services in this area. A full DHB review followed and the clinical board unanimously voted for this unit to remain closed. Priorities were set for the recommendation of a maternal and child health hub to be based in Stratford and upgrade Hawera maternity facility. 2015/16 work plan.</li> <li>2015 Cervical ripening (CR) working group with representatives from SEM, Obstetricians, core and NZCOM is going to trial the introduction of secondary services commencing all (CR) for post dates women following primary/secondary interface meetings. Admissions will be tailored to suit ward acuity and safe staffing.</li> </ul>

Enablers/Support cont'd				
Priority area	Planned local actions to deliver quality improvement	Expected outcomes	Measured by	Progress
Workforce planning and forecasting for medical staff - work with RANZCOG to plan for O&G placements in identified areas	<ul style="list-style-type: none"> <li>Quantification of percentage of consultant time spent in obstetrics to ascertain level of obstetric workforce need</li> <li>Quantification benchmarked across other three regions by RDOTs</li> <li>Strategic plan for sustainable obstetric physician service provision inclusive of obstetric anaesthetists, SMOs, RMO training, and placements is developed</li> </ul>	Robust understanding of workforce issues and identification of workforce needs for the future	Total number of obstetric registrars over positions available	<ul style="list-style-type: none"> <li>Visit from RANZCOG approved two registrar positions for Taranaki DHB.</li> <li>2015 has seen the first time two Obstetric registrar positions have been filled.</li> </ul>
Electronic Discharge summaries (EDS) are completed on discharge from the secondary services and are accessible to primary maternity providers and GP's	<ul style="list-style-type: none"> <li>Carry out Failure Mode Effect Analysis (FMEA) to ascertain why they are not meeting auditable standard</li> <li>Provide definitions and flow chart for condition and process of completing EDS</li> </ul>	All mother and babies admitted under secondary care have an EDS completed and available to primary carers	Number of secondary admissions having and EDS generated	<ul style="list-style-type: none"> <li>All primary access agreement holders have access to éclair and concerto to view EDS.</li> <li>Project completed in Sept 2014. EDS poster and procedure on who requires an EDS including definitions of primary/secondary conditions has been developed and displayed.</li> </ul>
Use ICT to improve information sharing - improve access to information between LMCs and with consumers	<ul style="list-style-type: none"> <li>Web portal for LMCs and consumers in place</li> <li>Application development for LMC and consumer smartphone use explored</li> </ul>	Increased access to information for consumers and LMCs	Shared electronic space open to LMCs and consumers to access information.	<ul style="list-style-type: none"> <li>Consumers can access Taranaki DHB internet site including information on how to access a midwife; also information can be accessed through the Taranaki DHB MQSP Facebook page.</li> <li>MIMAG still investigating smartphone applications.</li> </ul>
Progress connected health concepts to improve access to clinical maternity information - implement national maternity client information system	<ul style="list-style-type: none"> <li>Work with regional ICT to develop implementation plan</li> <li>Participate in MCIS system development at the national level, working with the clinical reference group and CleverMed</li> <li>Implementation plan commenced in early adopter site</li> </ul>	<ul style="list-style-type: none"> <li>Regional implementation plan and timeframe available</li> <li>Users of the system provide feedback to influence system development</li> </ul>	MIMAG representation on national Maternity Client Information system (MCIS)/working group to assist in developing New Zealand IS platform)	<ul style="list-style-type: none"> <li>MIMAG.</li> <li>2015 wireless is now available in maternity and Computers on Wheels have been implemented.</li> <li>MCIS will be implemented in the future, awaiting work plan.</li> </ul>

## Midland Maternity Action Group (MMAG) – 2014/15 Work Plan (with progress commentary)

**Chair** Corli Roodt (Clinical Midwife Director, Waikato)

**Vision** to lead regional maternity activity on behalf of Midland DHBs to grow the right skilled health practitioners to provide maternity care – improving the quality, safety and experience of care; improving equity and accessibility to care, resulting in the best value from Midland's resources

**Key objectives:**

- undertake an agreed regional work programme that supports the implementation of the National Maternity Quality and Safety Programme (MQSP)
- improve consistency of practices and coordination of responsive maternity services through working collegially and cooperatively to develop regional standards, guidelines, etc to enable the best use of resources
- improve access to information sharing for LMCs, maternity service providers and consumers
- maternity workforce development to reduce vulnerability and to increase sustainability

<b>Initiative 1</b>	<p>Support the reduction of the smoking rates of pregnant women, support the reduction of the SUDI rates for Midland, and support the improvement of breastfeeding rates:</p> <ul style="list-style-type: none"> <li>• continue the implementation of the Midland safe sleep programme across Midland to reduce Māori SUDI rates, in alignment with national indicator (&lt;0.5 per 1,000 live Māori births)</li> <li>• enable training around best practice to support attainment of quit smoking support indicator for pregnant Māori women within Midland (95% of in-patient hapū woman offered quit support)</li> <li>• pilot an initiative that incentivizes smoking quit support uptake amongst pregnant women in Waikato. Evaluation used to inform regional roll-out/ learnings. (95% of in-patient hapū woman offered quit support)</li> <li>• complete Mama Aroha breastfeeding training with key health practitioners inclusive of midwives, LMCs / Māori provider staff across Midland region (% of Māori infants fully and exclusively breastfed at 6 weeks (68%), 3 months (54%), 6 months (59%) improving trend evidenced)</li> <li>• networking and sharing of resources throughout Midland re breastfeeding</li> <li>• explore the development of IT applications and the use of the regional website to improve access to information for all parents, particularly Māori and vulnerable mothers</li> </ul>				
<b>Initiative aligns with MoH Regional Objectives:</b>	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources
<b>Milestone</b>	Q4 – 2014/15				
<b>Measurable</b>	<ul style="list-style-type: none"> <li>• all providers of maternity services are trained in promoting safe sleeping messages, as part of the Midland Safe Infant Sleeping (Birth to 1 Year) Policy and the Midland Safe Sleep Programme</li> <li>• progress towards a rate of &lt;0.5 SUDI/1000 live Māori births</li> <li>• all maternity providers have access to education around smokefree pregnancy</li> <li>• an increase in the educational resources that maternity providers are able to access ie online MoH ABC smoking cessation recommendations programme, and/or study sessions</li> <li>• progress towards 90% of all pregnant women, particularly Māori women, who identify as smokers at the time of confirmation of pregnancy in general practice or booking with an LMC are offered advice and support to quit, eg MoH ABC smoking cessation recommendations programme</li> <li>• an improvement in accessible consistent breastfeeding information</li> <li>• progress towards a 5% increase of infants fully and exclusively breastfed, particularly amongst Māori, for babies at 6 weeks</li> </ul>				
<b>2014/15 Progress Report</b>	<p><b>What are the problems to be resolved?</b> MMAG needs to understand Midland DHBs maternal smoking rates, SUDI rates, and the challenges to breastfeeding for women to drive down smoking exposed pregnancies, SUDI rate and early breastfeeding cessation rates. MMAG aims:</p> <ul style="list-style-type: none"> <li>• smokefree pregnancy - continue to reduce the rate of smoking in pregnancy</li> <li>• safe sleep - continue to support safe sleep practices</li> <li>• breastfeeding – continue to improve breastfeeding rates and that support is available for women when facing challenges with breastfeeding</li> </ul>				
	<p><b>Supporting consumers and health care providers of maternity services so we can better meet community needs:</b></p> <p><b>Smokefree pregnancy</b></p> <ul style="list-style-type: none"> <li>• <b>sharing of resources</b>, eg Waikato DHB making available a six poster set to raise awareness of benefits and support for smokefree pregnancies. A better use of resources for the region through sharing. Posters are individualised and printed at Waikato DHB (Waikato, BOP, Lakes, and Taranaki have taken up this offer)</li> </ul>				

	<ul style="list-style-type: none"><li>• <b>regional purchasing of CO monitors to make savings</b> - for use in primary and community clinics with smoking cessation advice for pregnant women. Purchase led by Waikato MQSP and progressing through Waikato DHB procurement for distribution to Midland DHBs. Training DVD to support the implementation of the CO monitors to be developed and shared in Midland to support LMCs in their smoking cessation consultations with women</li><li>• <b>training support</b> – offered through the Midland Safe Sleep Programme to all Midland Pepi-Pod® distributors and card holders which includes personnel/kaimahi from hospital and community maternity and paediatric units, Lead Maternity Carers (LMCs), Maori and Pacific NGOs, Wellchild/ Tamariki Ora providers and Family Start, Pepi-Pod® programme</li></ul>					
	<b>Safe sleep</b>					
	<ul style="list-style-type: none"><li>• <b>Midland Safe Sleep Programme</b> - established in partnership with Te Puna Oranga (Waikato DHB Maori Health Service) on behalf of Nga Toka Hauora (Midland Maori General Managers Forum, MMAG, and in partnership with Change for our Children – supported by Midland Safe Infant Sleeping (Birth to 1 Year) Protocol for DHB contracted facilities, safe sleep sticker alert system, UK UNICEF resources, and some investment support for safe sleep devices<ul style="list-style-type: none"><li>▪ there is emerging evidence that suggests that the joint efforts in the Midland region are beginning to impact on SUDI rates:<p><i>‘Fact: Infant death rates were rising in Midland from 2003 to 2011 and fell sharply in the 2012-2014 period. There were 47 fewer deaths overall during 2012-2014 compared to the previous period, and 33 less for Māori (70% of the recent change).’ ‘Midland has had the greatest recent change (from 3.5 to 2.4 deaths per 1000 live births during 2012-2014). This reduction was against a previous upward trend during the 2003-2011 period from 3.0 to 3.5 deaths per 1000 live births.’</i></p><p>(source: The Rainbow Report, 2015, Change for Our Children)</p></li></ul></li><li>▪ Midland’s work around SUDI has gained international recognition (2014 International Congress on Stillbirth, SIDS and Baby Survival, Amsterdam, September 2014)</li></ul> <li>• <b>safe sleep refresher training</b> – key messages in safe sleep, smokefree, breastfeeding, immunisation, shaken baby prevention, family violence and safe handling. Offered to all Midland Pepi-Pod® distributors and card holders which includes personnel/kaimahi from hospital and community maternity and paediatric units, Lead Maternity Carers (LMCs), Maori and Pacific NGOs, Wellchild/ Tamariki Ora providers and Family Start., Pepi-Pod programme</li> <li>• <b>national safe sleep day</b> - MMAG financial support for local DHB activities promoting safe sleep messaging in DHB communities</li>					
	<b>Breastfeeding</b>					
	<ul style="list-style-type: none"><li>• <b>Midland breastfeeding mobile phone application</b> - commenced exploratory project to proof of concept (due 30 June 2015) with a content developer, graphic designer, web layout and app. development company contracted to support the development. The ability to connect and offer support to women through the use of technology and more specifically mobile phone applications, is one of the recommendations under the theme of ‘information’ identified in the NZ Institute of Rural Health’s ‘Midland Region Rural Maternity Services Consumer Engagement Study’, published 2014. A teen mums focus group, public health, Maori health, rural based LMCs, Plunket, and consumer reviews of content are planned for June 2015</li><li>• <b>breastfeeding and healthy attachment study day with a NICU SCBU focus</b> – MMAG provided financial and logistical support for a successful study day on 1 May 2015 in Tauranga. 88 Midland participants attended, including NICU/SCBU Nurses, Midwives, home birth educators, Plunket and mental health. The study day was facilitated by Carol Bartle, with guest speaker Dr Alison Barrett and complimentary feedback was received on the informative and thought provoking content and knowledgeable speakers</li><li>• <b>Mama Aroha Talk Cards</b> – support breastfeeding training of maternity staff and those involved in the Midland Safe Sleep Programme (via Te Puna Oranga) to better support women and families in Midland</li><li>• <b>Midland breastfeeding consumer survey and health professional survey feedback (2014)</b> - utilise feedback received to inform the content of the App. and to improve communication with consumers and health professionals.</li><li>• <b>sharing of resources</b> - Midland MQSP Sub-Group of coordinators/project managers share local DHB initiatives and the learnings arising, eg BOP’s ‘As Soon As Pregnant’ campaign, Taranaki’s ‘5 things to do within the first 10 weeks’ campaign, Waikato’s overview of its flu immunisation plan for maternity services, and Lakes ‘Falling in Love With You, Baby’ project</li></ul>					
	<b>Inputs &amp; Resources</b>					
	MMAG / Midland Regional Smokefree Programme / Midland Regional Training Network (MRTN) / Midland GMs Māori Health					
	<b>Responsibilities</b>					
	MMAG/ MQSP sub-group / Breastfeeding/BFHI sub-group / Midland GMs Māori Health					
	<b>Enablers</b>					
Midland Regional IS						
<b>Initiative 2</b>	Improve patient care, quality, and safety through establishing a robust maternity/neonatal transfer system – implement consistent system for maternity transfers and repatriations across Midland and beyond: <ul style="list-style-type: none"><li>• Midland Maternity Services: Transfer and Repatriation Standards - quality indicators and standards for maternity transfers developed and implemented to underpin transfers</li><li>• analysis and review of transfer system efficiency and repatriation numbers/ appropriateness</li></ul>					
<b>Initiative aligns with MoH Regional Objectives:</b>	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	



Milestone	Q4 – 2014/15				
Measurable	<ul style="list-style-type: none"> <li>improved consistency of practices and systems through development of regional wide standards, procedures and processes</li> <li>facilitating improved coordination and responsiveness of services to those requiring maternity services in Midland in a cooperative and coordinated manner</li> <li>working collegially and cooperatively to make best use of resources and/or to implement regionally consistent systems and processes</li> </ul>				
2014/15 Progress Report	<p><b>Working together as a region to develop and implement a consistent system for maternity transfers and repatriations across Midland and beyond:</b></p> <ul style="list-style-type: none"> <li><b>Midland Maternity Transfer and Repatriation Standards</b> (draft) - developed with full obstetric SMO engagement, six month trial undertaken followed by MMAG's formal review of feedback received. A further case review is underway to identify any issues with transfers involving requests for NICU beds at the region's tertiary facility. The Standards are to be extended to also include the transfer and repatriation of postnatal women and their babies in Midland. The Standards are expected to be finalised and implemented June 2015.</li> </ul>				
Inputs & Resources	MMAG / Midland Regional IS				
Responsibilities	MMAG				
Initiative 3	<p>Workforce:</p> <ul style="list-style-type: none"> <li>Intelligence – design a strategy for a sustainable maternity workforce across the region, including rural and remote rural areas with the skills and knowledge required to meet the needs of women within the Midland population. Ensure stronger engagement with workforce monitoring in conjunction with GPs HR to enable DHBs to understand maternity workforce issues, eg a pipeline supply, age, work, and preferences</li> <li>Utilisation – identify future maternity workforce requirements and develop plans to ensure ongoing, safe and appropriate maternity care provision</li> </ul>				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources
Milestone	Ongoing				
Measurable	<p>Workforce:</p> <ul style="list-style-type: none"> <li>Intelligence: <ul style="list-style-type: none"> <li>robust data collected on numbers of health professionals working in maternity services across the Midland region to understand current workforce in primary care (both rural and urban), secondary, and tertiary settings</li> <li>birthing populations and their outcomes mapped against requirements for maternity care</li> <li>map the learning needs to each occupational group to identify gaps in knowledge, skill and number of health practitioners</li> </ul> </li> <li>Utilisation – explore: <ul style="list-style-type: none"> <li>options for innovative models of service delivery to allow practitioners to work throughout the breadth and depth of their scope, enable role substitution where possible (e.g. midwifery-led clinics), collaborative models including allied health practitioners</li> <li>training and education models to facilitate the inclusion of General Practitioners into rural maternity services</li> </ul> </li> </ul>				
2014/15 Progress Report	<p><b>What are the problems to be resolved?</b> A focus is required to:</p> <ul style="list-style-type: none"> <li>support a sustainable rural maternity service to improve accessibility for women living in Midland's rural locations</li> <li>understand the current workforce and the utilisation of the future workforce, eg regional passport with transportability of certifications, leadership succession, and development</li> <li>consider emergent health issues, eg gestational diabetes management, obesity, pre-term births, etc, and align a regional education plan to support the maternity workforce to meet the ongoing educational needs around complex care</li> </ul> <p><b>Listening to consumers and maternity health care providers so we can better understand the needs of women, their families, and health care providers:</b></p> <ul style="list-style-type: none"> <li><b>formal rural consumer research in Midland</b> – HealthShare Ltd commissioned the NZ Institute of Rural Health on behalf of the Midland DHBs and MMAG. NZIRH Report published 2014 '<i>Midland Region Rural Maternity Services Consumer Engagement Study</i>', with recommendations based on themes of access to services, quality of clinical care, information, role of partners, family and friends, and culture</li> <li><b>Midland consumer survey 2014 (including rural)</b> – consumer feedback (162 responses) being used to provide a consumer perspective to maternity's breastfeeding services and the pilot breastfeeding mobile phone App. content</li> <li><b>Midland maternity and Wellchild health care providers (HCP) survey 2014 (including rural)</b> – HCP feedback (28 responses) being used to provide a health care provider perspective to maternity's breastfeeding services and the pilot breastfeeding mobile phone App. content</li> </ul> <p><b>Planning so we can sustain and develop maternity services in Midland's communities (particularly rural and remote rural):</b></p> <ul style="list-style-type: none"> <li><b>Midland midwifery graduate ePortfolio (Phase I)</b> – continue to explore utilising the Midland Learning platform to support evidence of midwifery competency requirements for Midwifery Council auditing purposes and making best use of DHB resources. A template has been developed for starting an ePortfolio, with Midland maternity educators enrolled in a course set up for the regional programme, and accessed through an electronic pathway</li> </ul>				



	<ul style="list-style-type: none"> <li><b>Midland midwifery graduate programme (Phase I)</b> – a Midland Midwifery Programme has been created utilising the Midland Learning platform to support the delivery of the midwifery graduate training programme, central place for DHB specific resources such as orientation information, maps, contacts; and a forum for Educators to lead group discussions, and peer support. The programme also contains the doorway to Midland midwifery graduate ePortfolios</li> <li><b>Midland midwifery ‘passport’ for a virtual midwifery group to work across the region’s maternity services (Phase II)</b> – utilising the Midland Learning platform to provide transportability of ‘digital artefacts’ via a secure electronic tool</li> <li><b>Midland Workforce Advisor (Midland Regional Training Network) (ongoing)</b> - collating workforce data, including training institutions, to provide regional workforce analysis, cross referencing supply and service demand with maternity analytics</li> </ul> <p><b>Training so we can improve the quality of care provided to Midland’s communities (particularly rural and remote rural):</b></p> <ul style="list-style-type: none"> <li><b>Midland regional training workshops</b> – MMAG support for education across the region, eg, safe sleep, breastfeeding training as part of the Midland Safe Sleep Programme (2014/15), perinatal mental health study days (2014), Midland water birth/active birth study days (2015), Midland SCBU/NICU staff breastfeeding and healthy attachment study day (1 May 2015). Vicki Culling workshops (perinatal and infant loss: an introduction; holding on and letting go: facing an unexpected diagnosis in pregnancy; post-mortem and subsequent pregnancy – 2014/15)</li> <li><b>Midland regional maternity education calendar</b> – a shared calendar was trialed in 2014, and individual DHB calendars uploaded to regional website in 2015 to better support midwifery annual practising requirements and Maternity Educator backfill (when required)</li> <li><b>Midland new graduate midwife guidelines which support safe practice</b> – guideline developed for Midland DHBs to use as a template (excepting Waikato as a tertiary facility) to protect and nurture new graduate midwives in their first year of practice to progress from competent to confident midwives</li> <li><b>Midland CTG monitor standards</b> - developed by MMAG and referred to Midland’s Chief Financial Officers, DHB purchasing leads and regional procurement advising the standard of monitor, functions and features required by maternity services, and providing collated feedback following clinical trials in DHB maternity facilities</li> </ul>					
<b>Inputs &amp; Resources</b>	MMAG / Midland Workforce Advisor/Midland Regional Training Network/Midland Workforce Development					
<b>Responsibilities</b>	MMAG / Midland Workforce Advisor/ Midland Regional Training Network/ Midland Workforce Development					
<b>Enablers</b>	MMAG / Midland Workforce Advisor/ Midland Regional Training Network/ Midland Workforce Development					
<b>DHB Contribution</b>	Midland GMs HR					
<b>Initiative 4</b>	<p>Improve access to pregnancy and parenting (P+P) classes, particularly for rural and Māori pregnant women, with the aim to increase the number of vulnerable pregnant women who enrol in P+P / antenatal classes, especially in rural and high deprivation areas:</p> <ul style="list-style-type: none"> <li>MMAG to support and advise the implementation of P+P service specifications at a local level</li> <li>MMAG to collaborate with Midland planning and funding divisions to receive regular information/data on P&amp;P utilisation and ethnicity</li> </ul>					
<b>Initiative aligns with MoH Regional Objectives:</b>	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services	
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources	
<b>Milestone</b>	Q4 – 2014/15					
<b>Measurable</b>	<ul style="list-style-type: none"> <li>P+P classes well attended</li> <li>increased number of Kaupapa Māori P+P / antenatal classes available across the region</li> <li>improved Māori attendance</li> </ul>					
<b>2014/15 Progress Report</b>	<p><b>What are the problems to be resolved?</b></p> <ul style="list-style-type: none"> <li>improved access to pregnancy and parenting education/classes is required, particularly for rural and Māori pregnant women, with the aim to increase the number of vulnerable pregnant women who enrol in pregnancy and parenting/ antenatal classes, especially in rural and high deprivation areas</li> <li>Midland DHB planning and funding divisions are engaged with MMAG to support the implementation of the pregnancy and parenting service specifications at a local level</li> <li>regular information and data (including ethnicity breakdown) on the utilisation of Midland’s pregnancy and parenting/antenatal education/classes is required by MMAG from the Midland DHB planning and funding divisions</li> <li>Māori and Pacific fair the poorest in terms of maternal and infant health outcomes, therefore an investment toward developing a curriculum for Māori has yet to be realised</li> </ul> <p><b>Supporting consumers and maternity health care providers, with a focus on pregnancy and parenting, so we can better meet community needs:</b></p> <ul style="list-style-type: none"> <li><b>hapu wananga curriculum and toolkit development for Midland</b> - MMAG partnership with Te Puna Oranga (facilitator endorsed by Nga Toka Hauora, MMAG, the Ministry of Health (MoH) and Waikato DHB Planning and Funding) to lead the development and implementation of a kaupapa Maori pregnancy and parenting programme curriculum and toolkit for the Midland region. The intent of the curriculum and toolkit is to grow the number and breadth of culturally-appropriate pregnancy and parenting programmes in the Midland region that can be used in both rural and urban settings.</li> </ul>					

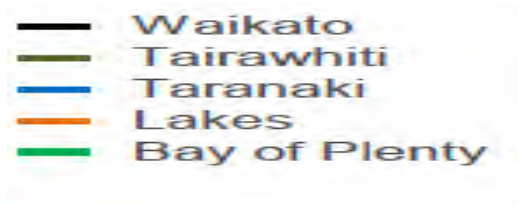
	<ul style="list-style-type: none"><li><b>MMAG advisory role with Midland Planning &amp; Funding</b> - MoH pregnancy and parenting service specification recently released. The information component of the specification provides an opportunity to reduce duplication and explore a value-for-money single Midland-wide information service. This will support savings through a single RFP process and offer consumers national and local resources, a single contact phone line, with local content managed by a single provider.</li></ul>				
Inputs & Resources	MMAG				
Responsibilities	MMAG/ MQSP sub-group / Midland GMS Māori Health				
Enablers	PFALT				
Initiative 5	Improve LMC registration so that access to care is increased – increase the number of women registering with an LMC in their first trimester: <ul style="list-style-type: none"><li>each local MQSP governance board to consider how to improve LMC access and share initiatives/learning/strategies across the Midland region.</li></ul>				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources
Milestone	ongoing				
Measurable	<ul style="list-style-type: none"><li>improved LMC registration across the Midland region</li><li>improved access to LMC maternity care across all ethnic groups</li></ul>				
2014/15 Progress Report	<b>Listening to consumers to inform initiatives that improve LMC registration so that access to care is increased, and sharing our ideas and resources as a region:</b> <ul style="list-style-type: none"><li>a recent study of Midland’s rural maternity consumers, and a consumer survey on breastfeeding provides us with consumers’ viewpoint on the maternity care they have received.</li></ul> <b>Key reflections from Midland maternity consumers are:</b> <ul style="list-style-type: none"><li><b>finding a Lead Maternity Carer (LMC)</b> - <i>“we are restricted here, well rurally anyway, because you don’t really have a lot of choice”, and “I found my LMC at five months...I live out of town....have no transport I made her come to visit me”, and “we just found a card at the video shop”</i></li><li><b>LMC backup</b> - <i>“If I went into labour on her [LMC] non-working days I would get whoever was on call – I didn’t know that would happen...it made me worried in case I got someone else, ...”</i></li><li><b>information</b> - <i>“the information was there but I don’t learn like that, I need someone to tell me stuff, if I have to read it all I don’t bother too much”, and “she was really hands on but I kind of found that a lot better than saying here is a piece of paper, read it through”</i></li><li><b>breastfeeding support</b> - <i>“... would be great to have short simple tips of how to actually breastfeed, baby position, latch on, how to know if they have had enough, are they sucking....”</i></li><li>working together as a region to share learnings, strategies and resources that encourage women to register with their LMC early, eg BOPDHB’s ‘As Soon As Pregnant’ campaign, Taranaki’s ‘5 things to do within the first 10 weeks’ campaign</li></ul>				
Inputs & Resources	MMAG				
Responsibilities	MMAG/ MQSP sub-group				
Enablers	Midland Regional IS				
DHB Contribution	Midland DHB MQSP Governance Boards				
Initiative 6	Strengthen consistency of practices through shared educational activities and shared resources – maximise collaboration between Midland regional maternity educators, lactation consultants, BFHI coordinators, safe sleep champions: <ul style="list-style-type: none"><li>investigation into the use of Moodle as an electronic platform for e-learning modules to share education across the region<ul style="list-style-type: none"><li>regional education plan is developed, with activities and associated expenditure prioritised</li><li>regional education calendar available on regional website for all maternity service providers, including LMCs and medical practitioners</li><li>regional education arranged through MMAG, ie, offer of a workshop/s in each Midland DHB with a particular focus on perinatal and infant loss and perinatal and maternal mental health</li></ul></li></ul>				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources
Milestone	ongoing				
Measurable	<ul style="list-style-type: none"><li>consistent and supported maternity education delivered across region</li><li>increase in focus on the multi-disciplinary team’s knowledge around perinatal and infant loss and maternal mental health</li></ul>				

2014/15 Progress Report	<b>What are the problems to be resolved?</b> A coordinated pathway and accessible information is required to support a seamless referral process between Midland's community practitioners and secondary services to enable the right referral, to the right agency, at the right time, is accessible to women requiring maternal mental health services.				
	<b>Supporting consumers and health care providers of maternity services, with a focus on perinatal mental health and the bariatric pregnant woman, so we can better meet community needs:</b> <ul style="list-style-type: none"> <li>• <b>Midland regional perinatal mental health study days (2014)</b> – training to improve services for consumers</li> <li>• <b>initiating drafting of regional Map of Medicine pathway 'Perinatal Mental Health (Primary)'</b> – supporting the linking between primary, secondary and tertiary services with consumers</li> <li>• <b>pre and post pregnancy directories, including referral forms and contact details</b> – directory template being completed through each of the Midland MQSP coordinators (based on Taranaki's work), with contact and referral information</li> <li>• <b>linking of local pre and post pregnancy directories with Map of Medicine 'perinatal mental health (primary)' pathway</b> - supporting health care providers to appropriately refer consumers to support services and improve access for consumers</li> <li>• <b>Vicki Culling workshops (perinatal and infant loss: an introduction; holding on and letting go: facing an unexpected diagnosis in pregnancy; post-mortem and subsequent pregnancy)</b> –supported by MMAG and offered to all Midland DHBs</li> <li>• <b>Midland breastfeeding and healthy attachment study day (1 May 2015)</b> – topics included bonding, attachment, proximity and separation</li> <li>• <b>sharing of resources</b> – eg Lakes DHB's sharing of 'Falling in Love With You, Baby' project with Midland DHBs</li> <li>• <b>'Midland management of the bariatric pregnant woman' (draft) protocol</b> (based on Taranaki DHB's protocol) – in the process of feedback and review of suggested amendments to regionalise; regional e-learning package (based on Taranaki DHB's package) to be available once protocol is finalised</li> </ul>				
Inputs & Resources	MMAG / Midland Regional Training Network (MRTN) / Midland Regional IS				
Responsibilities	MMAG/ ME&ML sub-group / Breastfeeding/BFHI sub-group				
Enablers	Midland Regional IS				
Initiative 7	Inclusion of consumers in the Maternity Quality & Safety Programme (MQSP) governance boards at each Midland DHB to enable consumer informed decision-making: <ul style="list-style-type: none"> <li>- consumer voice (via survey, individuals, focus group, complaints and compliments) is collected and informs the future direction of service delivery for the Midland region</li> <li>- local MQSP consumer representatives have a Midland virtual forum space to share ideas and connect with each other to strengthen consumer input into maternity services</li> </ul>				
Initiative aligns with MoH Regional Objectives:	1: Improve Māori health outcomes		2: Integration across continuum of care		3: Improve quality across all regional services
	4: To build the workforce		5: Improve clinical information systems		6: Efficient allocation of public health system resources
Milestone	ongoing				
Measurable	<ul style="list-style-type: none"> <li>• all Midland DHBs have a consumer representative on their local MQSP governance boards, and their maternity service improvement initiatives are underpinned and shaped by consumer input</li> <li>• development of a virtual forum space for regional consumers commenced</li> </ul>				
2014/15 Progress Report	<b>Listening and supporting consumers to participate in the ongoing quality and safety work of maternity services in Midland so we have consumer informed decision-making:</b> <ul style="list-style-type: none"> <li>• consumer members included at each MQSP governance board (Waikato initially had a consumer on the governance board and is in the process of appointing a new consumer)</li> <li>• MMAG financial and travel support provided for Midland MQSP consumer members to attend the MoH consumer forums held in August 2014 and May 2015</li> <li>• Midland MQSP Consumer Member Sub-Group formed to provide a support structure for consumers in the region to meet via teleconference as needed</li> <li>• consumer members involved in supporting the circulation of the Midland Breastfeeding Consumer Survey throughout the region and to provide feedback on draft content for the Midland breastfeeding mobile phone application</li> <li>• invitations extended to the hosting DHB's MQSP consumer members to attend regional MMAG meetings</li> </ul>				
Inputs & Resources	MMAG				
Responsibilities	MMAG/ MQSP sub-group				
Enablers	Midland Regional IS				
DHB Contribution	Midland DHB MQSP Governance Boards				

## Performance against Clinical Indicators

Taranaki DHB have analysed the clinical indicators provided by the MoH and data obtained by local and regional data analysts. Areas for improvement in practices and outcomes, as well as areas that we excel in, are identified.

### Clinical Indicators

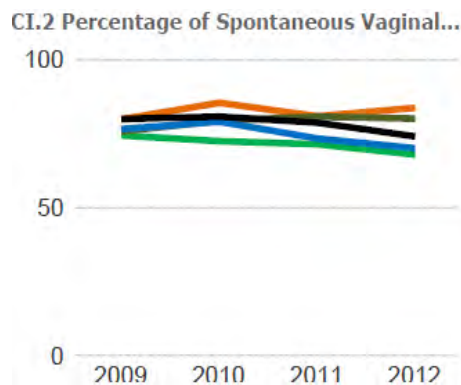


#### Indicator 1: Registration with an LMC in the First Trimester of Pregnancy

**STRENGTH:** Taranaki has a small increase in rates over the last four years please see page 36 - 98% of women are registered under an LMC.

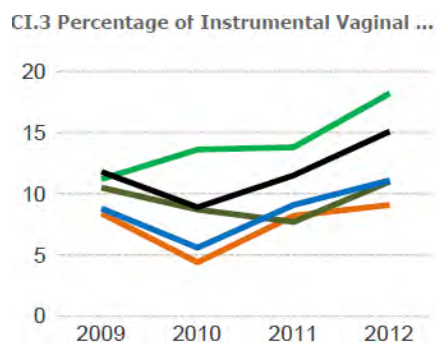
#### Indicator 2: Spontaneous Vaginal Birth

**Decreasing INVESTIGATE:** Taranaki's rate is declining and has a rate of 70.2% in 2012, 73.5% in 2011, 79.1% in 2010, and 76.6% in 2009; although it is still above the national average of 68.6% it is currently being investigated and linked to the rising Caesarean Section (C/S) and instrumental rates. (See C/S audit page 43).



#### Indicator 3: Instrumental Vaginal Birth

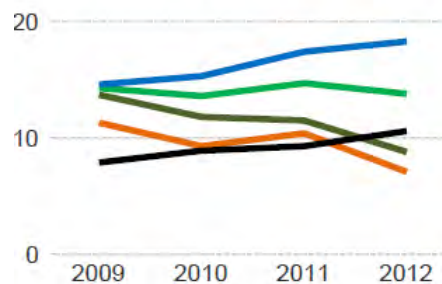
**INCREASING:** Taranaki has a rate of 11.1% in 2012, 9.1% in 2011, 5.6% in 2010, and 8.8% in 2009; but below the national average of 15.3%.



#### Indicator 4: Caesarean Section among Primiparae

**INCREASING INVESTIGATE:** Taranaki has an increasing rate of 18.3% in 2012, 17.4% in 2011, 15.3% in 2010 up from 14.6% in 2009 and above the national average of 15.8%. Benchmarked against the other Midland DHBs, Taranaki has the highest rate and this is an area for investigation. An audit on C/S has been completed, see page 43. Actions to improve rates are to be agreed upon and further exploration to inform practice. It would be useful to know the C/S rates for private obstetricians locally and around other areas of New Zealand to be able to compare/benchmark local data.

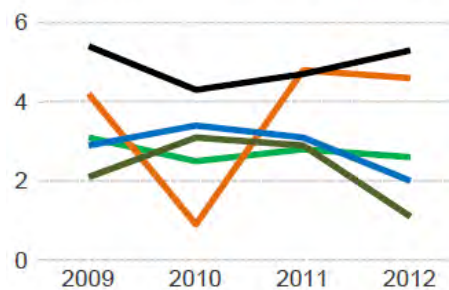
CI.4 Percentage of Caesarean Sections



#### Indicator 5: Induction of Labour among Primiparae

**STRENGTH:** Taranaki has rates of 2% in 2012, 3.1% in 2011, 3.4% in 2010, and 2.9% in 2009 and under the national average of 4.2%.

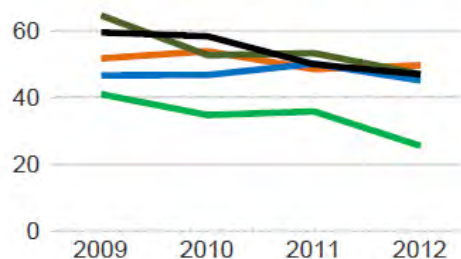
CI.5 Percentage of Labour Inductions



#### Indicator 6: Intact Lower Genital Tract - Vaginal Birth

**STRENGTH:** Taranaki has consistent rates of 45.1% in 2012, 50.2% in 2011, 46.7% and 46.6% in 2009, 2010 against the average 28%.

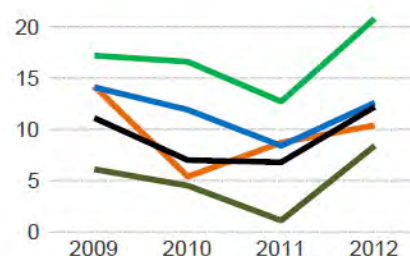
CI.6 Percentage of Vaginal birth with int...



#### Indicator 7: Episiotomy and No 3<sup>rd</sup> or 4<sup>th</sup> Degree Tear

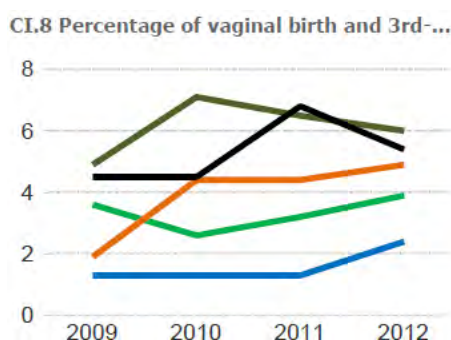
**STRENGTH:** Taranaki has rates of 12.6% in 2012, 8.4% in 2011 which is well below the national average of 20.6%.

CI.7 Percentage Episiotomy without 3r...



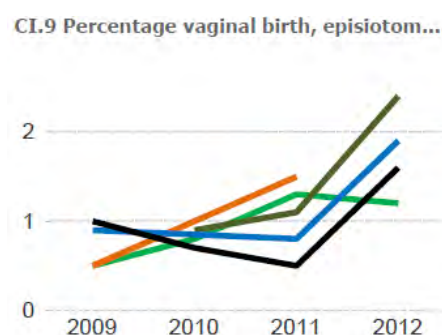
#### Indicator 8: 3<sup>rd</sup> or 4<sup>th</sup> Degree Tear Sustained with No Episiotomy

**STRENGTH:** Taranaki has a rate of 2.4% in 2012, 1.3% in 2011, national average is 3.7%.



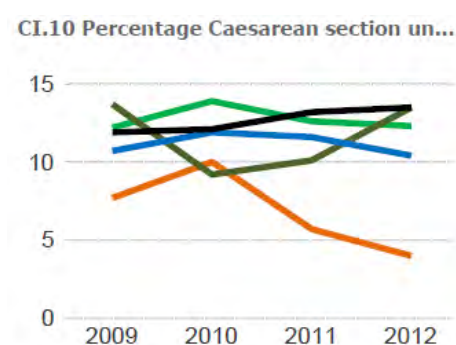
#### Indicator 9: Episiotomy and 3<sup>rd</sup> or 4<sup>th</sup> Degree Tear Sustained

**INCREASING:** Taranaki has a rate of 1.9% in 2012, 0.6% in 2011, 0% in 2010, and 0.9% in 2009; above the national average of 1.6%. Numbers are very small to have confidence in these figures but will be highlighted to the practitioners.



#### Indicator 10: General Anaesthesia for all Caesarean Sections

**DECLINED:** Taranaki has a declined rate of 10.4% in 2012, 11.6% in 2011, 11.9% in 2010 and 10.7% in 2009 which is above the national average of 8.6%. The general operating theatres which are used for C/S' are a considerable distance from the maternity unit and until a location is found to house the maternity unit nearer to the operating theatres, this rate is unlikely to change significantly. However audits have been undertaken by the anaesthetic team and a portable CTG monitor and delivery beds with battery backup have been introduced as a quality improvement to try and reduce these rates.

