



TARANAKI DISTRICT HEALTH BOARD

MATERNITY ANNUAL REPORT

1 JULY 2016 - 30 JUNE 2017



High praise for the Maternity Quality Safety Committee

Belinda Chapman, Taranaki DHB Associate Director Midwifery and Maternity Quality Safety Committee Chair (MQSC) recently received a letter of praise from the Ministry of Health, acknowledging the time and effort that was put into creating the maternity annual report 2015/2016.

The letter noted that the report was comprehensive and detailed the service



improvement activities well. They thanked Belinda and the committee members for the hard work over the last year and the continued dedication in providing quality maternity care. In addition to this, they thanked Taranaki DHB for leading the way in 2016 by becoming the only DHB to excel in the DHB Maternity Quality and Safety programmes.

The letter also highlighted how maternity annual reports are an important part of engaging with the sector and a wonderful way to share all that the DHB has accomplished over the last 12 months. The national Maternity Quality and Safety Programme requires all DHB's to produce an annual maternity report, this programme has been in place since early 2012.

MATERNITY QUALITY COMMITTEE MEMBERS



Belinda Chapman,
MQSP Coordinator/
Associate Director
of Midwifery



Mary Lawn, Child
& Maternal Health
Clinical Services
Manager



Amanda Antoine,
Clinical Midwifery
Manager



Sharon Howe,
Quality Rep and
Midwife Educator



Jane Bocock,
Clinical Nurse
Manager,
Neonatal Unit



Des Paulson, Q&R
Advisor - Pt Safety,
Risk Management



Christine Strydom,
Consumer
Representative



Dr John Doran,
HOD - Paediatrics,
Paediatric
Medicine



Dr Jeremy Smith,
Obstetrician



Lydia Rae, Prof.
Lead - Social Work,
Social Workers



Patrick Morris,
Perinatal Mental
Health



Carol Wells,
Postnatal
Coordinator, LMC



Bernadette Winks,
Rural LMC



Glenda Martin,
Core Midwife
and NZCOM
Representative



Marnie Reinfelds,
Portfolio Manager,
Planning & Funding

Contents

Taranaki District Health Board Vision	4
Maternity Services Vision.....	4
Message from Dr Jeremy Smith (Head of Department), Mary Lawn (MCHS Manager) and Belinda Chapman (ADOM).....	5
Message from the Chair Midland Maternity Action Group (MMAG)	6
Setting the scene.....	8
Purpose and executive summary	10
Summary of the aims and objectives of the Maternity Quality & Safety Programme (MQSP) in 2016/17	11
MQSP governance and operations	12
Who does MQC link with locally?	14
Profile of Taranaki	15
Maternity services in Taranaki	19
Workforce and staffing	21
Consumer report to Taranaki DHB MQSC for 2016/2017	27
Complaints.....	28
Compliments	28
Performance against clinical indicators	29
Summary of 2016/17	38
Rural and primary maternity facilities and primary LMC services:	39
Patient safety	39
Registration with a Lead Maternity Carer and early pregnancy care	42
Smoking in pregnancy	45
Outpatient antenatal services	47
Variation in gestation of birth.....	49
Level 1 caesarean section calls 2016	53
Taranaki DHB perinatal related (PMMR) deaths by primary perinatal death classification 2016	56
Support for vulnerable pregnant women and families.....	60
Taranaki Safe Sleep and Pepi Pod Audit 2016.....	62
Highlights - supporting safe sleep practices.....	63
Pregnancy Help Taranaki donation.....	65
Family violence (FV) training and screening	65
Perinatal mental health.....	66
Baby Friendly Hospital Initiative	69
Highlights - supporting breastfeeding.....	70
Summary of the Taranaki DHB Universal Newborn Hearing Screening and Early Intervention Programme 2016/17	74
Alignment with the aims and objectives with the national priority and recommendations	91
Summary MQSP Strategic Plan deliverables for Taranaki DHB and the Midland region.....	93
MQSP Strategic Plan deliverables for Taranaki DHB and the Midland region	101
Summary MQSP Strategic Plan deliverables for Taranaki DHB and the Midland region.....	105
Appendix 1 - Welcome to the Secondary Care Antenatal Service brochure	109
Appendix 2- Helpful questions for community screening	110
Appendix 3 - Expected screening of MH in a pregnant client	111
Appendix 4 - Perinatal mental health flow chart.....	112
Appendix 5 - Perinatal mental health local referral pathway	113
Appendix 6 - Newsletter	114
Appendix 7 - Midwifery professional development	118
Appendix 8 - Quality audit and reporting grids.....	120
Acknowledgments.....	122

Taranaki District Health Board 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 Māori 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 / Nga Tikanga

The actions and behaviours described below are how we aim to contribute to all our relationships including those with our patients, clients, whanau, 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



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
- KITE TAIAO
- MAU TONU



Message from Dr Jeremy Smith (Head of Department), Mary Lawn (MCHS Manager) and Belinda Chapman (ADOM)

We have had a busy year since the 30th June 2016 report was written.

Taranaki DHB remains committed to the Maternity Quality and Safety Programme (MQSP), the committee is delighted to have achieved the excelling domain. Since this programmes inception it has brought significant improvements to our maternity services as well as improved collaboration, communication and relationship's with our community midwives, stakeholders and consumers.

Our governance group has continued to meet monthly; progressing the work plan as well as reviewing local maternity audits, reports and initiatives. The committee continues to report to the Taranaki clinical Board on an annual basis.

Although we are still working from the old maternity unit at Base Hospital, we have had significant upgrades to the equipment we use on a daily basis, and have state of the art fetal heart rate monitors and resuscitation equipment, so look to the future with optimism. Additionally Hawera maternity unit has completed its re furnish and upgrade.

We now have five medical consultant staff which means we have been able to broaden our service to include provision of some in-house scanning. Once we have a contemporary scanning machine this service will evolve and will include a streamlined day stay service "one stop shop" for checking the progress of complicated pregnancies. We are hopeful that our specialists will now be able to take sabbaticals to bring fresh thoughts and enthusiasm to our service.

Succession planning for senior medical staff is in place so we can enhance the range of skills and diversity within

the department. Our unit has recently been re accredited by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists for training of registrars, and the quality of our unit allows two posts to be available. Accreditation is earned, not given lightly, so thanks are given to all the doctors' nurses and midwives, and others who contribute every minute of the year to the smooth running of the Maternity Service.

As always our goal is to provide Mother and Baby services in a safe and appropriate manner. The key to this remains collaboration and cooperation at all levels of care. To this end it has been gratifying to welcome "home grown" midwives onto the staff as we continue to be able to employ new graduate midwives for their midwifery first year of practice following the completion of their Taranaki based training. It is also positive to see Maori midwives who have trained here choosing to work here, because this enables us to be certain that our service remains relevant to all in our community, all around Taranaki.

This past year has sustained the improved ability to attract and recruit midwives for vacancies advertised both in the hospital and community however solutions are still being explored to manage staffing in the peaks and troughs of day to day variance of patient numbers and acuity in the maternity units. The project coordinator for the Midland Maternity Action Group (MMAG) is going to be missed; this is an opportunity to thank her for all her commitment and work to coordinate this group as the Midland regional services plan no longer has this programme under its 2017-2012 plans. It is hoped that MMAG will continue its regional work now that good working relationships have been formed around the regional so that quality and safety initiatives can continue to be progressed.



Message from the Chair

Midland Maternity Action Group (MMAG)

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

- **BOP DHB:** Matthias Seidel (SMO rep.), Thabani Sibanda (SMO rep.), Marg Norris (Midwifery Leader), Karen Palmer (Senior Lactation Consultant; Chair, Breastfeeding/BFHI Sub Group), Sachit Gagneja (MQSP Programme Manager)
- **Lakes DHB:** Simon Ewen (O&G HOD), Sue Finch (Clinical Midwife Manager/ MQSP)
- **Hauora Tairāwhiti:** William Weideman (SMO rep.), Liz Lee-Taylor (Director of Midwifery and Clinical Midwife Manager)
- **Taranaki DHB:** Anene Chukwujama (SMO rep.), Belinda Chapman (Assoc. Director of Midwifery/ MQSP), Sharon Howe (MQSP/Maternity Educator)
- **Waikato DHB:** Corli Roodt (Associate Director of Midwifery; 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)
- **Director, Nursing/Midwifery rep.:** Sue Hayward (Waikato DHB)
- **Public Health Service rep.:** Louise Harvey (Toi Te Ora)
- **Planning & Funding rep.:** Becky Jenkins (GM Planning & Funding, Taranaki DHB), Jenny James (Portfolio Manager, Taranaki DHB)
- **HealthShare Ltd:** Suzanne Andrew (Project Manager), Honor Lymburn (Clinical & Systems Data Analyst)

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's main focus over the past 12 months has been the development of the **Midland Breastfeeding Framework** – providing the knowledge, insight and practical tools to implement a comprehensive and equitable range of initiatives and services that support breastfeeding in the Midland region. Stakeholder focus groups with mamas and with maternity staff and service providers have been held across the region.

Other MMAG regional initiatives and collaboration have focused on:

- Embedding of the **Midland breastfeeding smartphone application 'BreastFedNZ'**, and undertaking a post implementation review. This project was supported by the findings of the NZ Institute of Rural Health's 'Midland Region Rural Maternity Services Consumer Engagement Study' (June 2014) recommending that Midland maternity services look to develop a pregnancy phone app.

BreastFedNZ was launched in late August 2015



and offers free and timely information and support for consumers on iPhone and android. The app is supported by a 'Breastfed NZ' Facebook page and a website www.breastfednz.co.nz, offering free print design files. Working with Midland Public Health and Population Health Services has enabled the incorporation of breastfeeding accredited spaces into the app's GPS activated map function. As at 30 May 2017 there have been over 12,000 app downloads, with positive feedback received from consumers, Lead Maternity Carers and maternity staff.

- Supporting **maternal mental health in Midland** – seven workshops were held across the region, facilitated by Carla Sargeant, Voice for Parents. The workshops were open to primary maternity, Well Child Tamariki Ora providers, and maternity staff, with content developed to meet local identified needs. These workshops have been well attended and encouraging feedback has been received on the content covered.
- Continuing the **Midland Safe Sleep Programme** success in reducing the sudden unexpected death in infant (SUDI) rates;

"In Midland, the Pēpi-Pod programme was applied consistently and appropriately by distributors, Portable Sleep Spaces were acceptable to and used appropriately by recipient families, and safety advice was reflected in snap shots of infant care. Post-perinatal death rates (7 days to 1 year, all causes) have fallen since the start of the intervention period in 2011, especially for Māori. This

fall has continued for Māori infants and stabilised for the region as a whole. While cause and effect cannot be claimed it is likely, given the reach and impact described here, that the sleep space programme has made a significant contribution to mortality changes in the region."

Excerpt from 'Update on the Midland Pēpi-Pod® Programme' prepared for Midland Maternity Action Group, October 2016.

- developing the **Midland Use of Donor Breastmilk Protocol** (and information leaflet) – guiding health care providers in the management of donor breastmilk in DHB facilities, meeting the World Health Organisation's Baby Friendly Hospital Initiative (BFHI), and further supporting women to establish breastfeeding following birth.
- the continued close working of Midland midwifery educators and lactation consultants has supported their practice.

Although MMAG will no longer form a regional clinical action group under the 2017-2020 Midland Regional Services Plan, the group 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, Associate Director of Midwifery,
Waikato DHB Chair, Midland Maternity Action Group**

Setting the scene

To set the scene, the following diagram demonstrates the relationship between Taranaki DHB's vision, missions and aims, the Health Quality & Safety Commission's Triple Aim, our defined dimensions of quality that are then supported by Clinical Governance behaviours, our Quality & Risk Management Framework and the Treaty of Waitangi principles.

Taranaki Together, A Healthy Community Taranaki Whanui He Rohe Oranga

- 1 A person-centered system
- 2 A one team approach across the system
- 3 Proactive models of care
- 4 Workforce resourcing to match models of care
- 5 Empowered individuals, families and communities
- 6 Increased investment in preventive activities
- 7 Coordinated health and social services
- 8 Interventions that are culturally appropriate
- 9 Planned and coordinated use of technology
- 9 Delivery of reliable and quality care

Enhanced patient experience

Our population will understand how, when and where to access the right health services and is supported with information to achieve their health goals. Patients will receive integrated services – centred around their needs.

Improved population health and equity

Services are targeted at those most likely to benefit, with the workforce matched to population needs and enabled to support better health outcomes.

Improved value for money

Prevention and earlier intervention activities has reduced demand, and more services are offered in community settings at lower system cost. Hospital services are more focused, with clearly defined care pathways to guide safe and effective patient journeys.