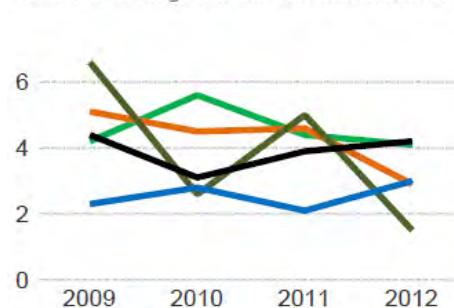




Indicator 11: Postpartum Haemorrhage (PPH) Blood Transfusion after Caesarean Section Birth

*INCREASING:* Taranaki has rates of 3% in 2012, 2.1% in 2011, 2.8% in 2010, and 2.3% in 2009, just below the national average of 3.2%. Numbers are low to be able to have confidence in these rates however PPH has been audited in 2014/15. Please see results and actions in Appendix 1.

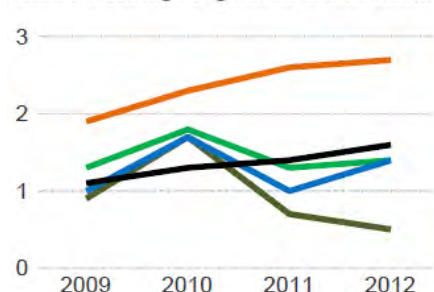
CI.11 Percentage Caesarean and blood t...



Indicator 12: PPH and Blood Transfusion after Vaginal Birth

*STRENGTH:* Taranaki has a rate of 1.4% in 2012, 1% in 2011, 1.7% in 2010, up from 1% in 2009, below the 1.6% national average.

CI.12 Percentage vaginal birth and bloo...



Indicator 13: Diagnosis of Eclampsia at Birth Admission

*STRENGTH:* Taranaki had no cases reported in 2012.

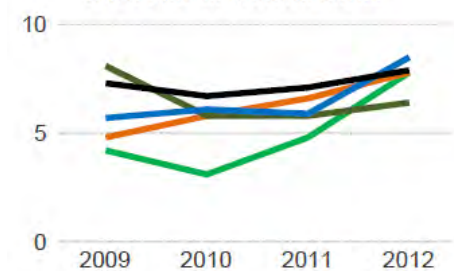
Indicator 14: Maternal Tobacco use During Postnatal Period

*WEAKNESS:* Taranaki has a rate of 19.1% of women identified as smokers during the postnatal period, two weeks after the birth, above the national average of 13.9%. This needs to be further broken down into domicile, ethnicity and age to see if there are local areas of the population that can be targeted (see the smoking among pregnant women section).

Indicator 15: Premature Births (Delivery from 32-36 Weeks)

*INCREASING:* Taranaki has an increased rate of 8.5% compared to 5.9% in 2011, 6.1% in 2010 up from 5.7% in 2009; the national average has risen to 7.6%. An audit has been undertaken in 2014/15 please see page 39.

CI.15 Rate of Preterm births



## New Clinical Indicators

The latest MoH data is forecasted to be available in July 2015 so has not been available for reporting on in this report. Local work has already commenced however on examining local High Dependency Unit and Intensive Care Unit admissions (see data section – Appendix 2, page 91), term babies transferred to the Neonatal Unit (NNU) – see NNU admissions section page 43 – and VBAC (see section on C/S – page 42). All small for gestational age (SGA) and cases of eclampsia are reviewed at the weekly case review session.

## **Snapshot of Taranaki DHB Maternity Services 2014/15**

The recommendations of the National Monitoring Group have been taken forward by Taranaki DHB MQSP.

### Timing of Registration with an LMC

In 2014, posters and 4000 rack cards were distributed around Taranaki GP practices, schools, youth services, pharmacies, clinics and appropriate places to target the pregnant female population to promote early engagement with an LMC. Additionally the MQSP Coordinator/ADOM, Antenatal Clinic Coordinator

(ANC) and CD of Obstetrics has met with practice nurses and GPs to provide an update on early pregnancy care including assessment and screening as well as how to assist the pregnant woman in finding an LMC.

This presentation was well received and will be repeated in the South Taranaki district, and it is planned to continue on an annual basis.

Early engagement with an LMC data is displayed in the MQC newsletter which is circulated to maternity practitioners and stakeholders including GPs to inform them of the progress we are making.

Taranaki Maternity Quality & Safety Facebook page also targets women with information to encourage early engagement with an LMC.

The data tables show that Taranaki DHB is continuing to improve the rate of early engagement with an LMC and has the highest rate in the Midland region. Additionally there is a steady increase in first trimester registration of pregnant Maori women however there is still work to

be done to encourage early engagement of pregnant Maori and Pacific women.



**Pregnant...**

**5 things to do within the first 10 weeks**

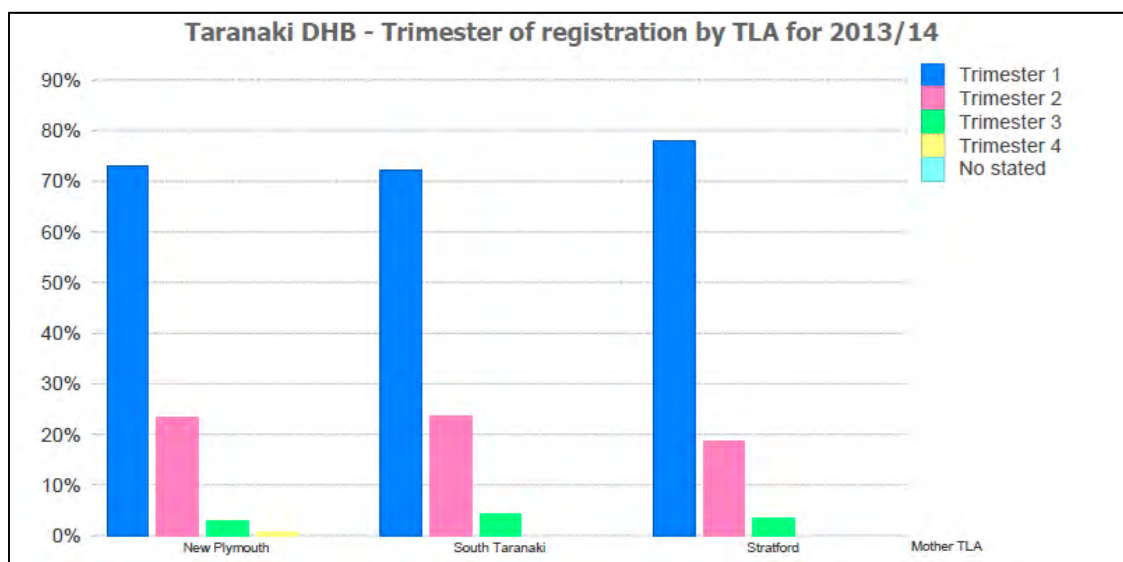
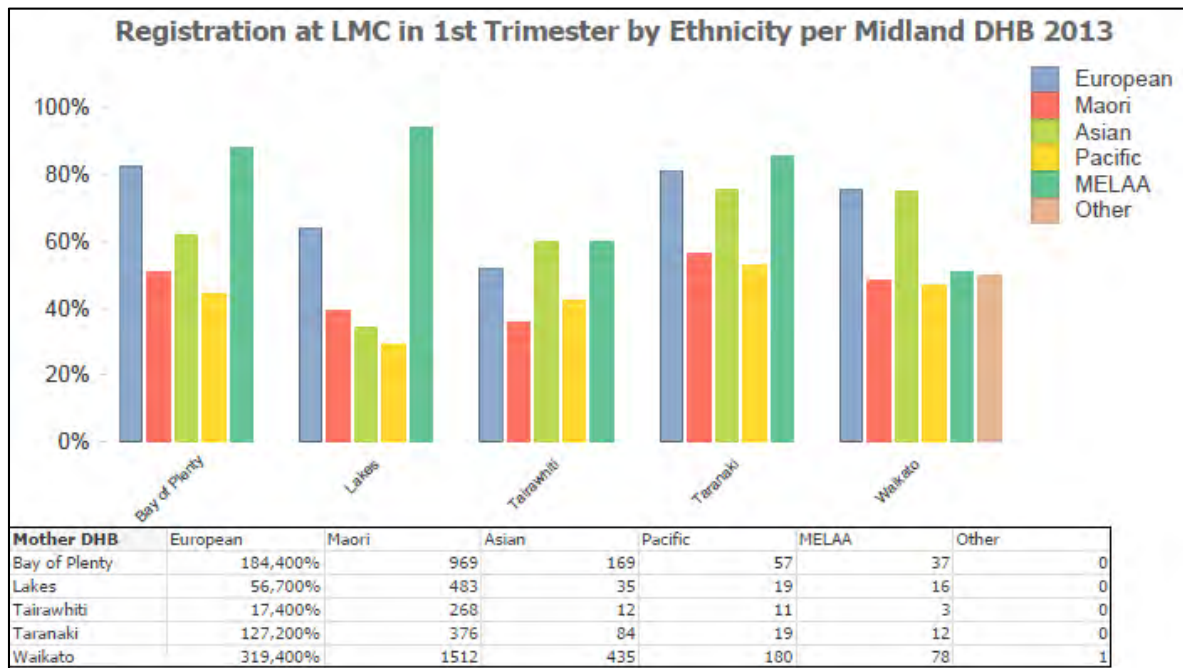
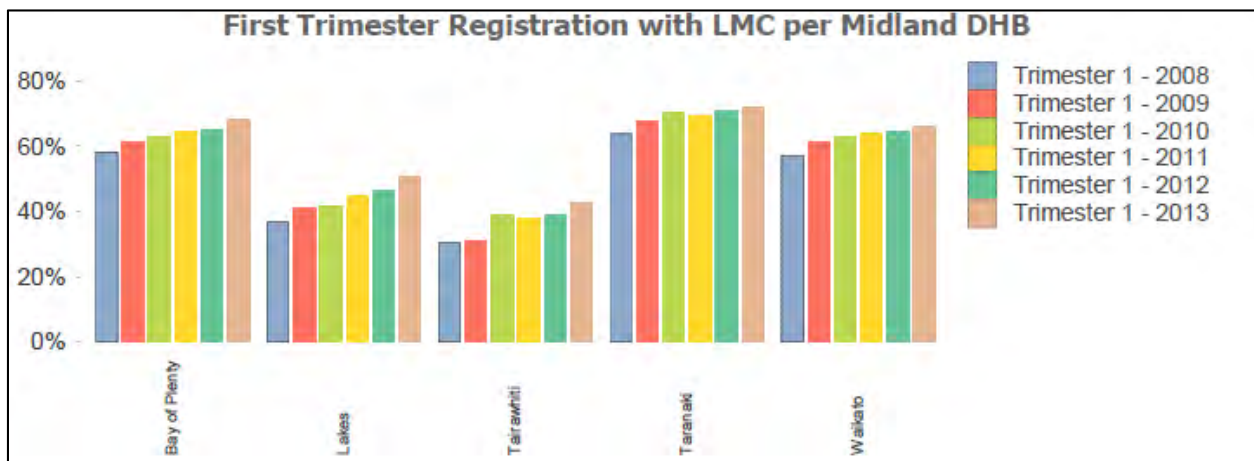
The top "5 in 10" list doesn't change no matter how many times you have given birth, your age, ethnicity, or where you live.

- 1. Find a Lead Maternity Carer**
- 2. Consider early pregnancy screening**
- 3. Take iodine and continue folic acid**
- 4. Eat well and exercise**
- 5. Avoid smoking, drinking and other drugs**

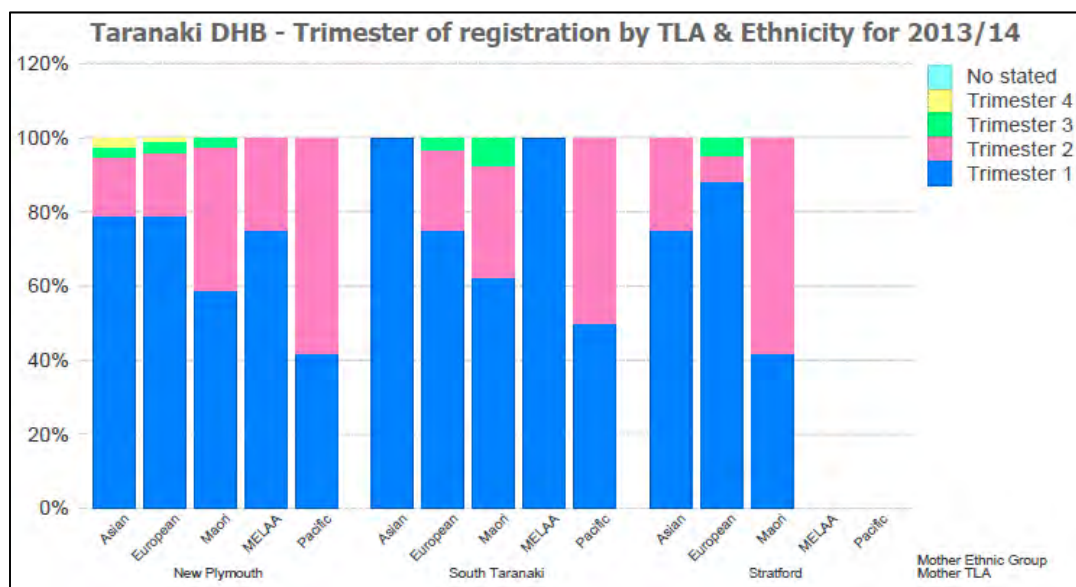
**www.findyourmidwife.co.nz**  
**0800 MUM2BE (0800 686 223)**

Find an LMC here by scanning this QR code or go to [www.tdhb.org.nz](http://www.tdhb.org.nz) and search LMC

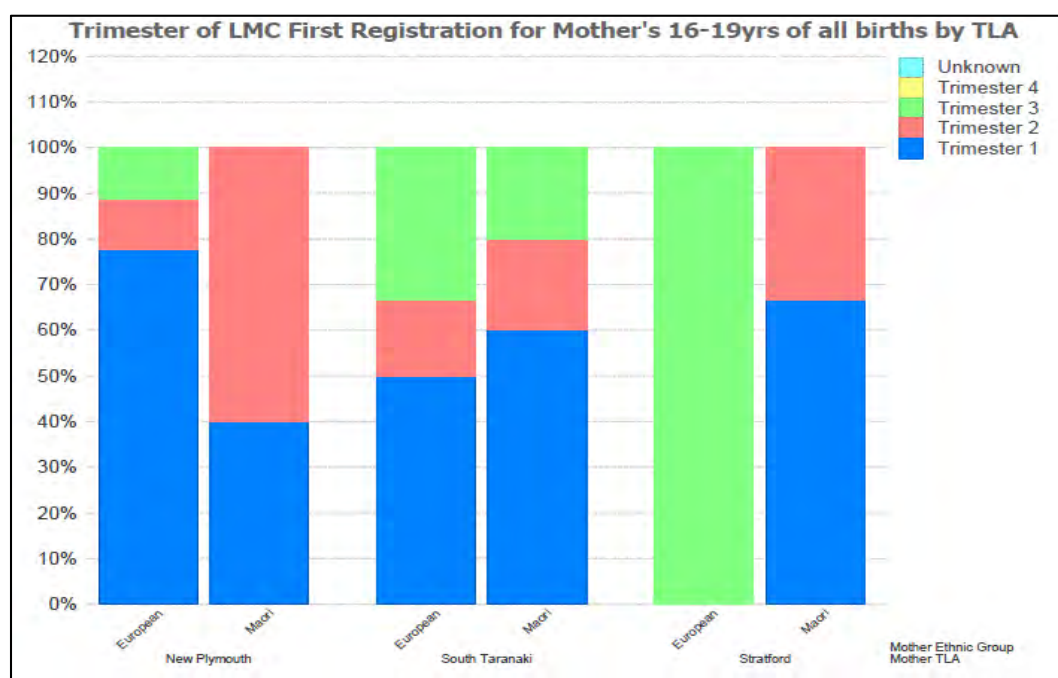
 



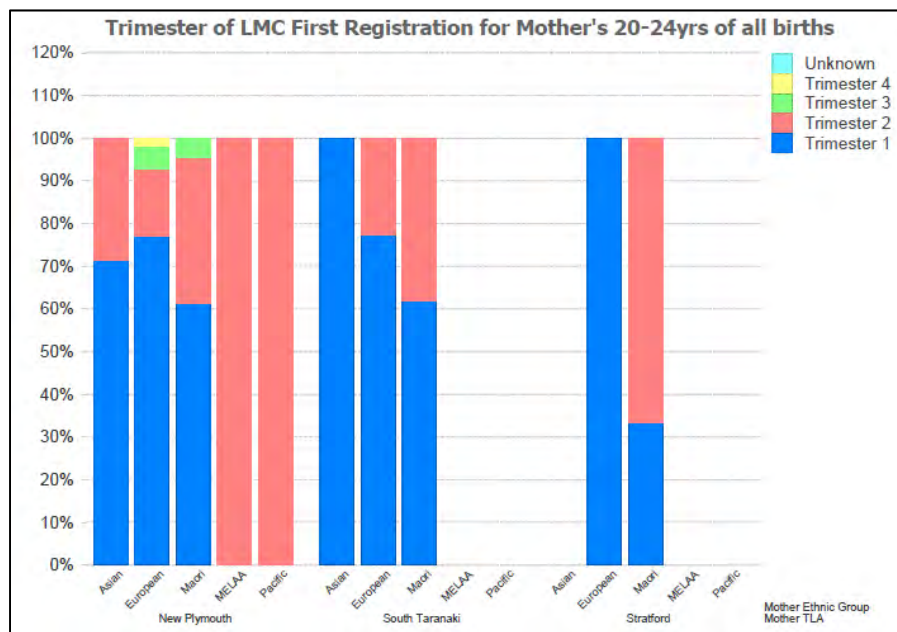
The Stratford area has the highest number of early engagement with an LMC however South Taranaki have increased the most significantly, from 61% in 2011. Stratford has the lowest number of Maori and New Plymouth has the lowest number of Pacific women engaging early with an LMC (however these numbers are small and difficult to generalise on) and could be targeted to improve these rates further.



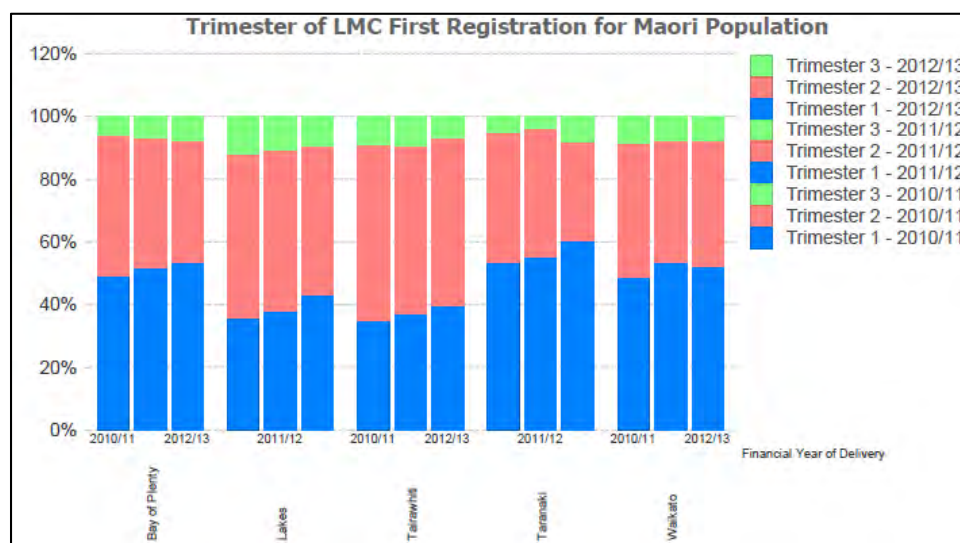
New Plymouth 16-19yr Maori women have the lowest rate of early engagement with an LMC however the numbers are small and therefore difficult to generalise on. No European teenage pregnancies engaged in the first trimester in the Stratford area which is also difficult to generalise on due to small numbers but could be an area for further marketing. The 16-19year old pregnancy rate has dropped significantly, probably due to improvements with accessing long term contraception methods.







Maori and Pacific ethnicities have lower numbers of early engagement than the European and Asian ethnicities. Taranaki however has the highest rate of early engagement of Maori women with an LMC in the Midland region. Further targeting and campaigning to book early with an LMC should be encouraged within these communities and will require further investigation with Maori consumers, Iwi and health providers to explore how this can be done.



## **Variation in Gestation at Birth and Caesarean Section**

Taranaki DHB NNU collects data on all admissions to the unit this includes preterm births. The NNU Clinical Nurse Manager (CNM) reports regularly to the Taranaki DHB MQSP for auditing purposes. Additionally Taranaki DHB has undertaken a retrospective audit to monitor the consistency in the rate of preterm birth and evaluate the management of delivery timing in relation to preterm births. What is concerning is this audit shows a further increase from the 2012 clinical indicators of 8.5% to 9.6%. It is noted this is also a national trend.

The percentage of late preterm births has declined by 3% (although they make up the larger percentage of overall preterm births) while the moderate preterm births (32-33+6 gestation) have increased by 10%. While the audit did not show any obvious reasons for Taranaki DHB's above average rate of preterm births when compared to other similar sized DHBs it does inform us of areas to target with education:

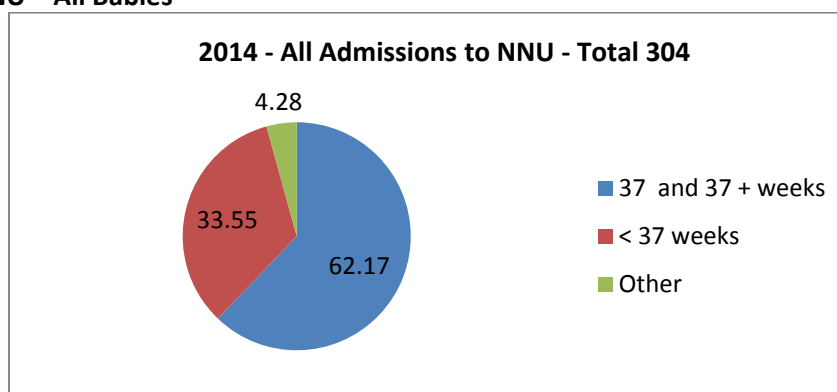
- Assessment and investigations can be improved
- Conservative management of PPROM
- Documentation

- Implementation of tocolysis
- Fetal fibronectin testing and multiple pregnancy

Since this audit was completed, Amnisure testing has been introduced for cases of prolonged premature rupture of membranes (PPROM)/premature rupture of membranes (PROM) where there is doubt that the amniotic membranes have ruptured. This test has already prevented induction of labour in some late preterm cases. It is hoped this will have a future impact on Taranaki DHB's variation in gestation of birth rates. Ongoing monitoring of preterm births will continue in Taranaki DHB.

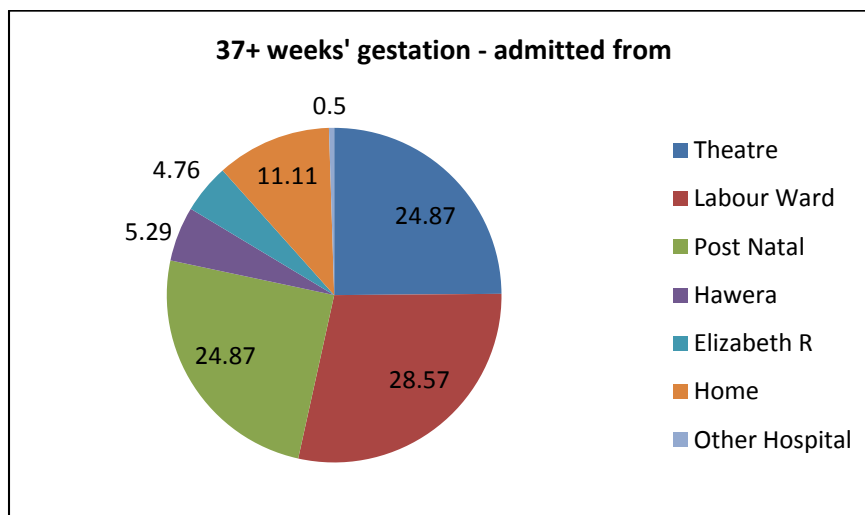
### **Variation in Gestation in Relation to NNU Admission, Taranaki DHB**

#### **Admissions to NNU – All Babies**



There was a significant increase in the total number of admissions of babies to the NNU in 2014 (304) compared to 2013 (245).

There were 189 (62.17%) babies, gestation > 37 weeks, admitted to the NNU. Of these, 54 (17.76%) stayed for less than 24 hours. The average length of stay for the remaining 135 babies, gestation > 37 weeks, is four days.

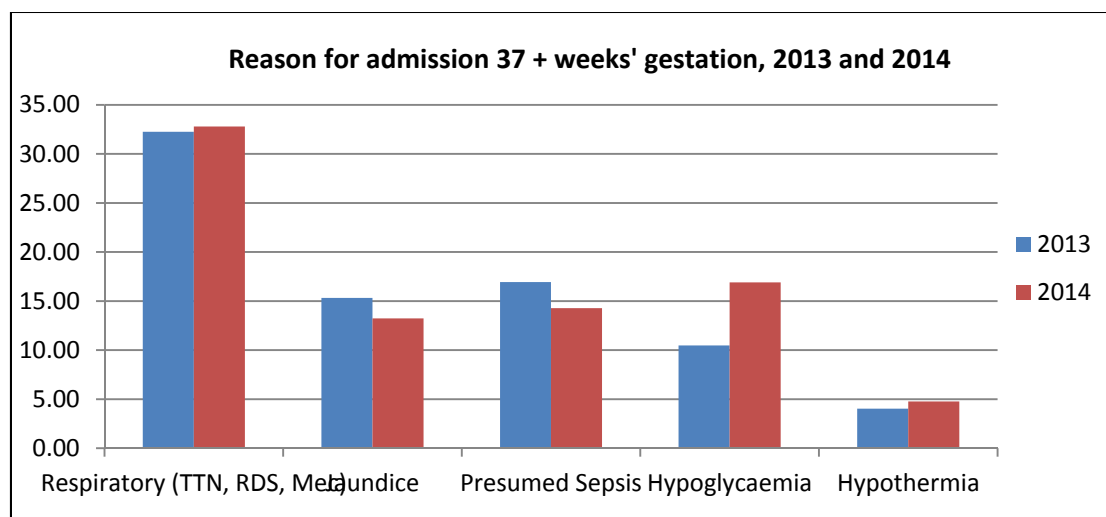
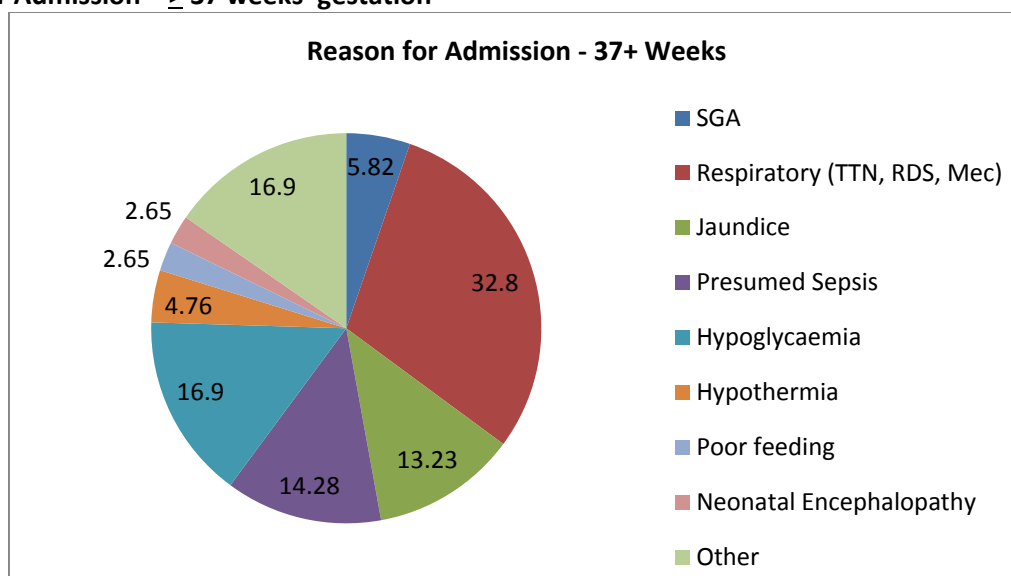


Exploration of how and where babies are observed as they transition to extra-uterine life, whilst maintaining baby with mum, continues to be discussed and work plans updated. The co-location of NNU with Maternity (as is proposed in the future) remains an important factor.

Post Anaesthesia Care Unit (PACU) staff have requested education on assessment and care of the baby, including skin to skin and initiation of breastfeeding, to enable them to safely keep mother and baby together post caesarean delivery. This education is planned for 2015/16. Additionally it is still the intention to review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres to enable a core midwife/nurse to attend all C/S to provide early newborn and delivery care. This project will commence once the safe staffing review/variance in staffing needs has been addressed.



## Reason for Admission – $\geq 37$ weeks' gestation



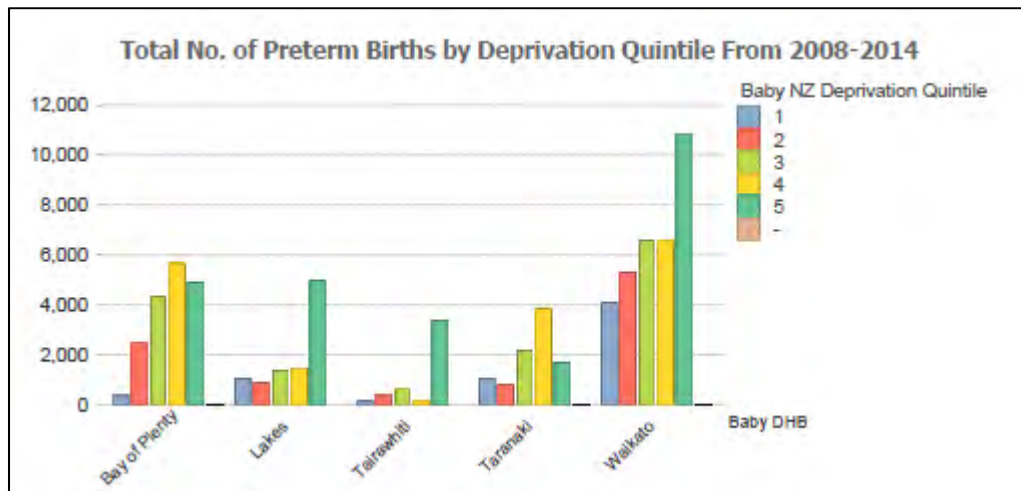
Thirty (30) of the 54 babies who were admitted for < 24 hours, 16 from theatre and 12 from the Labour Ward, were admitted for a period of observation because of respiratory symptoms – Transient Tachypnoea of the Newborn (TTN), meconium exposure, delayed onset breathing, post maternal GA, cyanotic episodes, other respiratory distress.

Admissions for treatment of jaundice is slightly lower than 2013. The education of staff with the introduction of the 'Care of the Jaundiced Baby' protocol may have resulted in earlier assessment and initiation of treatment and for two of the admissions that came through NNU for assessment, the treatment was completed in the postnatal ward.

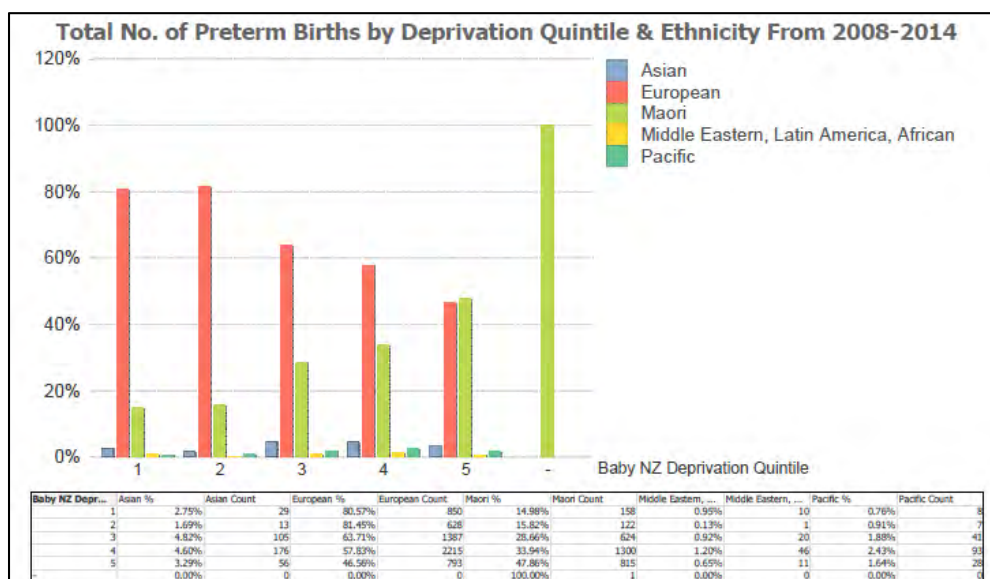
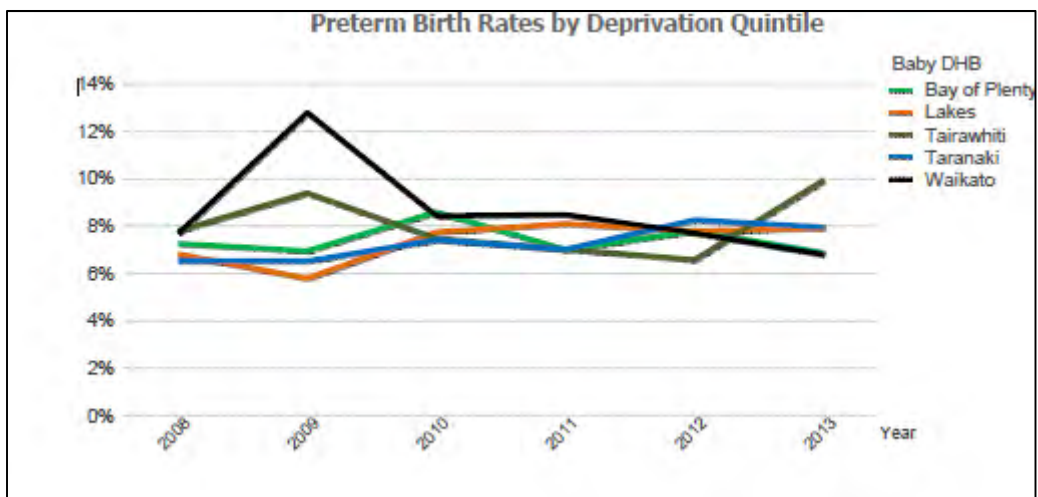
Admission for treatment of hypoglycaemia may be due to increasing numbers of mothers with gestational diabetes. Education and training of staff in both the NNU and the maternity unit however, together with closer liaison in the care of the at-risk newborn, may reduce the number of admissions. Education is also being planned for the PACU staff which will include monitoring of blood glucose and early breastfeeding.

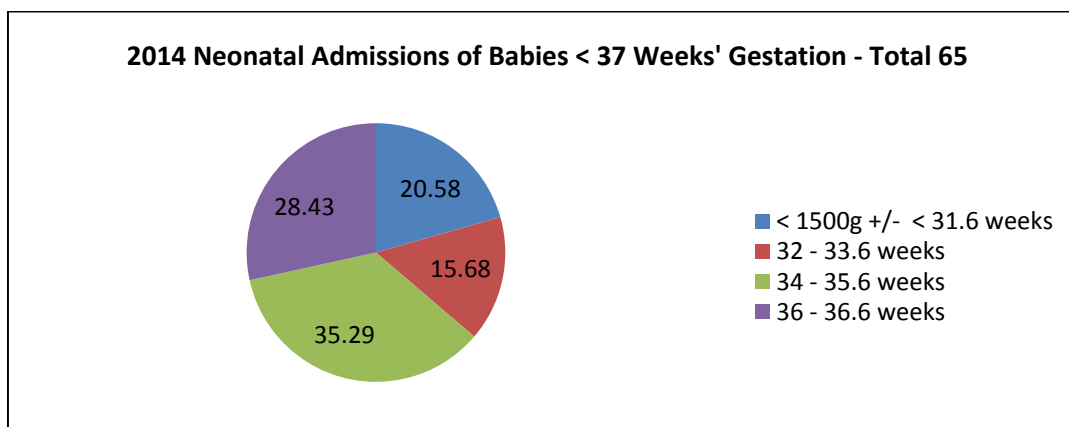
'Other' category included babies admitted for abdominal distension, abdominal wall anomaly, congenital heart disease and boarder baby whilst mother in ICU.

## Admissions to NNU – Babies < 37 weeks



Interestingly Taranaki's lower deprivation quintiles have higher rates than the higher deprivation quintile, unlike other DHB's.





35.29% of preterm infants admitted to NNU were 36–36.6 weeks' gestation. Some, but not all, were admitted following delivery and were transferred after a few days for continuing care in the Postnatal Ward. Care of the late preterm infant is the current focus of education for neonatal and maternity staff. In 2015/16, we will be monitoring the total number of babies of 36–36.6 weeks' gestation that are born in Taranaki and the percentage of those that need admission to NNU. Closer liaison between midwifery and nursing staff in postnatal and neonatal will aim to allow mothers and babies with 'special' needs to remain together.

### **Caesarean Section**

The ANC and secondary Obstetricians have noticed an increase in requests from pregnant women for elective C/S and a decrease in uptake of VBAC.

Period	VBAC rate
Jul-Dec 2010	20.80%
Jan-Jun 2011	16%
Jul-Dec 2011	25.60%
Jan-Jun 2012	18.60%
Jul-Dec 2012	18.90%
Jan-Jun 2013	27.20%
Jul-Dec 2013	19.60%
Jan - Jun 2014	16.80%

There has also been a noticeable increase in women requesting C/S for other reasons other than repeat C/S such as previous haematoma, haemorrhoids, post traumatic stress disorder, increasing maternal age, IVF pregnancy, multiple births. This has been identified in a recent audit which was conducted on the Primiparae C/S rate.

Despite tight counselling of women and promotion of vaginal birth this does not prevent women seeking a private obstetrician and paying for an elective C/S. Education of pregnant women, their families and the public is a priority by LMCs, childbirth educators and secondary services to control/curb this escalation both locally and nationally.

The antenatal clinic and secondary services has seen an increase in complexity of women entering the services such as women with medical disorders (which in the past may never have been fit or well enough to become pregnant), obesity, gestational diabetes, older women (over 40 years of age) and multiple pregnancy, and could be a compounding factor to the escalating C/S rate however Taranaki DHB is committed to exploring how this rate can be curbed

National and international guidelines have influenced obstetric decision making for earlier gestation delivery for gestational diabetics on insulin and multiple births which is likely to have impacted on both the induction of labour and elective caesarean rates. Additionally there is emerging evidence of the benefits of

C/S at 38 weeks in women who have had three previous C/S' which will also affect the variation in gestation at birth in the future. Taranaki DHB does have a policy that elective C/S' are not performed prior to 39 weeks' gestation unless it is medically indicated, in which case antenatal steroids are recommended to reduce the risk of neonatal admission due to respiratory complications.

Delivery	2010	2010 Rate	2011	2011 Rate	2012	2012 Rate	2013	2013 Rate	2014 (excl Dec)	2014 (excl Dec) Rate
Elective Caesarean	173	12%	159	11%	197	14%	178	13%	174	14%
Emergency Caesarean	179	13%	162	12%	184	13%	161	12%	152	12%
Total Caesareans	352	25%	321	23%	381	28%	339	25%	326	26%
<b>Total Deliveries</b>	<b>1393</b>		<b>1390</b>		<b>1379</b>		<b>1362</b>		<b>1239</b>	

Data indicates that Taranaki DHB C/S rates are above the national average and are the highest in the Midland region and warrants investigation. As a result of a recent audit conducted on the Primiparae undergoing C/S, 2015/16 will see further exploration on the following on:

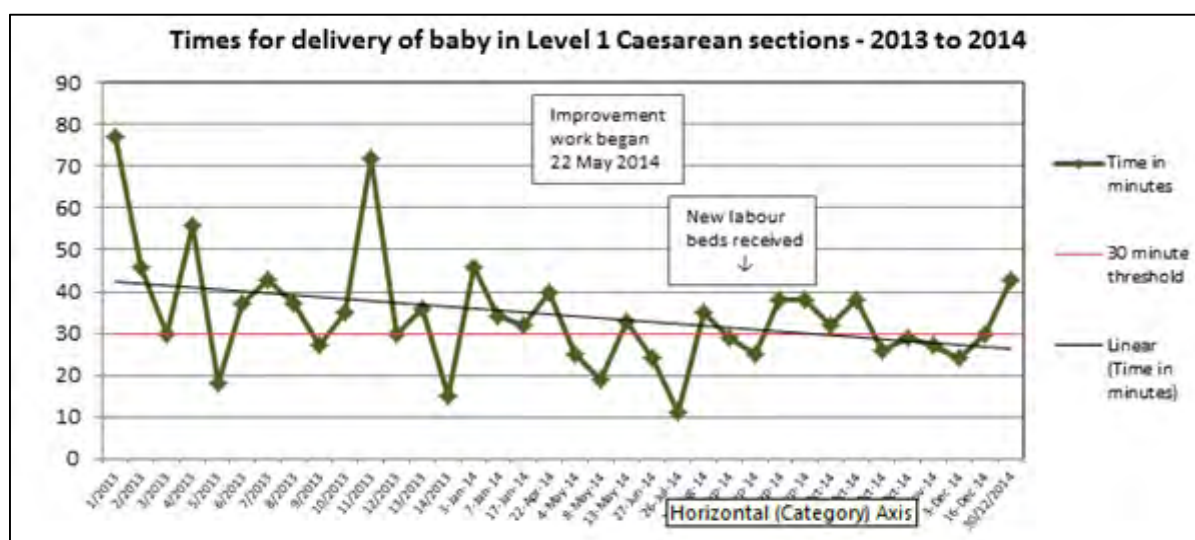
- C/s for maternal request after the audit showed 25% of Primiparae C/S represented this category.
- C/s for failure to progress where 39.7% represented this category.
- Abnormal CTG where 29.3% were for this category. Although these cases did not undergo thorough critical evaluation the audit suggests in some cases the CTG did not warrant a C/S at the time of decision, however this in itself does not indicate the C/S could have been prevented at a later stage of labour.

Additionally audit should include examining individual obstetric practitioner's decision making for elective C/S and the gestation at which the C/S was performed. Since late 2012, any elective C/S prior to 39 weeks' gestation warrants an explanation and is discussed in the morning ward round.

Similarly all inductions of labour are discussed at the morning ward round/team meeting for relevance of indication and gestation; this was instigated in early 2012/2013 and may have reflected the improvement in the data for 2013 (below national average). An audit will also be facilitated on all induction of labours as we introduce a new system for referral and commencement of induction of labours and will be reported on in 2015/16.

### Level 1 Caesarean Section

There have been improvements in the timing from decision to delivery of the baby for Level 1 C/S. This is as a result of a multidisciplinary failure, mode effect analysis (FMEA) and improvement work carried out, which commenced in May 2014. New electronic delivery beds with battery backup were purchased as a result of the FMEA to allow immediate transfer to the operating theatre rather than having to move the patient to another transportable bed. This was identified as one of the leading causes of delay.



These rates will continue to be monitored and explored to further improve timing rates. The investigation of relocating the delivery suite nearer to the operating theatre would likely improve these timings as well as improving the General Anaesthesia (GA) C/S rates.

### **General Anaesthetic Caesarean Section**

A letter to the NMMG in February 2015 acknowledged there was a discrepancy in the number of cases reported via Taranaki DHB coding to the MoH in comparison to the local audit. Taranaki DHB is committed to accurate and meaningful data and sees interaction between clinicians and clinical coders as an integral part of this commitment. To this end it was our intention to increase joint clinical and coding reviews and information exchange sessions subject to increasing staffing levels to facilitate this, and recently a team leader of coding has been appointed.

The audit summary is as follows:

- All notes for C/S coded as a GA C/S were pulled.
- Our GA C/S rate was 10.9% (corrected this was actually 10.1%).
- The Royal College of Anaesthetist guidelines recommend <15% emergency C/S' are performed under GA; < 5% electives carried out under GA. No Australian/New Zealand anaesthetic guidelines exist to our knowledge.
- Out of 42 GA C/S' only 39 were in fact GA, this gives an actual rate of 10.1%. The obstetric registrar informed coding and medical records of this error.
- Our elective GA rate was found to be 4.6% (New Zealand average is 4.7%).
- Our emergency GA rate was 15% (New Zealand average is 11.9%). All cases performed under GA seemed broadly appropriate.

Reason for higher emergency GA rate:

- No consultant Obstetrician or Anaesthetist are onsite at night.
- No theatre in maternity.
- No theatre staff onsite after hours.

By the time staff arrive onsite at night often a GA C/S is a better option than a crash spinal which runs the risk of not working and needing a GA conversion. (The theatre ward manager audited her staff call-out response time in relation to time called to time onsite, and was found to be within the expected call-out time).

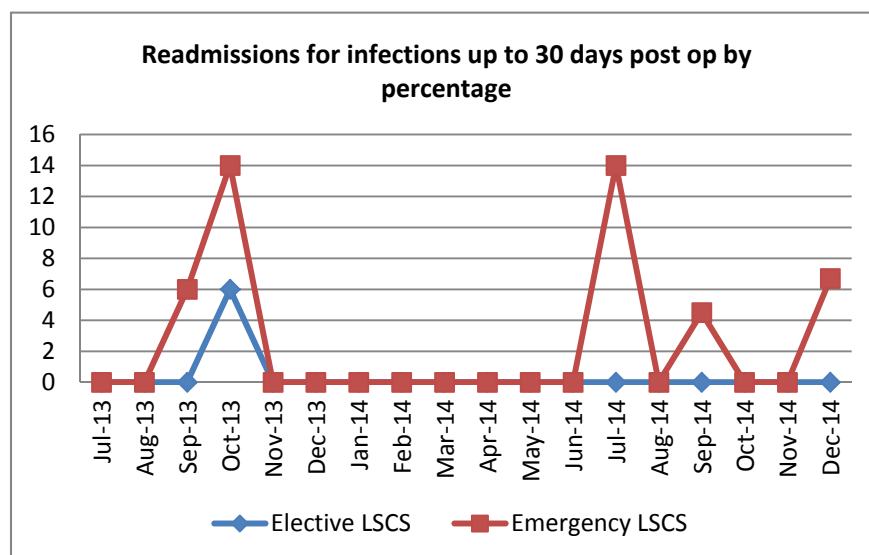
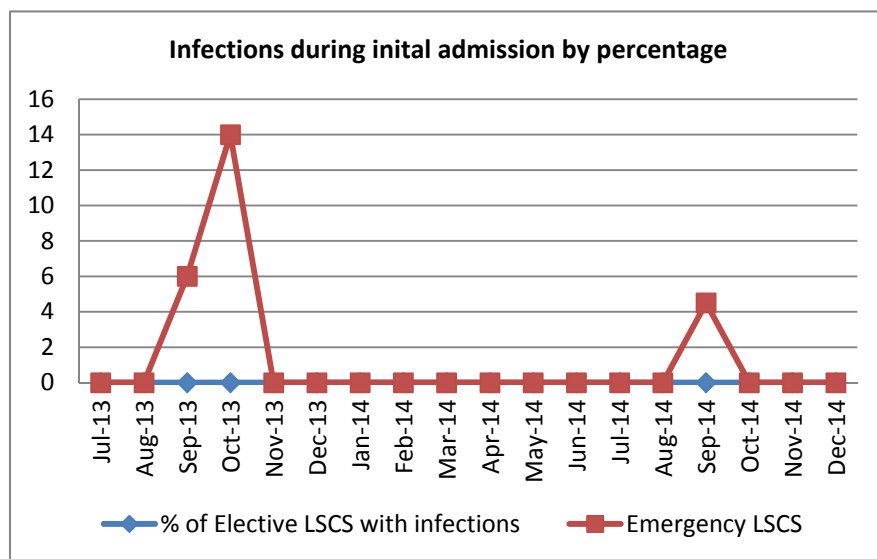
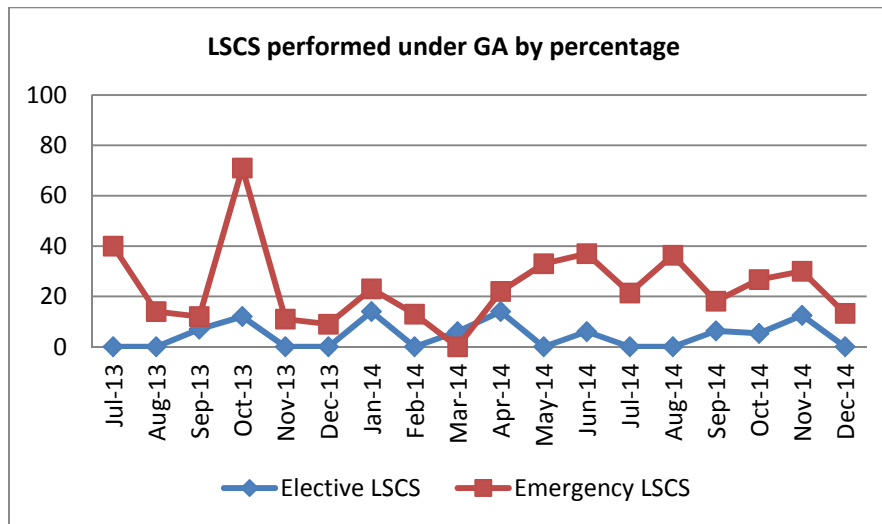
All Level 1 C/S' are carried out by the consultant anaesthetist who is well aware of the risks and benefits of regional/GA.

It has been recognised that better communication between maternity, anaesthetics and theatres will always improve the assessment of risk/benefit. The adoption of calling levels has been promoted and to assist this new call-out Proforma sheets have been devised to support switchboard/operators in calling a Level 1 C/S which involves communicating with maternity, theatres, obstetric neonatal and anaesthetic staff.

The audit can be repeated once we have the figures for the next triennium. The rates are not high enough to justify doing it sooner and the previous audit was deemed to be not overly concerning.

Our Quality & Risk member of the MQC continues to monitor as per the tables below.

## Taranaki Infection Control Dashboard Post Caesarean Section



Comments: The numbers for wound infection and blood transfusion are low and therefore difficult to analyse. It may be useful over a wider time period to monitor these and investigate if there are other compounding factors such as raised BMI, age, medical reasons such as diabetes. The PICO wound dressing was introduced in 2013/14 to try to reduce wound infection and hospital readmission rates but this is difficult to analyse given the small numbers.

As a result of the MQSP, Taranaki DHB purchased a clip on portable CTG monitor to allow continuous monitoring of the fetal heart rate while transferring Level 1 C/S cases to theatre. This has contributed to a reduction of the GA C/S rate by informing obstetric specialist decision making on the urgency of the case based on the CTG recording.



## **Maternal Mental Health Services**

The Perinatal Mental Health (PNMH) pathway is embedded in the pre and post pregnancy referral directory; this can be viewed in Appendix 3. The directory was developed to inform all primary and secondary maternity related practitioners and stakeholders of the services available and referral process which can be seen in Appendix 4.

The Community Mental Health Team Leader and Midwife Educator have presented to the GP forum, midwives, LMCs and neonatal staff the Taranaki DHB PNMH pathway and the screening tool required to accompany referrals (Edinburgh postnatal depression scale) however the score is not dependent on entry. If the practitioner is concerned, despite a low score, referrals will still be accepted. From 2015, this education will be implemented into the midwives practice day.

The Community Mental Health Team Leader has also presented at the NZCOM national conference in 2014 and has also discussed the referral pathway with the Well Child Tamariki providers and amended the pathway to include Plunket's PH3 screening tool. Additionally, the CD has meetings scheduled with GPs to investigate how the PNMH pathway is being received by GPs and to help understand and address any issues that they may have encountered. More broadly, Taranaki will participate in the Midlands Region Infant Perinatal Clinical Network and has representatives from the PNMH and infant mental health teams.

In April 2014, the MoH provided one-off funding to:

- Establish a Midland Regional perinatal and infant mental health clinical network
- Provide workforce development initiatives for staff employed in DHBs and Non-Government Organisations who deliver perinatal acute mental health options across the Midland region

The Midland perinatal infant mental health network is clinically oriented to provide:

- Specialist/advanced supervision for perinatal clinicians
- For the complex case presentation and discussion
- Advance training educational presentations training and speakers
- Network with colleagues thus improving working together, share knowledge and experiences, and foster collaboration across the Midland region
- Promote regional consistent development and use of evidence-based guidelines and best practice principles within perinatal specialist services
- Linkages with similar clinical networks in the Northern and Central regions
- Support the development and implementation of a consistent model of care across the region
- Lead strategic development and information sharing

### **Access to Mental Health Services for Pregnant Women and New Mothers**

- Taranaki DHB did not prioritise access for PNMH referrals for pregnant women and new mothers over and above standard adult referrals. A gap analysis locally informed Taranaki's tender (through MoH on a regional basis) for a 0.6 FTE Acute Perinatal Registered Nurse (RN) to augment the current work of the perinatal sub-specialty; this position was successfully appointed in May 2015. Taranaki DHB is now at the implementation stage of initiating this service. The priority for this role is to provide and mobilise a rapid response to the most unwell perinatal women referred.
- The Midland's five DHBs are working together through the Midland Health Network (MHN) to ensure there is alignment with the Region's needs. Some of the funding is being allocated to the development of a Perinatal Clinical Network and regional training.
- In 2013, a Midland Hui was held to discuss our local PNMH services including pathways, access to the services, priorities and actions to be made. The PNMH services are taking on board some of the feedback from the referrers and stakeholders present at this Hui which included maternity, LMCs and paediatric staff. The MMAG is working alongside the Midland Regional Network Team to produce a Primary Mental Health-Primary Care Map of Medicine Pathway and this is currently in draft format (see Appendix 4).
- 2015/16 will continue to promote integration with maternity services, Drug and Alcohol, WCTO and PNMH services.

- Progress information leaflets on PNMH services for women and another for the maternal-infant health practitioners and monitor:
  - access to maternal mental health services
  - timing of referral to face-to-face meeting
  - how many referrals are accepted
  - how many are not and reasons for this
  - gestation/age at referral
  - referral problem
  - age
  - ethnicity
  - parity/gravidity
  - who referred

### **Services to Vulnerable Pregnant Women**

The monthly multidisciplinary child, maternal and perinatal liaison meeting has continued to provide improvement in communication and interfacing of services between the maternity unit, maternal and child health social workers, PNMH services and drug and alcohol services to:

- Review all pregnancy and postnatal cases that present with maternal mental health issues in Taranaki DHB.
- Provide an MDT planning of care for pregnancy, labour and birth and for postnatal care in cases of concern.
- Collate and report feedback from PNMH clients' experiences in maternity/NNU services to identify any trends and assist in identifying and implementing improvements in practice.
- Assist in identifying areas for further education of staff where appropriate.

The new national toolkit for Maternity Care, Wellbeing and Child Protection Multi-Agency Group meetings has been received and localised (see Terms of Reference in Appendix 7). The 2015/16 plan is to implement this initiative. Stronger relationships have already been formed with the FVIP Coordinator, Taranaki DHB child protection officer and CYFS managers as part of this initiative.

### **Violence Intervention Programme (VIP)**

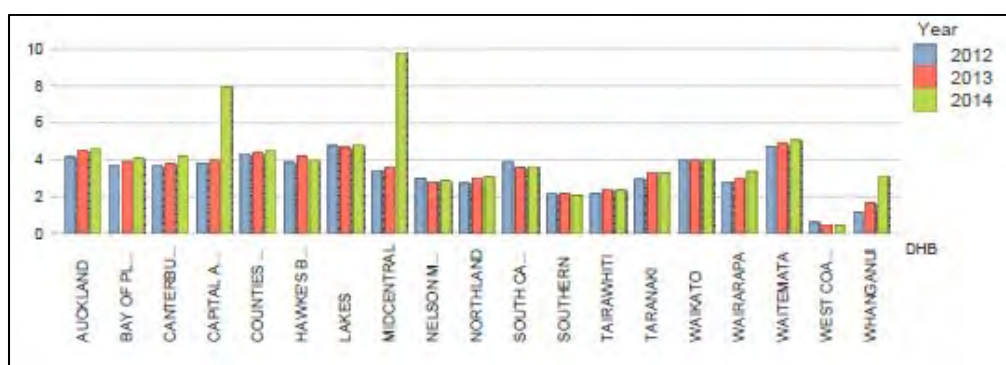
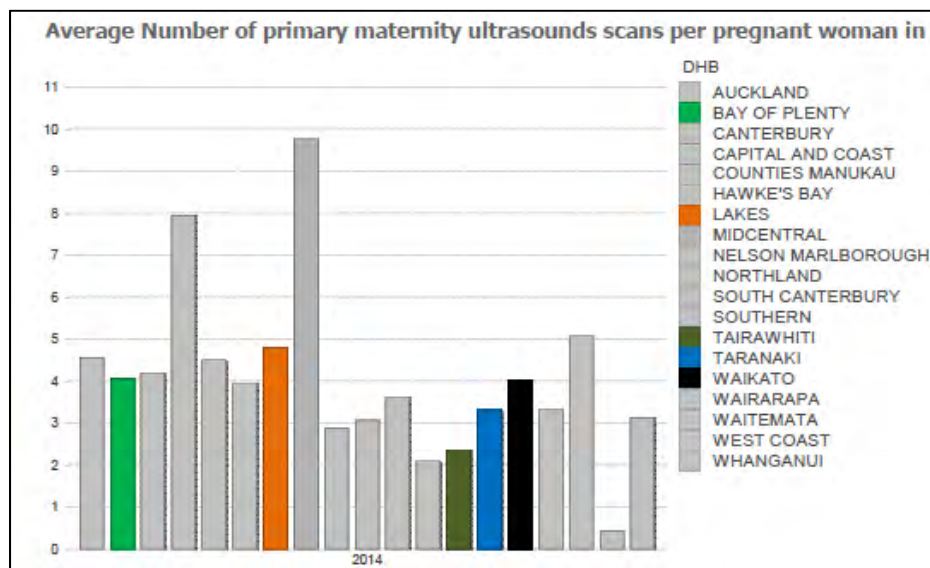
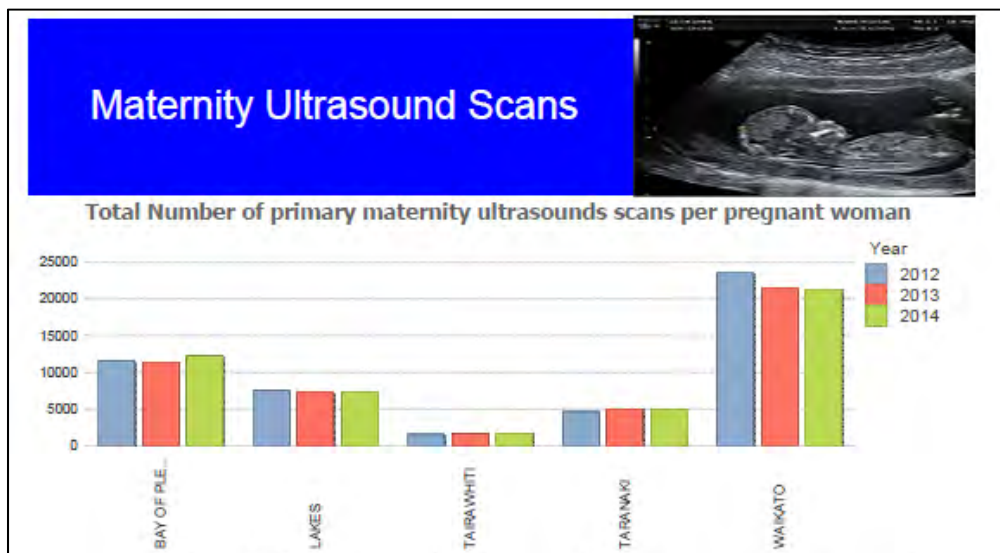
Taranaki DHB has participated in the inaugural VIP Snapshot. The VIP Snapshot's primary purpose was measurement for accountability. The Snapshot is aligned to current MoH and VIP initiatives to reduce family violence and provides an estimate of services being delivered to women and children across Aotearoa New Zealand's DHBs.

### **Results of Taranaki DHB VIP Snapshot**

Partner Abuse Clinical Audit	Nº of Eligible Woman Screened	IPV Screening Rate %	Nº Disclosed	IPV Disclosure Rate %	Nº IPV Off-site Referral	Nº IPV On-site Referral	IPV Referral Rate %
Postnatal Maternity Inpatients (Implementing VIP Service in second quarter 2014: NO)							
25 randomly selected records	18	72%	2	11%		2	100%
National Median (n= 18 hospitals)		56%		0%			100%
Child Health Inpatients (Implementing VIP Service in second quarter 2014: NO)							
50 randomly selected records	30	64%	2	6.7%		2	100%

Maternity Staff VIP Core Training rates are now at 99%. Risk assessment cards have been provided to all trained practitioners.

## Primary Maternity Ultrasounds



The Taranaki DHB ultrasound scan average has risen to over three in 2014 from 2.5 ultrasounds in the 2011/12 data. Taranaki DHB is aware of the increasing demand on the pregnancy ultrasound services. Taranaki DHB supports the NMMG changes they expect to see including the suggestion of an audit to be conducted by the MoH to investigate the rising numbers of primary ultrasound scans that are being requested through Section 88.

A Taranaki DHB internal audit would be useful to assess the number and reasons for repeat anatomy scans. Additionally there are no current national guidelines available to inform practitioners on the standards (how long each scan should take, timing of urgency of scan for example; in cases of urgent referral for suspected Intrauterine Growth Restriction [IUGR]). These would be useful for LMCs to have the confidence that once an urgent referral has been sent it would be actioned/prioritised within an agreed timeframe/benchmark.

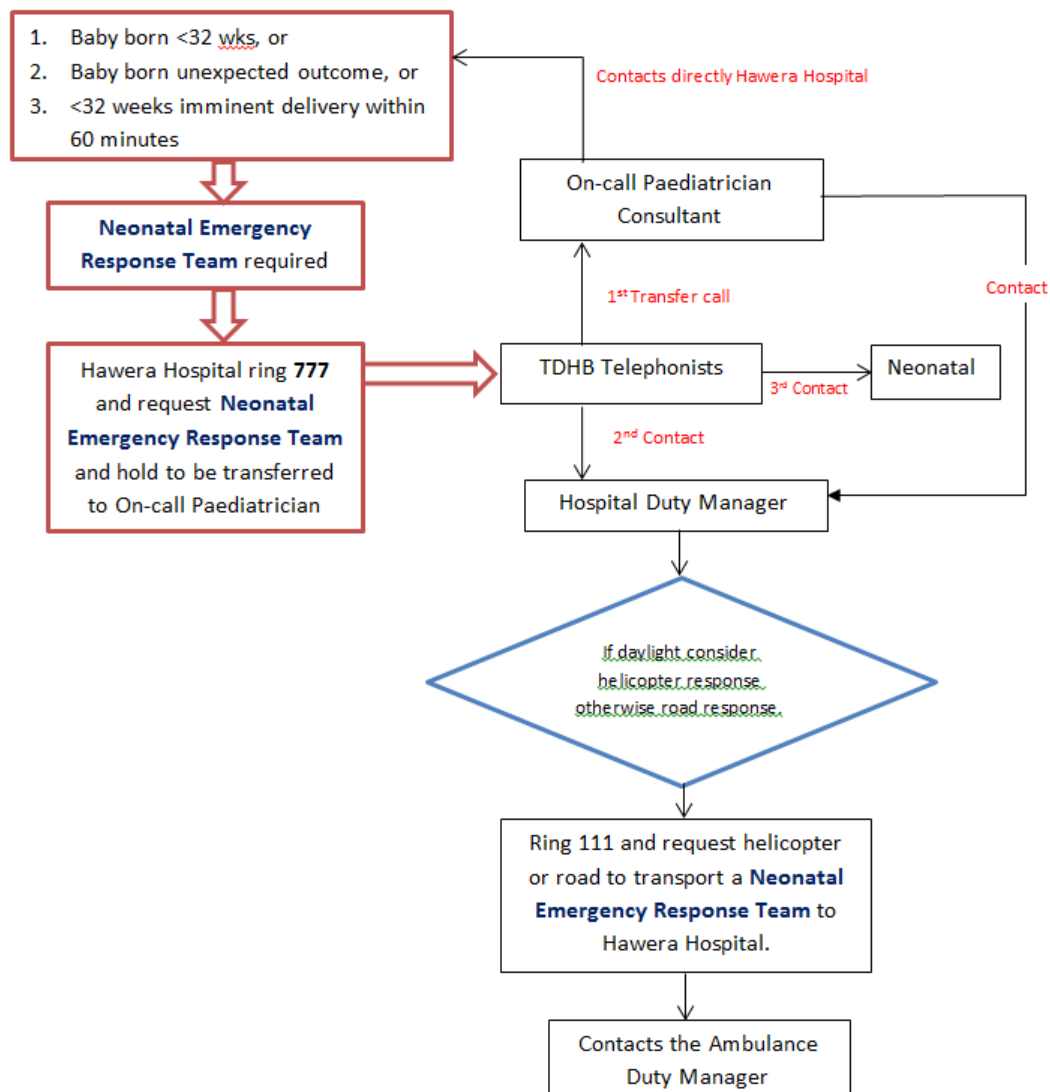
Access to primary ultrasound scans and NT scanning has improved with a local GP now offering this service for free as well as a practice in Wanganui for South Taranaki pregnant women. Unfortunately a local private obstetrician is withdrawing her services for NT scanning.

In 2015/16:

- Networking with consumers on reasons and expectations for ultrasound scanning in pregnancy will be a focus through our MQC consumer and information networks.
- Network with local primary ultrasound services, GPs and LMCs on referral for primary ultrasound scans.

## Guidelines for Referral and Transfer of Care including Emergency Transfers

Ongoing discussions with St John, Taranaki DHB hospital services and Hawera Hospital are taking place to improve the process and timing of emergency response requests from the rural primary unit. This should have a positive improvement on timing of retrieval. This work was initiated as a result of case review/reportable events in the primary maternity unit. Draft directives as follows:



**Assumptions made:**

- If helicopter used – The Neonatal Emergency Response Team (NERT) will make their own way to the helicopter.
- If by road – NERT will assemble at the main maternity entrance.
- NERT will only have two people travelling.
- The Hawera incubator will be used.
- Ambulance or helicopter is only arranged by the Hospital Duty Manager through 111.
- Hawera Hospital will wait for the arrival of the NERT at Hawera.
- Each participant to this process will have their own processes that will support this activation.

**Key Performance Indicator Measure for NERT**

From 111 – call to NERT arriving at Hawera Hospital – 95% of activations within 80 minutes.

**NEONATAL EMERGENCY RESPONSE TEAM – HAWERA HOSPITAL, TARANAKI DHB**

DATE:	PATIENT'S NHI: (if required)	
TIME:	DUTY MANAGER:	
<b><u>1<sup>st</sup> Transfer 777 caller straight through to Paediatric Consultant on-call</u></b>		
PAEDIATRIC CONSULTANT	<input type="checkbox"/>	TIME.....
<b><u>2<sup>nd</sup> Page DM on 4 031*98 (and your extn no.)</u></b> <b><u>When DM calls you advise that HAWERA have called 777 and require the</u></b> <b>NEONATAL EMERGENCY RESPONSE TEAM</b>		
DUTY MANAGER	<input type="checkbox"/>	TIME.....
<b><u>3<sup>rd</sup> Call NNU 7746 advise HAWERA has called for</u></b> <b>NEONATAL EMERGENCY RESPONSE TEAM</b>		
NNU	<input type="checkbox"/>	TIME.....
COMMENTS/NOTES (if applicable)		
<b>OPERATORS:</b>		
1.	2.	3.
Please send copies to: Belinda Chapman Jane Bocock		

Weekly case review sessions are held to review as per data sheet in Appendix 8; this includes all emergency transfers and any issues with emergency transport as well as timely referral and transfer of clinical responsibility.

All women have a named LMC and where there is a transfer of clinical responsibility to a specialist, a named obstetrician provides coordination of care.

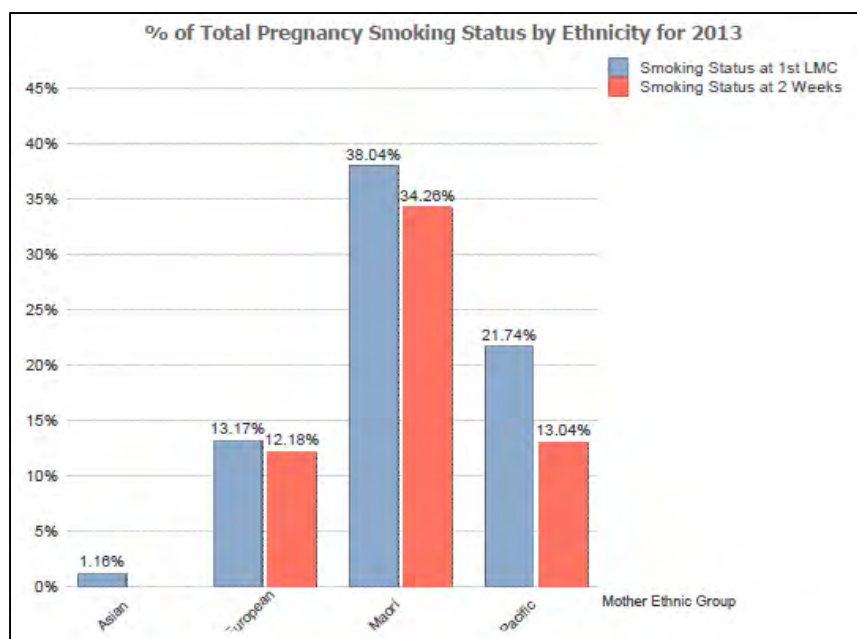
2015/16 will audit the guidelines of referral to ensure referrals are made and are appropriate. There has been a noticeable increase in the continuation of the midwife LMC in providing the midwifery component of care under the clinical responsibility of the obstetrician. This has been an advantage to women in the remote and rural regions of Taranaki. Communication between the secondary obstetrician and midwife in these circumstances is a priority and will be examined as part of the audit.

Hawera primary maternity unit has a weekly outpatient secondary obstetric and consultation antenatal clinic. In 2014, a dedicated 0.2FTE midwife was appointed to provide continuity of care to secondary outpatient women should their LMC exit the midwifery component of care until the woman is fit to return to primary care.

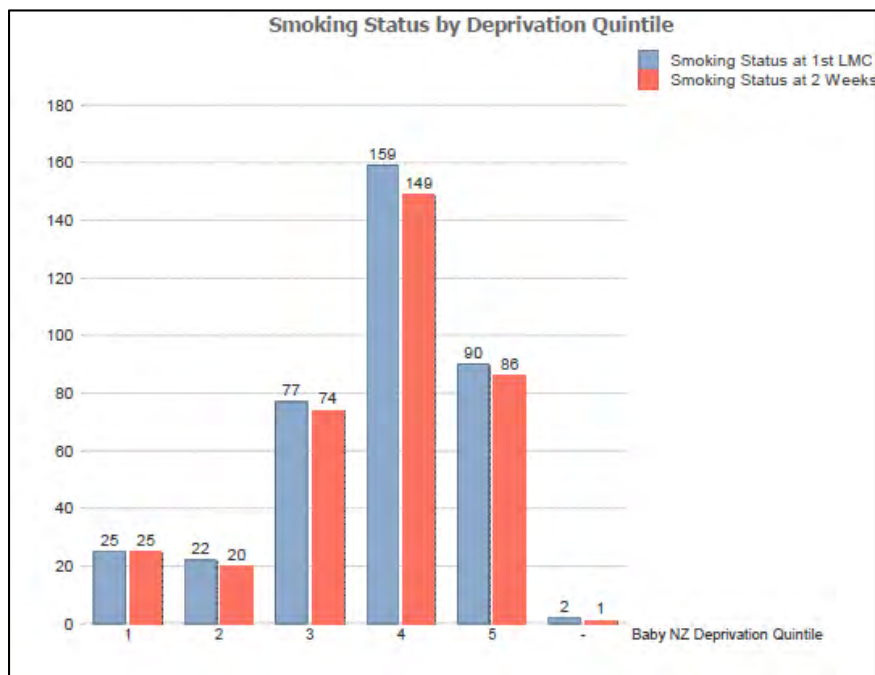
## **Smoking amongst Pregnant Women**

Taranaki DHB will continue to work with MMAG on:

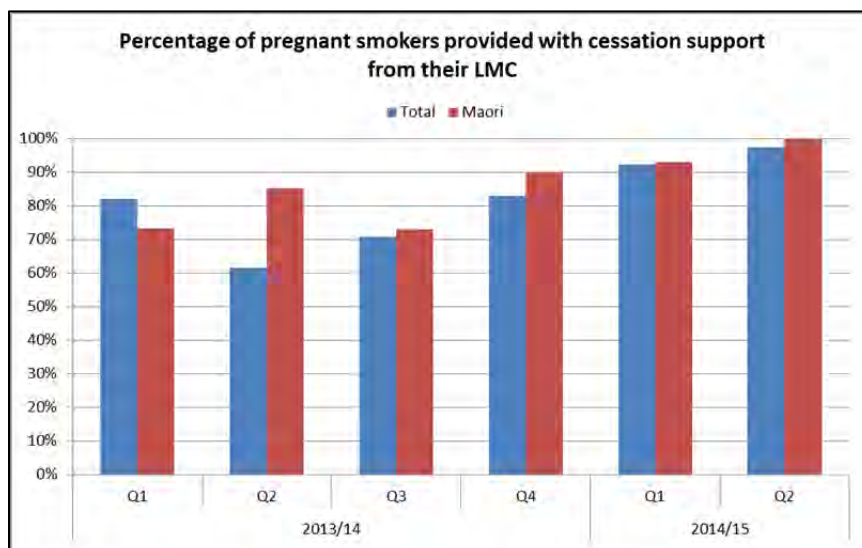
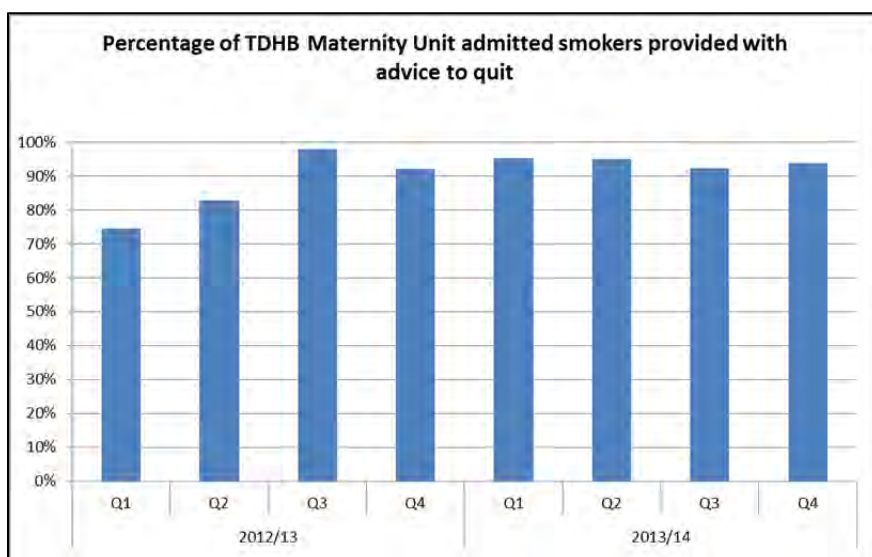
- Sharing of resources eg Waikato DHB has made available a six poster set to raise awareness of benefits and support for smokefree pregnancies. Posters are individualised and printed at Waikato DHB (Waikato, Bay of Plenty, Lakes, and Taranaki have taken up this offer, please see posters below).
- Regional purchasing of CO monitors to make savings – for use in primary and community clinics with smoking cessation advice for pregnant women. The purchase is led by Waikato MQSP and progressing through Waikato DHB procurement for distribution to Midland DHBs. A training DVD to support the implementation of the CO monitors is to be developed and shared in Midland to support LMCs in their smoking cessation consultations with women.

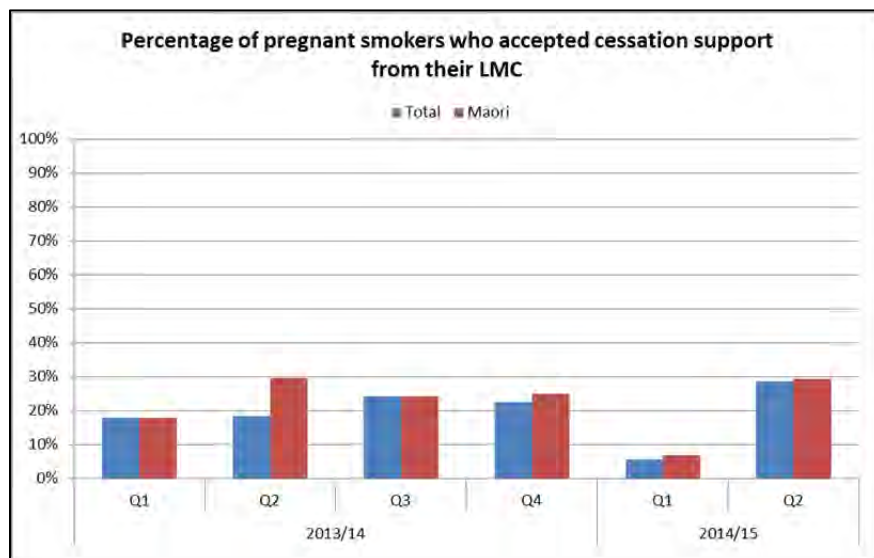






Smoking is highest amongst the Maori and Pacific pregnant women and in deprivation quintile 4. Working with smoking cessation providers and local Pacific groups, Iwi/Maori health providers to provide better help for smokers to quit is a priority.