Strengthened system resilience

Primary health care capacity has increased, providing better access and better quality services. The system is supported by a stronger evidence base that informs clinical decision-making and enhances patient care.

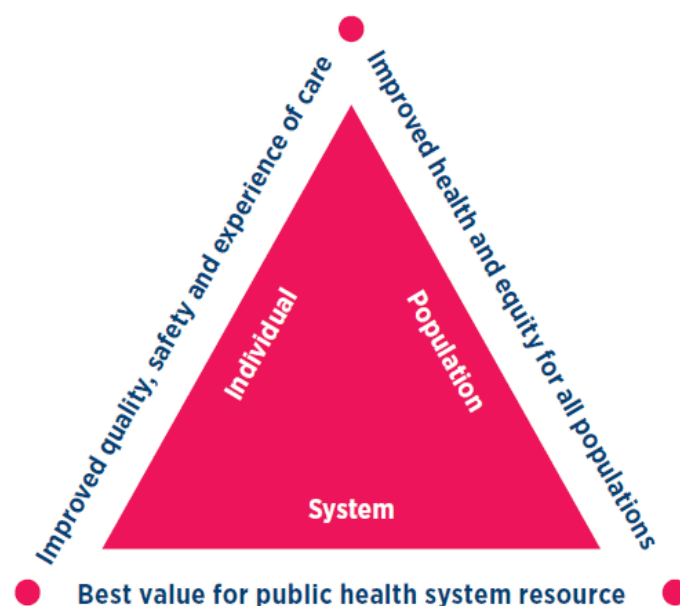
The Triple Aim framework has been used to ensure our priorities and actions consider the personal, population and system dimensions of health care...

The Triple Aim is an internationally recognised tool for ensuring that population health, patient experience of care, and value for money perspectives are considered simultaneously in health system planning and decision-making. We have used this framework to establish the Plan's priorities and actions.

Pae Ora is the government's vision for Māori health...and is integral to the delivery of the NZHS and Triple Aim. Pae Ora recognises the multifaceted needs of Māori through a holistic approach with three interconnected elements:

- ▶ Mauri ora (healthy individuals)
- ▶ Whānau ora (healthy families)
- ▶ Wai ora (healthy environments).

In improving Māori health using a Pae Ora approach, we have engaged with local stakeholders to understand how we can better collaborate with Taranaki Māori to improve equity of access and outcomes, and ensure that Māori are involved in both decision-making and service delivery.



The Triple Aim framework simultaneously considers individual, population and system dimensions of health care

People-powered

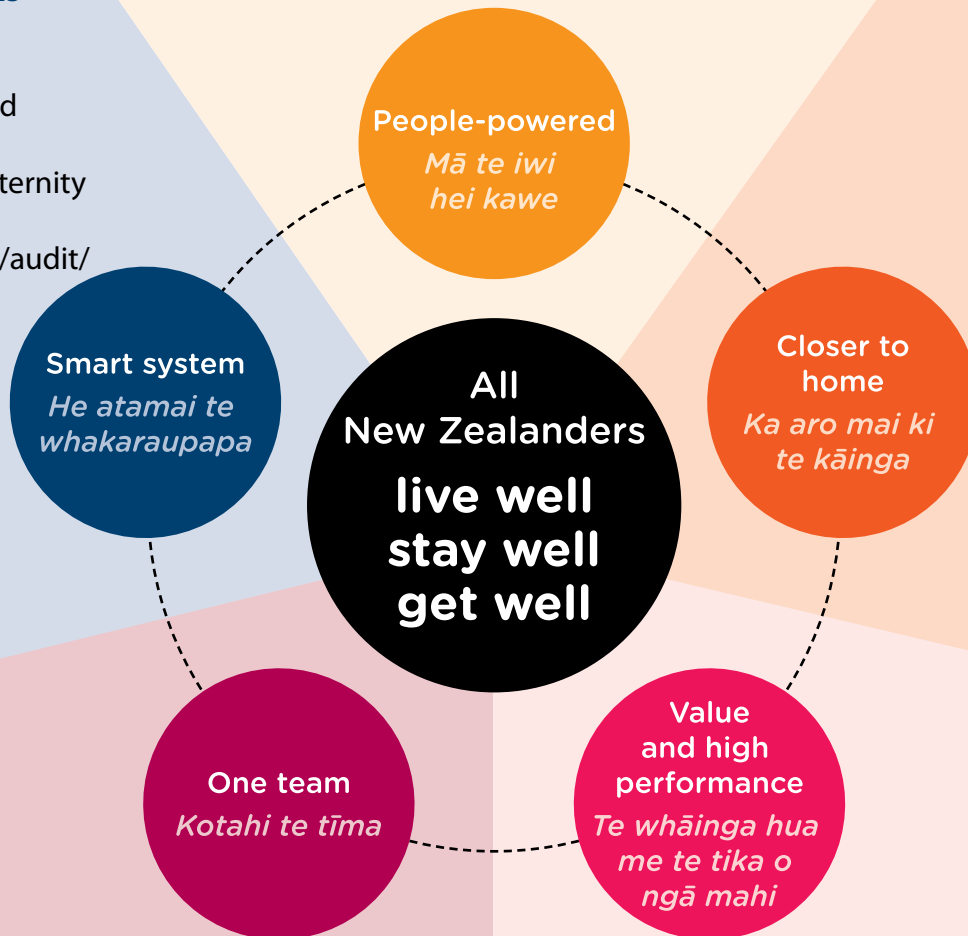
- Recruit/retain doctors and midwives
- Safe staffing/skill mix
- Consumers

Closer to home

- Young pregnant women/dental care
- Smoking cessation support
- Primary care integrated and accessible
- Primary birthing
- Rural isolation

Smart systems

- IT
 - NCHIP
 - Whiteboard
 - COWS
- National maternity record
- Clinical data/audit/coding



One team

- Vulnerable families
- PLM/MAG
- Working between primary and secondary
- Sustainable and adaptive, reflects demographics
- Strengthening partnerships
- National and regional training initiatives

Value and high performance

- Improved clinical outcomes
- Quality and safety
- Facilities up to date
- Equity and health outcomes

All women and babies will have high quality equitable and safe maternity care

Purpose and executive summary

This annual report meets the requirements of the service specifications for the Maternity Quality and Safety Programme (MQSP): Excelling DHB. It will be accessible to all maternity stakeholders, practitioners of maternity care and consumers via the Taranaki DHB website (www.tdhb.org.nz), hospital library, maternity and neonatal departments as have past MQSP reports.

This annual report demonstrates Taranaki DHB's delivery of the expected outputs of an excelling MQSP DHB and outlines the progress that Taranaki DHB is making with the three year plan 2015-2018.

The report describes Taranaki DHB's activities undertaken in 2016/17 and those intended to be undertaken to improve maternity quality, safety and clinical outcomes of its maternity services in 2017/18.

- Consumer has been actively involved for four years and is highly engaged and participates in the programme including improvement priorities and projects, a second consumer was recruited who identified as Māori ethnicity which unfortunately has recently resigned. Training and support is integral to the roles.
- The programme uses national, regional and local data to inform and assist in priority setting. Dashboards are available and also information is circulated via email and newsletters and presented at meetings.
- Taranaki DHB quality team are linked to and engaged with the programme.
- Maternity Quality Committee (MQC) is linked to Taranaki DHB's Executive Management Team and reports to the Clinical Board annually.
- Taranaki DHB MQSP has delivered meaningful improvements for women and their families/whanau.
- Taranaki DHB networks collaborate with the four other Midland Regional DHBs, sharing quality improvement initiatives and supporting each other, examples are the BreastFedNZ App, the transfer and repatriation guidelines, and the Quality and Leadership Programme for midwives.
- Taranaki DHB has received positive feedback from the National Maternity Monitoring Group (NMMG) in relation to the progress of the perinatal mental health Service.
- Taranaki DHB meets all of the New Zealand Maternity Standards audit criteria.
- Taranaki DHB continues to develop relationships and alliance with other maternity primary care providers including participating in the pilot of the alliancing project with our five leadership community midwives and the New Zealand College of Midwives.
- This annual report includes consumer feedback and how this has been responded to.
- Taranaki DHB facilitates information on how to contact Lead Maternity Carers (LMC) and provides information on the Taranaki DHB website www.tdhb.org.nz.
- The proportion of women accessing continuity from, and LMC for primary care, is reported in this report.



Summary of the aims and objectives of the Maternity Quality & Safety Programme (MQSP) in 2016/17

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

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 (MDT) meetings including access holders.
- 8.4 Produce an annual maternity report.
- 8.5 Demonstrate that consumer representatives are involved in the audit of maternity services at Taranaki DHB.
- 9.1 Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Taranaki region.
- 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.
- 10.2 The number of sentinel and serious events in which poor communication is identified is monitored and decreases over time.
- 11.1 National evidence informed clinical guidelines are implemented. (National postpartum haemorrhage (PPH) and observation of the mother and newborn implemented, working forwards with implementation of the gestational diabetes mellitus (GDM) guidelines).
- 21.1 100% maternity service specifications are implemented in each funded DHB-funded maternity service.

STANDARD TWO:

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.
- 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 Consumer feedback demonstrates that consumers consider the services to be culturally safe and appropriate
- 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.
- 19.2 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.

STANDARD THREE:

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.
- 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.
- 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.
- 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.

MQSP governance and operations

The Maternity Quality & Safety Programme (MQSP) Governance Group is known as the Maternity Quality Committee (MQC) and is chaired by the Associate Director of Midwifery (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.

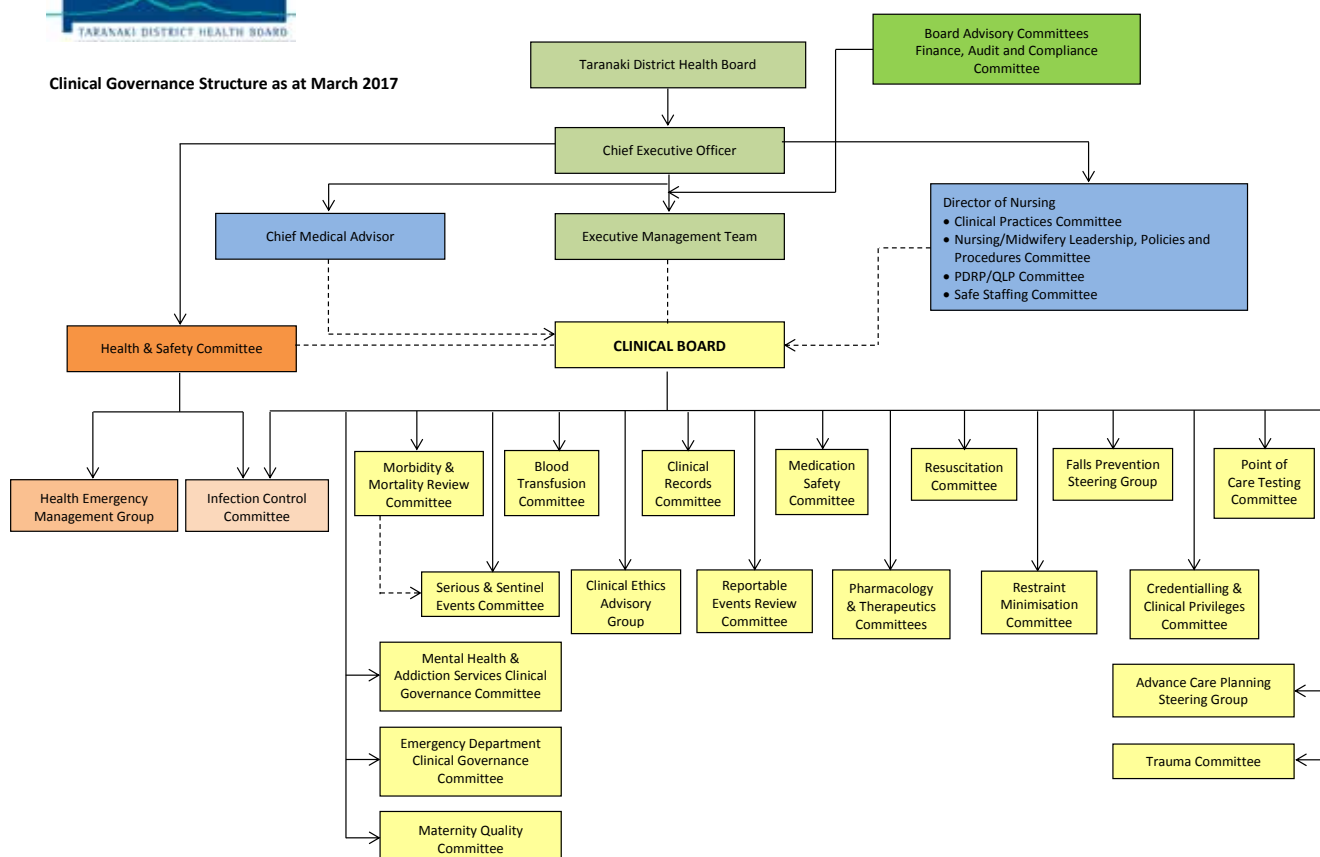
Its main functions are to:

- 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: Obstetrics & Gynaecology 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 prevention and control & quality improvement facilitator
- Clinical services manager for maternal & child health (CSM, M&CH)
- Quality and risk advisor
- Midwife educator (ME)/quality risk delegate
- Two LMC representatives
 - › Rural
 - › Urban
- Consumer representatives (one has resigned to recruit a second)
- Core midwife/New Zealand College of Midwives (NZCOM) representative
- Planning & funding maternity portfolio manager/Māori health representative





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

- Actions and themes arising from adverse events submitted to the Serious and Sentinel Events Committee (SSEC) and 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
- The National Perinatal & Maternal Mortality Review Committee.

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, Director of Nursing 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 formal contract with Taranaki DHB 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 consumer 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 Taranak, La Leche League and is completing her training as a childbirth educator. The committee's second consumer has recently resigned so we will be actively recruiting for this position in 2017/18

Who does MQC link with locally?

MQC and Taranaki DHB consider our local and national population when reviewing or considering changes and quality improvements by building on the guiding principles of the NZ Health Strategy and the Taranaki Health action plan including better public service targets. Taranaki DHB MQC has links with other teams within the DHB but also stakeholders who are linked to the project. Taranaki DHB work is on going with the aim to align with the triple aim. The MQC have continued to update and circulate the pre and post pregnancy support services directory to update service providers on the support services that are available around Taranaki, including how and who to refer to.

Linked services:

- Paediatric and neonatal services
- Newborn hearing
- Perinatal mental health, alcohol and drug, maternity social worker services
- Family Violence Intervention Programme
- Oranga Tamariki Child Protection, Child Youth & Family (CYFS) through the Maternal and Child Wellbeing Multidisciplinary Advisory Group and paediatric liaison meetings
- Pregnancy ultrasound services in the community and the DHB
- Taranaki Immunisation Strategy Group
- Māori Health Services
- Communications and information technology services
- Better help to stop smoking/smoking cessation providers; Tui Ora and Ngati Ruanui
- Breast feeding groups through the Baby Friendly Community Initiative; support/welcome here/health promotion/ community groups/ Tiaki Ūkaipō Governance Group (TUGG) - focusing on physical activity, healthy nutrition and breast feeding through the Mama Pepe Hauora programme and consumer groups such as La Leche League
- Child Health Service Level Alliance Team (SLAT), National Child Health Information Project (NCHIP) newborn enrolment, National Immunisation register, Well Child/Tamariki Ora (WCTO), oral health registration, primary health organisation and general practitioners
- New Zealand College of Midwives alliancing project
- Diabetic educator and dietician teams
- Quality and Risk, including Datix reporting, protocol and procedures
- WCTO providers eg Tui Ora and Plunket. Midland Maternity Action Group (MMAG).



Profile of Taranaki

Taranaki DHB delivers health services in Taranaki and in the Mokau area, which is part of the Waikato District Health Board. The district covers more than 7,000 square kilometres. There are a few densely populated centres in Taranaki such as New Plymouth, Stratford and Hawera. The rest of the population is scattered in and around small rural centres.

POPULATION PROFILE

According to Statistics New Zealand, in 2015/16 Taranaki DHB served a population of 118,560* people.

The Māori population is projected to increase to 20.6% of the total population by 2026. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2013 Census. Taranaki has 86.2% identified as European and other, 17.4% as Māori, 1.6% as Pacific and 3.5% as Asian.

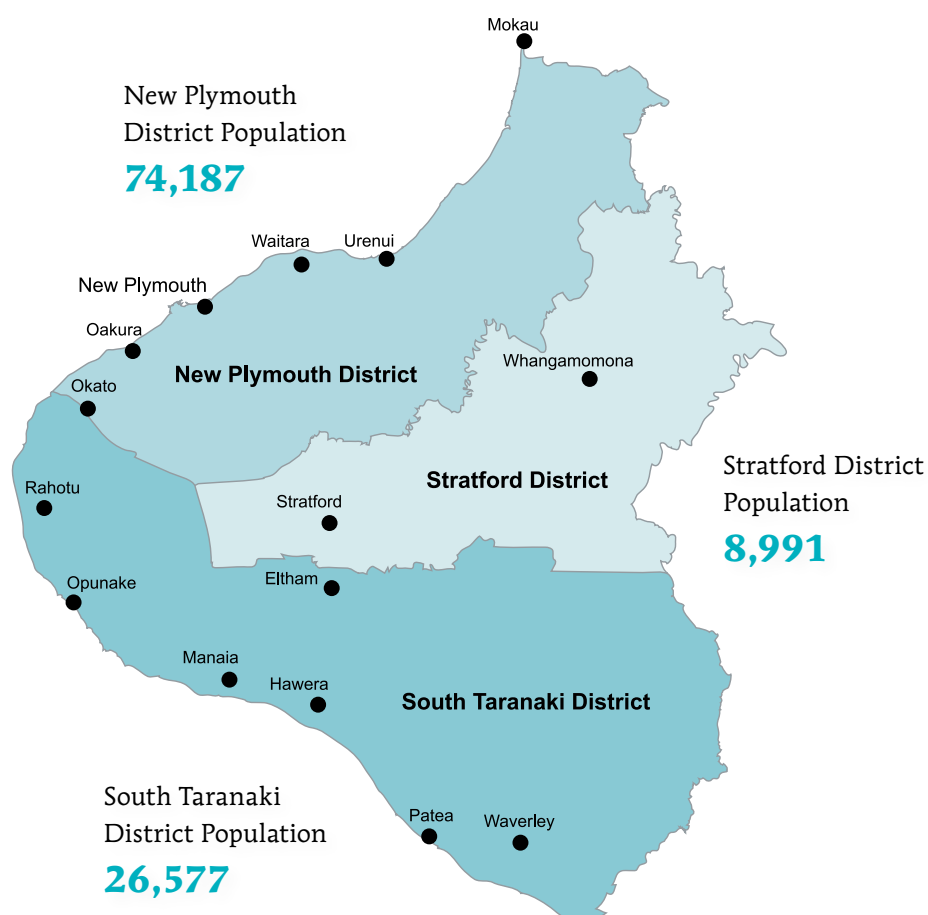
Note: Where a person reported more than one ethnic group, they have been counted in each applicable group. As a result percentages do not add up to 100%.

SOCIO-ECONOMIC INDICATORS

The Taranaki population sits around the centre of the socio-economic range.

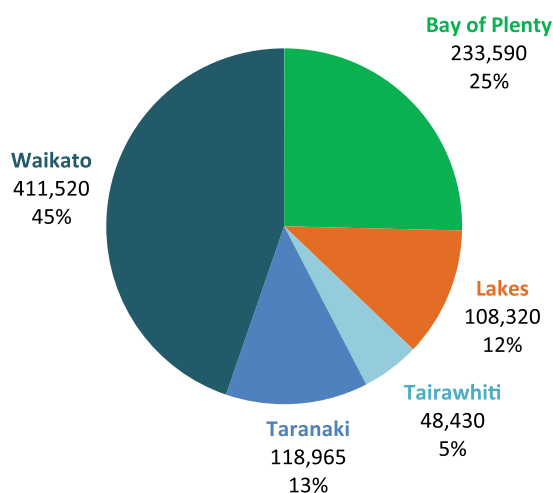
Around 43% of the Taranaki population live in NZDEP2013 Decile 6, 7 and 8 compared to 30% nationally. Non-Māori are over-represented in the wealthiest socio-economic deciles and Māori are over-represented in the lowest socio-economic deciles.

Within Taranaki, 32% of Māori live in the most deprived 20% of areas compared to 14% of non-Māori. In contrast, 7% of Māori live in 20% of the most affluent areas compared to 16.3% of non-Māori. Māori in Taranaki have six to seven years less life expectancy than non-Māori.

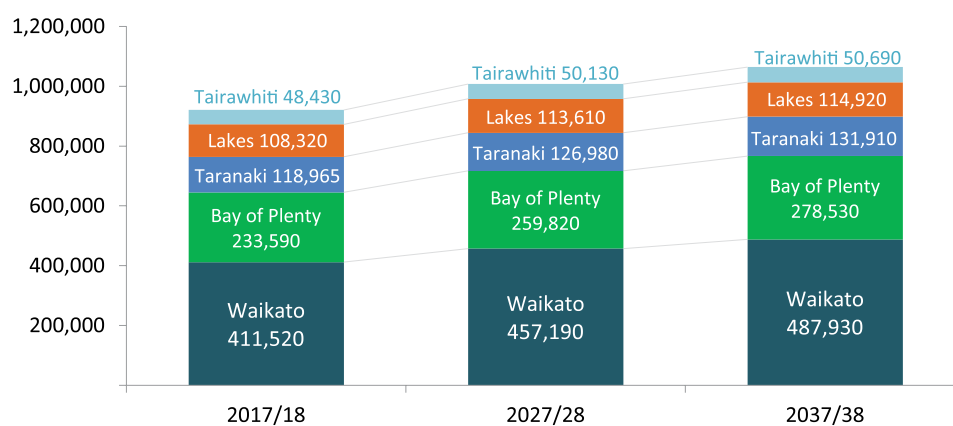


*Based on updated information received from Statistics New Zealand Population Projection released November 2014

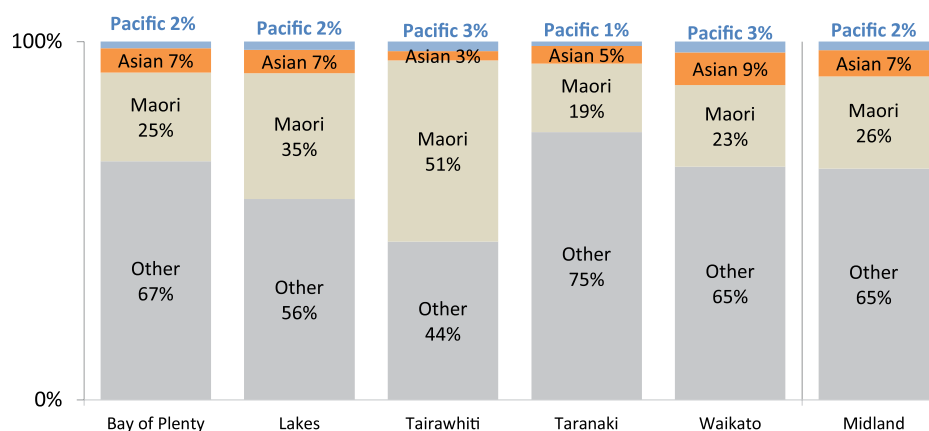
2017/18 Projected Population for Midland DHBs



Projected change to Midland Total population from 2017/18 to 2037/38

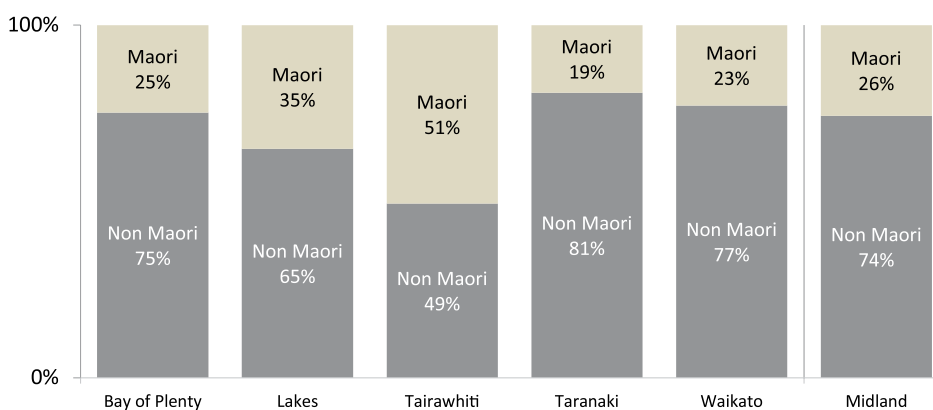


2017/18 Midland Total Projected Population by four main ethnicities

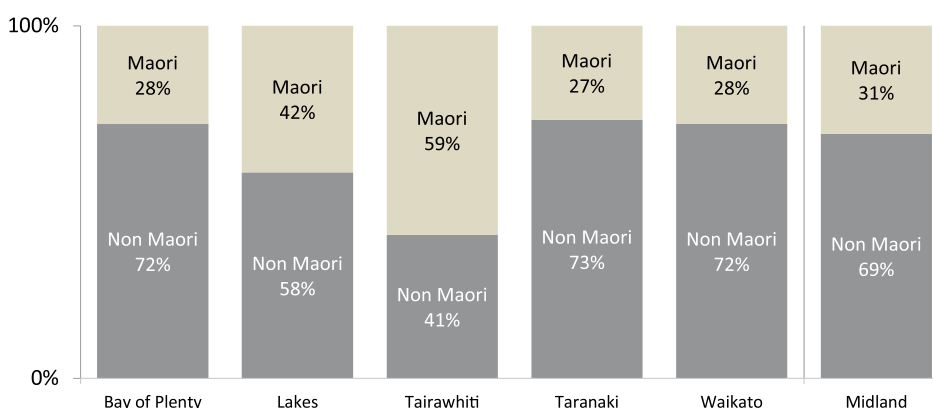


Data source: HealthShare Limited, sourced from MOH 2016 projected population tables by Stats NZ (published Nov 2016)