- In Taranaki, 83% of pregnant women were offered support to quit smoking from their LMC 2013/14 however the graphs show this percentage is consistently rising.
- In Taranaki, 23% of pregnant women accepted stop smoking support from their LMC 2013/14.
- Further evaluation of the data to explore if there are differences in age and domicile would be helpful to see if there are any trends that can assist in further reducing smoking



Resource developed by Waikato and adapted for Taranaki DHB through MMAG; six poster set to raise awareness of benefits and support for smokefree pregnancies.



## A smokefree message for *partners, family, whānau*

You have an important role to play in helping your pregnant partner/family member to quit and looking after the health of baby.



The more support my mum has, the easier it becomes for her to quit. The first six weeks after I am born can be a rough time for my mum, and she'll need your help to stay smokefree. Please don't smoke around my mum and me. Kia ora!"

**Create a smokefree beginning for me!**

We know that stopping smoking can be hard. It's ok to have a helping hand. **We're here to support you.**  
Talk to your midwife, LMC, GP or practice nurse about support or referral to a specialist stop smoking service. Otherwise directly call Quitline 0800 788 778 or our local Stop Smoking-Aukaiti KaiPaipa Services at Tai Ora Ltd (North Taranaki) 06 759 4064 and Ruatanihi Health Centre (South Taranaki) 06 278 1310

*Hapu Mama*  
smokefree pregnancies

Taranaki Together, a Healthy Community  
Taranaki Whānau He Kōwhiri

## Using NRT *in pregnancy*

Nicotine Replacement Therapy (NRT) helps you stop smoking by helping to reduce your cravings for a cigarette.



You still get nicotine but in a safer way and more slowly.

No nicotine is good for your baby but NRT is a lot safer than continuing to smoke.

**You can use nicotine patches, gum or lozenges when you are pregnant. These will help ease the cravings for cigarettes and are much safer than smoking.**

We know that stopping smoking can be hard. It's ok to have a helping hand. **We're here to support you.**  
Talk to your midwife, LMC, GP or practice nurse about support or referral to a specialist stop smoking service. Otherwise directly call Quitline 0800 788 778 or our local Stop Smoking-Aukaiti KaiPaipa Services at Tai Ora Ltd (North Taranaki) 06 759 4064 and Ruatanihi Health Centre (South Taranaki) 06 278 1310

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Taranaki Whānau He Kōwhiri

## Monitoring your *carbon monoxide*



Carbon Monoxide is a colourless, odourless, poisonous gas that is in cigarette smoke.

When you smoke the carbon monoxide passes through the placenta into the baby's blood and reduces the oxygen supply.

Baby gets almost double the carbon monoxide that you do because their blood is different to yours.

**Within 24 hours after your last cigarette the carbon monoxide will have left your blood stream and your baby will have normal levels of oxygen. We can show you this using the Carbon Monoxide Monitor.**

We know that stopping smoking can be hard. It's ok to have a helping hand. **We're here to support you.**  
Talk to your midwife, LMC, GP or practice nurse about support or referral to a specialist stop smoking service. Otherwise directly call Quitline 0800 788 778 or our local Stop Smoking-Aukaiti KaiPaipa Services at Tai Ora Ltd (North Taranaki) 06 759 4064 and Ruatanihi Health Centre (South Taranaki) 06 278 1310

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smokefree pregnancies

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Taranaki Whānau He Kōwhiri

## Secret ingredients, *what's hiding?*

There are secret ingredients, what chemicals are hiding in your cigarettes?



- Metopropolol**: A chemical used to kill fleas on your pets.
- Benzopyrene**: A chemical found in air and cigarette smoke. It is one of the most potent cancer-causing chemicals in the world.
- Acrolein**: A deadly poison that makes your lips burn and gives you bad breath.
- Acetone**: A chemical used as one of the active ingredients in nail polish remover.
- Lead**: Lead poisoning starts your growth, makes you vomit and damages your brain.
- Formaldehyde**: Embalmers use this to preserve dead bodies. It causes cancer, damages your lungs, skin and digestive system.
- Terpentine**: Terpentine is very toxic and commonly used as a paint stripper.
- Propylene glycol**: Apparently added to keep tobacco from drying out but scientists say it aids the delivery of nicotine to the brain.
- Butane**: Butane is highly flammable and one of the key components of gasoline.
- Cadmium**: Cadmium causes damage to the liver, kidneys and brain. It can stay in your body for years.
- Ammonia**: Apparently added for flavour but scientists have discovered ammonia helps you absorb more nicotine to keep you hooked on smoking.
- Benzene**: This cancer-causing chemical is used to make everything from pesticides to gasoline.

**Smoking is deadly and highly addictive. Smoking kills 5000 New Zealanders each year.**  
The products shown contain chemicals found in cigarettes or cigarette smoke. The products themselves are used for illustrative purposes only. When used as intended the non-tobacco products shown are safe.

We know that stopping smoking can be hard. It's ok to have a helping hand. **We're here to support you.**  
Talk to your midwife, LMC, GP or practice nurse about support or referral to a specialist stop smoking service. Otherwise directly call Quitline 0800 788 778 or our local Stop Smoking-Aukaiti KaiPaipa Services at Tai Ora Ltd (North Taranaki) 06 759 4064 and Ruatanihi Health Centre (South Taranaki) 06 278 1310

*Hapu Mama*  
smokefree pregnancies

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## **Consumer Report**

I, Christine Strydom, have been the consumer representative to the Taranaki DHB MQSP since its inception in December 2012. From the beginning I have felt a very valued member of the team, having received training in consumer services, confidentiality and I have a contract with Taranaki DHB to provide this service. The second year of this initiative is where I really started to feel useful. I volunteered to take the minutes for our meetings as well as collate data for our maternity inpatient feedback. These tasks have been very helpful in my own understanding of how the service works and user experience.

During 2013, I was very fortunate to attend the first MoH facilitated MQSP consumer forum in Wellington. This was an experience beyond measure. Meeting and networking with other consumers gave me a great feeling of unity and a greater understanding of this very varied role. My personal crusade is for all users of our service to be able to make truly informed choices. I know that if a person is not aware they have a choice they cannot make that choice or ask for more information regarding choices available. I am very happy that I feel supported by the Taranaki DHB MQSP in this point of view.

Ongoing discussion within the Taranaki DHB MQSP has led me to work very closely with our MQSP Coordinator setting up and piloting a consumer engagement survey. This survey covers the period from conception to six weeks post natal, looking at how and when consumers engage with maternity services. Development of this survey has been a great experience for me as I, once again, learned so much and was able to collaborate with various departments such as customer services. From first discussion to pilot was roughly 18 months duration having piloted two versions. Currently the aim is to survey 100 women out of an estimated 1,500 births for the 2015 year.

All consumers of the maternity service are invited and encouraged to provide feedback around the care they receive during their stay, either electronically through the Taranaki DHB internet site or by completing a "How are we doing form". Taranaki DHB uses this information to both celebrate success and to improve the service that is provided to women and their families. Customer feedback is logged with the customer services team and if a reply is required it is sent to the Child & Maternal Health Clinical Services Manager to undertake an investigation and co-ordinate a response to the patient. A letter of acknowledgement is sent to the patient and a reply is expected to be sent to the patients within 20 working days of receiving the feedback. If there is a delay in being able to respond, the patient is informed of this.

A maternity consumer satisfaction survey is carried out and evaluated annually. The 2013/14 survey summary is as follows:

- 55 maternity surveys were viewed – 48 women had care at Base Hospital and seven women had care at Hawera primary maternity

The results from this survey had similarities to the consumer satisfaction survey that was targeted at Base Maternity:

- Staff in all areas; midwives, theatre, NNU and obstetricians given very high praise
- "Midwives were really helpful, listened well => Surgeon, anaesthetist and my midwife were amazing had the best care!"
- Meal size and options remain an issue
- Side car cots (clip on cots) very much appreciated by Mums
- Some comments noted staff not completing well child books or breastfeeding charts

The results of this survey will be presented to staff and actions developed where appropriate.

Early in 2014 I was honoured to receive an invitation to be a part of the Expert Advisory Group (EAG) to the MoH for an evaluation of the National MQSP. Serving on the EAG has been a great privilege and an enormous learning opportunity.

Looking ahead to the next year there are a number of projects I am working on with the MQC Committee, some of these include:

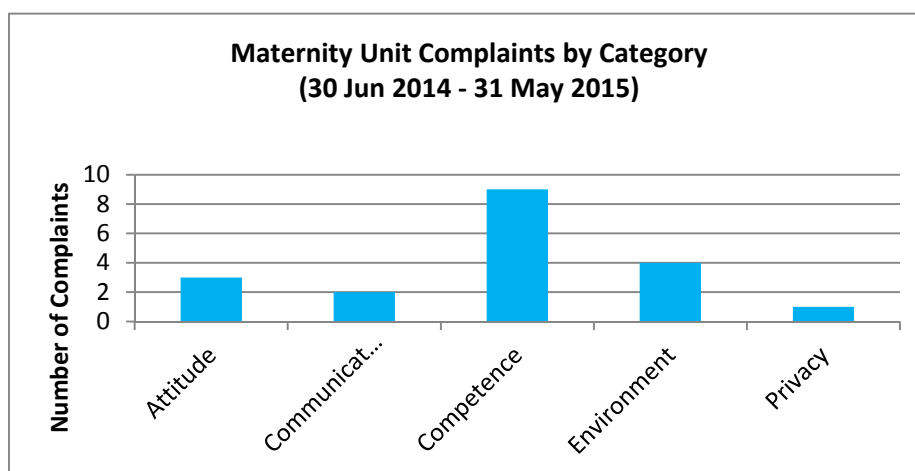
- Meet your maternity services road show
  - Initial concept for this project is to host afternoon or morning tea sessions in four areas around our district. During these sessions members of the public will be invited to meet and engage with maternity service providers in their area. Consumers' expectations on receiving ultrasound scans will be explored and discussed.
- Consumer engagement survey
  - This is a continuing project; we are currently identifying trends and gaps in the services as well as interviewing more respondents. Very early observations show even though 80% (21/26) of respondents confirmed pregnancy before six weeks, only 19% (5/26) went on to have a first appointment with a care provider before six weeks. From this we can deduce that more education is needed to make women aware of not only their options of first appointment care providers but also the necessity of having this first visit as soon as possible.
- Wahakura weaving
  - This is a very new project. As an MQSP, we would like to see more mums in our community having the opportunity to weave their own Wahakura. Currently a sub-group has been formed to investigate options for this which will be linked to the pregnancy and parenting antenatal education.
- Stratford maternity unit closure
  - As a consumer I have been involved as a community stakeholder in a number of meetings. A steering group is being formed to consult with community and stakeholders, with a mandate to present a proposal for a maternal and child health hub in Stratford.
- Second consumer
  - The MQC support and recognise a second consumer is needed. The goal is to recruit a second consumer identifying as Maori and being from the rural Taranaki community. I am developing an understanding of Maori Tikanga and have made contact with our local Maori health provider to act as a third party facilitator in this. I am planning to introduce myself to the community to build connections for this so we will be better equipped to have the appropriate representative on our group.

As the MQC consumer representative I monitor the Taranaki MQSP Facebook page which already has 72 members, with an average of three new members requesting to join per month. Prior to this page being formed, I was involved in the implementation of the MQC Taranaki DHB communications plan.

Due to Taranaki DHB policy around the use of social media, this forum is used as a noticeboard rather than a discussion forum. Examples are the implementation of a vending machine in maternity, notice of the new clip on cots to assist in safe sleep practices and postings of the next free Flu and Boostrix vaccination clinics for pregnant women held in the antenatal clinic.

Thank you so very much to Belinda Chapmen for all her support, emotional, professional and administrative. You are a true inspiration.

## **Taranaki DHB Complaints**



The above graph shows the number of complaints received into the maternity/gynaecology service and the reason for the complaint. In total 27 complaints were received, 47% or nine of these relating to competence, the remainder relating to staff attitude, communication, privacy or the physical environment (the current system has captured three competence and one environmental complaint associated with gynaecology services rather than maternity services). All complaints have been fully investigated and the complainant responded to in writing. The focus when investigating complaints is to review how care to our clients could have been improved, with a particular focus on safety as well as implementation of changes to reduce the risk of the event occurring again.

A new electronic system to register complaints is currently being implemented at Taranaki DHB; this will be adapted so that only complaints related to the maternity services will be captured in the future.

	N	Complaints	Compliments	Suggestions
<b>Maternity/Gynae</b>	27	6 (22%)	18 (67%)	3 (11%)
<b>All Departments</b>	78	33 (42%)	36 (46%)	9 (12%)

How are we doing forms are used to capture informal complaints/compliments and suggestions for improvement from patients and families.

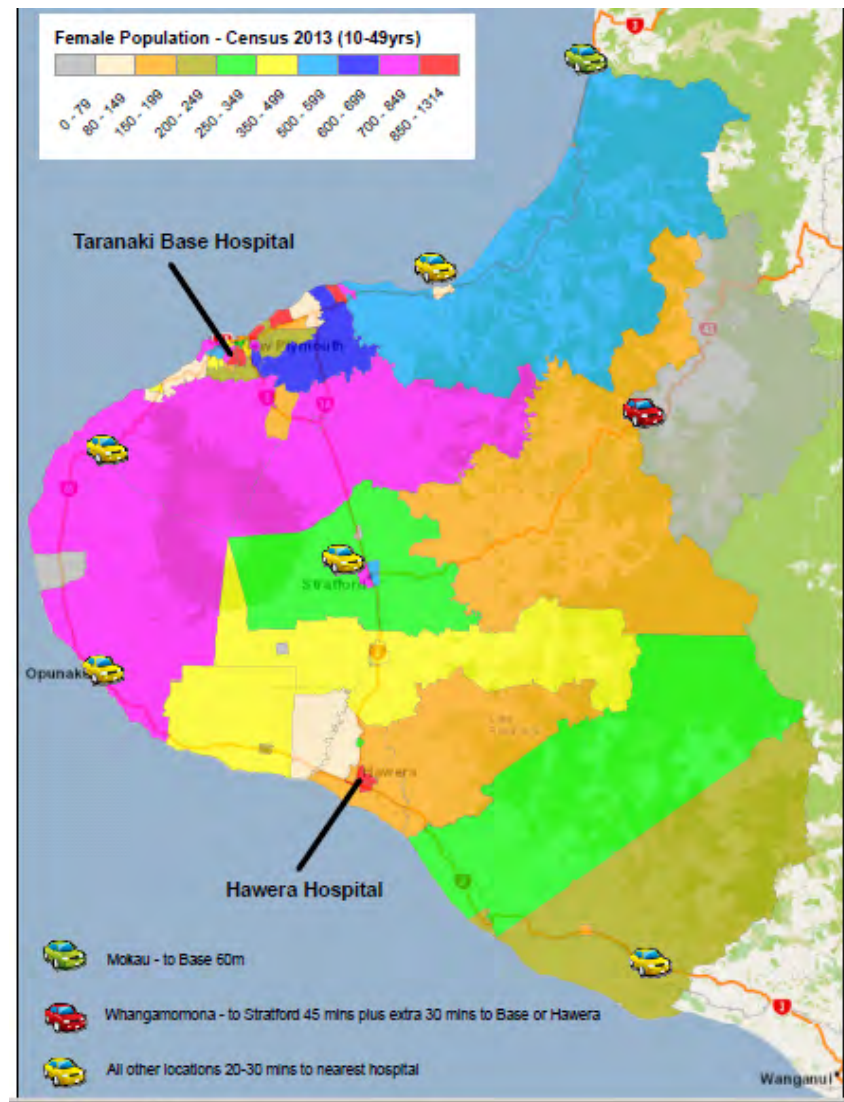
### **Complaints Received via the Health & Disability Commissioners Office**

Total complaints received equals three; all three are unresolved at this current time.



## Rural Maternity Services in Taranaki

Female birthing population and travel times to Taranaki Base Maternity and Hawera primary maternity facility



LMCs provide all primary maternity care around Taranaki. There have been no cases that have accessed the secondary services for “provider as last resort” where women have been unable to find an LMC in the past year.

In Taranaki, Primary Inpatient Maternity Services have been provided from Base Hospital, Hawera and Stratford (please see Appendix 1). Primary Maternity Services provide a valuable and essential component of maternity services provision available to the Taranaki community.

In 2014 the Taranaki DHB put out a request for proposal to contract the Stratford Primary Maternity facility and services at Elizabeth R following the exit of the previous contractors. The new provider “Maternity Services Taranaki Limited” (MSTL) commenced services on 1 July 2014 and had a two-year contract for the service to 30 June 2016. The service was contracted to provide between 60-80 births and 160 postnatal stays per annum. This represented approximately 4-6% of Taranaki births.

The closure of the Stratford Maternity Facility in November 2014 was a response to significant challenges and experiences the independent provider had in recruiting and retaining midwifery and nursing staff. These challenges have also been faced by Base and Hawera maternity services to some degree. An options appraisal was undertaken which involved consumer, stakeholder and practitioner consultation and feedback.

The “Triple Aim” was adopted as the framework for assessing options ensuring the dimensions of:

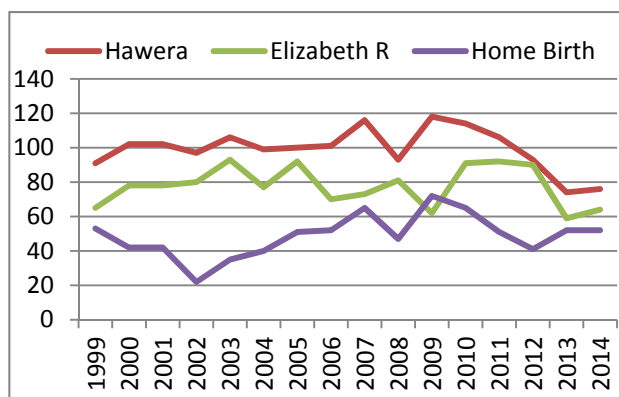
- Quality/patient experience
- Value for money/best use of resources
- Population health/equity

Each option was assessed to the extent to which it met these criteria.

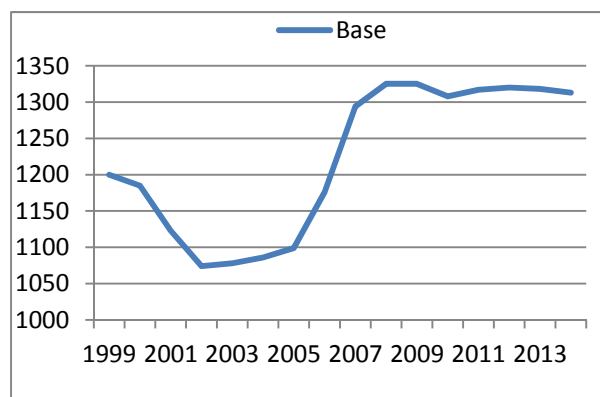
	Population Health Gain		Value for Money / Best Use of Resources	Quality and Safety	
<b>Option A:</b> DHB provides access to Maternity Services at Base and Hawera	Medium		High	Medium	
<b>Option B:</b> Birthing Unit only at Stratford	Low		Medium	Low	
<b>Option C:</b> In longer term Primary Birthing Unit established for Taranaki not necessarily in Stratford	Medium	High	Low	Medium	High
<b>Option D:</b> New provider of Birthing and Postnatal care based in Stratford	Medium		Low	Medium	
<b>Option E:</b> DHB Maternity Services provider of Birthing and Postnatal care based in Stratford	Medium		Low	Medium	High

#### Key points from the options appraisal were:

- Based on the 2013 Census, the number of women between the ages of 15-44 years in the Stratford district is 1650, of which 141 reside in Douglas (8.5%) and 0 in Whangamomona.
- The majority of Stratford District residents are 30 minutes from both Base and Hawera Hospitals with the exception of Whangamomona which is 80 minutes (100kms) to Base and 75 minutes (92kms) to Hawera.
- For the five year period between 2010 and 2014, there is a slight reduction in total births. In 2010, there was 1578 and in 2014 1505 [n=73].
- In 2010, 82.9% of all births were at Base Hospital and in 2014 this increased to 87.2%.
- In 2010, 5.8% of all births were at Elizabeth R this reduced to 5.4% in 2014.
- In 2013/14 78.6% [n=77] of all Stratford women gave birth at Base Hospital and 27% [n=21] gave birth at Elizabeth R.
- In comparison, 70.0% [n=271] of all South Taranaki women gave birth at Base, 8.3% [n=32] at Elizabeth R and 21.7% [n=84] at Hawera.
- In 2013/14 seven women from Douglas and Whangamomona gave birth at Base Hospital compared to four in 2012/13 in Elizabeth R. (*Note 2013/14 data not available for Elizabeth R*).
- For the four and a half months that the new contractors ran the contract there were no women domiciled in Douglas or Whangamomona who accessed services at Elizabeth R.
- 35.5% [n=21] of the birth events at Elizabeth R were for women domiciled in the Stratford District, 54.2% [n=32] for South Taranaki women and 10.1% [n=6] from New Plymouth District.



Percentage of Births by TLA by Maternity Facility



	Base Hospital	Elizabeth R	Hawera Hospital	Total
New Plymouth TLA	99.4% [n=929]	0.6% [n=6]	0.0%	935
Stratford TLA	78.6% [n=77]	21.4% [n=21]	0.0%	98
South Taranaki	70.0% [n=271]	8.3% [n=32]	22.0% [n=84]	387
<b>Total</b>	<b>1277</b>	<b>59</b>	<b>84</b>	<b>1420</b>

Source Data: MSTL and Taranaki DHB Patient Management System

The majority of Stratford and South Taranaki District women birth at Base Hospital. Of the estimate of 98 births of women domiciled to the Stratford District, 78.6% gave birth at Base Hospital and 21.4% at Elizabeth R. For South Taranaki domiciled women 70.0 % gave birth at Base Hospital, 8.3% at Elizabeth R and 22% at Hawera Hospital.

As a result of information gathering, the engagement process and the options appraisal the following recommendations were accepted by the Taranaki DHB:

	Recommendation	Progress	Status
1	Strengthen sustainability of service access at Base and Hawera	Status Quo	Completed
2	Maintain access to Primary Maternity at Base and Hawera	Status Quo	Completed
3	Strengthen model of care at HMU – aligning to Stratford	Actions to be developed	
4	Promotion of low-risk births at Hawera Hospital and Home Births	Actions to be developed	
5	Support and maintain midwifery workforce	Actions to be developed	
6	Exploration of a women's and child health hub	Actions to be developed	First meeting May 2015
7	Working with St John timely response and targeted training	In progress see emergency response section	Commenced May 2015
8	Consider options appraisal in future reviews	N/A	N/A

Taranaki DHB is committed to investigating colocation of maternity, neonatal and child health services, and the provision of a new maternity unit that is located nearer to the operating theatres. Part of this investigation should explore what the future of maternity services will look like in Taranaki DHB, including where primary maternity units are situated for best utilisation and provision of services. Further to this advertising and marketing of the advantages of primary care for antenatal, labour, birth and postnatal services for those women who meet the criteria needs to take place at national and local level to promote normal birth and to curb the escalating C/S rate.

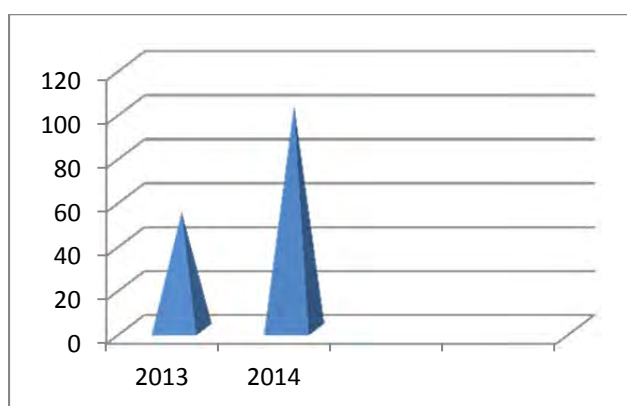
## Antenatal Clinic

There are eight obstetric secondary antenatal and consultation clinics per fortnight, a weekly secondary midwife clinic at Base Hospital and a weekly midwifery and secondary antenatal/consultation clinic held in South Taranaki to serve the rural women and families. These clinics are often full four weeks in advance due to the escalation in new antenatal referrals and the amount of follow-ups that are required, due to the increase in women who identify as requiring a secondary consult/transfer of care.

	2012	2013	2014
Nº of Antenatal Clinic Visits	803	927	881

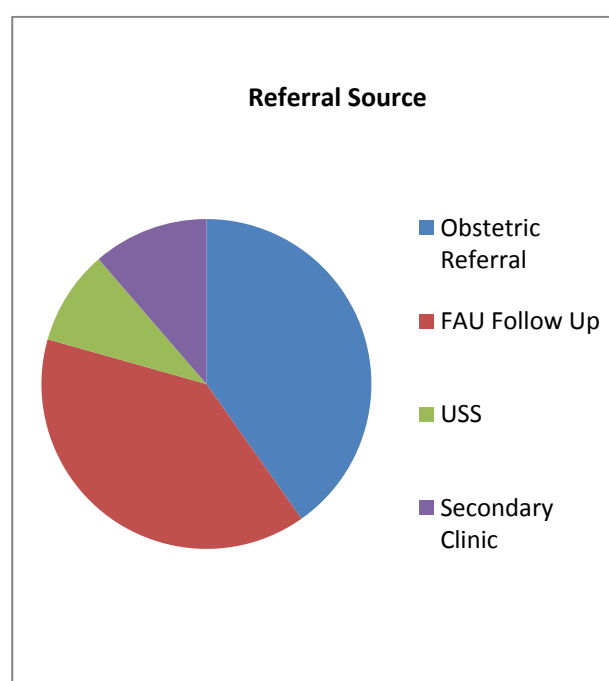
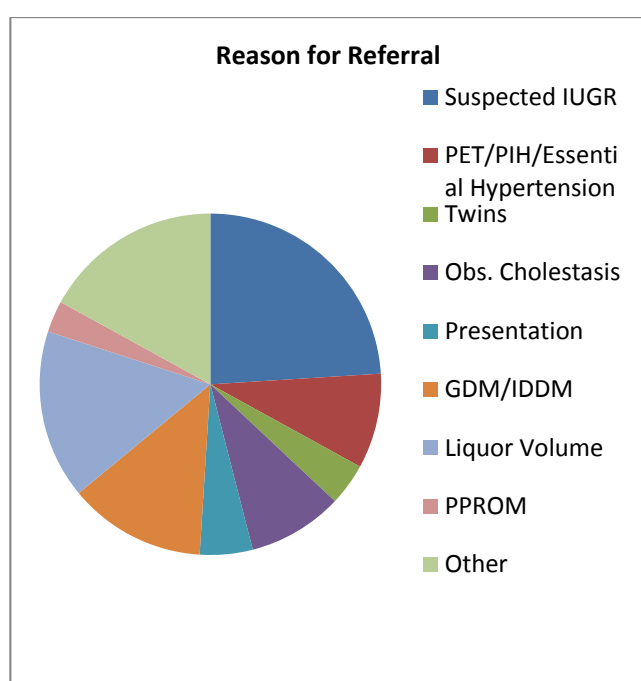
In 2014 there was a slight decrease as the antenatal clinic was without one obstetrician for some months which meant overflows were seen on the ward or in the FAU – there were 117 visits through FAU which combined is 998 visits – again a further increase.

Vaccination clinics for Boostrix and Flu are held fortnightly by the Antenatal Clinic Coordinator however as another midwife has just completed the vaccinator course, this may change to weekly over the flu season.



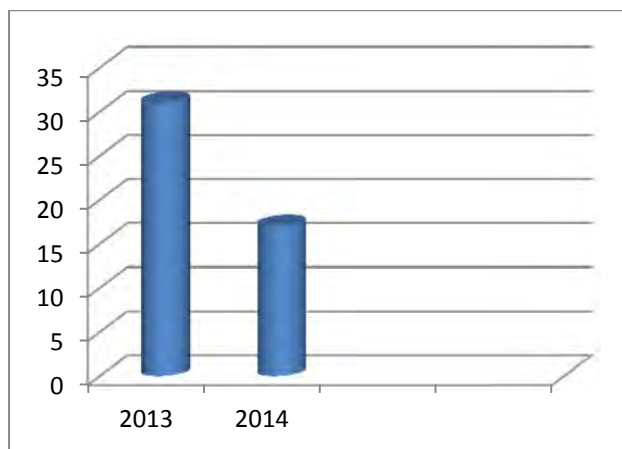
Fifty-one (51) women attended vaccination clinic in 2013, 102 women attended vaccination clinic in 2014 and we are well on the way for even more in 2015.

**Fetal Assessment Unit** – started March 2014. This is held every Wednesday and run by a core midwife and a registrar.



**Hip check clinic** – held twice weekly.

**Amniocentesis** – is done on Thursday mornings when required. Thirty-one (31) women had amniocentesis in 2013 and only 17 in 2014. Over 40% of these were for increased risk in MSS2, all were false positives and shows that when MSS1/combined screening is done it is more accurate.



### **Improvements Made and What's Going Well**

**Vaccination Clinics** – Antenatal clinic again achieved cold chain accreditation. The Antenatal Coordinator was involved in The Pertussis Immunisation in Pregnancy Safety (PIPS) Study aimed to monitor the safety of pertussis vaccine given during pregnancy. The role involved:

- providing women who had just received Tdap vaccination at the clinic with a Participant Information Sheet summary;
- briefing potential participants about the study and inviting interested women to be referred to the study team;
- faxing a completed Referral Form for each interested woman, with their consent; referral forms containing contact details, demographic and vaccine information (eg vaccine batch number, any previous history of vaccine reaction);
- ensuring that each interested woman had a study envelope, which included a clear plastic measuring tool and diary card to record any possible symptoms or events over the 48 hour period following vaccination;
- by the end of the overall recruitment period ANC Coordinator had referred 28 women to the study, a sizeable contribution.

**Fetal Assessment Unit** – This is helping alleviate the acuity on delivery suite. Over the last 12 months a total of 117 women have been seen. The majority of referrals are for Intrauterine Growth Restriction (IUGR) and for women who need to be seen urgently that have problems arising during ultrasound examination at the ultrasound high risk session.

**TV and DVD player** in antenatal clinic waiting room for antenatal education purposes.

**Permanent ward clerk for antenatal clinic** – an additional ward clerk 0.4 FTE has been appointed (this need was identified in the 2014/15 Maternity Annual Report). This has streamlined the service by having a methodical system regarding referrals and notes and releasing the ANC Coordinator from administrative tasks. Also having the same ward clerk helps with continuity and getting to know the women.

### **What Needs to Improve**

- Increasing elective C/S requests : It appears more women are asking for elective C/S for reasons other than repeat C/S. Examples include 3rd degree tears, cystocele, big baby, previous haemorrhoids, PTSD, IVF, Increased age. A working group to address this issue is in progress. Measures already taken include:

- a) Women are seen at an earlier gestation to discuss VBAC instead of the later 32 weeks' gestation.
  - b) After an emergency C/S the obstetricians are documenting in the operation notes if the woman is suitable for VBAC next time, this is followed by a visit to the inpatient in the first few post-operative days to enforce this. It is thought if the seed is planted early enough this may have a positive impact on mode of delivery in the next pregnancy.
  - c) Micro birth DVD - A new 60 minute documentary investigating the latest scientific research about the microscopic events happening during childbirth and why elective C/S can have life-long consequences for the health of our children and potentially could even impact mankind. Is played to women attending ANC to discuss VBAC.
- Lack of local MFM services for the women of Taranaki continues. Dr Michel Sangalli and Dr Jay Marlow, MFM specialists in Wellington are too busy to provide visiting MFM services to Taranaki. It is thought Dr Marlow may be happy to attend virtually, by video conference. We are waiting confirmation of this. There has been an increase in the number of women referred to MFM in the last 12 months. Appointments at tertiary hospitals in Auckland and Wellington are disruptive for the woman and family, and costly to Taranaki DHB.
  - Integration of gestational and pre-existing diabetes antenatal clinics with diabetic services : This was attempted in 2013/14 with a nominated specialist obstetrician but wasn't well attended by the Diabetic Clinical Nurse Specialists due to their workload, it was therefore discontinued. Taranaki DHB has agreed to participate in the TARGET (optimal glycaemic targets for gestational diabetes) national research project. A research midwife will lead this for Taranaki and hopefully help develop the antenatal diabetic services in the future.

### **Plans for 2015**

- A. Continue with the Fetal Assessment Unit.
- B. Continuity of care for high risk women both obstetric and midwifery.
- C. Establish relationships via telemedicine with Dr Jay Marlow in Wellington to reduce/avoid women travelling out of Taranaki.
- D. Ideally a role for a Diabetic Liaison Midwife to run a clinic for women with Type 1 and 2 diabetes and the ever increasing women with gestational diabetes.
- E. Focus on decreasing the C/S rate and increasing the uptake of VBAC.
- F. Initiate a virtual consultation clinic for LMCs to ask obstetric opinion/aid prioritisation of referrals. An example of this may be where a woman requires/meets the criteria for aspirin early in the pregnancy.

### **Alliancing with Primary Partners**

Maternity interface meetings and workshops between self-employed and employed midwives have been ongoing. These meetings provide a forum to voice any issues and help identify solutions for a harmonious working environment. Where issues have been identified working groups with specific goals have been set up and have representatives from all applicable practitioners, including NZCOM to problem solve and take initiatives forward together; an example is a more workable solution for women undergoing induction of labour that also meets the needs of LMCs and ward acuity.

Additionally a meeting has been held with GPs and practice nurses (see timing of LMC engagement section). The formulation of the pre and post pregnancy directory of maternity stakeholder information and communication of services has increased local knowledge and relationship between the services that are available and can be accessed.



## **Breastfeeding and Lactation Services**

### **Tiaki Ūkaipō – Breastfeeding Service**

During 2013 Taranaki DHB provided an application process for Lactation Consultant training scholarships, and from this four new Lactation Consultants were trained and accredited as International Board Certified Lactation Consultants (IBCLC) in October 2014. These four people are Lara Bertie, Anthea Brown, Paula Dawson and Adrienne Peters. They are all involved in the drop-in clinics and home visits for women in this programme, along with the Mama and Pepe Hauora Programme Coordinator, Julie Foley who is also an IBCLC. Referrals come through intake at Tui Ora, to be triaged and allocated to an IBCLC or peer supporter as appropriate. One of the challenges for this programme is that all IBCLCs also work for various organisations and are therefore not available for all days of the week. This has meant when urgent referrals come in that in many cases Julie has had to take this load, which also impacts on her other work.

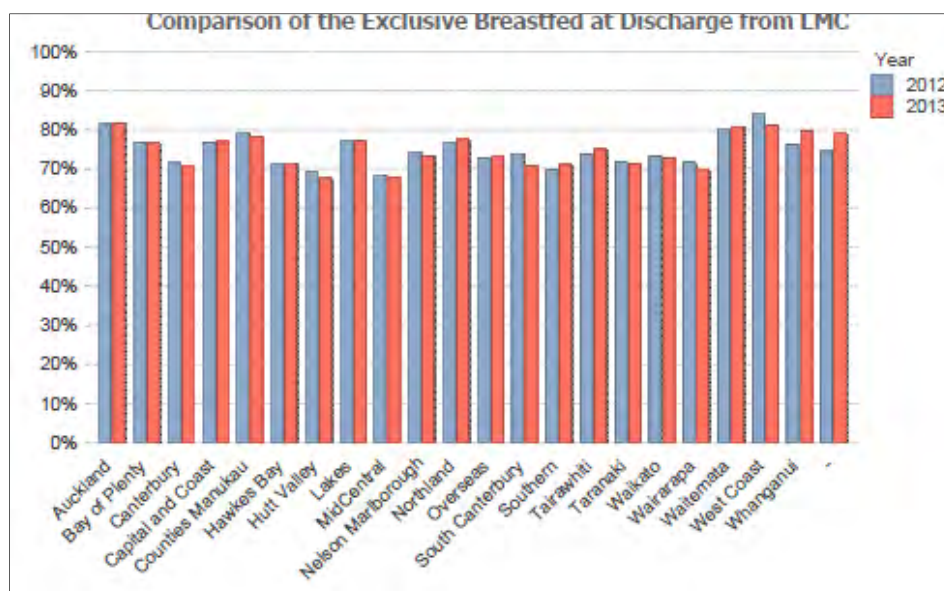
This community-based lactation service aims to both provide lactation services and support directly to women and also work collaboratively with LMCs, Tamariki Ora/Well Child providers, Childbirth Educators, Taranaki DHB maternity and neonatal staff, Taranaki La Leche League and other interested organisations who work with mothers, babies and whānau.

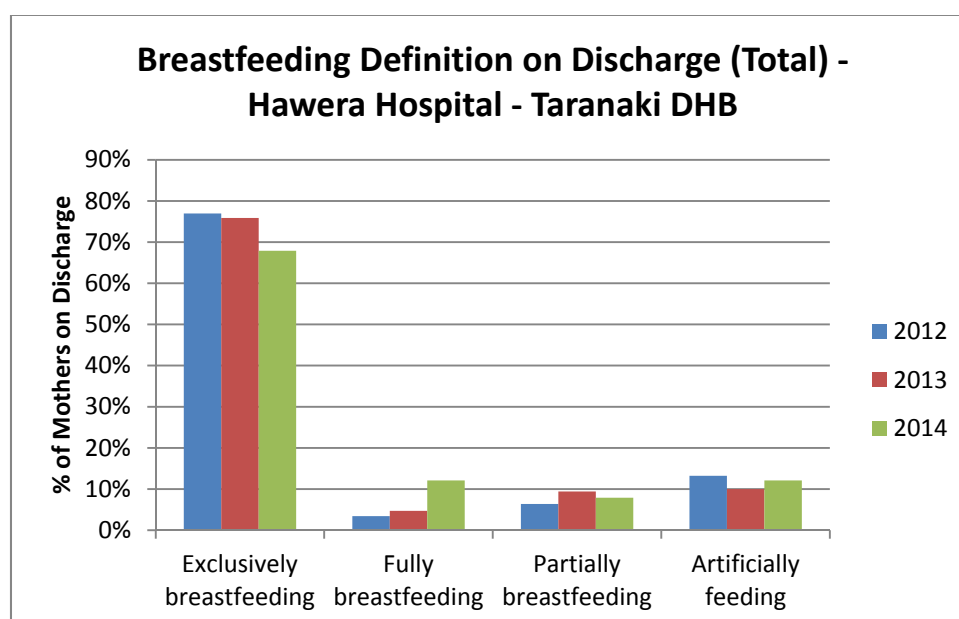
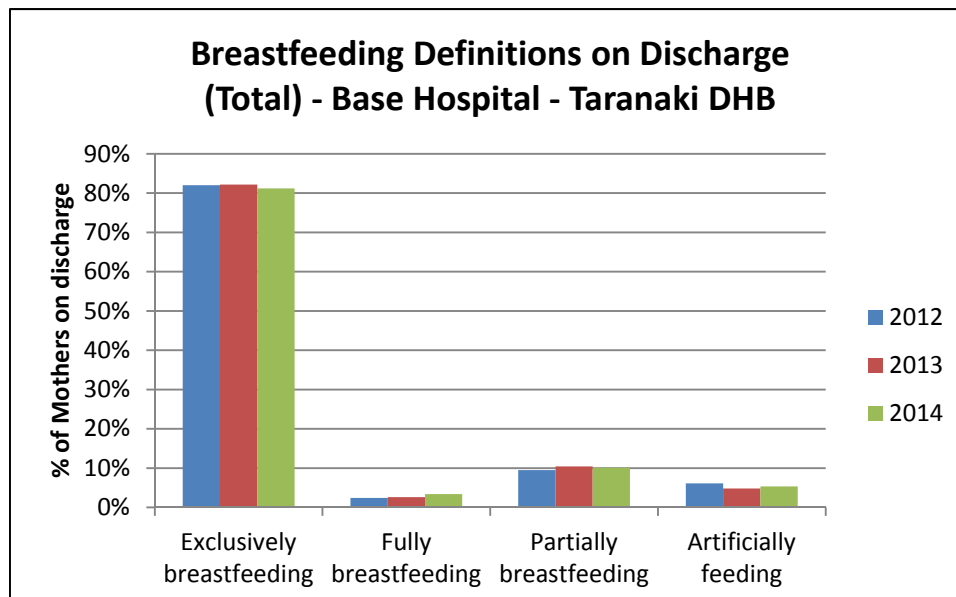
This programme includes community-based breastfeeding drop-in clinics and home visiting by Lactation Consultants and volunteer Breastfeeding Peer Supporters and includes breastfeeding education in either one-on-one or group settings.