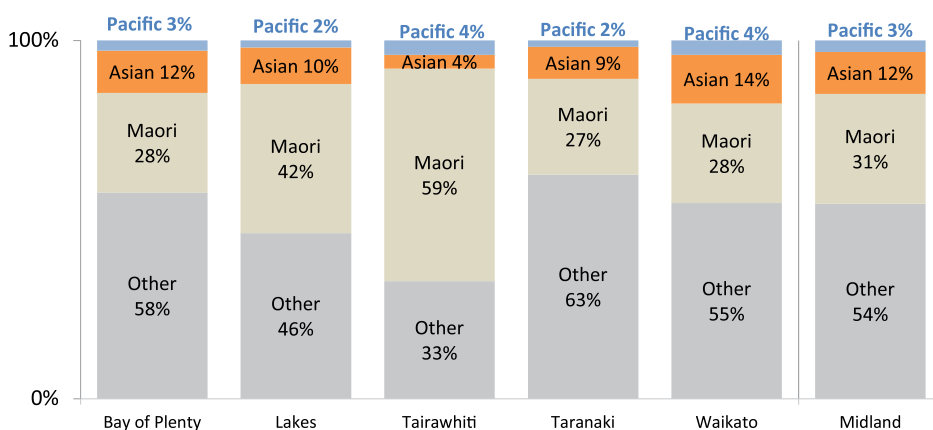
2017/18 Midland Total Health Projected Population by Māori/Non Māori



2037/38 Midland Total Health Projected Population by Māori/Non Māori



2037/38 Midland Total Projected Population by four main ethnicities

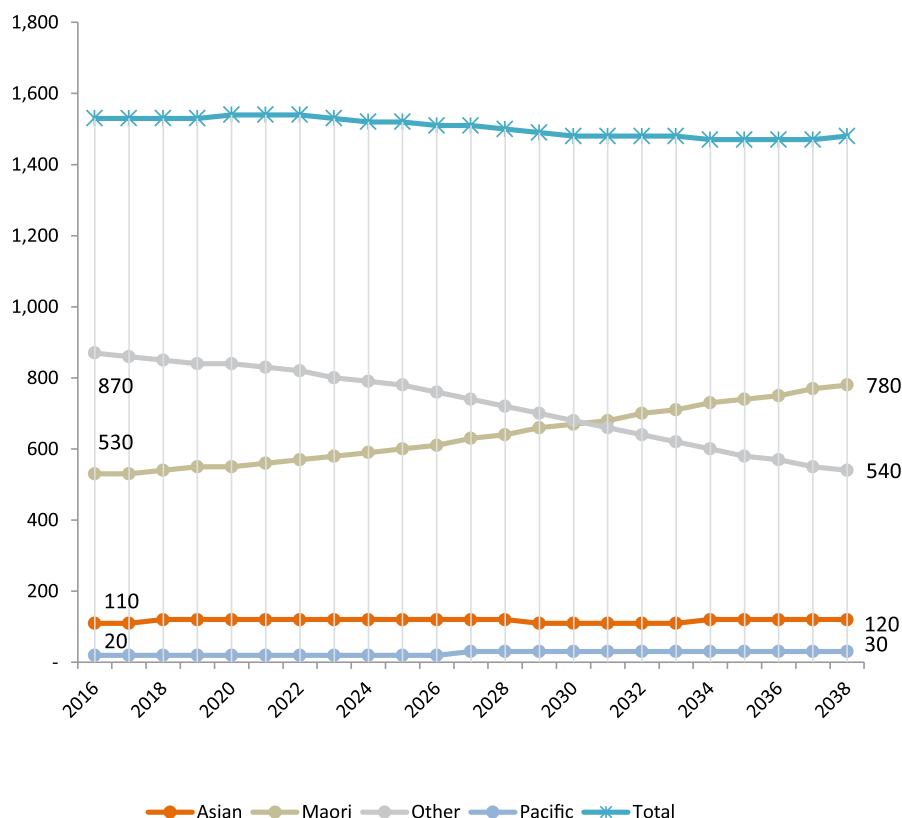


Taranaki birthing demography in comparison to the rest of New Zealand:

- Slightly younger than in NZ overall
- Less often Pacific
- More often European
- More often of average socioeconomic status opposed to extreme high or low deprivation

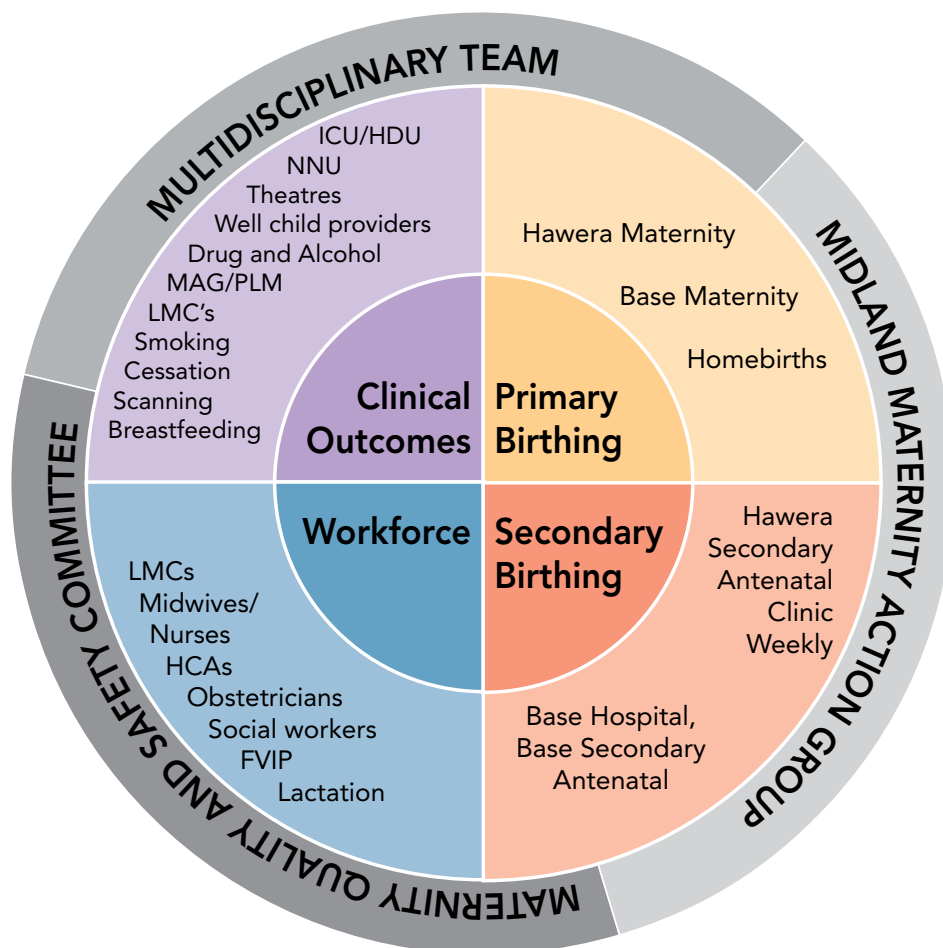
Data source: HealthShare Limited, sourced from MOH 2016 projected population tables by Stats NZ (published Nov 2016)

Projected births by ethnicity for Taranaki DHB 2016-2038



The Taranaki birthrate has been consistent over the last five years and is forecast to be consistent over the next 10 years, however it is predicted to see a rise in Māori births and reduction in European births

Data source: HealthShare Limited, sourced from MOH 2016 projected population tables by Stats NZ (published Nov 2016)



Maternity services in Taranaki



BASE HOSPITAL

PRIMARY & SECONDARY MATERNITY UNIT

Caesarean section
Complex delivery
Inpatient antenatal care
Inpatient postnatal care
Lactation consultant services
Level 2A neonatal services
Management of miscarriage
Newborn hearing screening
Normal delivery
Orthopaedic hip checks
Support for private obstetrician LMC (labour and birth)
Ultrasound



DELIVERY AND ANTENATAL WARD

- 1 pregnancy loss room "The Willow Suite"
- 5 primary and secondary birthing rooms
- 7 antenatal single rooms
- 1 birthing pool room

ANTENATAL CLINIC

Amniocentesis
Fetal day assessment
Outpatient specialist consultation clinics
Secondary antenatal team clinics
Secondary midwife clinics
Vaccination clinic for flu and pertussis

POST NATAL WARD

- 19 beds which include boarder mother facilities

LEVEL 2A NEONATAL UNIT

- 6 cots
- 2 intensive care cots

Homebirth is offered by Lead Maternity Carers in Taranaki



HAWERA HOSPITAL

PRIMARY MATERNITY UNIT

Inpatient primary postnatal care
Lactation consultant services
Newborn hearing screening
Normal delivery
Orthopaedic hip checks
Outpatient specialist consultation and secondary clinic

- 1 birthing room
- 4 postnatal beds

All Maternity Staff

We have...

5 REGISTERED
NURSES

36 Midwives

**1 Associate Director
of Midwifery**

36 LMCs

3 SENIOR
HOUSE
OFFICERS

1 Post Natal Coordinator

1 LACTATION
STATE CERTIFIED
NURSE

**1 Antenatal
Clinic Coordinator**

3 OBSTETRICIAN/
GYNAECOLOGISTS

1 Head of Department O&G

8 PAEDIATRICIANS

2 Medical Officers O&G

1 CLINICAL MIDWIFE
EDUCATOR

5 Healthcare Assistants

2 Ward Administrators
3 Midwifery New Graduate
1 Clinical Midwife Manager

1 ENROLLED
NURSE

3 Registrar O&G

One team

O&G = Obstetrician/Gynaecologist

Workforce and staffing

The midwifery and medical workforce has been stable over the last year. Taranaki DHB have implemented rostered registered medical officers and registrars to be on duty out of hours instead of being on call this has resulted in an increase in medical staff employed. We have also managed to fill all the available registered midwife positions with registered midwives.

MIDWIVES AND NURSES

There is stability in our Māori midwifery workforce. There has been a reduction in the average age of midwives now approximately 50 years of age. Taranaki DHB is aware of the number of midwives and nurses who will be nearing the age of retirement and are working together with the Auckland University of Technology (AUT) satellite midwifery training programme to try and predict and balance how many student midwives that are accepted for training. This is to ensure we have sufficient midwives but not too many that we are unable to employ or sustain positions for them either in the hospital or the community.

Midwives employed now have a contract that covers both base maternity and Hawera primary maternity units so that in times of sickness or shortages midwives can be deployed to either area to cover, reducing the fragility of services.

The voluntary bonding scheme is available to midwives in the Taranaki region and has attracted midwives to train and move to Taranaki. Additionally Taranaki DHB offer a one year new graduate midwifery position. This year Taranaki has had the luxury of three locally trained new graduate midwives graduate and stay in Taranaki. This has been achieved by planning and working together with the Midwifery First Year of Practice Programme to enable the best use of the new graduate position to effectively retain them.

Education of staff and Quality Leadership Programme (QLP)

The sharing of education templates and programmes with the other Midland DHB's has continued with the midwifery leaders, midwife educators and Midland Maternity Action Group (MMAG) coordinator; (the coordinator role from Healthshare will no longer be funded from 30 June 2017), working together to improve, access, equity, efficiency and quality of education programmes. A copy of the maternity education calendar can be found in Appendix 7.

Taranaki DHB has coordinated and worked with the Midland DHBs to complete the regional QLP guideline and processes for application and assessment. In 2016/17 50% of our midwives achieved the confident or leadership domains.

Recognising our midwives' achievements

An afternoon tea was held recently to celebrate the achievements of some of Taranaki DHB's midwives.

Cecile De Bock and Glenda Martin are the first Taranaki DHB midwives to complete the revised Quality Leadership programme, a national programme developed in collaboration with MERAS, NZ College Of Midwives, New Zealand Nurses Organisation and DHB midwife leaders that supports midwives to progress through domains of practice from 'competent' to 'leadership practitioners'.

Midwives Leonie Brown and Sandra Luxton completed the Maternity Complex Care course at Victoria University (Wellington). The first semester covered clinical assessment and reasoning and the second semester involved practical placements in various settings of secondary and tertiary units throughout the North Island.

As part of the course, Leonie completed placements where she could investigate how other maternity units managed the multiple paradigms of birth and risk. The course helped Leonie and Sandra to understand midwives' role as a complexity manager, broker and unpredictability monitor in modern day maternity settings and has allowed

greater insight into how high risk can be managed and reframed.

It has also allowed opportunities to improve knowledge and skill, and gain a deeper understanding of how New Zealand maternity services have evolved and how diversely they are managed in such a small country.



Taranaki DHB midwives gather to celebrate the achievements of Leonie Brown and Sandra Luxton.

Maternity staffing trial

Maternity staff were reporting an increase in acuity and difficulty in meeting the peaks and troughs of the service demands, which has continued to be a challenge in 2016/17.

The six month period of the staffing trial undertaken from April 2016 was to try and meet the times shown for increased acuity and staffing requirements such as:

Increased cases of maternal co morbidities including admissions to ICU and HDU and a caesarean section rate of 26-27% requiring longer length of stay than vaginal birth. The appointment of a registered midwife to work the Wednesday to Sunday night shift to work across the Labour Ward, Postnatal Ward and NNU as an extra circulating midwife occurred.

It was expected this would also assist in providing a DHB midwife or NNU nurse to provide care to the mother and baby at caesarean section in the operating theatre and recovery areas. The trial was evaluated but unfortunately did not provide the solution to the issue of meeting times of high and low acuity. The maternity service are now trialling a flexible shift roster of 4, 8 and 12 hour shifts to see if this enables a more sustainable workforce with the ability of staff to work up extra shifts when required to meet times of high acuity.

Additional to this other solutions are being investigated by examining clinical outcomes, length of stay, non midwifery tasks and how they may be better provided, on call provision as well as the model of care.

Core midwifery services for private obstetrician

Taranaki DHB continue to provide core midwifery services for labour and birth only to one private obstetrician and one primary GP obstetrician. This can create unpredictable workloads for the midwives in both the community and base maternity hospital birthing suites.

Access agreement holders:

There are currently 36 access agreement holders who advertise Lead Maternity Carer (LMC) services (both doctors and community midwives). Additional to this there are a small number of midwives who carry a very small caseload and do not advertise their services. There does not appear to be a shortage of LMCs in Taranaki as there have been no reported cases where the secondary services have provided services as "provider as last resort" to women that are unable to access an LMC.

Calendar Year	Turnover		
	Midwives	Nursing (Excludes Midwives)	Nursing +Midwives
2014	20.69%	4.69%	5.52%
2015	13.9%	9.4%	9.7%
2016	14.00%	10%	10.40%

Table 1: Age of Midwife Workforce

Age Grouping	2016 Headcount				2015 Headcount			
	Non Māori	Māori	Total	Dist	Non Māori	Māori	Total	Dist
26-35	7	4	11	26%	5	3	8	20%
36-45	7	2	9	21%	7	2	9	23%
46-55	11	3	14	33%	12	3	15	38%
56-65	6	1	7	17%	8	0	8	20%
65+	1	0	1	2%	0	0	0	0%
Total	32	10	42	100%	32	8	40	100%

Table 2: FTE and Age Statistics of Midwife Workforce

Unit name	Headcount		Total FTE*		Average Age		Min Age		Max Age	
	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
Base Maternity	32	29	22.1	20.5	46	45	29	28	62	61
Hawera Maternity Service	4	5	2.7	2.2	54	51	46	42	59	58
Pool/Casual Staff	6	6	0	0	44	54	32	42	66	65
Total	42	40	24.8	22.7						

*FTE is only for Primary position, does not include additional positions

Table 3: Age of Maternity Workforce

Age Grouping	2016 Headcount				2015 Headcount			
	Non Māori	Māori	Total	Dist	Non Māori	Māori	Total	Dist
26-35	12	4	16	24%	10	3	13	20%
36-45	9	2	11	16%	8	2	10	15%
46-55	17	4	21	31%	19	4	23	35%
56-65	15	1	16	25%	20		20	30%
65+	2		2	3%			0	0%
Total	55	11	66	100%	57	9	66	100%

Table 4: Age Statistics of Maternity Workforce

Unit name	Headcount		Total FTE		Average Age		Min Age		Max Age	
	2016	2015	2016	2015	2016	2015	2016	2015	2016	2015
Base Hospital	54	52	40.6	38.9	48	48	28	28	66	65
Hawera Maternity Service	6	8	4.0	3.4	57	55	46	42	67	66
Pool/Casual Staff	6	6	0.0	0.0	44	54	32	42	66	65
Total	66	66	44.6	42.3						

Celebrating our midwives



Taranaki DHB Maternity staff and students (Sharon Howe, Isobel Bedford, Carol Wells, Finola Mooney, Sharyn King, Karen Ferraccioli and Cat Baulderstone) and members of Active Birth Taranaki (and families) celebrated International Day of the Midwife with a home-baked afternoon tea.

International Day of the Midwife (IDM) was celebrated on 5 May and was a day to celebrate the work that midwives do, and the impact they have, on our whānau/families. This year's theme was about midwives, mothers and families: "Partners for Life".

In recent months we've had the great news that all three of our locally trained student midwives graduated with 100 percent! They will enter the workforce both in the community and in hospital maternity settings and will be supported by their local midwifery colleagues and the Midwifery First Year of Practice (MFYP) programme.

Thank you to all of our Maternity Department colleagues that assisted these new midwives in their achievement, having supervised, educated, trained and nurtured these women into successful midwives for our communities. Without partnering together this would not be possible.

Whether they become a community midwife, lead maternity carer (LMC) or hospital core midwife, the partnership model is alive and these new graduate midwives will be an important part of our future succession and sustainability programme to continue the current model of care. Taranaki DHB is in the enviable position of being able to retain those midwives that have trained locally.

New Zealand midwives are currently facing challenges such as increased demands being made on maternity services to meet

acuity, increasing comorbidities, staffing variance and ensuring the women and their families they work with can maintain access to equitable quality maternity care.

Additionally we are seeing urbanising of birth with rural women moving nearer to towns and a shift of births from rural localities to Taranaki Base Hospital, which now births 200 more babies per year than 10 years ago.

The key challenge that midwives now face is the ability to sustain their workloads. Over the last year we have been working together to try and find a solution to meet the high and low demand periods of maternity care, having completed a staffing trial.

The next step is to trial different shift/work patterns with a focus on safe staffing levels, continuity of care and, like other maternity units, trying to achieve the balance of ensuring midwives feel valued, listened to and have a good work-life balance.

DID YOU KNOW?
Taranaki Base Hospital now births
200 more babies
per year, than 10 years ago.



A day in the life of a Māori midwife

TAWERA TRINDER

A great experience with her own Māori midwife, Sharron Wipiti, inspired Tawera Trinder to become one herself. Tawera is proud to be a Māori midwife and a role model to others. She's passionate about her job, loves working with Māori families and hopes to improve the statistics around Māori health.

How did you become a midwife?

When I first studied I was 10 years out of high school, I enrolled at Waikato Institute of Technology and did a three year degree. I've been a qualified midwife for two and a half years now, am self-employed and also have a casual contract with Taranaki DHB.

Why is it important to have Māori midwives in our community?

We offer trust, competence, empathy, understanding, confidence and empowerment to mothers wanting a more cultural setting. Some mothers find Māori midwives more relatable and we can help with health inequities. Most of my mothers choose me because of my background and ethnicity.

What does a typical day as a midwife involve?

It's very very busy! I rush around between being a mum to my own two children as well as home visits to see all my mothers, both ante-natal and post-natal. My day can also be filled with hospital assessments, massive amounts of paperwork, meetings and of course a birth or two!

Highs and lows of your job?

Like any job there are both - the lows include the daunting amount of paperwork, having to be available 24/7 and seeing upset families if they experience complications.

There are so many highs, particularly working with whānau and making them feel comfortable about their journey to become parents. Building trust and friendships with the mothers is great, providing cultural support and of course seeing a new life being born and couples becoming parents.

Do you have any memorable births?

Yes, many. But one that stands out is a birth I witnessed where the baby was born in the caul. This is when the mother's 'waters' haven't broken and the baby is born inside the amniotic sac. It's very rare, occurring in fewer than 1 in 80,000 births. I've also helped a first time mum deliver in her bathroom at home which was totally unplanned! Another amazing experience was coming face to face with a baby's wide open eyes staring directly into mine during his birth.



What advice do you have for others wanting to become a midwife?

Have passion and compassion, be strong, show cultural diversity and have good support networks around you to help you carry out the job successfully. Also find out if you're eligible for a scholarship through Taranaki DHB, this financial support and mentorship was invaluable.

What advice do you have for Māori women/families who are pregnant, or looking to get pregnant?

Engage with a midwife as early as possible. Do your research about a midwife who would be suitable for you, with similar values. Involve your whānau in the pregnancy. Stay healthy and well for you and baby by avoiding drinking and smoking, by eating healthy and keeping fit and active.

maternity report

TDHB Scholarship project



NGĀ KŌRERO WHAKAMARAMA
Ngā Arawhata Tekau mō te Ūkaipō

10 steps to successful breastfeeding

- 1 Me whai kaupapa here mō te ūkaipō, mō ngā kai mahi hauora.
- 2 Me whakapakari i ngā kai mahi hauora i ngā pūkenga, kia whakatinanahia e rātou te kaupapa.
- 3 Pānuitia ki ngā wahine hapū ngā painga o te ūkaipō, me te whakahaere hoki i taua kaupapa.
- 4 Āwhinatia ngā whaene ki te ūkaipō ā rātou pēpi, i roto i te haurua hōra muri tata mai i te whānautanga. I muri tata tonu mai ote whanautanga waihotia pēpi kiriti ki te kiriti ki tona Whaea. Te iti rawa hauora kia whakahauhia ngā Whaea kia mohio Te wa pai ki te ūkaipō nga pēpi, Mehema Hoatu to Awhina.
- 5 Tohutohu ki ngā whaene, ki te ūkaipō ā rātou pēpi, me pēhea hoki ka mau tonu te rere o te wāli, ahakoa wehe rātou i a rātou pēpi.
- 6 Tohutohu ki ngā whaene, kia kaua e whāngai ā rātou pēpi ki ētahi atu tūmomo kai, wai rānei, ko te wai ū ānake. Waiho mā te takuta te ki menā ka whāngai ērā atu kai.
- 7 Me nohotahi te whaene me tōnā pēpi i te ruma kotahi mō te rua tekau mā whā hōra ia rangi.
- 8 Me akiaki kia whāngai i te wā e tangi kai ana te pēpi.
- 9 Tohutohu ki ngā whaene kia kaua e hoatu tētahi tūmomo titi tawhaiwhai, ki ngā pēpi kai ū.
- 10 Me whakaatu ki ngā whaene kei whea ngā roopu whakahaere ūkaipō mō te wā ka puta rātou i te hohipera.

- 1 To have a written breastfeeding policy that is routinely communicated to all health care staff.
- 2 To train all health care staff in the skills necessary to implement this policy.
- 3 To inform all pregnant women about the benefits and management of breastfeeding.
- 4 To help mothers initiate breastfeeding within a half-hour of birth. Place babies in skin to skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognise when their babies are ready to breastfeed, offering help if needed.
- 5 To show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infant.
- 6 To give newborn infants no food or drink other than breastmilk, unless medically indicated.
- 7 To practise rooming-in - allow mothers and infants to remain together 24 hours a day.
- 8 To encourage breastfeeding on demand.
- 9 To give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
- 10 To foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Ten Steps Posters Updated

These posters are an essential component to our maternity facilities NZBSA endorsement.

After consultation with TDHB Lactation Consultant Deb Wright and Iwi consultation, this design was finalised and will be displayed in Wards 14 / 15 / 2b / Antenatal Clinic.