### **Mama and Pepe Hauora Programme**

The Mama and Pepe Hauora Programme (MPH) is a population-based programme to promote key MoH messages for pregnant women, mothers, babies and children under the age of five years and their whanau around the topics of nutrition – including breastfeeding and physical activity – including active movement for pre-schoolers. There is a particular focus on reaching Māori women, women under the age of 18 years who are pregnant or have a baby, and rurally or socially isolated women, and their whānau.

Within this programme education about these topics is provided for community organisations or groups (as well as parents or parents-to-be); there is also maintenance of Baby Friendly Community Initiative (BFCI) accreditation by currently accredited organisations (Tui Ora, Taranaki Plunket and Taranaki La Leche League); and a focus on participation in Breastfeeding Welcome Here (BFWH) accreditation by early childhood settings and other public places. Community-based initiatives are also being funded to undertake a sustainable project that influences improved nutrition and/or physical activity for the focus populations.





One of the Taranaki DHB's lactation scholars is based in Hawera and holds lactation consultation clinics. She will be networking with the other Lactation Consultants and practitioners to identify improvements and initiatives to increase the breastfeeding rates in South Taranaki. Due to small numbers of discharges in Hawera even an additional one or two women who were not exclusively breastfeeding on discharge can have a high impact on the overall % of women breastfeeding.

Hawera and Base Hospital are both BFHI accredited.

Taranaki DHB works with the MMAG breastfeeding sub-group to develop and progress new initiatives such as a breastfeeding smart phone app and a guideline for the use of donor breast milk, this work will continue in 2015/16.

### **Gestational Diabetes Guideline, Healthy Weight and Issue of the Green Prescription**

The guideline has been circulated to all maternity practitioners in the MQC newsletter and discussed at multidisciplinary meetings, which includes the diabetic specialist team. Additional to this the link to the healthy weight gain in pregnancy and nutritional resources available from the MoH website has been circulated to maternity practitioners and in-service education on the issuing of the green prescription has also been held. 2015/16 will ensure these guidelines as well as the MOH quality standards for diabetes care toolkit (standard 20) are fully implemented.

## Information and Communications Technology

Information and Communications Technology (ICT) has improved with the introduction of computers on wheels (COWS) and wireless internet services. The data collection system is still a challenge but should improve in the future with the implementation of the national MCIS IT system. A closer relationship has been made with Midland and Taranaki DHBs' data analysts that has made better availability of data to present and display to staff and practitioners.

## Perinatal and Neonatal Mortality (PMMR) and Morbidity

Taranaki DHB has seen a reduction in the number of cases classified for perinatal mortality in 2014. Taranaki DHB has continued to have excellent attendance at PMMR meetings by combining the meetings with educational presentations, including inviting presenters such as Dr Jane Zuccollo and Dr Sue Belgrave in 2014. These meetings included discussion on the findings and recommendations of the national PMMR Committee and report. Taranaki DHB are committed to reducing barriers to enable access and early engagement in pregnancy care, provide better help for smokers to quit, implement initiatives to prevent obesity, promote and support healthy weight gain in pregnancy with a focus on healthy eating, diet and exercise (green prescription) and ensure continuity of specialist care is provided to unwell or unstable women, including the availability of multidisciplinary management plans being made available.

Every case of perinatal mortality is usually presented at each meeting. Additionally, case reviews are held for every baby that is cooled to look at the care provided and to examine if improvements in practice can be made. Neonatal encephalopathy cases are also presented at the local perinatal mortality meetings by the paediatric staff.

Taranaki DHB has initiated a protocol and process for sending placentae to Auckland for perinatal pathology examination/histology from babies born alive that meet the criteria as well as stillborn/neonatal deaths following Dr Jane Zucollo's presentation. This service could provide recommendations for care in future pregnancies based on the findings and help prevent morbidity/mortality in future pregnancies. In 2015/16 consumer representatives from the Maori, Indian and Pacific communities will be engaged to assist in getting important messages across for optimum pregnancy, labour and postnatal support and services to try and improve pregnancy outcomes for these ethnicities.

Figure 1.22: Crude stillbirth rate (per 1000 births) by DHB of residence (mother) compared to New Zealand stillbirth rate (with 95% CIs) 2007-2013

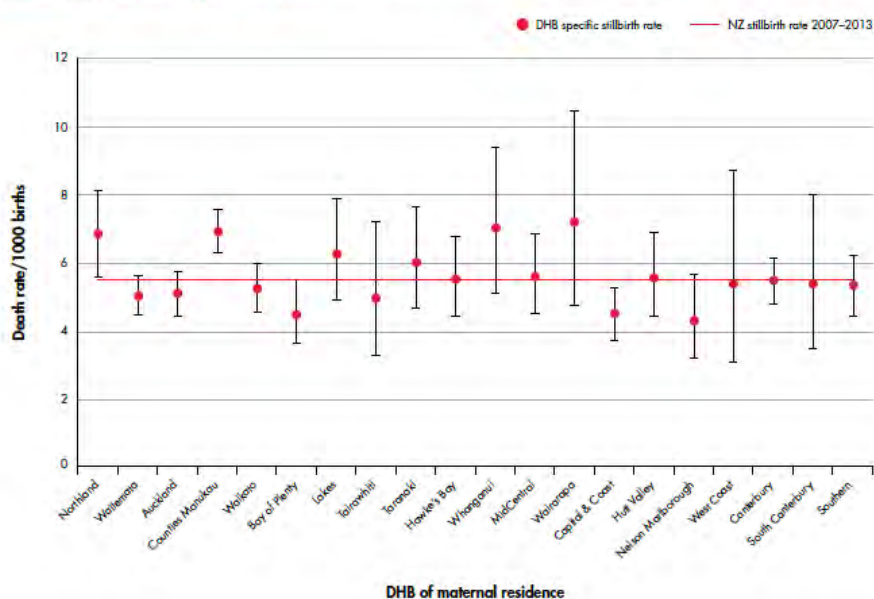


Figure 1.23: Crude neonatal death rate (per 1000 births) by DHB of residence (mother) compared to New Zealand neonatal death rate (with 95% CIs) 2007–2013

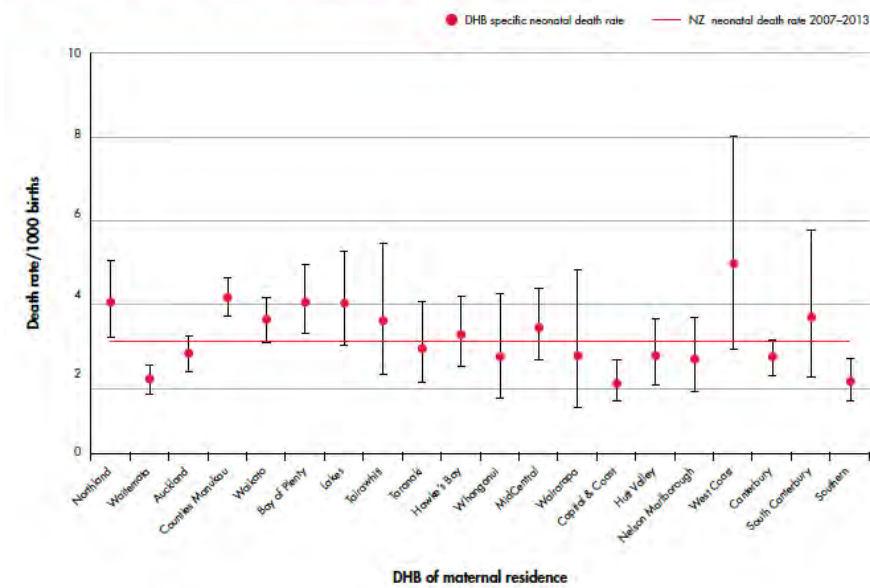
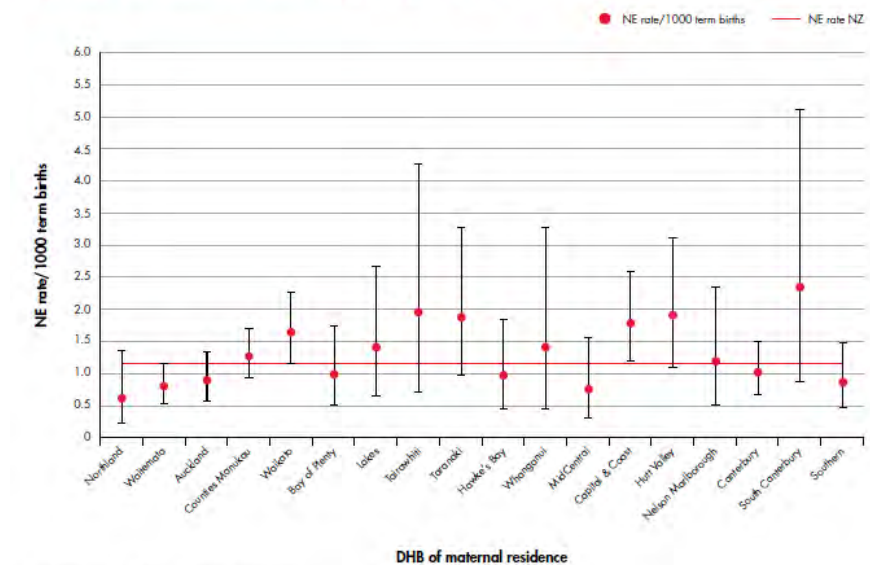
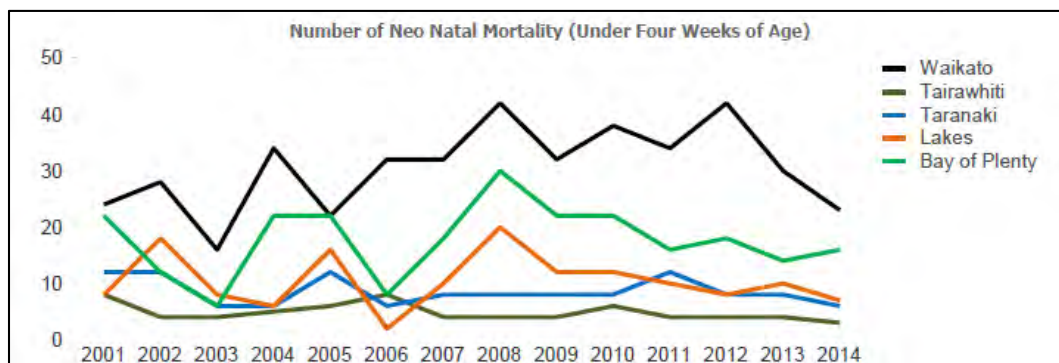


Figure 3.4: Neonatal encephalopathy rates (per 1000 term births) by DHB of maternal residence\* (with 95% CIs) compared to New Zealand neonatal encephalopathy rate 2010–2013



\* Excludes any DHB with fewer than three cases.

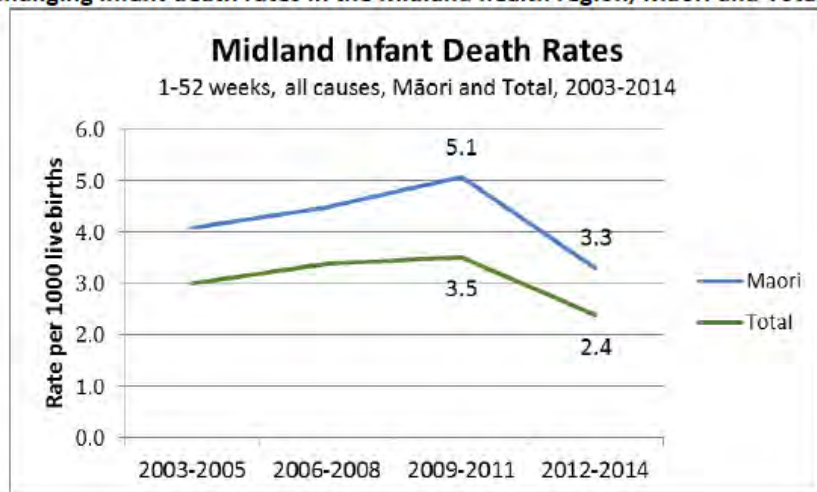
Figures 1.22, 1.23 and 3.4 above taken from the 9<sup>th</sup> Annual PMMRC report (2015)



Data obtained from Health share

## Safe Sleep : Sudden Unexpected Death in Infancy (SUDI)

Fig. Changing infant death rates in the Midland health region, Māori and Total



Graph taken from the Rainbow Report 2014

TOTAL	2003-2005	2006-2008	2009-2011	2012-2014
<b>Infant Death Rates</b>				
Northern	3.0	2.6	2.5	2.0
Midland	3.0	3.4	3.5	2.4
Central	2.5	3.7	2.5	2.0
Southern	2.1	2.2	2.0	2.2

Midland has the greatest reduction in Infant Death Rates

Taranaki and Lakes DHBs have similar population and birth numbers however Lakes have a higher Maori population and similar SUDI rates. It is likely the introduction of the Pepi-Pod distribution programme and safe sleep policy has had an impact on Taranaki's and Midland regions SUDI rates.

A regional safe sleep policy has been implemented along with safe sleep education, both locally and regionally. The highlight of our Pepi-Pod distribution programme and securing further Pepi-Pods for our babies/Pepi through the MMAG has been celebrated in an attempt to further reduce Taranaki's SUDI rate and promote safe sleep practices. A local company has donated funds to secure replacement of Pepi-Pods.

The 2014 National Safe Sleep Day was promoted in Taranaki by the display of safe sleep resources and messages in our local Warehouse shop as well as the wards, which was supported by our local safe sleep champions and distributors.



## Safe Sleep Day 6 December 2014



The safe sleep champion Merry Sorensen and Deb Harding (Tui Ora) were joined by volunteers from maternity, neonatal and well child providers in providing a display and colouring competition in the local Warehouse, New Plymouth Branch.

## Taranaki Pepi-Pod Programme Data Update

### Overview

There were 170 distribution, 128 (75%) follow-up and 18 (11%) feedback records entered on the programme database. Below is a Taranaki-specific summary (1 July 2013 - 21 April 2015).

#### Distribution (n=170)

Age of mother	
<20	27
20-24	57
>24	84
Mother uses CS Card	
Yes	129 (76%)
Mother's first born	
Yes	79 (47%)

Smoking in Pregnancy	
yes	119 (70%)
Smoking in Household	
yes	127 (75%)
Premature or Low Birth Weight	
yes	31 (18%)
Maori	
yes	123 (72%)

#### Follow-up (n=128)

Want to keep pod	115 (90%)
Sleep on back	124 (97%)
Firmly tucked	127 (99%)
Same room as parent	124 (97%)
In pod in risk places	115 (90%)
Any breastfeeding	105 (82%)
Smokefree/quit support	97 (76%)
Shots started/booked	82 (64%)

#### Feedback (n=18)

High rating (7-9/9) for support with	
safety	17 (94%)
convenience	14 (78%)
settling	14 (78%)
Overall idea	18 (100%)
Any bed sharing since getting pod	
Yes	16 (89%)
If yes, always usually in pod	14 (88%)

#### Births and deaths (data source: Statistics NZ customised report)

<b>Births in 2014</b>	
Maori	488
Total	1508

<b>Deaths</b>	<b>2006-2008</b>	<b>2009-11</b>	<b>2012-14</b>
Total	11	14	8

Infants 1-52 weeks, all causes of death



### Sample comments (unedited from 10 people [56%])

- Fantastic idea and concept....love it!!!
- Fantastic idea. My son's sleeping is so much better after starting with the Pepi-Pod. Makes it so much easier having 3 older kids.
- It should be made available to everyone.
- It is wonderful, having baby close to us and knowing he is safe, and a life saver when he is unsettled or over tired. Such an awesome solution. Thank you :)
- It gives us security knowing that he can be beside us still in bed and he's alright in the Pepi - Pod, gives him security too knowing that we are there and he feels safe. He's also settling more now in his own bed in cradle. Thank you so much! :)
- I'm telling everyone about it, coz everyone should know about it not just those who need it, everyone :) then maybe it might be made available to everyone as well.
- It was great to be able to put the Pepi-Pod on the couch in the lounge so that I could always be close to baby and allowed me to engage with my three other children.

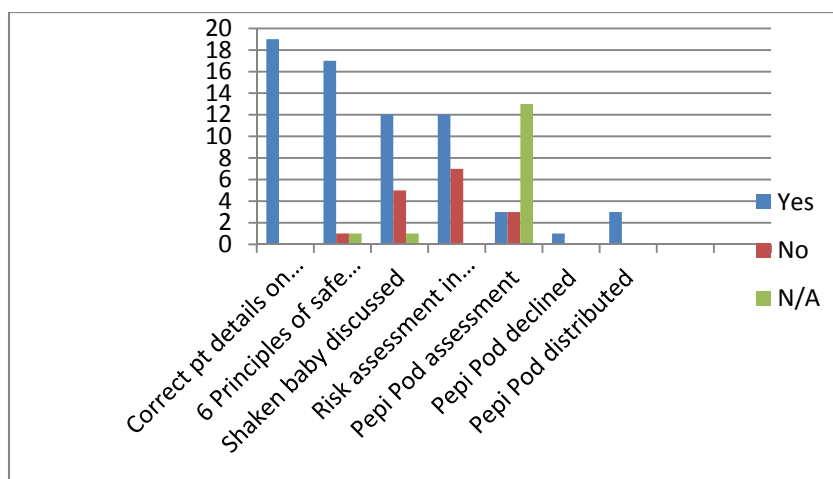
Prepared by Stephanie Cowan (Programme Director) (22/4/2015)

### Safe Sleep Audit by Merry Sorensen – May 2015

Objective: To evaluate safe sleep standards and SUDI within Base Maternity.

Ward Area: Base Maternity Unit

Auditor: Merry Sorensen (E/N) Safe Sleep Champion Pepi-Pod Co-ordinator



### Findings

- Satisfactory result for six principals for Safe Sleep.
- Room for improvement regarding “shaken baby” and asking the question.
- Room for improvement regarding risk assessment, two patients given ‘low risk’ when mothers BMI >30 (actually found to be >40).
- Discussion required at ward meeting and next Safe Sleep in service/study day regarding risk assessment evaluation, Pepi-Pod assessment, and document assessment and not required due to low risk.

## Hapū Wānanga Curriculum and Toolkit Midland Region Maori Community Consultation Road Show – April-May 2015

Te Puna Oranga (Māori Health Service, Waikato District Health Board) is leading the development and implementation of a kaupapa Māori Pregnancy & Parenting Programme (Hapū Wānanga) curriculum for the Midland region.

The intent of the curriculum and toolkit is to grow the number and breadth of culturally-appropriate pregnancy and parenting programmes in the Midland region. The programme will adopt a partnership approach that enables clinicians/birth educators and Māori health workers to work together to deliver Hapū Wānanga programmes that are both clinically and culturally sound. The curriculum content will be underpinned by the cultural needs and beliefs of Māori and will align to Ministry of Health Pregnancy and Parenting Programme Specifications.

To provide Māori communities an opportunity to feed into the design of the curriculum and toolkit, Te Puna Oranga visited three areas within the Midland region.



✱ A total of 91 people participated in the consultation road show including; pregnant wāhine, tane, Māori community and health workers, Māori midwives and nurses, marae committee members as well as hapū and iwi within the Midland region. Participating organisations included:

- Hapu Ora Midwives
- Hauiti Hauora
- Heart Foundation
- Korowai Aroha
- Lakes District Health Board
- Manaaki Ora / Tipu Ora
- Manawanui Massage
- Midland Health Network
- Ngati Maniapoto Marae Pact Trust
- Ngati Porou Hauora
- Plunket/kaiawhina
- Raukura Hauora o Tainui
- Taranaki District Health Board
- Taumarunui Community Kokiri Trust
- Tutama wahine O Taranaki
- Waahi Whaanui
- Waikato District Health Board
- Whai Marama Youth Connex
- WINTEC Maori Midwifery students
- Turangawaewae Marae
- Tuakana Teina Insight
- Tui Ora Ltd
- Turanga Health
- Te Papa Takaro o Te Arawa
- Te Runanga o Kirikiriroa
- Tipu Ora
- Te Hauora o Turanga nui a Kiwa
- 

The workshop began with identifying key issues faced by Māori living in the Midland region followed by identifying current support services and programmes available and key gaps in service provision and supports. Participants spent the remainder of the workshop contributing to the modules of the curriculum and creating interactive activities to integrate in the curriculum as tools to support future facilitators to better engage Māori.

Te Puna Oranga will be completing consumer focus groups in May and June 2015 and a draft curriculum will go out for further consultation in July 2015. The curriculum and toolkit will be completed by October 2015.

## **Safe Sleep & Mama Aroha Breastfeeding Talk Card Refresher Training Road Show April-May 2015**

Te Puna Oranga (Māori Health Service – Waikato District Health Board) provided face-to-face training sessions for health professionals in the Midland region in April and May 2015. The sessions were:

- **Safe Sleep & Pēpi-Pod® Refresher Training**
- **Mama Aroha Breastfeeding Talk Card Training**

### **SESSION 1: Safe Sleep/Pēpi-pod® Refresher Training**

The Midland Safe Sleep Programme is a comprehensive health programme designed to respond to key issues affecting whānau that may place a pēpi at risk of Sudden Unexpected Death of an Infant (SUDI). The programme provides an enhanced model that provides a coordinated approach forward in relation to key messages associated with the distribution of Pēpi-pod® safe sleep devices across Midland.

The Safe Sleep & Pēpi-Pod® Refresher Training session was designed for Pēpi-pod® distributors and card holders in the Midland region as well as those interested in promoting safe sleep practices in their work, namely Maori community providers. The training included:

- Midland Pēpi-Pod® stats
- National SUDI research /trends
- Dr David Tipene-Leach (via video presentation)
- Change for our Children update (Stephanie Cowen via Alys Brown)
- Revision of safe sleep messages
- Safe sleep sticker

Workshop exploring what is working well, what isn't and opportunities.

### **SESSION 2: Mama Aroha Breastfeeding Talk Card Training**

Mama Aroha Talk Cards were designed in 2009 by Mama Aroha Director - Amy Wray, with the needs and wants of Māori women and their whānau in mind. Merging evidence-based and best practice breastfeeding approaches within the context of a Māori world view; the Mama Aroha Talk Cards provide the perfect visual tool to support health professionals to better engage whānau in conversations, education, decision-making and support around breastfeeding. This Combo Set is useful to anyone who has a basic understanding of breastfeeding information and skills, particularly those who work with pregnant women or families with young pēpi.

The intent of the Mama Aroha Talk card training was to equip the health workforce with relevant knowledge and tools to enable them to better support Māori whānau to establish and maintain breastfeeding. The Mama Aroha Talk card training was a half-day workshop that compliment and sequentially followed the Midland Safe Sleep Programme training.

✠ A total of **121** people participated in the Safe Sleep and Mama Aroha Breastfeeding Talk Card refresher training across the Midland region.

The training was designed to build champions within each of the five districts in the Midland region. This means that each respective district will lead their own safe sleep and breastfeeding initiatives and any ongoing training required in their own communities. This will ensure sustainability of training programmes such as this.

## Workforce

### Medical Vacancies

Taranaki DHB has had a stable O&G Consultant workforce over the last year. Additionally a second O&G registrar has been appointed for the first time in 2015. This has improved work conditions for the pre-existing registrar position and provides more senior support for the self-employed midwives, core midwives and duty obstetricians.

### Midwifery Vacancies

There has been an improvement in recruiting midwives for Hawera and Taranaki Base over the last year. All the temporary Registered Nurse (RN) positions that were employed to cover midwifery positions that were unable to be filled have now been replaced with midwives. Taranaki has historically been in this position before only to find repeated difficulty in appointing midwives to cover for example maternity leave and resignations. Twenty-five percent (25%) of midwives in Taranaki DHB are over 55 years old (see tables below); it can still be considered a fragile workforce and will still require active recruitment in the future.

It is pleasing to see with more midwives graduating from the local satellite training and by providing local midwifery student placements for WINTEC our Maori midwifery workforce has increased to 21% (7/33).

The Postnatal Coordinator role was advertised and the position was reappointed in 2014, a midwife LMC returning to the DHB has embraced this role and is making good progress with new and existing initiatives. This role provides leadership and enhances the effective coordination of the postnatal services.

It is still evident that maternity is in need of a new unit that is on one level in order that we can manage the available FTE more efficiently and effectively, especially during times of high acuity. This would also improve continuity of midwifery care and supervision for less skilled members of staff and student midwives. Having a unit that is closer to the operating theatres or having its own obstetric theatre would be much more advantageous than the current situation. While the current infrastructure still exists there have been ongoing meetings between core midwives representatives, New Zealand Nursing Organisation (NZNO), Maternal & Child Health Clinical Services Manager, Clinical Managers and ADOM to explore and investigate more flexible and sustainable staffing levels to address times of high acuity on the wards.

Auckland University of Technology continues to offer local satellite midwifery training to undergraduate midwives. 2015 has seen three new graduate midwives in the core and self-employed midwifery workforce who are now undertaking the Midwifery First Year of Practice programme (MFYP). This local based training will help replace midwives/future succession planning and will provide long-term sustainability of the midwifery workforce.

**Table 1 : Age of Midwife Workforce**

Age Grouping	Total 2015	Distribution	Total 2014	Distribution
26 - 35	8	20.0%	8	20%
36 - 45	9	22.5%	9	23%
46 - 55	15	37.5%	13	33%
56 - 65	8	20.0%	8	20%
65+	0	0	2	5%
Total	40		40	
		100%		100%

**Table 2 : Average Age of Midwife Workforce 2014 & 2015**

UNIT NAME	Headcount		Average of Age		Min of Age		Max of Age	
	2014	2015	2014	2015	2014	2015	2014	2015
Base Maternity	27	29	45	45	26	28	66	61
Hawera Maternity Service	6	5	53	51	41	42	68	58
Pool/Casual Staff	6	6	48	54	40	43	63	65
<b>Total</b>	<b>40</b>	<b>40</b>						

### Education of Staff

The Taranaki DHB Midwife Educator (ME) has undertaken and gained training in the certificate in adult education. The ME is networking with the other Midland DHBs through MMAG to share education templates and resources. This has been a valuable initiative having devised joint midwifery education templates that have been approved by the Midwifery Council of New Zealand (MCNZ). This means if the Taranaki DHB educator cannot deliver education due to for example sickness, another Midland ME can visit and deliver the same programme.

An annual maternity education calendar can be viewed in Appendix 5. Additional to this calendar are ward based in-service education sessions and e-Learning modules, as well as the online K2 cardiotocography (CTG) learning package. All education is offered to all maternity practitioners, both employed and self-employed. Taranaki DHB is continuing to encourage employed midwives to engage with the Quality Leadership Programme (QLP) and participate in post graduate education. Two midwives are undertaking the midwifery complex care course through Victoria University in 2015.

### Access Agreement Holders

There are 74 active access agreement holders throughout Taranaki DHB who claim through Section 88, this has increased from 50 in 2014 and 43 in 2013. These include midwives, GPs and private obstetricians. Taranaki DHB has not received any reports of ineligible New Zealand women who are unable to access an LMC. Rural midwives have utilised the rural midwife locum service for leave.

### Core Midwifery Services for Private Obstetricians

The unpredictable workload has decreased for core midwives providing labour and birth services to primary obstetrician and GP clients, now only having one private obstetrician and one GP having this agreed arrangement.

# MQSP STRATEGIC PLAN DELIVERABLES FOR TARANAKI DHB AND THE MIDLAND REGION

## List of Priorities, Deliverables and Planned Actions for 2015/16

### Maternity Quality Committee (MQC) Work Plan

**Chair:** Belinda Chapman (ADOM, Taranaki DHB)

**Vision:** To lead local maternity activity on behalf of Taranaki DHB that improves patient safety, quality of care, equity of access, and population health outcomes.

#### Key Objectives:

- Undertake an agreed local work programme that supports the implementation of the National Maternity Quality and Safety Programme (MQSP)
- Improve consistency of practices and coordination of responsive maternity services through working collegially and cooperatively to develop local and regional standards, guidelines, etc to enable the best use of resources
- Improve access to information sharing for LMCs, maternity service providers and consumers.
- Maternity workforce development to reduce vulnerability and increase sustainability

	Project	Expected outcome	Progress	Outcomes	Responsibility
1	<b>Inclusion of consumers in the Maternity Quality &amp; Safety Programme (MQSP) governance at Taranaki DHB to enable consumer informed decision-making</b> <ul style="list-style-type: none"> <li>• Consumer engagement survey</li> <li>• Meet your maternity services road show</li> <li>• Consumer engagement survey</li> <li>• Wahakura weaving</li> <li>• Stratford Maternal and child health hub, consumer representative</li> <li>• Consumer representative for the Maori, Indian and Pacific ethnicities identified and utilised to assist MQC</li> <li>• Promotion of primary birth campaign (use of primary facility and homebirth)</li> <li>• Upgrade of Hawera primary maternity unit</li> </ul>	<p>Consumer voices (via survey, individuals, focus group, complaints and compliments, road show) is collected and informs the future direction of service delivery for Taranaki DHB.</p> <p>Local MQSP consumer representatives have a Taranaki DHB forum space to share ideas and connect with each other to strengthen consumer input into maternity services.</p> <p>Consumers have knowledge and understanding of maternity and primary ultrasound services</p>	Survey has been piloted		Consumer; ADOM; planning and funding



	Project	Expected outcome	Progress	Outcomes	Responsibility
2	<p><b>Improve LMC registration so that access to care is increased – increase the number of women registering with an LMC in their first trimester</b></p> <ul style="list-style-type: none"> <li>• Create a pathway for GP's &amp; practice nurses for referral to LMC, primary ultrasound and secondary antenatal clinic</li> <li>• Meet with GPs and practice nurses in South, central and North Taranaki to update on LMC and maternity services, assessments, screening and referrals</li> <li>• Continue 5 top things to do in the first 10 weeks of pregnancy</li> </ul>	<p>Improved first trimester LMC registration across Taranaki DHB.</p> <p>Improved access to LMC maternity care across all ethnic groups.</p>			ADOM;ANC coordinator; Educator; CD O&G; LMC rep,
3	<p><b>Preterm and Late Preterm Births</b></p> <p><b>Monitor and evaluate underlying reasons for and the number (% of total) of preterm births</b></p> <p><b>Investigate any improvements that can be made to prevent preterm births</b></p> <p><b>Education on assessment, investigation and treatment for preterm labour, PPROM, tocolysis and fetal fibronectin testing</b></p>	<p>Data captured to benchmark regionally and nationally.</p> <p>Identify areas for improvement:</p> <ul style="list-style-type: none"> <li>• Early enrolment with an LMC;</li> <li>• Healthy women and healthy babies.</li> </ul> <p>Reduce the numbers of preterm births.</p>	Data being captured and reported to MQC.		CD O&G; NNU CNM; ADOM ; Educator
3A	<p><b>Neonatal Admissions</b></p> <p><b>Continue to monitor numbers of term, late preterm and preterm admissions to NNU, include the total number of babies born in Taranaki from 36-36+6 weeks' gestation</b></p> <p><b>Identify and explore reasons for admission</b></p> <p><b>Monitor length of stay</b></p> <p><b>Identify areas for improvement in the care of the late preterm infant so that mother and baby can remain together in the postnatal ward</b></p>	<p>Reduction in Neonatal unit admissions</p> <p>Benchmarking – regionally and nationally.</p> <p>Keeping mothers and babies together; plan for co-location of Maternity, Neonatal and Child Health Services. Post natal ward staffing available for transitional care. Closer liaison and integration of postnatal and NNU staff</p>			NNU CNM; Educator; CD O&G; CMM

	Project	Expected outcome	Progress	Outcomes	Responsibility
		<p>Training and education of all Maternity and Neonatal staff in the care of the late preterm infant.</p> <p>Training of maternity, NNU and PACU staff on care of the “at risk newborn” including monitoring of blood glucose and early breastfeeding</p>			
4	<p><b>Maternity services</b></p> <p><b>Investigate co-location of Maternity (antenatal/postnatal/labour) and neonatal services (to be nearer to the child health services and operating theatres)</b></p> <p><b>Explore what the future maternity services will look like in Taranaki DHB (is a primary unit required in New Plymouth?)</b></p>	<p>Integrated Antenatal / Postnatal/Labour and birth services with Neonatal unit adjacent to improve continuity, effectiveness and efficient use of staff and equipment.</p> <p>Promote skill mix, education and learning environment.</p>	<p>Security to the existing areas improved with video surveillance and remote access at Base Hospital</p>		<p>CSM M&amp;CHS; ADOM; CMM; NNU CNM, Planning and Funding</p>
	<p><b>Strengthen the model of care at Hawera Maternity unit-aligning with past Stratford unit</b></p>	<p>Safe, low tech homely environment that is whanau/family friendly and meets the needs of the local population for low risk birthing</p> <p>Promotion/campaign for low risk births/increase in birth rate at Hawera maternity unit</p> <p>Timely emergency response and skills from St John and base hospital for neonatal retrieval</p>	<p>See draft Neonatal Emergency response, page 50</p> <p>Meeting May 2015 with St John to plan way forward</p>		<p>CMM, M&amp;CHS, ADOM, LMC's, Planning and funding, consumer, St John</p>

	Project	Expected outcome	Progress	Outcomes	Responsibility
	<b>Exploration of a maternal and child health hub for Stratford and surrounding districts</b>	Key stakeholders and community groups identified Governance group established Feasibility for hub assessed Report on findings completed	Draft project plan 5/6/15 Agreed governance structure and participation 18/6/15		Planning and funding, M&CHS, ADOM, consumer
<b>6</b>	<b>Improve screening and services for vulnerable perinatal women, babies and families</b> Provide information on Maternal mental health services to stakeholders and clients Collect data to inform services on the delivery of PMMH services	<p>A. Update Pre and post natal referral directory implemented and sent to all stakeholders of maternity.</p> <p>Acute Perinatal Mental Health nurse position is established and prioritises PNIMH referrals</p> <p>Maternity providers, clients and stakeholders have knowledge of the Perinatal mental health services by the provision of an information leaflet for the maternal-infant health practitioners and one for clients</p> <p>Data is collected on access to PNIMH services, timing of referral to first meeting, how many referrals and how many are accepted, reasons for referral, gestation/baby age at referral, age, ethnicity, parity/gravidity, who referred</p> <p>Improved integration of PNIMH, maternity, drug and alcohol and well child provider services</p>		<p>ADOM</p> <p>PMMH, CMM, ADOM</p> <p>PMMH</p> <p>PMMH</p> <p>PMMH, A&amp;D, ADOM, CMM</p>	

	Project	Expected outcome	Progress	Outcomes	Responsibility
		B. FVIP screening and training on how to screen and refer is available to all maternity practitioners. 100% maternity patients screened for FVIP.			CSM M&CHS; CMM; Educator; FVIP Coordinator
		C. Implementation of Maternity care, wellbeing and child protection multi agency group meetings.			CMM; FVIP Coordinator; ADOM, child protection coordinator, maternal social worker PNMH
7	Investigate rising primary maternity ultrasound scans Explore consumer, primary practitioner and providers of primary ultrasound scans expectations of primary ultrasound scans	Reasons for escalating primary ultrasound scanning identified and addressed Referrals for ultrasound scans meet section 88 criteria	.		CSM M&CHS; ADOM; CD O&G; CD Radiology
8	Caesarean Section (C/S) Monitor timing of decision to delivery of Level 1 C/S Monitor GA C/S rate Audit elective C/S for gestation, reason and individual obstetrician practice to identify any trends Retrospective audit on emergency C/Section for failure to progress and non reassuring CTG to identify any education needs required on intrapartum care and CTG interpretation	Timings of Level 1 C/S is within the recommended 30 minutes for Level 1 C/S. C/S rates among primiparae and multiparae compare to similar populations e.g. Lakes DHB. C/S performed only if clinically indicated prior to 39 weeks' gestation. Reduction in C/S rate Any education requirements are identified and addressed	Hard data obtained		Core midwife; QEC; CMM; CSM M&CHS; ADOM; CD O&G; Anaesthetist; OT CNM
10	Hip check services reviewed to improve consumer satisfaction	Hip check provides a service that is timely, accessible and satisfying to consumers.			M&CHS; CMIM

	Project	Expected outcome	Progress	Outcomes	Responsibility
11	<p><b>A. Antenatal Clinic Services</b></p> <p>Establish a virtual consultation clinic for cases e.g. may require aspirin in early pregnancy, early advice required from specialist</p> <p>Improve uptake in VBAC and decrease elective C/S rate</p> <p>Investigate if a clinical midwife specialist in gestational diabetes would improve the services &amp; outcomes for Gestational Diabetes Mellitus (GDM) clients</p>	<p>Virtual consultation clinic is established to free up timely antenatal specialist appointments</p> <p>Increase in VBAC rates. VBAC counselling and education is consistent and as per RANZCOG guidelines.</p> <p>Decrease in elective C/S rates</p> <p>GDM women have timely services for healthy eating, healthy weight gain, exercise monitoring and treatment in pregnancy, labour and birth.</p> <p>Number of green prescription referrals in pregnancy</p> <p>Continuity of midwifery and medical care.</p>	FAU commenced service in May 2014.		<p>ANC coordinator; Core Midwife; CMM</p> <p>CMM; ANC coordinator; ADOM; CSM M&amp;CHS</p>
	<p><b>B. Timely access to Maternal Fetal Medicine (MFM) services by establishing relationships and developing telemedicine/ communication</b></p>	<p>MFM services are accessed within seven working days of referral with a focus on consultation being provided by telemedicine where appropriate.</p>			Obstetrician; ANC coordinator
12	<p><b>Review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres</b></p>	<p>All C/S cases have a core midwife/nurse who is responsible to provide early newborn and delivery care in the operating theatre.</p> <p>Reduction in number of babies admitted to NNU for &lt;24hrs</p>			<p>QEC; ADOM; NNU CNM; CMM; OT CNIN; CSM M&amp;CHS</p>

	Project	Expected outcome	Progress	Outcomes	Responsibility
13	<p>Stop smoking support for pregnant women, partners and whanau</p> <p>Better support for pregnant women to stop</p> <p>Ensure all pregnant women who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support for hospital based</p> <p>To monitor the number of pregnant smokers to specialist stop smoking services</p> <p>To develop and establish a referral process and pathway for hospitalised pregnant smokers to specialist stop smoking cessation services by December 2015</p>	<p>Posters distributed and displayed around Taranaki promoting pregnant women and families to quit smoking</p> <p>Purchase of 2 CO monitors in use in primary community to support LMC's in smoking cessation promotion</p> <p>Increase in number of pregnant women who have received NRT, referral and or quit smoking who are hospitalised</p> <p>Maintain 95% of hospitalised pregnant women who are screened for smoking status, and those identified as smokers are offered effective advice, support and referral to cessation support</p>	Posters received in June 2015		Smoking cessation coordinator, CMM
14	<p>Pregnancy and parenting services meet the requirement of consumers</p> <p>Investigate along with MMAG how we can better meet the needs of consumers</p> <p>Investigate if Child Birth Educator (CBE) demand meets the services, explore options to train more CBEs.</p> <p>Work with LMC's and the Te Kawanu Maro Mama, Matua, Pepi, Tamariki services to increase uptake to pregnancy and parenting education</p>	<p>See MMAG</p> <p>Number of child birth educators meet the needs of the services</p> <p>30% Maori, Pacific and teen 1<sup>st</sup> time parents/pregnant women complete DHB funded pregnancy and parenting education</p>			MMAG; Planning and Funding
15	<p>Audits:</p> <p>Guidelines for referral</p>	All women are referred to a specialist in a timely manner and meet the recommendations of the guidelines of referral			ME, O&G, QR, ADOM, CMM, LMC, ANC coordinator



Project	Expected outcome	Progress	Outcomes	Responsibility
Care of the pregnant bariatric woman	Ensure care of the pregnant bariatric woman aligns with local guidelines			
Post partum haemorrhage	PPH care aligns with national and local guidelines.			
Elective caesarean section	All elective C/Section have a valid indication and fully informed choice. Are >39 weeks' gestation unless clinically indicated			
Emergency C/S: CTG interpretation, failure to progress cases	All emergency C/S for CTG abnormality and failure to progress are indicated	Hard data obtained		
HDU/ICU admissions:- Assess number of admissions, reason for admission, emergency or routine admission?	All women are admitted for appropriate reasons and care examined to identify improvements for practice			
16	Continue to explore how staffing levels can better meet the requirements of ward acuity and variance of wards Trendcare implementation to allow accurate reporting HCA role review is completed	Staffing levels meet the ward acuity, reduction in staff deficit forms IRR testing completed 100% compliance of staff in engagement with Trendcare HCA role has increased job satisfaction. HCA role integrated into team work		CMHSM, CMM, ADOM, HR, NZNO/MERAS, core staff, Trendcare Coordinator
17	Full implementation of the guidelines: Gestational diabetes (GDM) guideline MOH quality standards for diabetes care toolkit, 2014, standard 20 MOH guidance for Healthy weight gain in pregnancy (2014)	Baseline data established on number of women who have had HbA1c <20weeks 100% pregnant women referred to the secondary antenatal clinic and specialist diabetes services who are diagnosed with GDM Pregnant women who are identified as obese and suitable are offered the green prescription		CNS diabetes, midwife educator, ANC coordinator, ADOM

# APPENDICES

## Appendix 1 : Alignment of Aims/Objectives with National Priority and Recommendations

### Standard One:

Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.

#### 8.2 Report on implementation of findings and recommendations from multidisciplinary meetings

##### Multi-disciplinary review processes/meetings that have been coordinated

- Monthly MQC meetings.
- ADOM meetings with urban, remote rural and rural midwives.
- Weekly case review linked to the new Maternity Obstetric Outcomes: trend monitoring, case review, near misses and reportable events protocol (see Appendix 8 for data collection form).
- Bi-monthly self-employed and Taranaki DHB maternity/neonatal /anaesthetic service meeting.
- Weekly core midwifery meetings.
- Monthly perinatal, maternal and infant health liaison meeting.
- Bi-monthly complex care meetings (includes maternity social workers, diabetes educators, obstetricians, registrars, obstetric house surgeons, NNU manager, paediatrician, antenatal clinic coordinator (ANC), Clinical Midwifery Manager (CMM) and ADOM.
- MMAG meetings: Sub-groups include midwifery leaders' meetings, midwifery educators and leaders, breastfeeding/BFHI and Midland MQSP.
- CMM and ADOM included in the monthly paediatric liaison meeting to discuss potentially vulnerable unborn babies.
- Maternal and Child Health Services meeting.
- Perinatal and Maternal Mortality meetings twice yearly.
- National MQSP forum.
- Taranaki Immunisation Strategy Meetings quarterly.

##### Changes in clinical practice and quality improvements that have been driven by MQSP initiatives and above meetings

- WIFI to Base Maternity areas.
- Computers on Wheels.
- Huntleigh CTG including telemetry.
- Huntleigh Dopplers inserted on stands to prevent loss and damage.
- Introduction of Velosorb suturing material.
- ISBARR Tear off Pads (Appendix 9).
- New Maternal Care Plan (CAR).
- New Infant Care Plan (CAR).
- New digital thermometers.
- Electrical Socket implemented in Labour ward hallway outside birthing pool room to allow Telemetry for VBAC's to birth in pool.
- Yankurr suction catheters for adult and infants in all rooms.
- Disposable instruments-suturing, episiotomy and birthing instruments.
- PPH blood loss collection bin.
- Iron Posters (see newsletter Appendix 11).
- Smoking cessation posters (see smoking section).
- Top 5 things to do in first 10 weeks (see LMC registration section).
- Amnisure testing for PROM diagnosis where undetermined to reduce Induction of labour rate.
- New epidural pumps.
- CTG envelopes for safer storage.
- Microwave for sterilising breast milk and expressing equipment.

- Bags for expressed breast milk storage instead of pots.
- Toilet seat raiser for C/S patients.
- Boarder mothers makeover of room.
- Security system for Maternity/NNU and digital phone system.
- Fetal day assessment unit.
- Acute perinatal mental health nurse (0.6FTE).
- Antenatal clinic midwife drop in clinic for flu vaccine and Boostrix.
- Dashboards for KPIs and information are displayed in Wards 14 and 15.
- Maternity internet site has been updated on the description of the maternity services including information on stakeholders and how to access an LMC including a contact list of LMCs in Taranaki, also provided is information on how to access a midwife through the link [www.Findyourmidwife.co.nz](http://www.Findyourmidwife.co.nz) site.
- Revised Quality Reporting Grids – draft (see Appendix 6).
- Revised Maternity Audit Grid – draft (see Appendix 6).
- Yearly maternity education calendar developed/updated (see Appendix 5).
- Documentation PROFORMA's for shoulder dystocia, cord prolapse and newborn resuscitation.
- Placental Histology Protocol.
- Newborn enrolment system for women with unknown GP to encourage early enrolment of the baby for timely immunisation.
- Smoking cessation KPI data collected.
- Implementation of audits to ensure adherence to MEWS protocol.
- Escalation protocol for times of high acuity and staff absence developed and linked with Care Capacity Demand Management.
- Regional Safe Sleep Policy and in-service education sessions, regional education implementation; audit to be implemented to ensure compliance.
- National observation of mother and baby guideline adopted locally.
- Breastfeeding : Antenatal Colostrum Expressing (ACE), mothers' quiet room area which enables privacy and quiet to feed or express if she wishes.
- Introduction of anew protocol 'Care of the Jaundiced Baby' with more education around assessment and care of the baby in the postnatal ward, in addition to how to use either the Bilibed or the Bilisoft.
- Fentanyl PCA protocol for women in labour who are not suitable for epidural anaesthesia.
- Jadelle contraceptive insertion prior to discharge for transient women at risk of repeated unwanted pregnancy.
- Furnishing of the 'The Willow Suite' for parents who suffer baby loss.
- Pre-mix Magnesium Sulphate infusion bags implemented.
- General Anaesthesia (GA) C/S audit.
- Purchase of portable cardiotocography machine (CTG) for continuous fetal monitoring to try and reduce GA C/S rate.
- Maternity referral guidelines : Patient status boards reflect the new maternity referral guidelines and in-service education/meetings to discuss the new referral guidelines.
- Lactation Consultant scholarships now IBCLC accredited and community Lactation Consultants clinics implemented.
- Rural maternity unit meetings via video conferencing facility implemented.
- Pepi-Pod provision, referral process and named distributors.
- MQC stakeholder newsletter (see Appendix 11).
- Checklist and pre and postnatal services referral directory see Appendix 3.
- Newborn hearing screening service – clinical governance provided by MQC.
- Review of the PPH protocol to come in line with the national guideline.
- Elective C/S not booked prior to 39 weeks' gestation unless medically indicated (antenatal steroids recommended if booked prior to 38+6 weeks' gestation).
- Audits on preterm births and NNU admissions (see preterm birth and variation in gestation of birth section), C/S, PPH, and documentation, MEWS, FVIP screening.
- Top 5 things to do in the first 10 weeks of pregnancy posters and rack cards.
- Guthrie test cards are taken to the New Zealand mail box daily Monday-Friday by the ward clerk to improve timings of receipt by laboratory. KPI displayed on ward dashboard for all practitioners to see/be aware of targets.
- Ward dashboard displays HIV screening rates. Practitioners asked to identify declines on lab request forms so overall % can be calculated.

## **SUMMARY OF AUDITS 2014**

### **1. Electronic Fetal Monitoring (IEFM)**

#### **Recommendations from Findings**

- Two incidences identified where IEFM not provided where indicated as per RANZCOG guidelines – one woman arrived pushing and birthed on arrival in room so not practicable.
- Discussion with other practitioner and recommendations made for practice.
- FSE application education so increased appropriate use.
- Repeat audit 2015.
- All Taranaki DHB Maternity employees to complete K2 package (offered free to LMCs).

#### **Incidental Findings**

- Cord gas education required on how and when to take.
- Level of C/S to be written in notes.
- Document liquor color at C/S.

### **2. Safe Sleep Audit (please see safe sleep section)**

### **3. Postpartum Haemorrhage (PPH)**

#### **Recommendations from findings**

- Taranaki DHB's PPH rates are consistent with other DHBs around the country. Comparison with other regional units would also be valuable.
- Ninety-four percent (94%) of the women who went on to have a PPH had an identifiable risk factor. This allows for planned management to help reduce the risk of PPH (active management of the third stage with close availability of further management strategies and staff) along with safety measures such as delivery in an obstetric led unit, IV access and cross matched blood.
- Education of staff is recommended on identification of risk factors in pregnancy and effective management planning.
- It was difficult from the notes to identify if risk factors had been recognised and whether women had been informed of their risk and if fully informed, management plans had been made with the patient. This could be rectified by increasing the space allowed for identification of risk factors and plans on the booking sheet. Also having a copy of the woman's individual birth plan in the hospital records will allow all staff to be aware of the woman's desires, thoughts and informed choices for labour and delivery.
- Future PPH audit recommended to explore management of PPH.

### **4. Documentation**

#### **Positive Points Noted**

- Notes were sequential in all.
- All entries timed and dated except one
- Smokefree form completed in all but three.
- Allergy status marked clearly in all but one.

#### **Recommendations**

- Repeat Audit 2015.
- Performance improvement support of core staff not meeting expected standards.
- All core staff to complete Effective Midwifery online documentation package.
- Staff not meeting expected standards to undertake documentation workshop and have notes checked daily until effective documentation maintained.

### **5. ISBARR**

**All notes in use in maternity on this day were audited to see if the ISBARR tool had been used. All 10 had occasion where the tool could have been used.**

### **Recommendations**

- Tear off pads instead of stamp.
- Re-audit 2015 x two.
- Further education on ISBARR tool.
- ISBARR education in orientation package for staff.

## **6. Antenatal Colostrum Expressing (ACE)**

### **Findings**

- All 10 women agreed was a positive experience and would consider again in future.
- Would recommend to others.
- Range of EBM from 1ml to 240mls collected.
- Seven women commented that the EBM was given within few hours of birth – one in operating theatre.
- One woman said expressing improved my volume of colostrum at birth which improved my confidence to breastfeed a pre-term baby post C/S”.
- “OT staff were unaware of ACE but did ‘administer’ it to my baby”.
- “Found expressing before birth boosted my confidence for feeding after the birth”.

## **7. Baby ID Bands**

### **Recommendations**

- More care when applying the labels so they do not fall off.
- Review of baby label product.
- Ask the parents to alert staff ASAP if labels do fall off.
- Re-audit in four weeks and hopefully 100% of babies will be labelled correctly.

## **8. MEWS**

- Ten MEWS charts from clinical notes were audited and 8/10 of the observations were found to be complete (two months earlier only 5/10 were complete) so 100% improvement.
- Override algorithm completed on five occasions only.
- Score recorded on three charts only – but these were correct.

### **Recommendations:**

- Regular ongoing MEWS audits and summary fed back to staff at ward meetings.
- Discussion with individual staff members when incorrectly or incomplete completion.

**Preterm Birth (see variation at gestation of birth section – page 38)**

**10. Caesarean Section in Primiparous Women (see C/S section – page 42)**





## New meeting initiatives

### Maternity Obstetric Outcomes

Trend monitoring, case review, near misses and reportable events protocol (see Appendix 8 for data collection form).

### Weekly Multidisciplinary Meeting

Taranaki DHB has progressed with multidisciplinary meetings and increased the number of case reviews and debrief sessions since the implementation of the Maternity Obstetric Outcomes : Trend Monitoring, Case Review, Near Misses and Reportable Events Protocol. A weekly case review meeting enables the obstetric medical team, core and self-employed midwives and other related professions such as maternity social workers, neonatal staff and anaesthetic staff to discuss trends and cases in a collaborative, safe and non-punitive environment and provide an opportunity to apply the latest literature to practice and test our current knowledge and practices in an attempt to have best practice and outcomes within our units.

### Meetings to Discuss Potentially Vulnerable Unborn Babies

The monthly paediatric liaison meeting includes an invitation to the CMM and ADOM and accepts antenatal referrals so that discussion, planning and support can be implemented. Relationships and networking with the services that attend these meetings are enhanced. 2015/16 will see the implementation of the maternity care, wellbeing and child protection multi-agency group meetings.

### VTE Assessment

Meetings have been held to develop a VTE assessment process. An assessment template and process has been developed, piloted and implemented which is inserted into all inpatient admission records (please see Appendix 10).

## 8.4 Produce an annual maternity report

Taranaki DHB produced its first Maternity Annual Report in June 2013 and will continue to report on the Taranaki DHB maternity services on an annual basis, this includes an annual report to the Taranaki DHB Clinical Board.

## 8.5 Demonstrate that consumer representatives are involved in the audit of maternity services at Taranaki DHB

Taranaki DHB is committed to training and ensuring consumer representation on the MQC. The Taranaki DHB consumer representative has completed Taranaki DHB training in confidentiality and customer service; she has a contract and is remunerated for her valuable contribution (see consumer section).

## 9.1 Plan to provide and report on appropriate and accessible maternity services to meet the needs of the Taranaki region

### Maternity Facilities

The Taranaki region hosts both primary and secondary birthing facilities; these are Base Hospital (New Plymouth) and Hawera Hospital (South Taranaki), the primary maternity facility in Stratford closed in November 2014 (see section on rural maternity services).

#### Taranaki DHB Maternity Facilities

- Taranaki Base Hospital primary and secondary births
- Hawera Hospital primary birthing facility
- Home birth, offered by midwife LMCs
- Total Taranaki approximate births 1,508 (stable birth rate but an increase in births at Base Hospital and Hawera Hospital due to closure of Elizabeth R in Stratford)

#### Taranaki Base Hospital

- 1,326 (increase of 19 from 2013) total births
- 63 primary obstetrician/LMC births (decreased from 136 in 2012)
- 210 secondary births (including transfer of care in labour, similar to 2014)
- Epidural service
- Level 2A Neonatal Unit

#### Taranaki Base Hospital Staff

Three employed Taranaki DHB obstetricians (two have full-time contracts and one has a part-time contract) plus one full-time senior MOSS works on the O&G roster. Additionally, one obstetrician (not contracted to Taranaki DHB) works privately and has an access agreement for Taranaki DHB.

- 1 MOSS (0.5FTE, additional to MOSS position above)
- 2FTE obstetric registrar
- 2FTE house surgeons
- ADOM (0.6FTE)
- MQSP project coordinator (0.2FTE)
- Clinical Service Manager, Child & Maternal Health (1.0FTE)
- Midwifery, nursing and administration staff (29FTE) which includes 0.8FTE Lactation Consultant and 1.0FTE CMM, 0.4 PN FTE coordinator and 0.6 FTE Midwife educator

#### Taranaki Base Antenatal Clinic

- Co-ordinated by antenatal clinic midwife coordinator
- Maternal fetal medicine (MFM) specialist clinic no longer offered due to the shortage of MFM specialists/resignation of previous specialist
- Outpatient specialist consultation clinics
- Secondary antenatal team clinics
- Secondary midwife clinics
- Fetal day assessment unit
- Amniocentesis clinics

The antenatal clinic coordinator provides continuity of midwifery care and education for secondary patients in the antenatal period. Additionally secondary patients have a nominated obstetrician for antenatal care to promote continuity of obstetrician.

#### Antenatal and Labour Ward

- 5 delivery rooms (for primary and secondary births)
- 1 pregnancy loss room named "The Willow Suite"
- 1 birthing pool
- 7 antenatal rooms
- Operating theatres (which are located in the main hospital block six to seven minutes' walking distance)

**Postnatal Ward**

- Located on a separate floor above the labour ward
- Total of 19 beds – nine single rooms plus two single rooms with en-suite, two four-bedded rooms
- Accommodates boarder mothers when no facilities available in NNU

**Taranaki Base Hospital Neonatal Unit**

- Approximately 304 admissions (Increased by 59 since 2013)
- 6 cots
- 2 intensive care cots
- Accepts >1,000gms and >28 week gestation
- 8 paediatricians (6.7FTE) + 1 Advanced Trainee
- 4 senior house officers (SHO)
- 2 registrars
- Nursing staff (13.5FTE)
- Neonatal Homecare SCN (Lactation consultant 0.8FTE)

**Hawera Hospital Primary Maternity Facility (DHB)**

- Hawera Hospital is a primary maternity facility with a rural health focus that is one hour by road from Taranaki Base Hospital
- 89 births in 2014 (up from 79 2013)
- 1 GP LMC and eight midwife LMCs access this facility
- Hawera is supported and managed by the CMM, ADOM and the Clinical Services Manager; these staff cover both Base and Hawera sites
- 2 O&G consultants share outpatient, secondary care maternity and colposcopy clinics in Hawera, visiting at least fortnightly to achieve this
- 0.2FTE secondary outpatient antenatal clinic midwife
- Midwifery primary unit staff in Hawera consists of 3.5FTE midwives and 1.4FTE registered nurse, the core midwives all have an access agreement to also provide LMC services at Hawera

**Home Births**

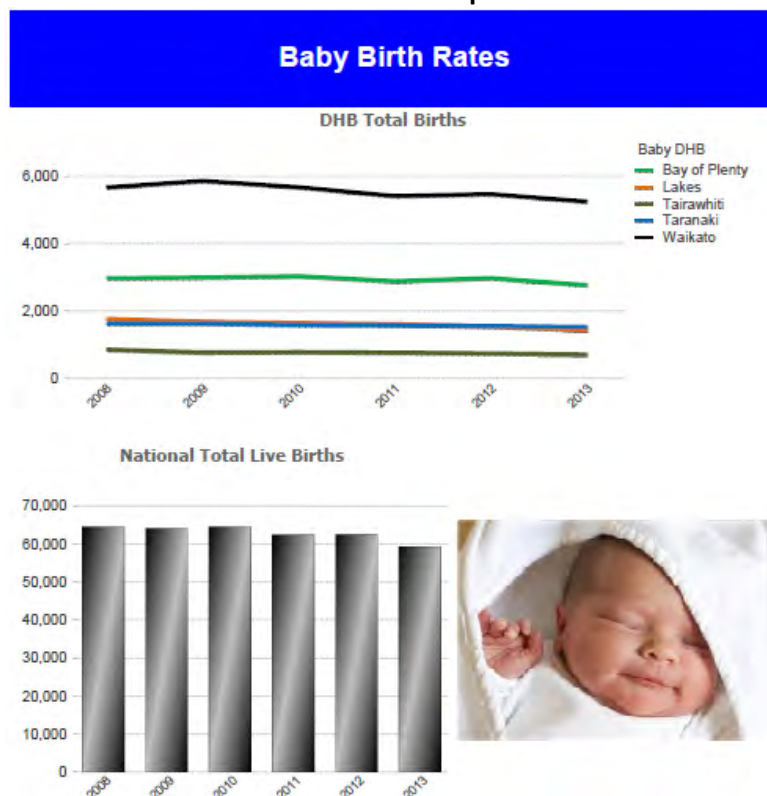
Approximately 52 births in 2014 by self-employed midwife LMCs however there is difficulty in accessing accurate data.



## Appendix 2 : Data Tables and Analysis

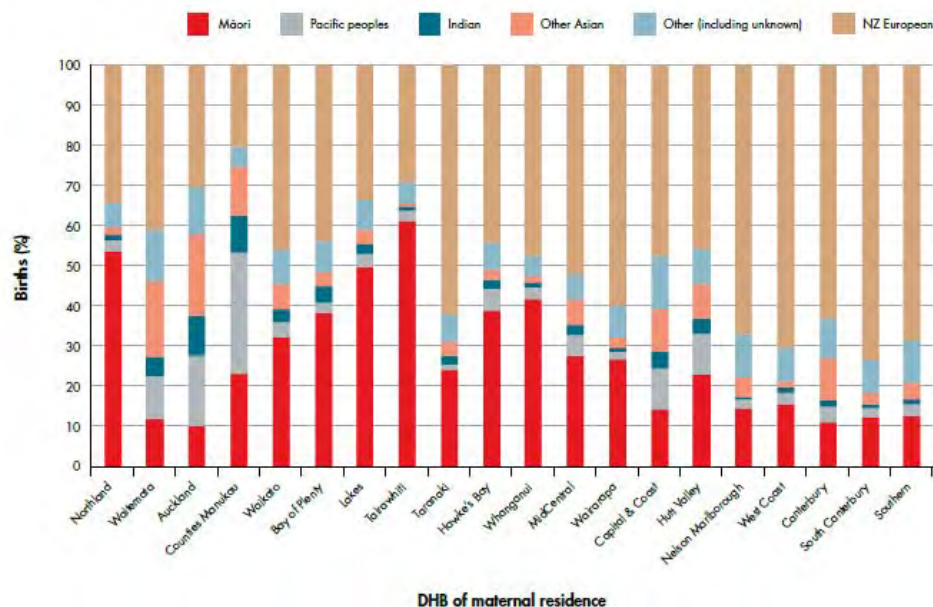
### Demographics and Data

Midland Data: Please note that all data for Taranaki DHB is presented in **BLUE** within the Midland DHB data



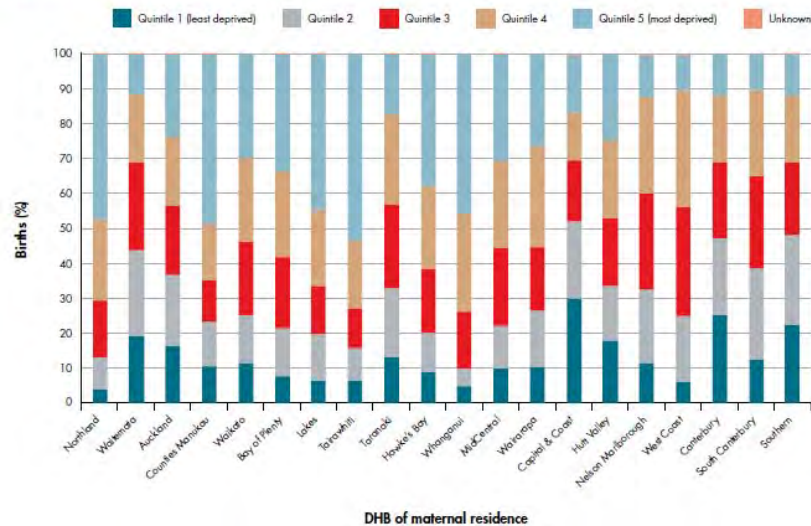
#### DHB of residence and ethnicity

Figure 1.9: Distribution of maternal prioritised ethnicity by DHB of maternal residence among birth registrations in 2013 (total births excluding unknown DHB=59,840)



#### DHB and socioeconomic deprivation

Figure 1.10: Distribution of deprivation quintiles (NZ Dep2013) by DHB of maternal residence among birth registrations in 2013 (total births excluding unknown DHB=59,840)



Figures 1.9 and 1.10 above are taken from the 9<sup>th</sup> PMMRC Annual report (2015)

**Taranaki Change in 5 year births**

	2010		2014		Variance	
Base Hospital	1308	[82.9%]	1313	[87.2%]	+5	[+4.3%]
Elizabeth R	91	[5.8%]	64	[4.3%]	-27	[-1.5%]
Hawera Hospital	114	[7.2%]	76	[5.0%]	-34	[-2.2%]
Home Births	65	[4.1%]	52	[3.5%]	-13	[-0.6%]
Total	1578		1505		-73	

Source Data: NMDS and Taranaki DHB IBA Patient Management System

The birthing pattern at Base Hospital shows a significant proportion of South Taranaki women accessing both primary and secondary level care at Base Hospital. In 2013/14 there were 271 women domiciled to the South Taranaki District who birthed at Base Hospital, 84 births at Hawera and 34 at Elizabeth R.

Note: Due to the varying data sources and whether calendar or financial year was used – numbers across the tables included vary.

**Table 1: Birthing numbers 1999 – 2014 (16 years)**

	Base	Hawera	Elizabeth R	Home Birth	Total Taranaki
1999	1200	91	65	53	1409
2000	1185	102	78	42	1407
2001	1123	102	78	42	1345
2002	1074	97	80	22	1273
2003	1078	106	93	35	1312
2004	1086	99	77	40	1302
2005	1099	100	92	51	1342
2006	1176	101	70	52	1399
2007	1294	116	73	65	1548
2008	1325	93	81	47	1546
2009	1325	118	62	72	1577
2010	1308	114	91	65	1578
2011	1317	106	92	51	1566
2012	1320	93	90	41	1544
2013	1318	74	59	52	1503
2014	1313	76	64	52	1505
Average	1221	99	78	49	1447

Source Data NMDS and MOH

*\*Note home birth figures were unavailable for 2013/14 therefore an average was used*

The table above demonstrates the rising births at Base hospital compared to primary unit/homebirth. National and local campaigning is planned to promote primary normal birth in the future.

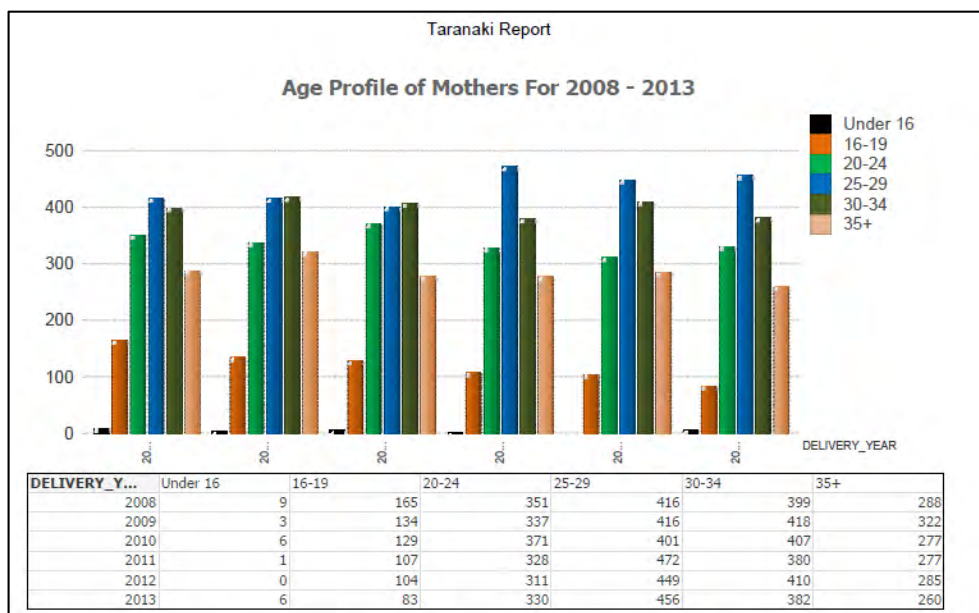
**Table 2: % of Postnatal Stays by TLA by Maternity Facility**

	Base Hospital	Elizabeth R	Hawera Hospital	Total
New Plymouth TLA	97.7% [n=835]	2.3% [n=21]	0.0%	856
Stratford TLA	50.7% [n=70]	48.6% [n=67]	0.7% [n=1]	137
South Taranaki	50.3% [n=247]	13.0% [n=64]	36.7% [n=180]	491
<b>Total</b>	<b>1152</b>	<b>152</b>	<b>181</b>	<b>1484</b>

Source Data: MSTL and Taranaki DHB Patient Management System

*\*Note for Stratford and South Taranaki women there are a higher number of postnatal events than birth events, due to women receiving postnatal events at Base Hospital before being transferred to either Elizabeth R or Hawera*





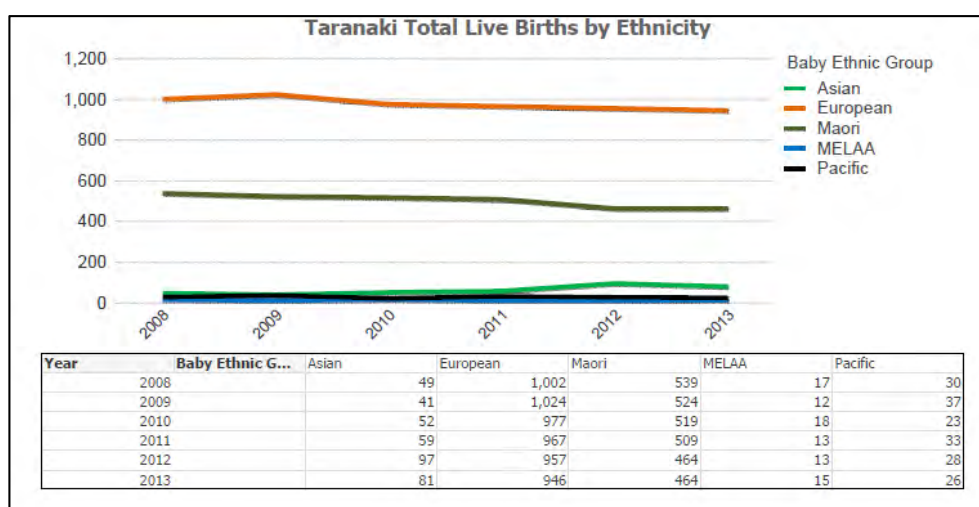
## Age and Demographics

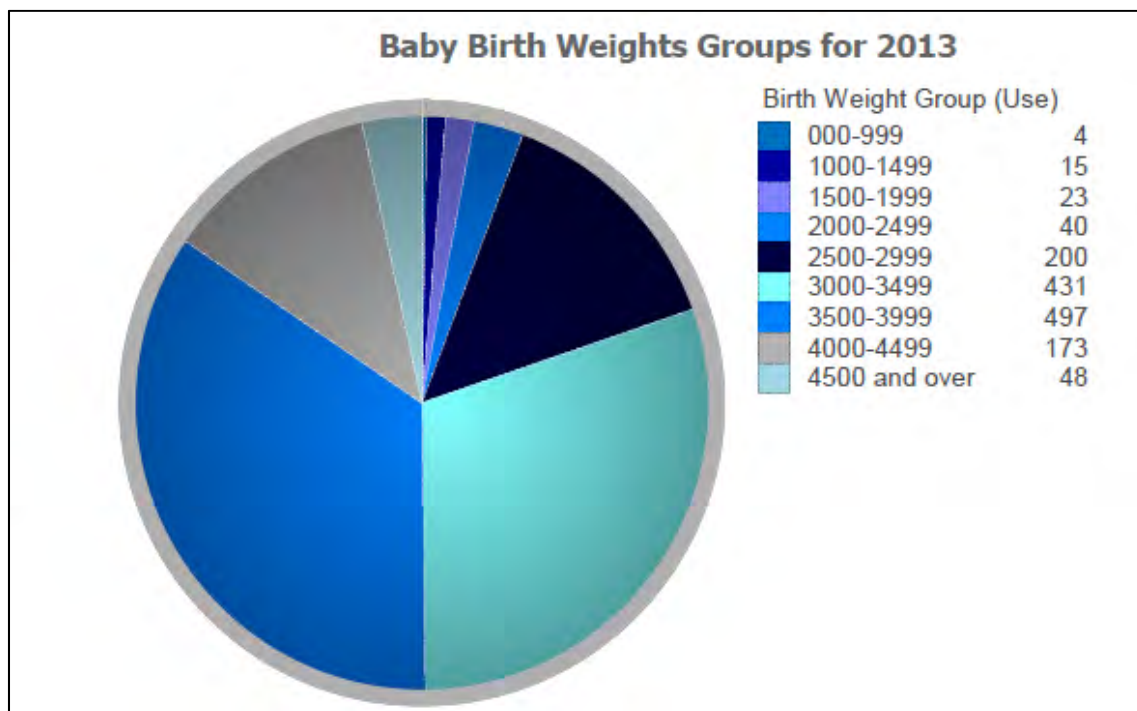
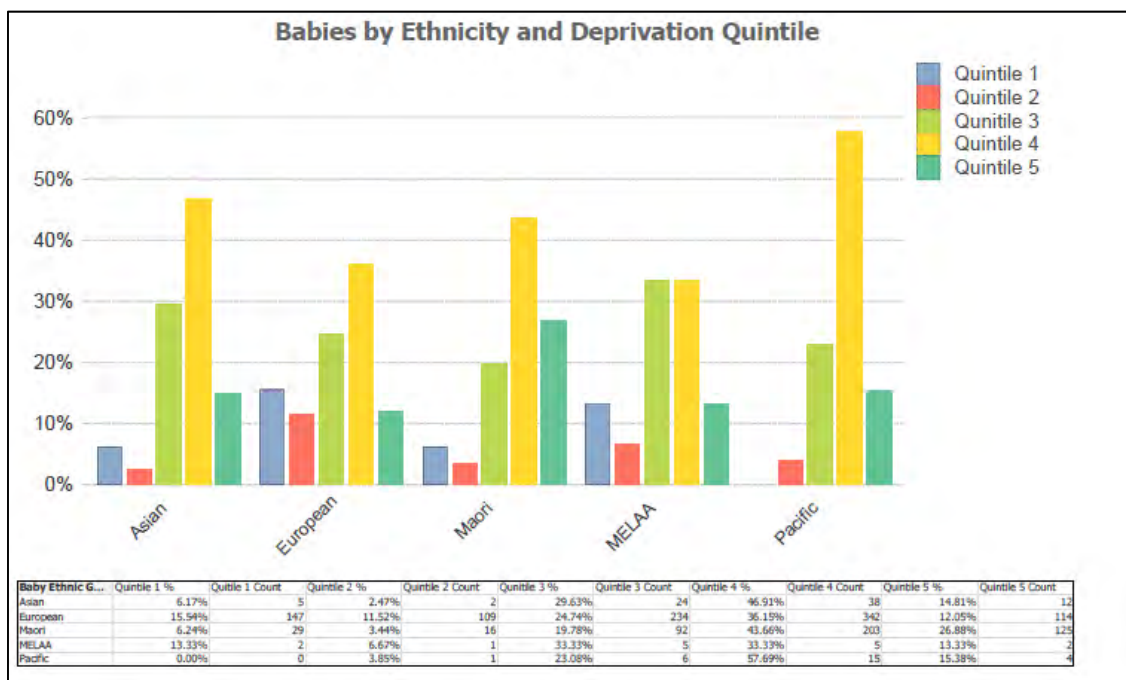
The most common age group delivering their first child (Primiparae) in Taranaki is the 25-29 age group for European (rural or urban) and 20-24 age group for Maori (rural or urban) and for all ethnicities, 25-29 age group is the most common; this is closely followed by the five years above or below this. Most women therefore are having their first baby between 24-34 years of age. This is consistent with our falling teenage pregnancy rate, possibly due to better education and access to long-term contraception such as the Jadelle.

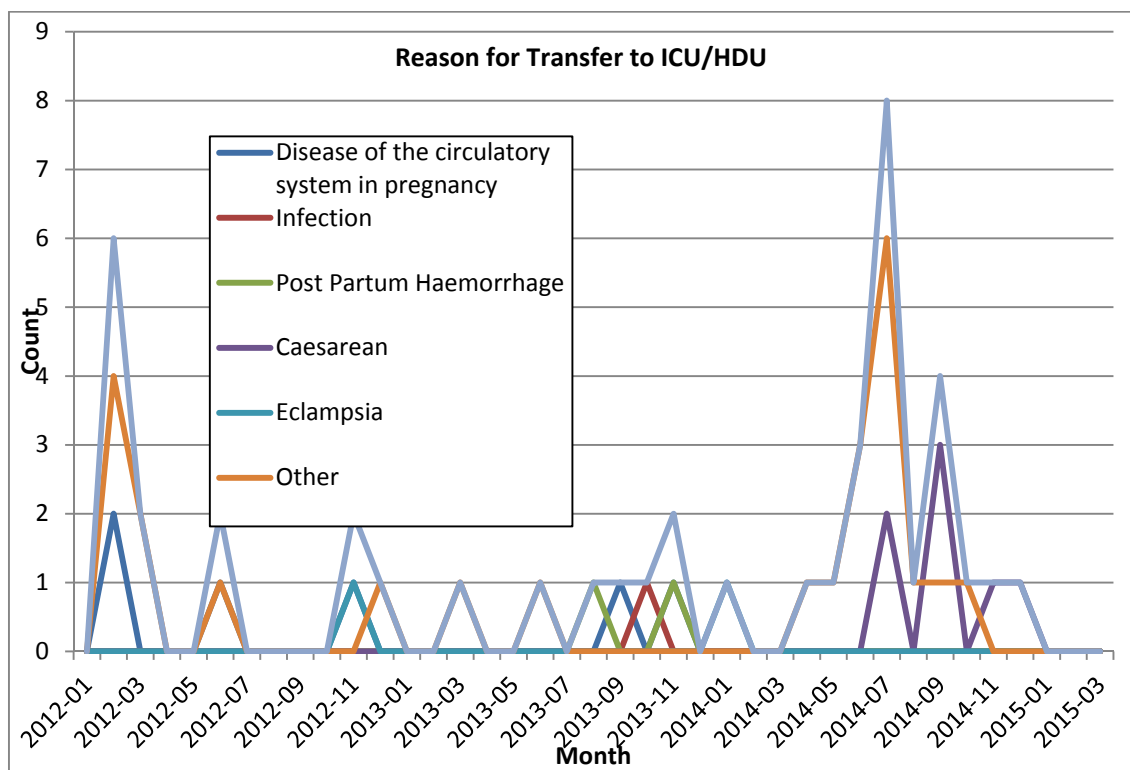
Taranaki has the lowest teenage pregnancy rates in Midlands (largely due to fewer Maori teenage births – from the highest in 2009 to second lowest in 2012).