1


**CLEAR WALL PLAN
REVISITED**

2

**NEW WORKS
CREATED**

3


**FINISHED WORKS
DISPLAYED**



Benefits of an upright birth poster



Graphs from the latest MOH clinical indicators in maternity



"Positions to adopt in labour / birthing" poster



USING DATA TO CREATE OPPORTUNITIES FOR IMPROVEMENT

The MOH 2015 Clinical Indicators in Maternity Report was used to highlight our regions statistics / trends over a 7 year forecast in the areas of:

- Spontaneous Birth Rates
- Instrumental Birth Rates
- Caesarean Section Rates

I used these graphs along side our Maternity Services Vision:

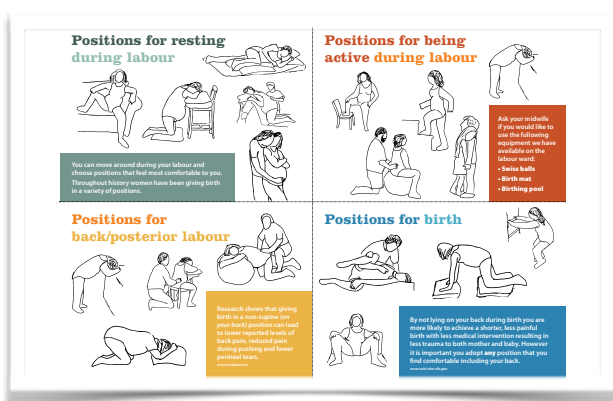
"Taranaki together, committed to caring in pregnancy, birth and beyond, for a healthy community".

Creating a series of three A2 posters which will be displayed in Labour ward corridor on the KPI boards. The intention of this display has the goal of "Improving physiological birth rates in our maternity facility".

The posters which flank the graphs promote labour and birthing positions and information that has been compiled from information from RANZCOG, NZCOM and AGOG statements.

Images used with permission from local and overseas artists.

It was my desire to see information presented in a colourful, easy to read, interesting format that is easy for women to engage with. I hope that this information can be useful in womens birth journey's and the benefits reflected in future statistics





Consumer report to Taranaki DHB MQSC for 2016/2017

This year marks my fourth year as part of the MQSC. It has been an amazing journey seeing the group grow and evolve. Under the leadership of our wonderful coordinator, Belinda Chapman, we have achieved excellent status by the MoH recently, the only DHB in the country to do so. Tu Meke! As a consumer I feel appreciated and valued as part of this group.

In the past year I have had the privilege to put together the first annual Maternity Roadshow during August 2016 at Waitara. This event aimed to bring maternity service providers and consumers, existing and potential, together to raise awareness as well as to build relationships. This was achieved in an expo type setup with service providers each having a stall and consumers dropping in over the course of the day. We also had morning tea available. On the day we had one of the wettest days of the year. This led to lesser than expected consumer turnout with only about 40 consumers on the day. Feedback was only positive with all service providers and a number of consumers very keen for the next event. The next roadshow is set for 19 October

2017 in Stratford. I am very happy with this achievement and hope it will continue as an annual event travelling around the mountain.

In 2014 it became apparent that there was a critical shortage of Childbirth Educators (CBEs) in the Taranaki region. At that stage there were three practicing CBEs in the region with one retiring at the end of 2014. There are six antenatal education providers in Taranaki this is too much work for two educators. I felt that my passion for consumer education and involvement would be very well suited to CBE and started my two year diploma course in 2016. This was done by my own accord. Being a CBE enriches my input as consumer rep to the MQSC. I am very excited to see Hapa Wananga implemented here in Taranaki. I believe health education to be of great importance to all consumers and service providers alike.

I look forward to the 2017/2018 to keep building on the success we have already achieved.

Complaints

Maternity services have a similar number of complaints received in the last year as the year prior. The graph below shows the highest number of complaints received are for attitude, which is down from six in 2015 to five in 2016.

Complaints related to competence have reduced from nine to four over the last three years the other categories are very similar.

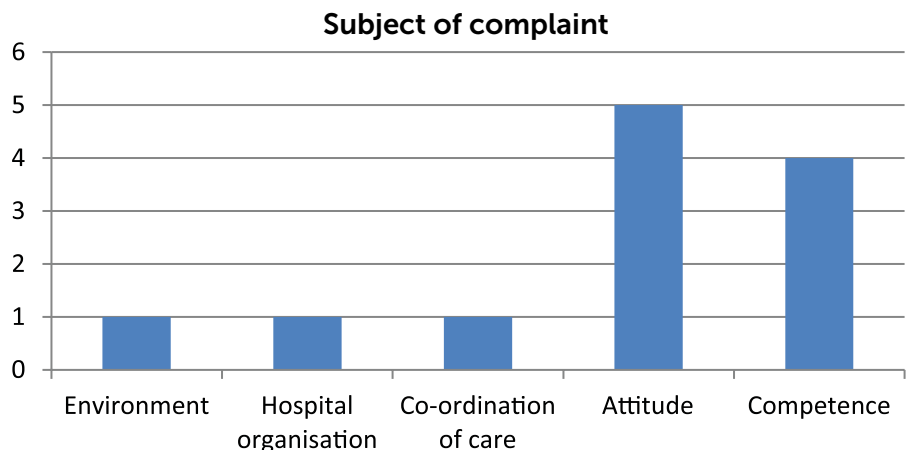
All complaints are fully investigated by the clinical midwife manager or service manager and the complainant is responded to in writing. The focus when investigating complaints is to review how our consumers experience could have been improved with a focus on quality, safety and

implementing change to improve our services.

A new Datix reporting system was implemented to Taranaki DHB in December 2015. This system captures and registers complaints received, work is being carried out

on generating reports for this field to discuss at the governance meetings.

'How are we doing' forms are available in all of our maternity facilities which are used to capture consumer feedback which includes compliments, suggestions and complaints which are fed back to our staff.



Compliments

“

“Staff have been amazing! Staff were consistently kind and helpful. It has made our whole family enjoy the experience. Thank you all very much especially the night nurses, Sharon and Virginia.”

Compliment from mother about care and support given by doctor and midwife during the birth of her son. “Thanks for your time, effort, support and love.”

”

“Treatment received has been awesome. The nurses, midwives and doctors have made the journey bearable. Thank you for everything, the medical treatment, the advice and the laughter and positivity, you guys are amazing.”

“Thank you for the outstanding level of service, advice, care and friendship. We were made to feel so comfortable by all the staff during our 3 day stay. Assistance with feeding solutions and latching assistance were always spot on.”

“Amazing, caring, patient and informative attitude and actions of staff in maternity.”

”

“Great care in maternity, staff professional, knowledgeable, kind and supportive. I felt safe and want staff to know that their care was truly appreciated.”

“Roanna in maternity is doing a fantastic job. She explained everything in a simple pleasant way. So kind caring and thoughtful.”

“Over the moon with how the paediatric team, obstetric team, ward 15 staff and especially the neonatal team and midwife, cared for me. Words cannot describe how thankful I am for all the help and fast actions of the staff on duty.”

Performance against clinical indicators

From 2009 to 2015, there was a national statistically significant increase in the proportion of standard primiparae who had:

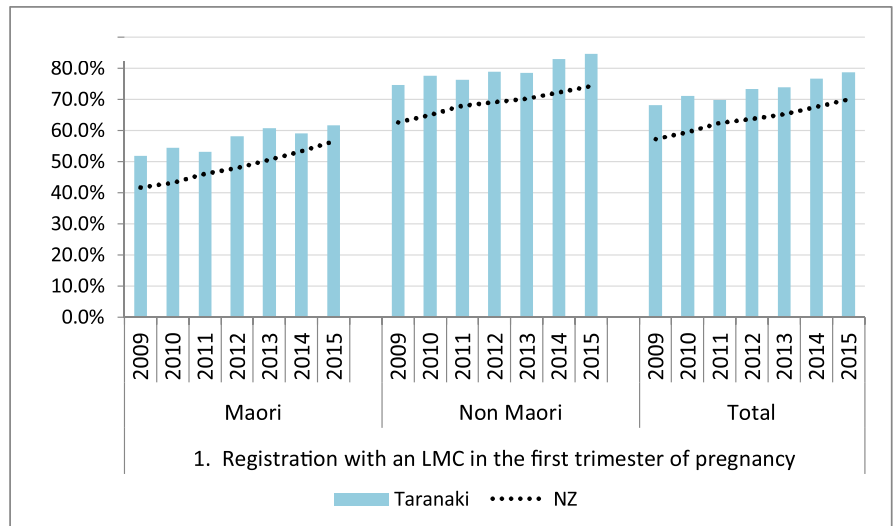
- an instrumental vaginal birth (indicator 3)
- a caesarean section (indicator 4)
- an induction of labour (indicator 5)
- an episiotomy without third or fourth-degree perineal tear (indicator 7)
- a third or fourth-degree tear and no episiotomy (indicator 8)
- an episiotomy and a third or fourth-degree tear (indicator 9).

Conversely, there was a significant decrease in the proportion of standard primipare who had:

- a spontaneous vaginal birth (indicator 2)
- an intact lower genital tract (indicator 6).

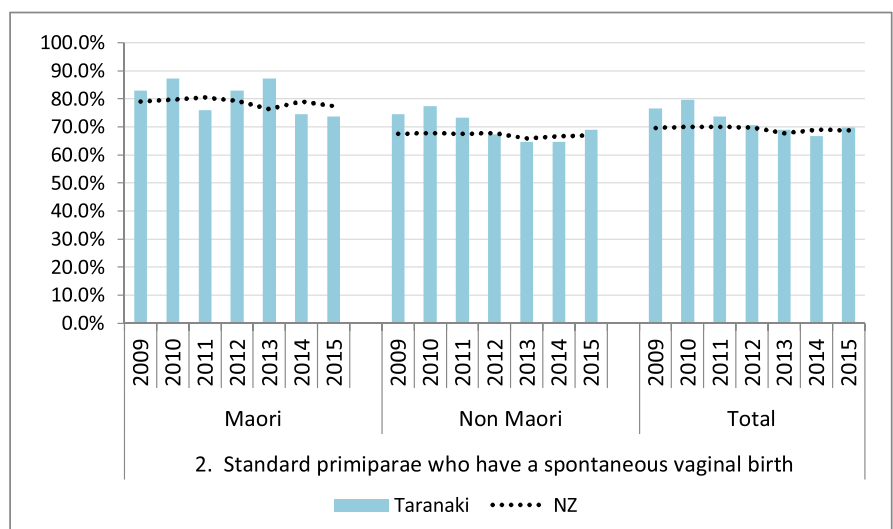
Indicator 1: Registration with an LMC in the first trimester of pregnancy

STRENGTH: Taranaki has increased in rates over the last five years - 98% of women are registered under an LMC. The national rate has increased to 70%. Taranaki Base has a rate of 78.7% in 2015, 76.7% in 2014 73.7 in 2013, and 73.4% in 2012.



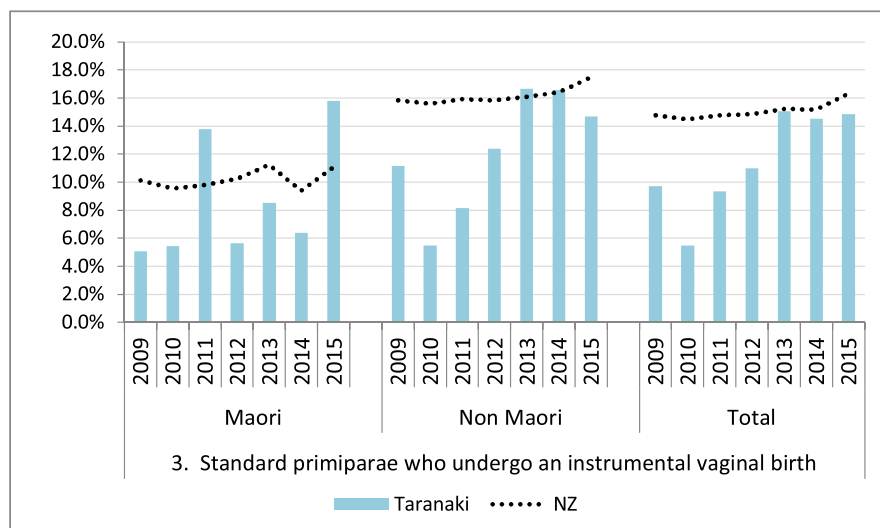
Indicator 2: Spontaneous vaginal birth

Nationally and locally decreasing:
The national rate in 2015 was 68.7% Taranaki's overall rate has slightly increased to 69.8% in 2015 however Taranaki Base hospital rate in 2015 is 67% sitting below the national average rate. Previous rates are; 66.7% in 2014, 69.3% in 2013, 70.2% in 2012, 73.5% in 2011, 79.1% in 2010, and 76.6% in 2009.



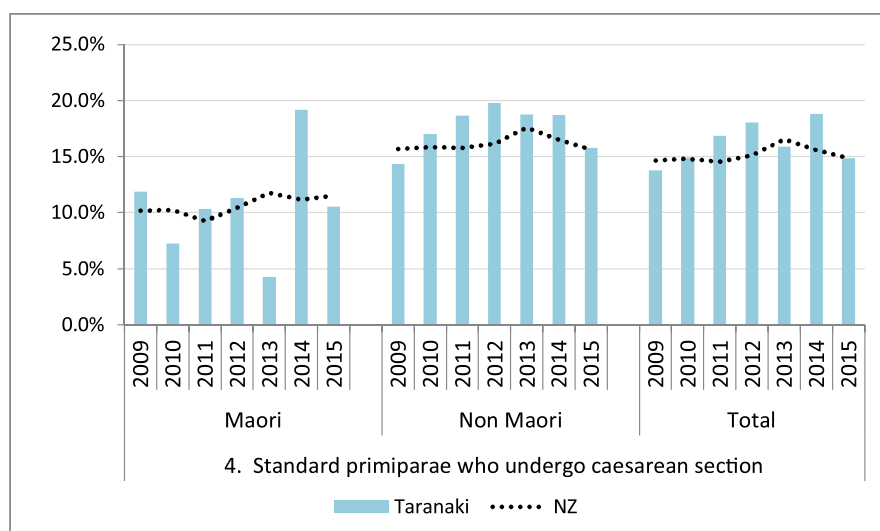
Indicator 3: Instrumental vaginal birth

Increased: Taranaki has an overall rate of 14.9% in 2015 up from 14.5% in 2014, 15.1% in 2013, 11.1% in 2012, 9.1% in 2011, 5.6% in 2010, and 8.8% in 2009; below the national average of 16.3%. Findings from case review sessions has identified that education on indications to commence active management of labour should continue to be a focus.



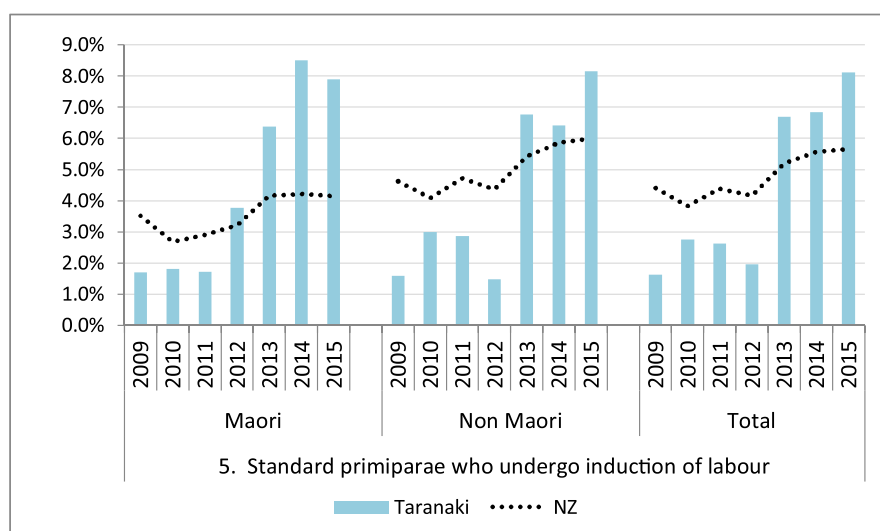
Indicator 4: Caesarean section among primiparae

Decreased: Taranaki has decreased to 14.9% by domicile and to 16.5% at Taranaki Base hospital (national rate of 14.9%) from 18.8% in 2014; 15.5% in 2013, (Taranaki base hospital rate has had a significant increase to 21.4% from 18% in 2013) and from 18.3% in 2012, 17.4% in 2011, 15.3% in 2010 and 14.6% in 2009. With the Maternity Obstetric outcomes and case review sessions this may have had an impact on reducing this rate.



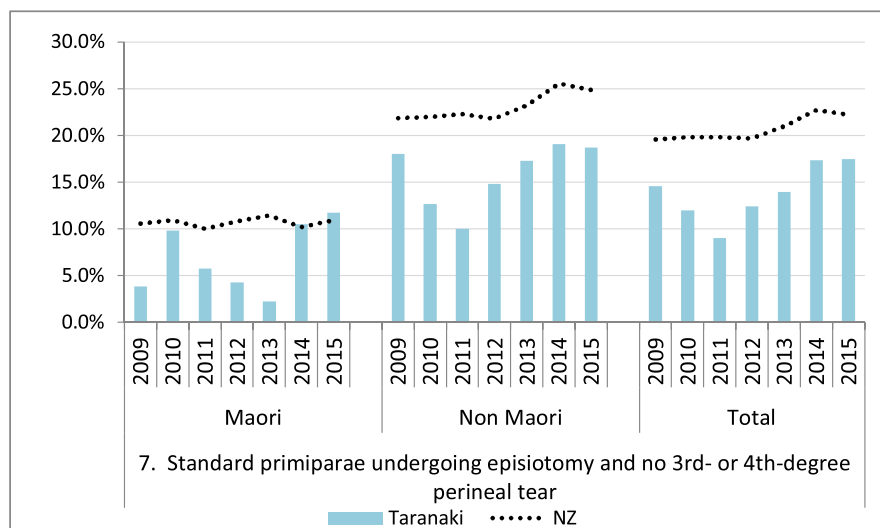
Indicator 5: Induction of labour among primiparae

INVESTIGATE: Taranaki base rate has significantly increased to 9.8% (national rate 5.7%) from 6.8% in 2014, 6.7% in 2013, 2% in 2012, 3.1% in 2011, 3.4% in 2010, and 2.9% in 2009. This is above the rising national rate of 5.6%. This has been audited in 2016/17 and it was found a number of the cases the MOH counted as a standard primipara did not fit this definition. Additional work plans to assist in identifying clinical indicator 20 may have increased the induction of labour rate.



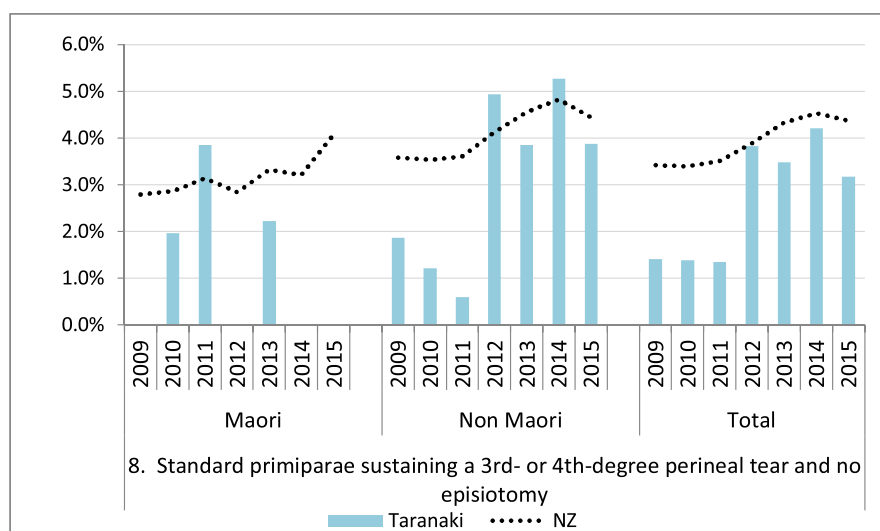
Indicator 7: Episiotomy and no 3rd or 4th degree tear

Taranaki has a static rate of 17.5% (however bas hospital has increased to 19.1%) from 17.4% in 2014, up from 13.9% (Taranaki Base rate is 15.4%) in 2013, 12.6% in 2012, 8.4% in 2011 it remains below the national average of 22.2%.



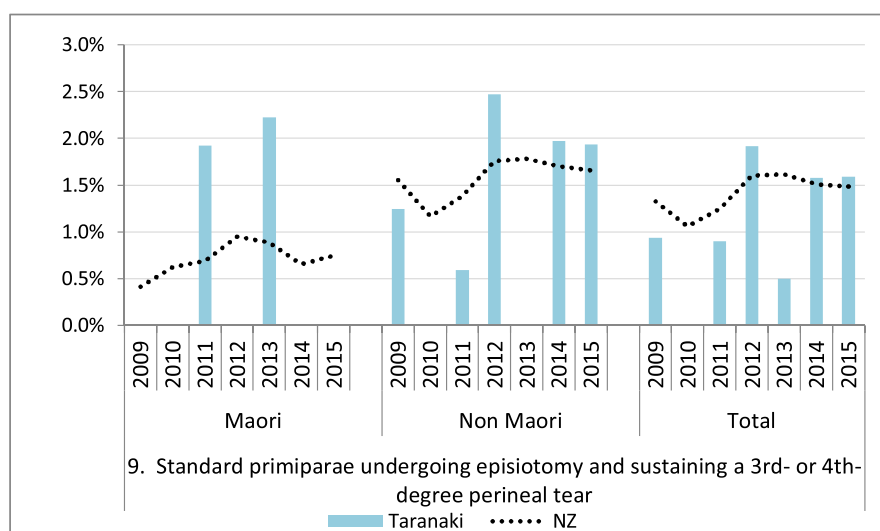
Indicator 8: 3rd or 4th degree tear sustained with no episiotomy

STRENGTH: Taranaki has a rate of 3.2% (base hospital 3.7%) down from 4.2% in 2014, up from 3.5% (Taranaki Base 4.4, up from 4.1% in 2013) in 2013, 2.4% in 2012, 1.3% in 2011, national average is 4.5%. in 2015 Numbers are low so confidence is low.



Indicator 9: Episiotomy and 3rd or 4th degree tear sustained

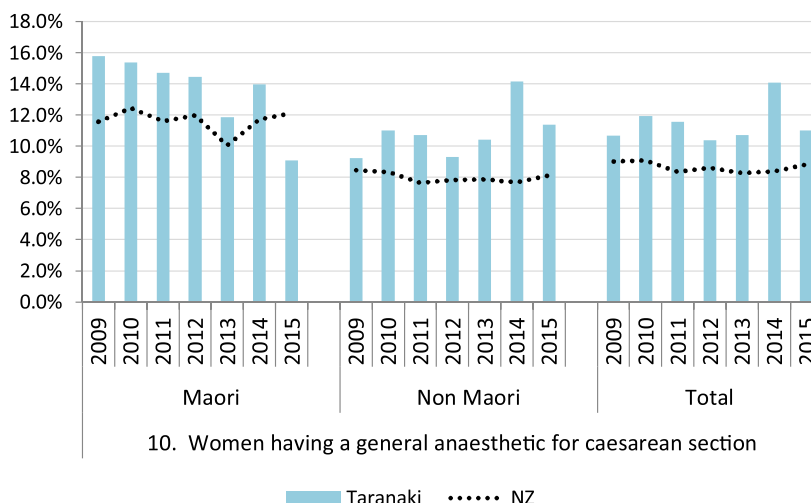
Taranaki has a rate of 1.6% in 2015 and 2014, up from 0.5% (1.3% up from 0.6% in 2013 in Taranaki Base) in 2013, 1.9% in 2012, 0.6% in 2011, 0% in 2010, and 0.9% in 2009; above the national average of 1.5% in 2015. Numbers are very small to have confidence in these figures but will be highlighted to the practitioners.



Indicator 10: General anaesthesia for all caesarean sections

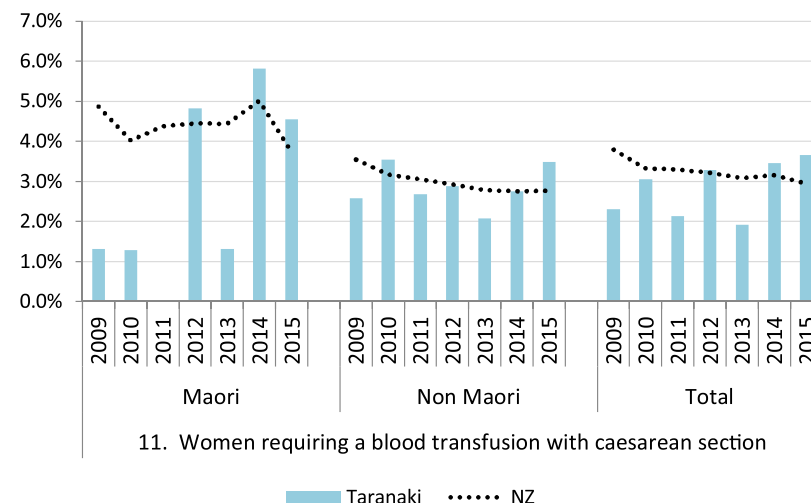
Decreased: Taranaki has a rate of 10.6% at base hospital down from 14.1% in 2014 up from 10.7% (Taranaki Base is 14.2%) in 2013, 10.4% in 2012, 11.6% in 2011, 11.9% in 2010 and 10.7% in 2009 which is above the national average of 8.8%. The general operating theatres which are used for caesarean section 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 were introduced as a quality improvement to try and reduce these rates, these did seem to impact on the rates.