The total “Births Rural Urban Taranaki” graph shows that over the last few years actual urban and rural births have remained surprisingly constant and equal around 65 per month for each category.

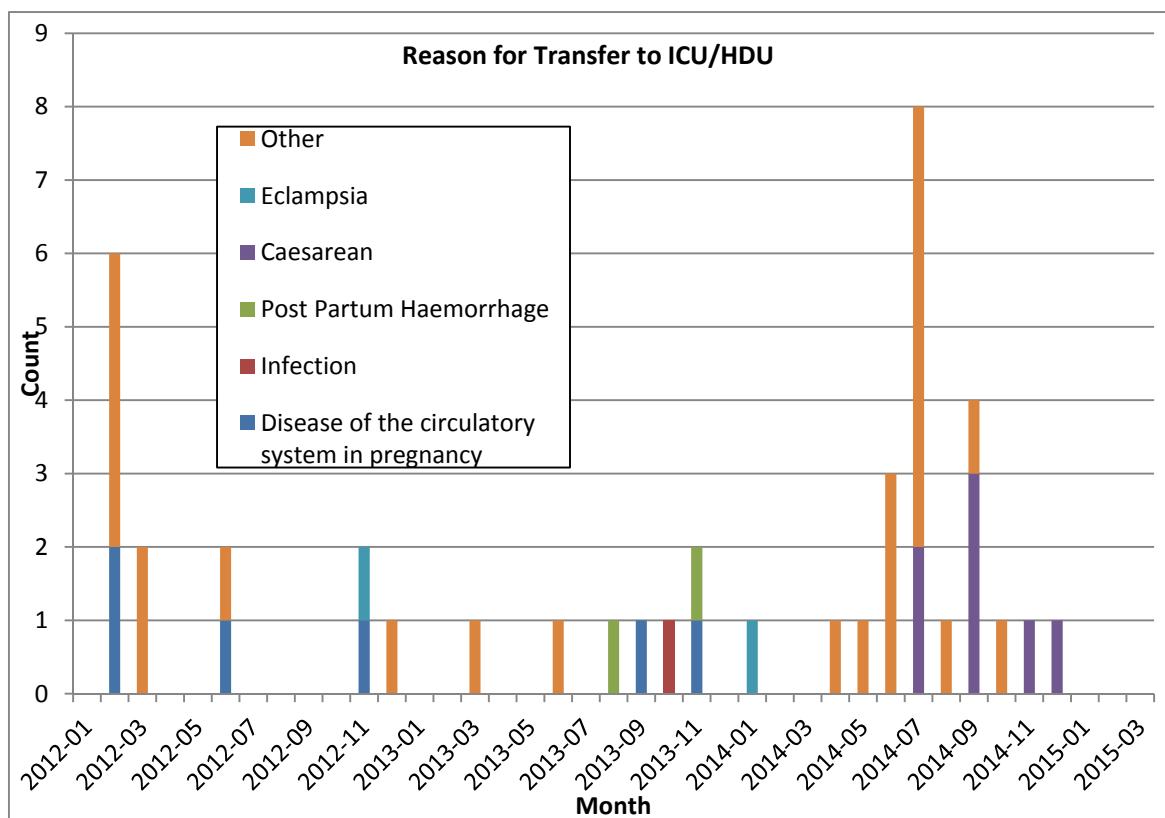
Comment: The majority of pregnant women in Taranaki DHB come from New Zealand European and Maori ethnicities however there is a noticeable increase in Asian ethnicity within the region. This has the potential to have an impact on family support, language, cultural beliefs and post natal support services. This ethnicity is also at increased risk of gestational diabetes and complications that are associated with this.







An audit is currently being undertaken to investigate the reasons for admission for HDU and whether HDU admission was indicated. HDU admission has the impact of separation of mother and baby, it also increases the number of babies admitted to NNU due to HDU not having adequate staffing/facility for caring for the newborn baby.



]

### Appendix 3 : Pre and Post Pregnancy Support Services Checklist and Directory

During your, or the kaimahi hauora interactions with the mother, you will be able to fill in this simple checklist below. Be sure **not** to make this a question/answer form but more of an informal discussion during the time of stay in hospital.

Checklist	Tick for yes
<b>Mother or baby Maori</b>	
<b>Baby born with low birth weight</b>	
<b>Mother under 20 years old</b>	
<b>Come from or will live in a high deprivation area</b>	
<b>Baby will be formula fed</b>	
<b>Addiction issues</b>	
• Smoking	
• Drugs	
• Alcohol	
• Gambling	
<b>Requiring Pepi-Pods or wahakura</b>	
Are they experiencing or have experienced:	
Extreme budget restraints (income not covering outgoings)	
Domestic violence	
CYF involvement of either parent or partner	
Family violence concerns	
Criminality or offending behaviour concerns	
Mental health concerns (MMH Pathway)	
Concerns regarding previous trauma (TABs/?)	
Cognitive or developmental impairment	
Concerns parenting ability or life skills	
Concealed/unwanted pregnancy	
Attachment concerns	
Transient lifestyle	
Poor engagement with maternity care	
Do they have poor social supports	
Living alone	
Estranged from family/whanau	
Or from another district and have no family/whanau support close	
Obesity BMI over 40	
Poor housing conditions	
<b>Vulnerable Women and Babies</b>	

**If you have ticked any of the above, please see the Pre and Post Pregnancy Support Services Directory for referral pathways**

## Pre and Post Pregnancy Support Services Directory

### Last Updated February 2015

The below directory will help you refer your patient or client to the appropriate health worker or organisation. Please ensure you have consent to refer before making contact. Many of these contacts also allow self-referral.

Click on the blue hyperlinks in the “how to refer” column to be taken to the related referral form or information.

Support needed because	Ante Natal	Post Natal	How to refer
<b>Mother or baby Maori</b>	TKM Alliance GP services	Maori health team	Raana or Denise 7537777 ext 7587 or 6707 <a href="mailto:raana.solomon@tdhb.org.nz">raana.solomon@tdhb.org.nz</a> <a href="mailto:denise.smith@tdhb.org.nz">denise.smith@tdhb.org.nz</a>
<b>Well child /Tamariki Ora provider</b>	Tui Ora Tamariki Ora Service  Tui Ora Mama & Pepe Kaiawhina	Tui Ora Tamariki Ora Service  Tui Ora Mama & Pepe Kaiawhina	<a href="mailto:deb.harding@tuiora.co.nz">deb.harding@tuiora.co.nz</a> Team Leader Well Child Service 06 7594064 ext 6320 0277064032  Phone 06 7594064  Contact Deb Harding or Tui Ora via email or fax Email: <a href="mailto:intake@tuiora.co.nz">intake@tuiora.co.nz</a> Fax: 06 7591799  As above
<b>Well child/Tamariki Ora provider</b>	Plunket Well Child Tamariki Ora schedule 4-6 weeks to 5 years	<b>Plunket</b>        <b>Volunteers:</b> Parenting groups Car seat hire Safety gates <b>Antenatal</b>	Area Manager: Sarah Mulcahy <a href="mailto:sarah.mulcahy@plunket.org.nz">sarah.mulcahy@plunket.org.nz</a> 768 3601 ext 67601 0212263066 Clinical Leader: Gina Newman <a href="mailto:gina.newman@plunket.org.nz">gina.newman@plunket.org.nz</a> 0274977673 Community services leaders: Mahina Leong <a href="mailto:mahinaarangi@plunket.org.nz">mahinaarangi@plunket.org.nz</a> Admin: Krissy Stanford: <a href="mailto:krissy.stanford@plunket.org.nz">krissy.stanford@plunket.org.nz</a>  New baby case referral from LMC by 4 weeks: Fax: 067695458 If additional support needed the Plunket team can start working with families in partnership with LMC's as early as needed

Mother under 20 years old	Young Parent Programme	Tania Judson 7583666 ext 848	Young Parent Programme	Tania Judson 7583666 ext 848 (YMCA) <a href="mailto:tania.judson@npymca.org.nz">tania.judson@npymca.org.nz</a>	No referral template. Phone or email contact for self-referrals.
	Stratford Teen Parent Unit	Stacey	Stratford Teen Parent Unit  Youth Service (under 19 years) (Benefit administration and SW support) SWITCH – Young Mums Peer support (for those on a benefit and under 19)	Tracey Burnell 06 765 0402 0278578590 <a href="mailto:tpu_stacey@stratfordhigh.school.nz">tpu_stacey@stratfordhigh.school.nz</a>  Simone Betsy 027 210 3221 0508496884 – toll free <a href="mailto:simone.betsy@tuiora.co.nz">simone.betsy@tuiora.co.nz</a>	No referral template. Phone contact for self--referrals Requirements: Under age of 19 at start of that year Pregnant of primary care giver Desire for further education
	Tui Ora Tamariki Ora Service and  Tui Ora Mama & Pepe Kaiawhina	<a href="mailto:deb.harding@tuiora.co.nz">deb.harding@tuiora.co.nz</a> Team Leader Well Child Service 7594064 ext 6320 0277064032  06 759 4064	Tui Ora Tamariki Ora Service  Tui Ora Mama & Pepe Kaiawhina	<a href="mailto:deb.harding@tuiora.co.nz">deb.harding@tuiora.co.nz</a> Team Leader Well Child Service 7594064 ext 6320 0277064032  06 759 4064	Contact Deb Harding or Tui Ora via email or fax Email: <a href="mailto:intake@tuiora.co.nz">intake@tuiora.co.nz</a> Fax: 06 75 91799  As above
	Community Kaiawhina South Taranaki NAV team c/o Ruanui Health  North Taranaki Tui Ora	Jo Larsen (T/O Nurse, Youth) And Marilyn Chittenden (NP, T/O Nurse) Honey Grindlay & Lou Berry (Whanau ora Navigators) 06 2781310 Billy Tipene (Senior)	Kaimahi Hauora	<a href="mailto:marilyn.chittenden@ngatiruanui.org">marilyn.chittenden@ngatiruanui.org</a> <a href="mailto:jo.larsen@ngatiruanui.org">jo.larsen@ngatiruanui.org</a> <a href="mailto:billy.tipene@ngatiruanui.org">billy.tipene@ngatiruanui.org</a>	
Come from or will live in a high deprivation area	Young Parent Programme	Tania Judson 7583666 ext 848	Young Parent Programme	Tania Judson 7583666 ext 848 <a href="mailto:tania.judson@npymca.org.nz">tania.judson@npymca.org.nz</a>	No referral template. Phone or email contact for self referrals.



<b>Barriers to breastfeeding</b>	Taranaki DHB lactation consultant  Mama pepi Hauora Tui Ora	Deb Wright 7537777 ext 8750  Adrienne Peters (Hawera) 06 2787109 ext 6891  Julie Foley 7594064 ext 6213	Lactation consultant	Taranaki DHB Deb Wright: <a href="mailto:debbie.wright@tdhb.org.nz">debbie.wright@tdhb.org.nz</a> <a href="mailto:adrienne.peters@tdhb.org.nz">adrienne.peters@tdhb.org.nz</a>  <a href="mailto:julie.foley@tuiora.co.nz">julie.foley@tuiora.co.nz</a>	Referral forms: <a href="#">Tui Ora Referral Form – Breastfeeding</a>  <a href="#">Lactation Consultancy Referral Form</a>
<b>Addiction issues</b>					
<b>Smoking</b>	Smokefree Pregnancy Tui Ora	Emma Dillon 7594064 ext 6036 <a href="mailto:emma.dillon@tuiora.co.nz">emma.dillon@tuiora.co.nz</a> Fax 067591799	Cessation Services Ruanui Health Hawera GP services	Archie Hurunui 0272372337 06 2781310 ext 7016 <a href="mailto:archie@ngatiruanui.org">archie@ngatiruanui.org</a>	
<b>Drugs</b>	Alcohol & Drug team	7537777 ext 8555	Alcohol & Drug team	7537777 ext 8555 <a href="mailto:rose.taylor@tdhb.org.nz">rose.taylor@tdhb.org.nz</a>	<a href="#">Community Services – Mental Health and Addictions Referral Form</a>  Referral template using email. Walk-ins or phone conversations in regard to potential referrals.
<b>Alcohol</b>	Alcohol & Drug team	7537777 ext 8555	Alcohol & Drug team	7537777 ext 8555 <a href="mailto:rose.taylor@tdhb.org.nz">rose.taylor@tdhb.org.nz</a>	<a href="#">Community Services – Mental Health and Addictions Referral Form</a>  Referral template using email. Walk-ins or phone conversations in regard to potential referrals.
<b>Gambling</b>	Problem Gambling Foundation	Sandy Cummings 7696020 027 787 1817 Counsellor and Health Promoter Kings Building, 36 Devon Street West, New Plymouth Phone: (06) 769 6020 Mobile: (027) 787 1817	Problem Gambling Foundation	Sandi Cummings 7696020 0277871817 <a href="mailto:scummings@pgfnz.org.nz">scummings@pgfnz.org.nz</a>	Referral form: <a href="#">Problem Gambling Referral Form</a>  Explains preferred contacts as well.

Requiring Pepi-Pods or wahakura	LMC, well child providers		LMC, well child providers Requires an exchange card Obtained from LMC/well child provider.	Pepi-Pod distributors, Taranaki DHB Ward 15. 732 7777 ext 7750	There is an exchange card system for Pepi-Pods, obtained from the LMC, well child provider or Neonatal or paediatric wards. Then an appointment is made (via contacting the post natal ward on 7537777 ext 7750) for an appointment to get the Pepi-Pod from a Pepi-Pod distributor and the education on safe sleep. For Hawera contact Hawera maternity Bernadette Winks for an appointment.
			Contact Amanda Simpson or Lynette Gilligan or Tui Ora via email or fax Email: <a href="mailto:intake@tuiora.co.nz">intake@tuiora.co.nz</a> Fax: 06 75 91799	Tui Ora Contact (Tamariki Ora Nurse) 06 7594064 <a href="mailto:lynette.gilligan@tuiora.co.nz">lynette.gilligan@tuiora.co.nz</a> <a href="mailto:amanda.simpson@tuiora.co.nz">amanda.simpson@tuiora.co.nz</a>	Contact Marianne George or Lynette Gilligan or Tui Ora via email or fax Email: <a href="mailto:intake@tuiora.co.nz">intake@tuiora.co.nz</a> Fax: 06 75 91799
	Safe sleep champion		Safe Sleep Champion - see above	<a href="mailto:merry.sorensen@tdhb.org.nz">merry.sorensen@tdhb.org.nz</a>	
Are they experiencing or have experienced;					
Extreme budget restraints (income not covering outgoings)	Work and Income	0800559009	Work and Income	Query email (no names) <a href="mailto:NPY_Client_Query@msd.govt.nz">NPY_Client_Query@msd.govt.nz</a> <a href="mailto:karen.coleman008@msd.govt.nz">karen.coleman008@msd.govt.nz</a> (for further info about WI services) Kelly Kemp Integrated Services Case Manager 06 968 6695 <a href="mailto:kelly.kemp001@msd.govt.nz">kelly.kemp001@msd.govt.nz</a>	No template, refer with a description outlining situation and reason for referral, through email.
	Budget Advice	7585996	Budget Advice	<a href="mailto:np.budget@xtra.co.nz">np.budget@xtra.co.nz</a>	

CYF involvement of either parent or partner: Child Protection	CYF Liaison	Rein Reinfeld 06 968 3337 Cell: 029 650 1630	LMC, Maternal and Child Health Social Worker	Rein Reinfeld 06 968 3337 Cell: 029 650 1630 <a href="mailto:rein.reinfeld001@cyf.govt.nz">rein.reinfeld001@cyf.govt.nz</a>	Referral template Telephone 0508 FAMILY 0508 (326459)  Also need to be clear that Taranaki DHB staff/LMCs should follow the Taranaki DHB policy/process when making a notification to CYF (you could check this with Carol Shenton at the hospital). Note the above is only for non-Taranaki DHB staff.
	<b>Immediate Danger</b>	<b>Police: 111</b>	<b>Immediate Danger</b>	<b>Police: 111</b>	Phone 111
	Taranaki DHB Child Protection Coordinator	Carol Shenton: 06 7537777 ext. 8437 <a href="mailto:carol.shenton@tdhb.org.nz">carol.shenton@tdhb.org.nz</a>	Taranaki DHB Child Protection Coordinator	Carol Shenton: 06 7537777 ext. 8437 <a href="mailto:carol.shenton@tdhb.org.nz">carol.shenton@tdhb.org.nz</a>	Phone or email
	Maternal & Child Health Social Worker	Lydia Rae Vivien Jones Lisa Wall <a href="mailto:lydia.rae@tdhb.org.nz">lydia.rae@tdhb.org.nz</a> <a href="mailto:vivien.jones@tdhb.org.nz">vivien.jones@tdhb.org.nz</a> <a href="mailto:lisa.wall@tdhb.org.nz">lisa.wall@tdhb.org.nz</a>	Maternal & Child Health Social Worker	Lydia Rae Vivien Jones Lisa Wall <a href="mailto:lydia.rae@tdhb.org.nz">lydia.rae@tdhb.org.nz</a> <a href="mailto:vivien.jones@tdhb.org.nz">vivien.jones@tdhb.org.nz</a> <a href="mailto:lisa.wall@tdhb.org.nz">lisa.wall@tdhb.org.nz</a>	Phone (Taranaki DHB Operator) or email
Family violence or domestic violence concerns: Partner Abuse	<b>Immediate Danger</b>	<b>Police 111</b>	<b>Immediate Danger</b>	<b>Police 111</b>	Phone 111
	Tu Tama Wahine O Taranaki	06 7585795 <a href="mailto:reception@tutamawahine.org.nz">reception@tutamawahine.org.nz</a>	Tu Tama Wahine O Taranaki	06 7585795 <a href="mailto:reception@tutamawahine.org.nz">reception@tutamawahine.org.nz</a>	Phone and fax referral See VIP Referral Form
	Taranaki Women's Refuge	Crisis Line: 06 7695533 Call Free: 0800 827 973 <a href="mailto:admin@taranakiwomensrefuge.co.nz">admin@taranakiwomensrefuge.co.nz</a>	Taranaki Woman's Refuge	Crisis Line: 06 7695533 Call Free: 0800 827 973 <a href="mailto:admin@taranakiwomensrefuge.co.nz">admin@taranakiwomensrefuge.co.nz</a>	Phone and fax referral See VIP Referral Form
	Relationship Aotearoa: Counselling	06 758 3803 0800 735 283 <a href="http://www.relationshipsaotearoa.org.nz">www.relationshipsaotearoa.org.nz</a>	Relationship Aotearoa: Counselling	06 758 3803 0800 735 283 <a href="http://www.relationshipsaotearoa.org.nz">www.relationshipsaotearoa.org.nz</a>	Phone and fax referral See VIP Referral Form

	Work & Income: FV Response	Lee Haskell Family Violence response Coordinator 06 968 6699 <a href="mailto:lee.haskell001@msd.govt.nz">lee.haskell001@msd.govt.nz</a>	Work & Income: FV Response	Lee Haskell Family Violence response Coordinator 06 968 6699 <a href="mailto:lee.haskell001@msd.govt.nz">lee.haskell001@msd.govt.nz</a>	Refer through Work and Income
	Taranaki DHB Maternal & Child Health Social Worker	Lydia Rae Vivien Jones Lisa Wall <a href="mailto:lydia.rae@tdhb.org.nz">lydia.rae@tdhb.org.nz</a> <a href="mailto:vivian.jones@tdhb.org.nz">vivian.jones@tdhb.org.nz</a> <a href="mailto:lisa.wall@tdhb.org.nz">lisa.wall@tdhb.org.nz</a>	Taranaki DHB Maternal & Child Health Social Worker	Lydia Rae Vivien Jones Lisa Wall <a href="mailto:lydia.rae@tdhb.org.nz">lydia.rae@tdhb.org.nz</a> <a href="mailto:vivian.jones@tdhb.org.nz">vivian.jones@tdhb.org.nz</a> <a href="mailto:lisa.wall@tdhb.org.nz">lisa.wall@tdhb.org.nz</a>	Phone (Taranaki DHB operator) or email
	Taranaki DHB Violence Intervention Programme Coordinator	Marianne Pike 06 753 7777 ext. 8973 <a href="mailto:marianne.pike@tdhb.org.nz">marianne.pike@tdhb.org.nz</a>	Taranaki DHB Violence Intervention Programme Coordinator	Marianne Pike 06 753 7777 ext. 8973 <a href="mailto:marianne.pike@tdhb.org.nz">marianne.pike@tdhb.org.nz</a>	Phone or email
<b>Behaviour concerns leading to prison</b>	Youth justice service if under 17	0800 559 009	Youth Justice Social Worker		
	Tui Ora		NP Police	Meryn Wright <a href="mailto:meryn.wright@police.govt.nz">meryn.wright@police.govt.nz</a> 759 5500 0272533963	
<b>Perinatal Mental health concerns (MMH Pathway)</b>	Perinatal Maternal Mental Health Pathway	Patrick Morris Team Leader 06 7537749 ext 8547 <a href="mailto:patrick.morris@tdhb.org.nz">patrick.morris@tdhb.org.nz</a> Intake Coordinator <a href="mailto:mentalhealth.referrals@tdhb.org.nz">mentalhealth.referrals@tdhb.org.nz</a>	MMH pathway GP services	Patrick Morris Team Leader 06 7537749 ext 8547 <a href="mailto:patrick.morris@tdhb.org.nz">patrick.morris@tdhb.org.nz</a> Intake Coordinator <a href="mailto:mentalhealth.referrals@tdhb.org.nz">mentalhealth.referrals@tdhb.org.nz</a>	<a href="#">Perinatal Mental Health Pathway</a>
	Police if life is in immediate danger otherwise Mental Health Crisis Team	Crisis team via hospital switchboard 06 7536139 Or cell 0508 277 478 Leave message usually reply in 20 mins	Police if life in immediate danger otherwise Mental Health Crisis Team	Crisis team via hospital switchboard 06 7536139 Or cell <b>0508 277 478</b> Leave message usually reply in 20 minutes	

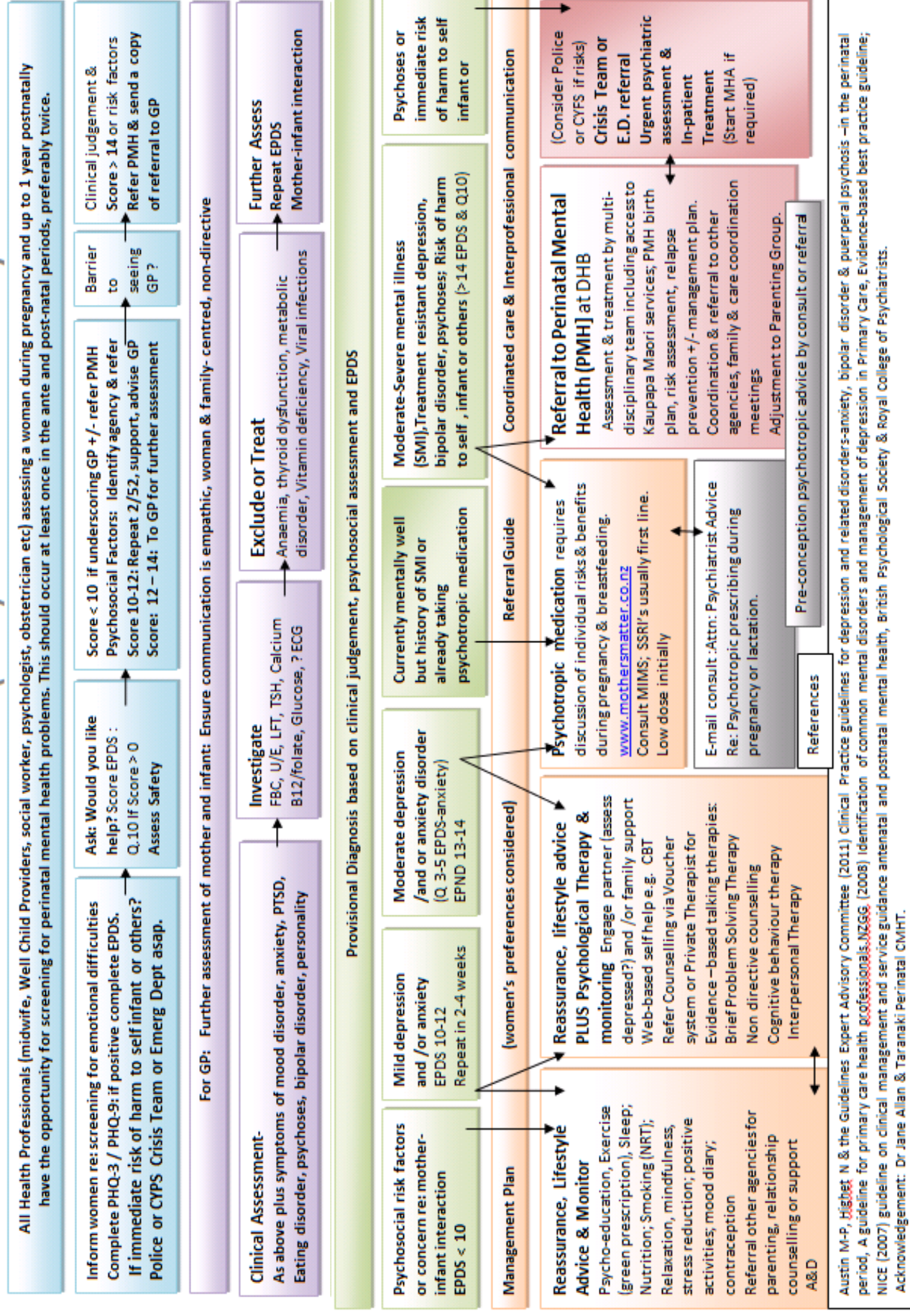
<b>Tui Ora Mental Health Concerns (Including perinatal and infant mental health)</b>	Infant Mental Health in development – current peri-natal mental health as per Maternal Mental Health Pathway	Intake Coordinator <a href="mailto:mentalhealth.referrals@tdhb.org.nz">mentalhealth.referrals@tdhb.org.nz</a> Tui Ora Perinatal and infant mental health social workers: Sally Phillips and Carolyn Ravek 06 7594064 (Mama Pepe/Tamariki Ora Team)	Infant Mental Health in development – current peri-natal mental health as per Maternal Mental Health Pathway	Intake Coordinator <a href="mailto:mentalhealth.referrals@tdhb.org.nz">mentalhealth.referrals@tdhb.org.nz</a> Sally Phillips and Carolyn Ravek 06 7594064	Via DHB Maternal Mental Health Pathway  <a href="#">Perinatal Mental Health Pathway</a>
<b>Family concerned about mental health</b>	Supporting Families-Whanau in Mental Health Taranaki	Main Office: 06 757 9300 North Taranaki: Gareth Andrews 0275551503 South Taranaki: Bernie Kira 027 5556808	Support, Advocacy, Information and Education for loved ones of someone who has a mental health concern.	<a href="mailto:manager@sftaranaki.org.nz">manager@sftaranaki.org.nz</a> Or <a href="mailto:gareth@sftaranaki.org.nz">gareth@sftaranaki.org.nz</a> Or <a href="mailto:bernie@sftaranaki.org.nz">bernie@sftaranaki.org.nz</a>	Self-referrals accepted, referrals from other organisations via referral form contact main office.
<b>Concerns regarding previous trauma (TABs/?)</b>	TABS Trauma after Birth Information	<a href="http://www.tabs.org.nz">www.tabs.org.nz</a>	Trauma after birth pathway	Lydia Rae <a href="mailto:lydia.rae@tdhb.org.nz">lydia.rae@tdhb.org.nz</a>	
<b>Language barriers</b>	Kaumātua	South Taranaki Aroha Wharemate ext 6707 North Taranaki Matua Ramon Tito ext 7482	Kaumātua	South Taranaki Aroha Wharemate ext 6707 <a href="mailto:arohawharemate@xtra.co.nz">arohawharemate@xtra.co.nz</a>  North Taranaki Matua Ramon Tito ext 7482 <a href="mailto:ramon.tito@tdhb.org.nz">ramon.tito@tdhb.org.nz</a>	
	Language line		Language line	Helen Burley Mike Burr <a href="mailto:helen.burley@tdhb.org.nz">helen.burley@tdhb.org.nz</a> <a href="mailto:mike.burr@tdhb.org.nz">mike.burr@tdhb.org.nz</a>	
<b>Concern regarding parenting ability or life skills</b>	Parents As First Teachers (PAFT) Barnados Taranaki / Wanganui	Angevahn, Service Manager P.A.F.T. <a href="mailto:angevahn@barnardos.org.nz">angevahn@barnardos.org.nz</a> DDI: 06 968 8531 Mobile: 027 672 70068536	Parents as First Teachers – P.A.F.T.	<b>PAFT Criteria</b>  <a href="mailto:angevahn@barnardos.co.nz">angevahn@barnardos.co.nz</a>	<a href="#">PAFT Referral Form</a>
	Open Home Child & Youth Health Programme Triple P Programme Mothercraft Waikato			<b>Taranaki Service Centre</b> 212 Coronation Avenue PO Box 208 New Plymouth Tel: 06 758 9971 Fax: 06 758 1969 Email: <a href="mailto:taranaki@ohf.org.nz">taranaki@ohf.org.nz</a> Practice Manager: Laura Brits	Open Home Child & Youth Health Programme: <a href="#">Open Home Child and Youth Referral Form</a> <a href="#">Triple P Programme Information</a> <a href="#">Mothercraft Waikato Referral</a>

	Maternal social worker		Maternal social worker	Lydia Rae <a href="mailto:lydia.rae@tdhb.org.nz">lydia.rae@tdhb.org.nz</a>	
	Tui Ora Youth services parenting courses – Tui Ora		With child under 5	Currently being replaced 759 4064 ext 6330 <a href="mailto:patsy.bodger@tuiora.co.nz">patsy.bodger@tuiora.co.nz</a>	
<b>Concealed/unwanted pregnancy</b>	Maternal Social	Lydia Rae Vivien Jones	Adoptions?	<a href="mailto:lydia.rae@tdhb.org.nz">lydia.rae@tdhb.org.nz</a> <a href="mailto:vivien.jones@tdhb.org.nz">vivien.jones@tdhb.org.nz</a>	
	Associate Director of Midwifery	Belinda Chapman	same	06 7537864 <a href="mailto:belinda.chapman@tdhb.org.nz">belinda.chapman@tdhb.org.nz</a>	
	Sexual Health Unit if termination requested		Surgical and medical terminations can be organised, along with sexual health checks and treatment, biopsies, wart treatment and HIV tests all free of charge.	Sexual Health Clinic, 188 Powderham Street, New Plymouth. Phone free 0508739432 Option 1.	Patients name, up to date address, DOB, NHI, current phone numbers are included Fax 06 7578316
<b>Transient lifestyle</b>	Find your Midwife website	Taranaki DHB accessing a midwife site	Kaiawhina	<a href="http://www.findyourmidwife.co.nz">www.findyourmidwife.co.nz</a> <a href="mailto:belinda.chapman@tdhb.org.nz">belinda.chapman@tdhb.org.nz</a> <a href="http://www.tdhb.org.nz/services/maternity/lmc_contacts.shtml">www.tdhb.org.nz/services/maternity/lmc_contacts.shtml</a>	If transient woman and is in advanced pregnancy with no LMC please contact Belinda Chapman so the woman can be followed up
			Tui Ora Tamariki Ora Service	Team Leader Well Child Service 06 75 94064 Ext 6320 0277064032	Contact Deb Harding or Tui Ora via email or fax Email: <a href="mailto:intake@tuiora.co.nz">intake@tuiora.co.nz</a> Fax: 06 75 91799
			Tui Ora Mama & Pepe Kaiawhina	Phone 06 75 94064	As above
<b>Poor engagement with maternity care</b>	Tui Ora Mama & Pepe Kaiawhina	Phone 06 75 94064	Maori Health Team	Raana or Denise 753 7777 ext 7587 or 6707	Tui Ora via email or fax Email: <a href="mailto:intake@tuiora.co.nz">intake@tuiora.co.nz</a> Fax: 06 75 91799



	Maternity social worker		Tui Ora Mama & Pepe Kaiawhina	Phone 06 75 94064	Tui Ora via email or fax Email: <a href="mailto:intake@tuiora.co.nz">intake@tuiora.co.nz</a> Fax: 06 75 91799
Poor social supports	Mama Pepi Hauora Tui Ora		Parent as first teachers	<a href="#">PAFT Criteria</a>	<a href="#">PAFT Referral Form</a>
Living alone	Mama pepi Hauora Tui Ora		Parent as first teachers	<a href="#">PAFT Criteria</a>	<a href="#">PAFT Referral Form</a>
Estranged from family/whanau or from another district and have no family/whanau support close	Mama pepi Hauora Tui Ora		Parent as first teachers	<a href="#">PAFT Criteria</a>	<a href="#">PAFT Referral Form</a>
Obesity BMI over 40	Dietitian	Clinical Dietitians, Taranaki DHB	Dietitian	Clinical Dietitians, Taranaki HB Ph: 06 7537751  Please fax the referral to: 06 7537709 Or <a href="mailto:dietitians@tdhb.org.nz">dietitians@tdhb.org.nz</a>	Referral from either a medical practitioner or an allied health worker Information required: Name, DOB & NHI Medical diagnosis & past medical history EDD Reason they have been referred to the Dietitian Whether a translator is required
Poor housing conditions	Mama pepi Hauora Tui Ora	Julie Foley 759 4064 ext 6213	Mama pepi	Julie Foley 759 4064 ext 6213 <a href="mailto:julie.foley@tuiora.co.nz">julie.foley@tuiora.co.nz</a> Updated in Feb	No template available.
	Housing Corp, Work and Income (screening)		WI, Social workers		
	WIZE better homes	Glenarr Huntley 027 706 8463	Tui ora WIZE better homes	Glenarr Huntley 06 759 4064 ext 6065 027 706 8463 <a href="mailto:glenarr.huntly@tdhb.org.nz">glenarr.huntly@tdhb.org.nz</a>	

# Perinatal Mental Health (PMH): Local Referral Pathway



## **Referral of Patients to be seen by Mental Health Services**

### **NON URGENT BUT NEEDING TO BE SEEN WHILST INPATIENT**

Advice and assessment on:

- Suicide risk
- Previous mental health diagnosis causing concern
- Depression with clinical indication
- Other mental health issues currently impacting on the clients ability to function
- Consult liaison RNs

**Services availability :**

**Mon – Fri 0800hrs – 1630hrs**

**After hours please contact on-call Psychiatrist**

### **REFERRAL FOR A CURRENT CLIENT OF MATERNAL MENTAL HEALTH**

This client group may be directly referred to Maternal Mental Health (Perinatal)

**Contact either their existing key worker or else the team leader on 8547**

### **ACUTE/URGENT PSYCHIATRIST ADVICE**

For serious mental health disorders requiring immediate advice

For urgent medication advice

### **CONSULTANT TO CONTACT THE ON-CALL PSYCHIATRIST VIA OPERATOR**

**Note:** Non urgent psychiatric follow-up required in the community – complete a comprehensive consultation referral and fax to the Intake Coordinator Adult Mental Health on 7673

### **PATIENTS AT RISK OF SELF HARM OR HARM TO OTHERS**

If an RN believes a patient is mentally unwell and a danger to themselves or others and they are attempting to leave, he/she should:

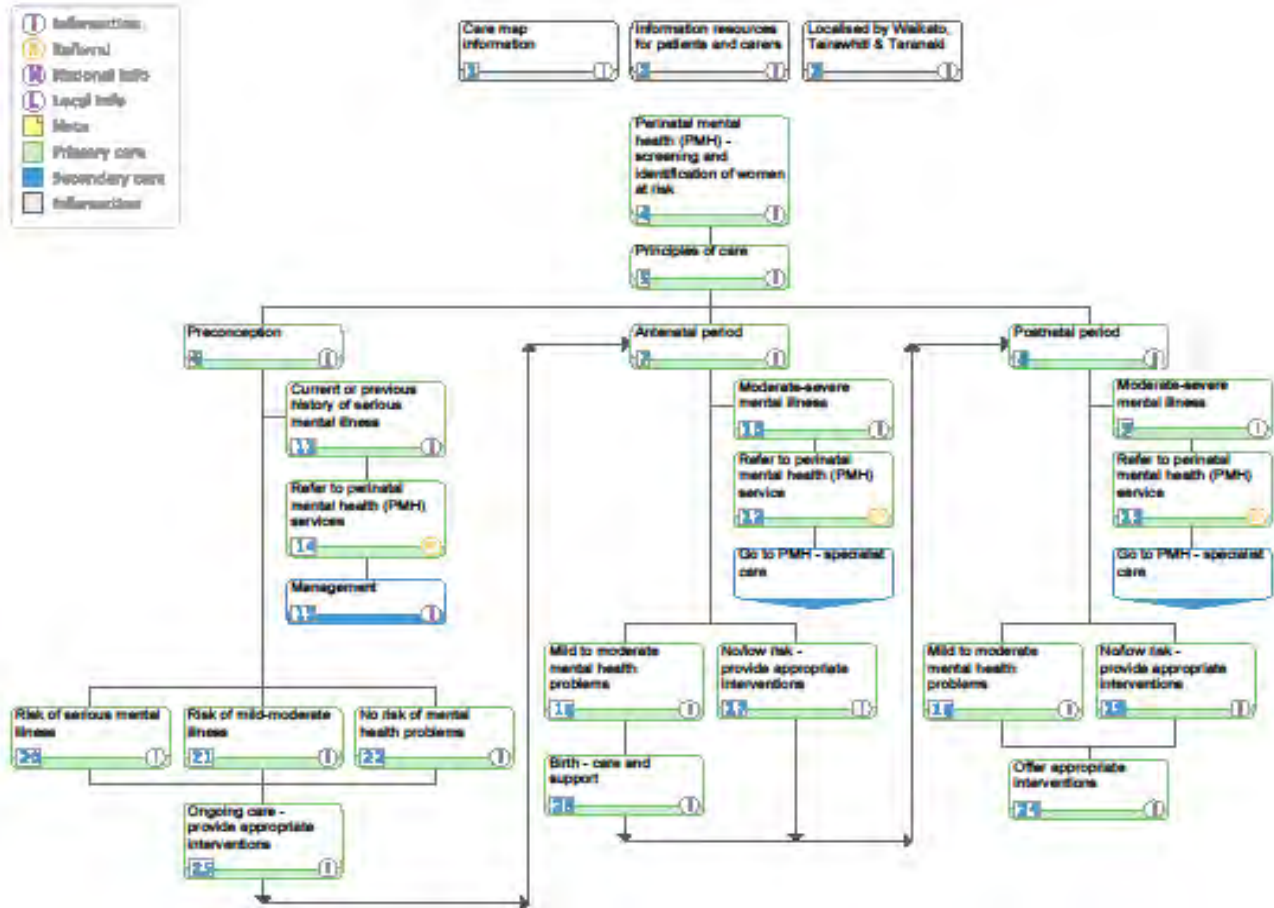
- Complete Section 111 Notice of Intention to Detain to be completed by RN
- RN who completed section 111 of the Mental Health Act is to complete Section 8A and doctor to complete Section 8B. Section 111 gives six hours holding time but in the spirit of the Act the Section 8A should follow promptly and the assessment at Section 8B should also be carried out in a timely manner within the six hours.
- Duly Authorised Officer (DAO) to be notified as soon as practicable from serving the Section 111. Contact one of the below:
  - Mental Health Liaison Nurse; pager 123
  - Mental Health Crisis Team; ext 7680
  - Night Triage Nurse; please contact through telephonist (between 2300-0800 hours)
- DAO will arrange assessment by a psychiatrist for Sections 10 and 11 and clinical report. In the time between assessments, the DAO will serve the Section 9 to the patient.
- If the patient is not reviewed by a psychiatrist within six hours then he/she cannot be detained any further.
- See Notice of Intention to Detain, Section 111 of the Mental Health Act, Nurses Holding Authority on the Intranet/Policies & Procedures/Core Nursing/Management.



This map is in the stages of being finalised and has been localised at Waikato, Taranaki and Tairāwhiti DHBs. The Midlands Health Network is managing the Midland Maps of Medicine pathways.

## Perinatal mental health (PMH) - primary care

MHN > WDHB pathway development > Mental Health



Published: Valid until: Printed on: 04-Mar-2015 © Map of Medicine Ltd

This care map is in development by . It is not yet approved for clinical use. A printed version of this document is not controlled so may not be up-to-date with the latest clinical information.

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## Appendix 5 : Midwifery Professional Development 2015

**REGISTRATION:** Bookings only accepted once course has been advertised.

Check Intranet page - Services/Education Centre/Training Courses to view registration details

COURSE NAME	HOSPITAL RN, MW	PRIMARY SECTOR	DATE(S)	FACILITATOR	APPROX. TIME
Epidural (1/2 day)	RM only		1 May, 30 October (Room 2 & 4 ED centre)	Sharon Howe/Tom Lupton/ Emma Patrick	1 230-1700
Blue sky interpersonal Relationship training	O&G Core RM LMC		4 June (Corp 1)	Sue Lennox/John Marwick	0830-1630
Immunisation Course	MIDWIVES ONLY		TBC	Mel H/Karen Janes	1 200-1400
Neonatal and Breastfeeding study day	All	All	18 Feb, 10 Nov (Lecture Theatre)	Sharon Howe	0830-1630
Newborn life support – full day	RN RM O&G Dr's & Paed Dr's ONLY		22 May, 13 Nov Clinical Skills Lab	Abi Webber/Sharon Howe	0900-1600
Newborn Life Support Refresher	RN RM Dr's Anaesthetic Technicians		6 <sup>th</sup> March 2 October Clinical Skills Lab	Abi Webber/Sharon Howe	0900-1100 1 200-1400
Maternal and Infant Workshop Healthy Start	RM		TBA	NZCOM	0830-0900
Pain Management	Core Midwives, RN's		3 March, 17 March, 12 May, 16 June, 21 July, 8 September, 13 October, 24 November (lecture theatre) Hawera 24 March, 6 October	Eileen Davey	0830-1200
Perineal Suturing (1/2 day)	RM only		13 <sup>th</sup> Feb, 3 November, (Rm 2 Feb & Rm 4 Nov) ED centre)	Sharon Howe/Eddie Williams	1 230-1630
Perinatal Mortality Meeting	O&G, NNU, Paeds, LMC's, Maternity		10 <sup>th</sup> Feb, 1 <sup>st</sup> September (auditorium)	Finola Mooney/Belinda Chapman	7-9pm
PROMPT Course	RM, Obst, Anaesthetists		3 <sup>rd</sup> July, 18 <sup>th</sup> Dec	PROMPT FACULTY	0800-1630

<b>Midwives Practice day</b>	<b>RM only</b>		3 March 22 September (Lecture Theatre)	Sharon Howe	0830-1630
<b>Midwives Emergency Refresher workshop</b>	<b>RM only</b>		27 March, 19 June, 4 Dec (Clinical Skills Lab)	Sharon Howe	0800-1630
<b>Wintec Preceptor Day</b>	<b>RM only</b>		TBA	Wendy/Liz	0830-1630
<b>Water Birth Workshop</b>	<b>RM,RN,</b>		19 <sup>th</sup> March (Barrett's Lounge)	Liz Lee Taylor	0900-1630
<b>Te Hapu Ora Smokefree</b>	<b>RM/RN O&amp;G</b>	<b>All</b>	January 21 <sup>st</sup> (Lecture Theatre)	Alys Brown	1000-1400
<b>Taranaki DHB FVIP Workshop</b>	<b>RM RN</b>		27 Feb. 20 March, 24 April, 22 May, 26 June, 31 July, 28 August, 25 September, 30 October, 27 November	Marianne Pike	0830-1630
<b>AUT Presentation</b>	<b>RM,RN, O &amp; G</b>		TBA	AUT	0830-1630

Midwifery Council of New Zealand (MCNZ) compulsory education requirements:

- Annual Midwives emergency day training which includes maternal resus to the standard of level 4, Neonatal resuscitation and emergency drill training. PROMPT and ALSO (not provided at Taranaki DHB) training days will cover an annual midwives emergency refresher workshop (once in every 3 years only, remaining 2 years must be Midwives emergency refresher workshop).Taranaki DHB PROMPT includes Newborn life support.
- Midwives Practice day every 3 years
- 3yearly attendance at a Breastfeeding approved workshop (minimum 4 hours), in addition must attend another education session with no hours specified which can be a conference, on line learning or other activities (it can be the 2<sup>nd</sup> half of a different full day breastfeeding related workshop)
- Midwifery standards review 2-3yearly
- Professional and elective education as stipulated by midwifery council

DHB requirements for Core Midwives

- Epidural study day 3 yearly
- Pain Management 3yearly
- Suturing workshop 3yearly
- NBLS full day (recommended to be attended 3 yearly but not compulsory)

Any questions please contact Belinda Chapman (ADOM) ext 8918 or Sharon Howe Midwifery Educator ext 825



## Appendix 6 : Quality Audit and Reporting Grids

### Taranaki DHB Maternity Quality Audit Grid 2015/16

	2015							2016				
	March	April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb
MEWS Audit CORE REP	😊						😊					
Customer Satisfaction Survey CONSUMER		😊										
Documentation Audit ME					😊						😊	
ISBARR Postnatal Coordinator			😊						😊			
Electronic Fetal Monitoring Audit ME						😊						
Referral Guidelines Audit ME									😊			
Safe Sleep Audit Safe sleep champion								😊				
C-section Audit O&G				😊							😊	

# Taranaki DHB Maternity Quality Committee Reporting Grid 2015/16

	2015								2016			
	March	April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb
<b>PMMR and case review/trends/great saves</b> <i>ME/ADOM</i>	😊						😊					
<b>Maternal mental health</b> <i>Numbers/Trends – MMH Team Leader</i>		😊					😊					
<b>Neonatal Unit</b> <i>Admissions/trends/issues CNM NNU</i>			😊									😊
<b>Complaints/consumer feedback trends</b> <i>Mat Child Health Manager/ CMM</i>		😊										
<b>Wound infections/general anaesthesia and blood transfusions (caesarean section)</b> <i>CNS – Infection Control</i>				😊					😊			
<b>HDU admissions Audit</b> <i>ME</i>			😊									😊
<b>Consumer report</b> <i>Consumer Representative</i>				😊								
<b>LMC Registration</b> <i>ADOM</i>											😊	
<b>Newborn Hearing Screening</b> <i>Allied Health Manager</i>								😊				



### *Terms of Reference*

### **DRAFT**

### **Maternity Care, Wellbeing and Child Protection Multi-Agency Group (MCWCP MAG) and Operational Guideline**

<b>Purpose</b>	<p>The purpose of this group is to enable the best possible outcomes for women and their families identified to have vulnerabilities during the maternity care period (antenatal to six weeks' post-partum), by working in partnership with them.</p> <p>Our aim is to strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.</p>
<b>Scope</b>	<p>All services who work with and care for women and their families during the maternity care period (antenatal to six weeks' post-partum).</p>
<b>Key Foundational Principles</b>	<ul style="list-style-type: none"> <li>• A focus on actions which support mother and baby safety.</li> <li>• All actions align with the philosophy of working in partnership with women and their families to inform and achieve healthy change.</li> <li>• Support for professionals to practice safely in their role and environments.</li> <li>• Aligned with health professional and child protection frameworks and laws in New Zealand.</li> <li>• Maximise a safe environment for both the families and the health professionals working with those families with complex health, social, cultural and economic needs.</li> <li>• Enabling transition of care pathways between maternity, social services, Well Child Providers and primary care.</li> <li>• Supporting integration of maternity services by providing clinical leadership across community and hospital settings.</li> <li>• Providing an effective forum for community based practitioners to engage with.</li> <li>• Enabling appropriate and safe information sharing between service providers.</li> <li>• Promoting shared understanding and interagency collaboration.</li> <li>• The Paramount Principle, provision of care in partnership with women and principle of maternal autonomy can work together to keep mothers and babies safe. In the unusual situation where these values conflict, the Paramount Principle shall guide decision making.</li> <li>• The purpose and principles of the MCWCP MAG meeting align with key objectives, actions and activities outlined within the <i>Children's Action Plan</i>.</li> </ul>

<b>Objectives</b>	<ul style="list-style-type: none"> <li>• To support and strengthen families to stay together; in particular the fostering of healthy attachments between the mother and her newborn baby.</li> <li>• To be proactive in identifying and building supportive networks that wrap around the family.</li> <li>• To provide a forum that enables sharing of information that ensures the best possible outcome for the woman and her family.</li> <li>• To enable participation, communication and partnership with all relevant parties.</li> <li>• To ensure there is a coordinated approach to case management and follow-up.</li> <li>• To facilitate and support effective multiagency partnerships.</li> <li>• To ensure effective communication pathways are established and maintained between all parties concerned.</li> <li>• To identify any strategic issues that impact on the provision of care and take appropriate action/develop a framework to enable a seamless service.</li> </ul>
<b>MAG Coordination</b>	A Coordinator/Facilitator (who holds a role based in the DHB) will take the role of receiving the referrals, preparing the meeting agenda and ensuring the appropriate communication is maintained, including inviting providers to attend and documentation in accordance with the meeting process (see Flowchart).
<b>MAG Facilitator</b>	The MAG will elect a Facilitator to Chair the MAG meetings and oversee the MAG coordination.
<b>MAG Membership</b>	<p>The MAG group will comprise a core group of senior professionals who will provide consultation for all cases reviewed; the core group will comprise of the following people:</p> <ul style="list-style-type: none"> <li>• Maternity services representative(s) e.g. Director of Midwifery and midwives in senior clinical roles</li> <li>• Senior social worker (Maternal and or Paediatric)</li> <li>• Child Protection Co-ordinator</li> <li>• Family Violence Intervention Co-ordinator</li> <li>• Child, Youth &amp; Family (CYF) representative (can be the CYF hospital social worker or a senior social worker from relevant sites)</li> <li>• Maori Health representative</li> <li>• Well Child Provider</li> <li>• Maternal/Mental Health Service</li> </ul> <p>The Lead Maternity Carer (LMC) and any relevant key worker <i>will always</i> be invited to attend the meeting when woman within their care are being discussed.</p> <p>Other relevant professionals may be invited by the Chair to either attend and or provide information depending on the case; they include:</p> <ul style="list-style-type: none"> <li>• Obstetrician</li> <li>• Paediatrician</li> <li>• Paediatric social worker</li> <li>• Special Care Baby Unit Clinical Nurse Manager</li> <li>• Adult addictions service</li> <li>• Police</li> <li>• Women's Refuge</li> <li>• NGO social support services e.g. family start, family works</li> </ul>

	<p>For discussion to be free and frank the woman, her partner and family/ whānau will not usually be invited to the team discussion but may be invited to the end of the discussion at the discretion of the Chair and the woman's LMC.</p>
<b>MAG Operation</b>	<p>The MAG operation includes three phases:</p> <ol style="list-style-type: none"> <li>1. Meeting preparation (receipt of referrals/updates of cases for MAG)</li> <li>2. MAG meeting; case review including development of support plan</li> <li>3. MAG follow-up documentation</li> </ol> <p>The meetings will be held (<i>frequency</i>) at the (<i>location</i>).</p> <p>The meeting agenda will be sent to the members (core and invited providers) at least x days prior to the meeting.</p> <p>Meetings will be booked into MAG members calendars at (<i>frequency</i>) intervals.</p> <p>There is an expectation that there is open communication between all parties concerned in the care of women and their families/whānau; enabling safe, appropriate decisions regarding care, unity in provision of agreed care, support and the recommendation for a child protection alert when indicated. There is also an expectation that professionals involved will work collaboratively and within the principles of safe practice. This team recommends that all women discussed within MAG receive an early referral to a Well Child Provider to facilitate seamless transfer between maternity and Well Child Services.</p> <p>Team administrator/support is essential for managing the MAG operational requirements e.g. minute taking, documentation, data entry and database management for reporting.</p> <p>The operation is detailed in the flowchart contained in Appendix 1.</p>
<b>MAG Pre-Meeting Phase including Referral Pathway</b>	<p><b>Referral Pathway</b></p> <p>Referrals can be made at any time by anyone involved in the care of pregnant women and their families to any member of the MAG team. The following points should inform the referral process:</p> <ul style="list-style-type: none"> <li>• Completion of a written referral is necessary.</li> <li>• Phone referrals require written referral follow-up.</li> <li>• Key concerns need to be identified.</li> <li>• In the event that family violence is the referral reason, completion of a family violence documentation form must accompany the written referral.</li> <li>• Existing key workers or agencies involved should be identified with their full name and contact details.</li> <li>• An urgent referral requires contact with a member of the senior midwifery team.</li> <li>• LMCs, GPs and key workers can expect to be contacted and invited to the next MAG meeting or an exceptional meeting in urgent situations.</li> <li>• There is an expectation that in almost all cases the referrer will discuss with the woman that the provider is going to refer her case for consultation with the MAG team. The referrer will indicate on the referral form if this discussion has <b>not</b> occurred and why (e.g. violent partner always present, risk of flight).</li> </ul>

	<ul style="list-style-type: none"> <li>• Referral reasons may include but are not limited to: <ul style="list-style-type: none"> <li>○ Concerns for care and/or safety of unborn child</li> <li>○ Mental Health concerns</li> <li>○ Insufficient social support, impacting on pregnancy, parenting or ability to care for a baby</li> <li>○ Family violence</li> <li>○ CYF history</li> <li>○ Drug and alcohol abuse</li> </ul> </li> <li>• An agenda will be drawn up prior to the meeting with the cases identified for discussion/consultation.</li> <li>• Ensure that MCWCP Patient Information Leaflet is provided to the woman.</li> <li>• Cases will be clustered based on the LMCs providing care to facilitate their attendance for the cases they are involved in.</li> <li>• If invitees/members are unable to attend, apologies will be sent to the Chair and plan to provide an email update to the Chair on cases they are involved in.</li> </ul>
<b>MAG Meeting Process</b>	<ul style="list-style-type: none"> <li>• All current cases and new referrals are reviewed.</li> <li>• Documentation of each case will be clear and accurate, and filed in the woman's clinical record.</li> <li>• The discussion and plan will be recorded in the following ways: <ul style="list-style-type: none"> <li>○ Meeting minutes shall record the cases discussed and brief plan, with clear accountabilities and timeframes</li> <li>○ New cases will have an individual MAG Support Plan initiated</li> <li>○ Review cases will have their MAG Support Plan updated as required</li> <li>○ Individual plans placed at the front of the woman's clinical record/maternity care record</li> <li>○ Appropriate linkage with Child Protection Alerts Policy as appropriate for the DHB</li> </ul> </li> <li>• Multi-Agency Safety Plan : In the event the case is referred to or by CYF, each woman's risk and protective factors will be discussed and a Multi-Agency Safety Plan (MASP) agreed and recorded. The MAG will discuss who the most appropriate professional will be to feedback outcomes of the MAG meeting and the support plan to the woman/whanau. In many instances this will be the woman's LMC but not in all circumstances.</li> <li>• A multi-agency postnatal discharge meeting, including family members, is held for those cases where comprehensive agreement and understanding of the support plan by all involved is required for the safety of the mother and infant.</li> </ul>
<b>Post MAG Process</b>	<ul style="list-style-type: none"> <li>• Minutes will be sent out within one week or within four days of the next meeting (<i>select one depending on meeting frequency</i>) to enable action points to be completed by the next meeting.</li> <li>• The MASP will be filed on the woman's clinical record/maternity care record.</li> <li>• The most appropriate professional involved in the woman's care will be responsible for discussing with the woman any plans developed with the MAG. That professional may bring other relevant professional(s) to the meeting to introduce them to the woman. All future care by the professionals involved will adhere to principles of safe, collaborative practice.</li> <li>• Feedback is provided to those key providers/agencies that provided information to the case consultation process.</li> </ul>



<b>Discharge Process</b>	<ul style="list-style-type: none"> <li>• Ensure all identified support agencies are engaged/referrals made.</li> <li>• Ensure that the Well Child Provider has received a comprehensive referral and is engaged.</li> <li>• Ensure that where a MASP (CYF involved) has been developed, that all parties are signed up to this plan.</li> <li>• Discharge MCWCP form completed, signed and filed in clinical records.</li> <li>• Ensure feedback to all agencies (referring and contributing) is provided.</li> <li>• Where DHBs have implemented the national Child Protection Alert System (CPAS), when criteria have been met i.e. a report of concern has been made to CYF, the MAG process will include reviewing the case to determine if an alert is recommended (if the recommendation is for an alert then the case will be referred for review by the CPAS Multidisciplinary Team).</li> </ul>
<b>Measurement Criteria</b>	<ul style="list-style-type: none"> <li>• Timely review and debrief of any adverse events and complex cases.</li> <li>• Wherever possible, data will be reported by ethnicity to ensure a quality service is provided to Maori, Pacific and other minority groups and contribute to reducing inequities in outcome for these population groups.</li> <li>• Suggested data to be collected includes: <ul style="list-style-type: none"> <li>○ number of women referred to the MCWCP</li> <li>○ proportion of cases referred that had LMC engagement in MCWCP consultation</li> <li>○ number of discussions per case</li> <li>○ number of referrals made per case</li> <li>○ proportion that were referred and engaged with Well Child Provider on discharge</li> <li>○ proportion that required Report of Concern to CYF</li> <li>○ proportion that resulted in a CYF Family Group Conference</li> <li>○ proportion that resulted in CYF obtaining court orders</li> </ul> </li> <li>• In addition, data may be gathered on the number of women identified late in pregnancy (after 38/40) with significant risks who had not been engaged in the MCWCP process.</li> <li>• Yearly audit of the referral form to ensure one exists for each woman and that the information is complete.</li> <li>• Survey of providers seeking feedback on the MCWCP process and their engagement.</li> </ul>
<b>Reporting</b>	<ul style="list-style-type: none"> <li>• Each MCWCP shall report via the Chair to the MCWCP Sponsor/ Governance Group quarterly.</li> <li>• An Annual Report shall be written at the end of the financial year for the Maternity Services Manager and copied to the managers of all contributing organisations to be distributed amongst referring clinicians. No identifiable details will be contained in any quarterly or annual report.</li> <li>• Copies may be sent to referring clinicians.</li> </ul>

<b>Reference Documents, Legislation</b>	<ul style="list-style-type: none"> <li>• New Zealand College of Midwives Handbook for Practice</li> <li>• Midwifery Council Code of Conduct</li> <li>• CYF, Police, HBDHB (2010) Memorandum of Understanding between Child, Youth and Family, New Zealand Police and District Health Board in relation to care and protection</li> <li>• Ministry of Health <i>Family Violence Intervention Guidelines – Child and Partner Abuse</i> (2002)</li> <li>• Taranaki DHB Child and neglect policy</li> <li>• Taranaki DHB Child protection alert management policy</li> <li>• Maternal Mental Health referral pathway</li> <li>• Taranaki DHB Family violence/partner abuse policy</li> <li>• Reducing inequalities best practice guidelines whanau ora</li> <li>• Children's Action Plan</li> <li>• Health Information Privacy Code</li> <li>• Children Young Person and their Families Act 1989</li> <li>• Vulnerable Children's Act 2014</li> <li>• Escalation ladder regarding sharing personal information of families and vulnerable children  <a href="https://www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children/">https://www.privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children/</a>  <a href="https://www.privacy.org.nz/assets/InteractiveEscalationLadder/PRCM1000-Escalation-Ladder-Infographic.pdf">https://www.privacy.org.nz/assets/InteractiveEscalationLadder/PRCM1000-Escalation-Ladder-Infographic.pdf</a></li> <li>• Sharing personal information of families and vulnerable children; Guideline for interdisciplinary groups  <a href="https://www.privacy.org.nz/assets/InteractiveEscalationLadder/PRCM1001-escalationLadder-hiRes.pdf">https://www.privacy.org.nz/assets/InteractiveEscalationLadder/PRCM1001-escalationLadder-hiRes.pdf</a></li> </ul>
<b>Definitions MAG</b>	Multi-Agency Group

Core member of the Maternity Care, Wellbeing and Child Protection Multiagency Forum agree to the Terms of Reference including the process for information sharing as outlined in this document.

Name	Signature	Date

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**AUTHORISED BY**

**Date of Approval:**

**Next Review Date:**

## Appendix 8 : Maternity Obstetric Outcome Data Collection Form 2015

Patient Bradma

Database Record: ☐ ☐ ☐ ☐

Date of delivery: ☐☐☐☐☐☐☐☐

Time of Delivery: ☐☐☐☐☐☐

Delivery Location: \_\_\_\_\_

Mode of delivery: ☐ Spontaneous Vaginal Birth ☐ Assisted Vaginal Birth ☐ Caesarean Section

Category	Fetal & Maternal Outcome			
		Circle	Yes	Comments/indication/gestation
Trend Monitoring (discussed at weekly case review forum meeting)	Transfer to or from tertiary centre	DS/W		
	Second Tri TOP for fetal abnormality	DS		
	Preterm birth < 37 weeks' gestation	DS		
	Spontaneous Vaginal birth	DS/OT		
	PPH ≥ 500 mls (vaginal birth)	DS/W		
	PPH ≥ 1000mls (caesarean birth)	OT/W		
	Anal sphincter trauma	DS/OT		
	Eclampsia diagnosed during birth admission	DS/OT		
	Decision –to-Delivery Interval >30 minutes for Level 1 caesarean cases	DS		
	Caesarean section elective-Primiparae	DS		
	Caesarean section elective-Multiparae			
	Caesarean section emergency-Primiparae	DS		
	Caesarean section emergency-Multiparae			
	General anaesthetic caesarean section	DS		
	Epidural in labour	DS		
	Uterine death /TOP > 20weeks	DS		
	Intact Perineum	DS/OT		
	3 <sup>rd</sup> or 4 <sup>th</sup> degree tears with no episiotomy	DS		
	Episiotomy extending to 3 <sup>rd</sup> or 4 <sup>th</sup> degree	DS		
	Induction of labour-Primiparae	DS		
	Induction of labour-Multiparae			
	Wound infections post caesarean	W		
	Number of days post natal inpatient stay ≥ 5 days	W		
	Smoking postnatally	W		
	VBAC	W/DS		
	GDM	W/DS		
	Assisted Birth <b>Forceps</b> <b>Ventouse</b>	DS/OT		

<b>Case Review</b>	Unexpected maternal transfers to ICU	<b>DS/OT W</b>		
	Eclamptic Seizure	<b>DS/W</b>		
	Visceral Trauma; Uterine scar rupture/dehiscence, urinary system or bowel trauma. 3 <sup>rd</sup> and 4 <sup>th</sup> degree tear	<b>DS</b>		
	Caesarean Hysterectomy	<b>DS</b>		
	Level 1 caesarean section	<b>DS</b>		
	NND/Intrauterine death /TOP >20weeks	<b>DS</b>		
	Transfer to or from tertiary centre	<b>DS</b>		
	Transfer in from primary unit/home by ambulance	<b>DS</b>		
	Blood transfusion post Vaginal Birth	<b>DS/W</b>		
	Blood transfusion post C/S birth	<b>OT/W</b>		
	Unexpected admission to the NNU from Delivery Suite/OT & PN when $\geq 37$ weeks' gestation and excluding fetal abnormality	<b>DS/W/O T</b>		
	Apgar score <5 at 5 min <b>and/or</b> <7 at 10 min, <b>and/or</b> cord pH <7.0	<b>DS/OT</b>		
	Post natal readmission	<b>DS/W</b>		
	Small for Gestational age (SGA)	<b>DS/W</b>		
<b>Mandatory Reporting</b>	<b>Intrapartum fetal demise</b>	<b>DS</b>		Reportable Event must be completed and copy attached. Line manager must be informed.
	<b>Maternal Death</b>	<b>DS/W</b>		Reportable Event must be completed and copy attached. Line manager must be informed.
Other concerning outcome - requesting review:				Detail and comment:

**Signed:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

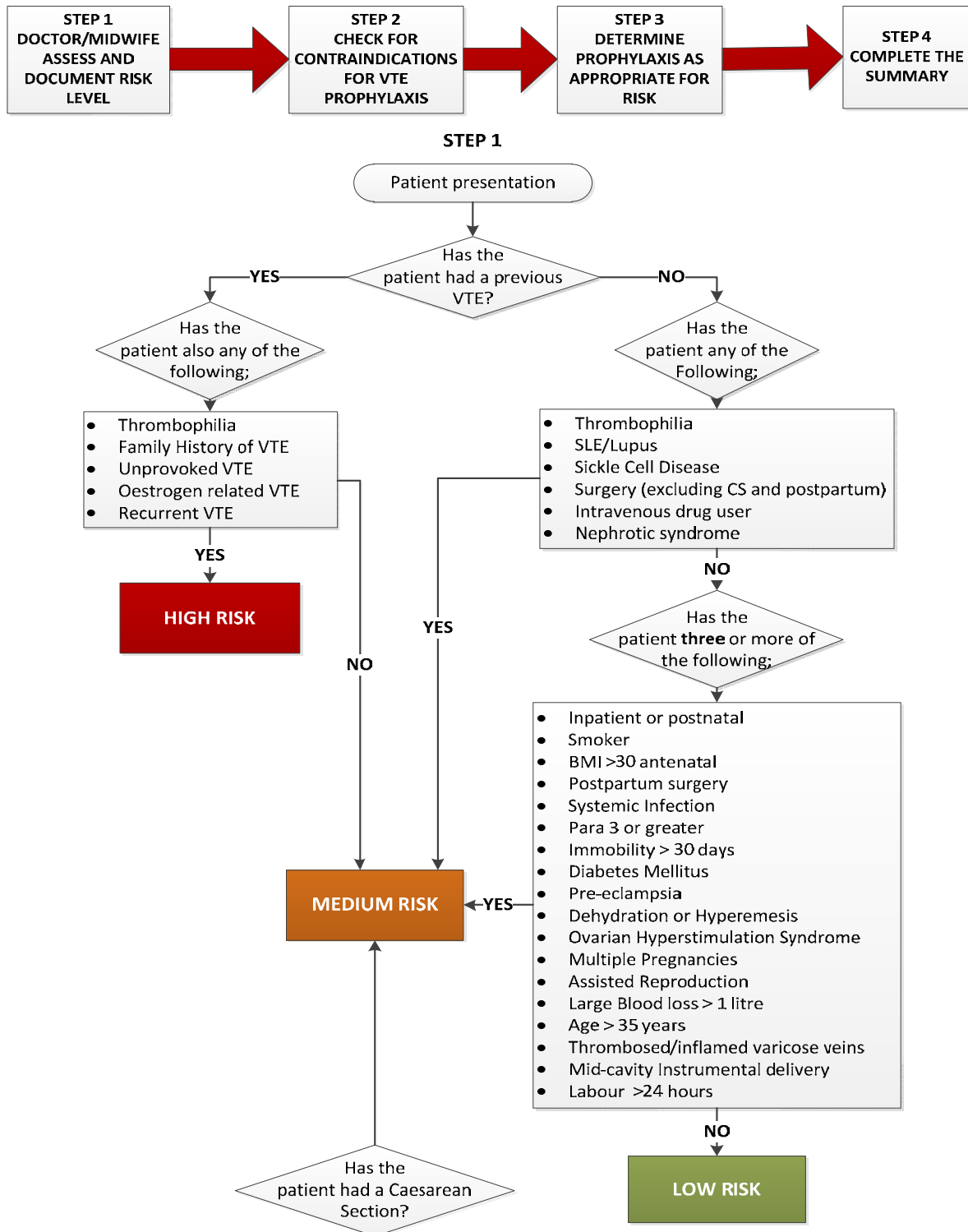
*Form to be forwarded to Midwife educator and ADOM on discharge.*

## Appendix 9: ISBARR Communication Tool : Obstetric/Neonatal

<b>I</b>	IDENTIFY	YOUR NAME ..... DESIGNATION ..... LOCATION..... CONSULTING WITH .....DESIGNATION..... LOCATION.....
<b>S</b>	SITUATION	THE REASON I AM CALLING IS: YOU ARE CALLING BECAUSE ..... ..... ..... .....  LEVEL OF URGENCY.....MEWS SCORE IF APPLICABLE.....
<b>B</b>	BACKGROUND D Eg Gravida, Parity, Gestation Previous C/S CTG status Epidural requested Hb Platelets	THE RELEVANT HISTORY IS: (PATIENT HX, TESTS, EAMINATIONS AND TX)..... ..... ..... ..... ..... ..... ..... .....
<b>A</b>	ASSESSMENT Eg Obs Blood loss PV loss Pain Uterine Activity VE Medication Birthweight Medication Apgars Feeding Blood Glucose Levels	MY ASSESSMENT IS: MOTHER Y/N      Baby Y/N ..... ..... ..... ..... ..... ..... ..... ..... ..... ..... ..... .....
<b>R</b>	RECOMMEND - ATIONS	WHAT I WANT IS:..... ..... ..... .....
<b>R</b>	RESPONSE	RESPONSE:..... ..... .....  DATE:..... TIME:.....SIGNATURE:.....FORM FAXED TO:.....  LMC:..... LMC ADVISED: Y/N .TIME:.....

## Appendix 10:

### OBSTETRIC VTE RISK ASSESSMENT AND VTE PREVENTION PROTOCOL





The Maternity Quality Committee is a clinical governance group that monitor and manage standards of clinical care, and are committed to ensuring a quality maternity service exists for the women and families of Taranaki.

## Appendix 11 : December 2014 - Issue 3

Merry Christmas everyone!



### Update time ☺National Maternity Monitoring Group (NMMG) annual report

The [NMMG's Annual Report 2014](#) has been recently published online. This is the second report. It makes recommendations to the Ministry of Health and District Health Boards for activities to ensure improvements continue to be made in the provision of maternity services. Taranaki DHB will use this report to guide planning and service deliverables for the 2015/16 Maternity annual report

**Maternity outcomes, trend setting, case review and reportable events guidelines.** These guidelines have now been in place for 12 months. They have provided valuable data and trends have been quickly identified, audited and education carried out. An example of this is a Postpartum Haemorrhage Audit designed and completed by Dr Rachel Greenwood and Tawera Trinder, a 3rd year Midwifery Student. An Outcome/Action table is being developed to complete the work.

### **Pepi Pods**

86 pods have now been distributed within Taranaki. Our Safe Sleep Champion and Pepi-Pod co-ordinator for Taranaki, Merry Sorensen also secured a \$10,000 donation from Shell Todd to ensure funding for future Pepi-Pods for Taranaki. Well done Merry!

### Shared Midland regional maternity education training, protocol/policy and resources

Progress continues with the Midland Maternity Action Group (MMAG) working together to share resources, education and training templates. The regional safe sleep policy is now implemented and due to be audited at Taranaki DHB in the New Year. The tertiary transfer and repatriation preterm labour pathway guidelines are complete and have been in place for 6 months. Feedback on the process is continuing until the end of the month and a review will then occur. The 5 Midland DHBs continue to have equitable training resources. In 2014, Taranaki DHB gained funding through MMAG for a resuscitation simulator doll. This assists with Newborn Life Support training for Midwives and O&G staff. The new Midwives recertification format has been in place since June this year. Four Midwives' Emergency Refresher Days and one Practice day have been held in Taranaki so far with excellent feedback. The 2015 Midwifery Education Planner has been finalised and distributed.

Please find the link here <U:\Maternity-Child\Base\Maternity\Admin\education\2015\PD planner\2015 Midwifery Draft PD courses-Final.doc>

### Consumer feedback

Our MQC Consumer went to a MQS consumer workshop in Wellington in August and it was a great success. A job description was discussed for the MQC consumers and what resources were being used and were available. Monthly teleconferences have been set up for the consumers in the M Midland Region to improve networking. Christine has also been invited to be part of the National Evaluation Committee for the MQSP programme. Congratulations.

After recognising a need for it, our Taranaki DHB MQC Consumer has also developed a Taranaki Maternity Consumer Facebook page, which she manages. This page allows mums in Taranaki to have an online support network within a safe setting.

Christine has also designed a Maternity Services Satisfaction Survey, which is being finalised and she will then be out and about on the ward surveying inpatient mums. The survey will also be available on line.

An Expression of Interest for a second consumer has been sent out with a view to recruiting a rural consumer if possible.



### **Early engagement with an LMC**

Work is continuing to encourage early engagement of pregnant women with an LMC before 10 weeks' gestation. There are no reports of women being unable to access a midwife or LMC in Taranaki and there is continued use of: [www.findyourmidwife.co.nz/midwives/taranaki](http://www.findyourmidwife.co.nz/midwives/taranaki) [www.tdhib.org.nz/services/maternity/lmc\\_contacts.shtml](http://www.tdhib.org.nz/services/maternity/lmc_contacts.shtml)

Karen Janes, Antenatal Clinic Co-ordinator, Belinda Chapman, Associate Director of Midwifery and Dr Jeremy Smith, Head of O&G attended a GP/Practice Nurse meeting in July. They gave a presentation to the GPs and practice nurses promoting timely referrals and supporting early registration with an LMC. They plan to organize another meeting in South Taranaki.



Posters and pamphlets were commissioned with the **5 Top Things to Do**, to encourage early engagement with an LMC. These are placed in GP surgeries, Health Centres, schools and in Taranaki Hospitals.

All enquiries to: [maternityqualityinfo@tdhib.org.nz](mailto:maternityqualityinfo@tdhib.org.nz)

The Maternity Quality Committee is a clinical governance group that monitor and manage standards of clinical care, and are committed to ensuring a quality maternity service exists for the women and families of Taranaki.



## Key initiatives 2014

### Placentas/whenua sent to perinatal specialist for histology

Placental histology is an essential component of post mortem examination but it can also be utilised for other indications, e.g. placental abruption, pre-eclampsia <34/40 gestation, sepsis in labour/maternal pyrexia, compromised condition at birth of fetus, to assist in identifying and informing any causes for concern that could affect any future pregnancies. Those that are clinically indicated for histological examination are now sent to a perinatal specialist in Auckland.

### Maternal and Infant Care Plans

As a result of the recent Certification audit, Maternity services in Taranaki need to ensure comprehensive, individualised plans of care for mothers and Infants, with documentation based on consumer/patient needs, goals/desired outcomes. Discharge plans should be formulated and documented and discharge checklists completed. These were designed, trialled and fully in use by October 2014

### ISBARR Communication Tool Tear off Pads

The Taranaki DHB ISBARR tool has been in place since April 2013. This provides Lead Maternity Carers and Self Employed Midwives (SEMs), with a structured approach to making verbal requests or verbal referrals within the service, reducing the likelihood of communication failure. An audit in early 2014 found the tool was not being well used. A solution to this was to develop the tear off pad which can be placed in the women's notes. Increased education was provided about the tool.

### Level 1 C/Sections

Following Certification Audit findings that the services was not always meeting required timeframes for the length of time from calling a Level 1 to birth, a process analysis was carried out. The findings from this analysis resulted in the purchase of two Affinity Labour Beds, with battery backup to decrease the transport time to the Operating Theatre. A C/Section flowchart has also been developed, which includes, Theatre, NNU, Maternity and the switchboard.

**From the MQS team at Taranaki DHB, have a wonderful Christmas and a happy and safe New Year ☺**

### Access to obstetric scans occurring in a timely manner

A referral pathway has been devised with expected timeframes/criteria. Primary first trimester scans for dating and threatened miscarriage can now be referred to a private GP provider which has helped to alleviate the wait time at Fulford Radiology.

Nuchal thickness (NT) scanning services are provided locally by a private obstetrician. Increased demand outweighs capacity and some women have not received a timely NT scan. Women can now travel to Wanganui to receive an affordable NT scan, when a local NT scan is unavailable.

### Iron Posters



These posters have been developed from a suggestion from Emma Patrick, Consultant Anaesthetist at Taranaki DHB. Her colleagues in Auckland had developed posters for their region and with agreement from ADHB, our own were developed and are now placed around Taranaki, bringing attention to the importance of dealing with iron deficiency before, during and after pregnancy.

**Pasifika Link for LMCs Taha** is a website developed for health professionals caring for Pasifika pregnant women, infants and their families. The educational components explore relevant aspects of Pasifika peoples living in NZ and health outcomes [www.taha.org.nz](http://www.taha.org.nz) **Tapuaki** [www.tapuaki.org.nz](http://www.tapuaki.org.nz) is also a new website about how Pasifika women can stay healthy during pregnancy and caring for a newborn. There are links to videos and stories from parents. Women can click on their island flag and the content is translated to their own language. Also available on iPhone and Android phones.

### Fetal Assessment Unit

A Fetal Assessment Unit (FAU) was implemented in May within the Secondary Antenatal Clinic. This is for urgent antenatal outpatient reviews to reduce acuity on the labour ward. This also provides continuity of midwifery and medical care for women. Data is also being collected on the sources of and reasons for referrals.