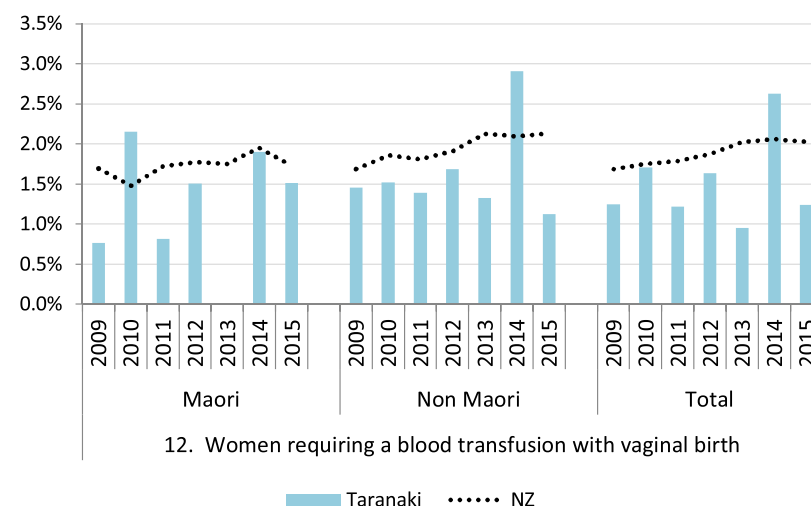
Indicators 11 Postpartum haemorrhage (PPH) blood transfusion after caesarean section birth

DECREASED: Taranaki has an increased rate of 3.7% in 2015 up from 3.5% in 2014, up from 1.9% in 2013, 3% in 2012, 2.1% in 2011, 2.8% in 2010, and 2.3% in 2009, around the national average is down to be 2.9% in 2015. Numbers are low to be able to have confidence in these rates however PPH has been audited in 2015/16 and 2016/17, results are in the audit section of this report.



Indicator 12: PPH and blood transfusion after vaginal birth

DECREASED: Taranaki has a decreased rate of 1.2% in 2015 from 2.6% in 2014, up from 0.9% in 2013, 1.4% in 2012, 1% in 2011, 1.7% in 2010, 1% in 2009, the national average is 2% in 2015.



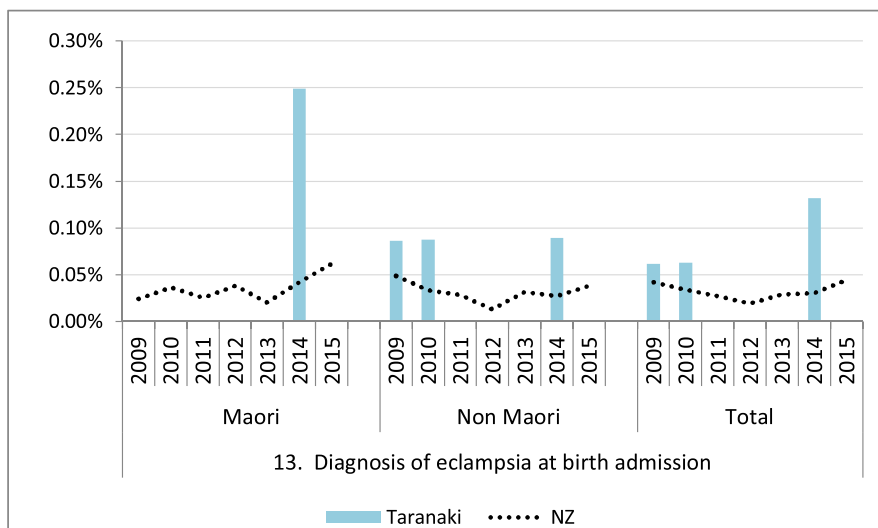
Indicators 13-15

Of women giving birth in New Zealand in 2015 the maternity clinical indicator reports:

- 26 women were diagnosed with eclampsia during the birth admission
- 30 had a peripartum hysterectomy
- 16 were admitted to an intensive care unit (ICU) and required over 24 hours of mechanical ventilation at some time during their pregnancy or postnatal period. They advise that district health boards with cases should investigate each case to determine if there were opportunities for prevention. The indicators 13-15 are included as a key indicator for case review in Taranaki DHB maternity obstetric outcome protocol.

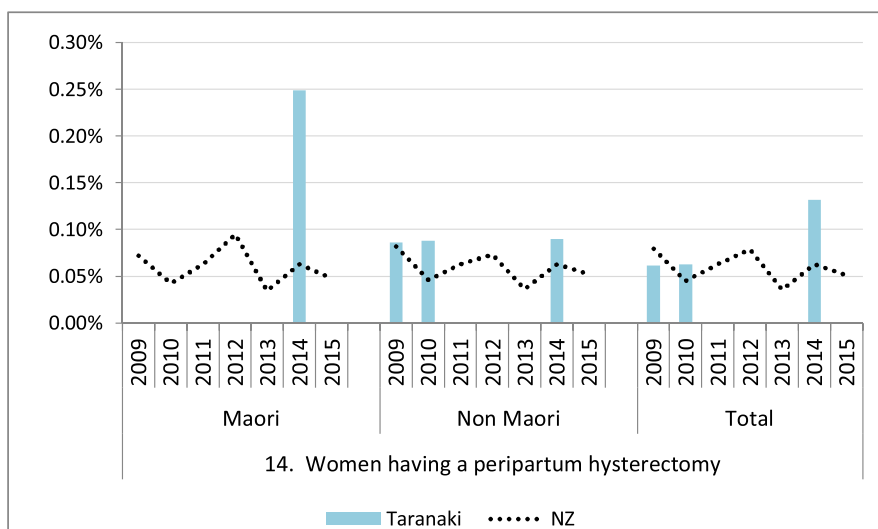
Indicator 13: Diagnosis of eclampsia at birth admission

Taranaki had no cases in 2015, 2 cases in 2014 whereas no cases were reported in 2013.



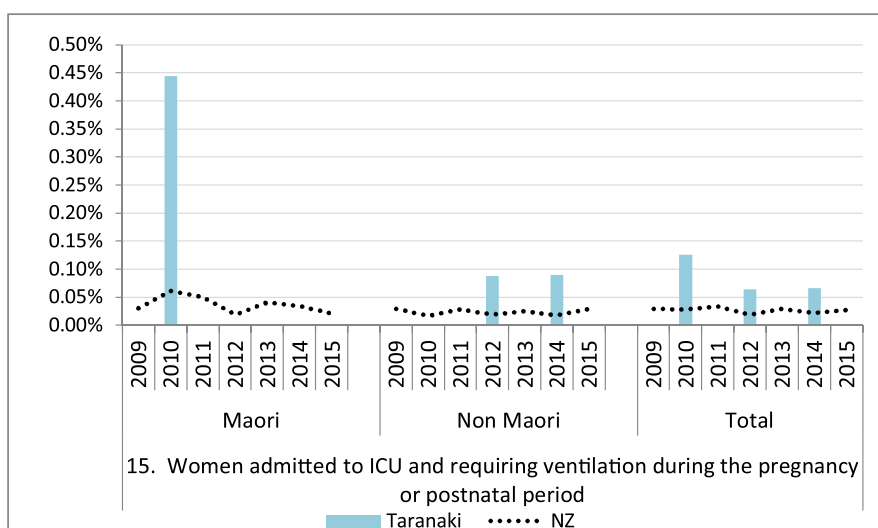
Indicator 14: Peripartum hysterectomy

Taranaki had no cases in 2015 down from the 2 reported cases in 2014 whereas no cases were reported 2013.



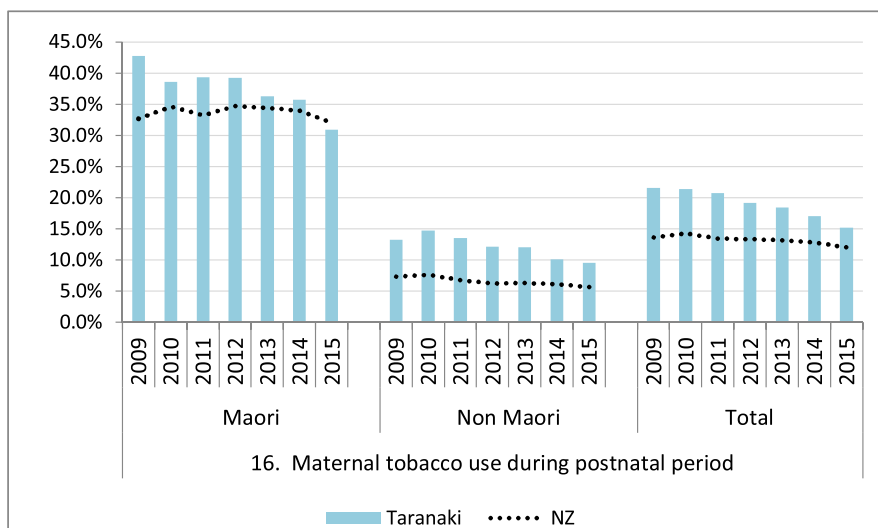
Indicator 15: Mechanical ventilation during pregnancy or postnatal period

Taranaki had no cases in 2015 down from 1 case reported in 2014 and no cases in 2013



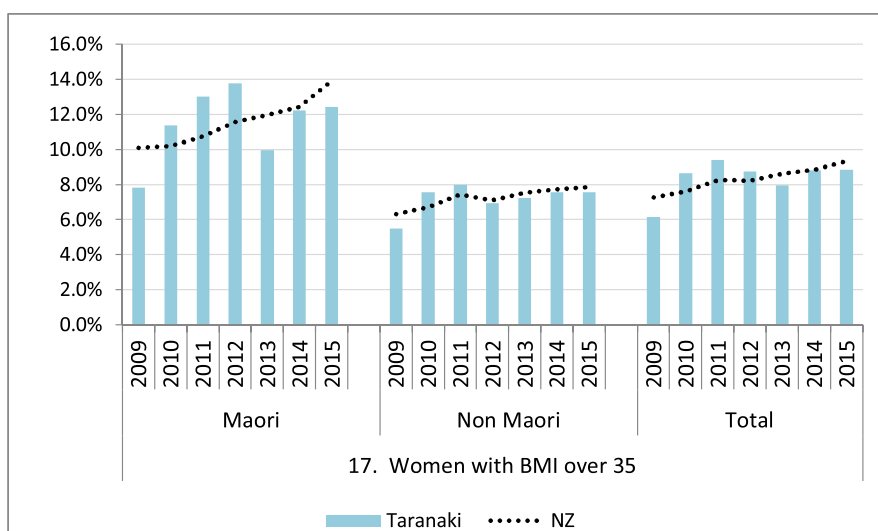
Indicator 16: Maternal tobacco use during the postnatal period

DECREASED: Taranaki has a continued decreased rate of 15.1% (13.7% in Taranaki Base) down from 17% in 2014, down from 18.3% in 2013 and 19.1% in 2012 this is above, the declining national average of 12% in 2015. South Taranaki has a greater prevalence of smoking amongst pregnant women and has a new smoking cessation provider contract (see the smoking among pregnant women section).



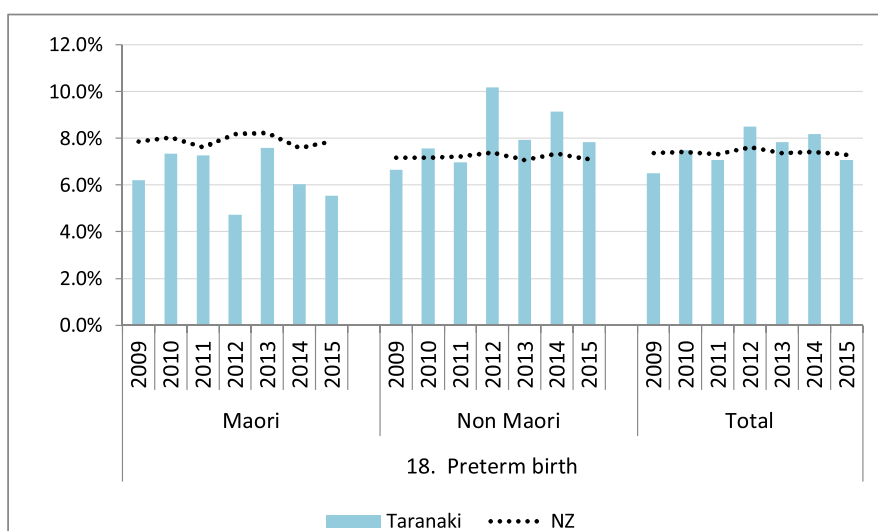
Indicator 17: Maternal obesity (BMI over 35 at registration)

Taranaki has a static rate of 8.8% in 2014 and 2015 however base hospital has risen to 9.3% in 2015, up from 8% in 2013, the national average rate has risen to 9.3% in 2015.



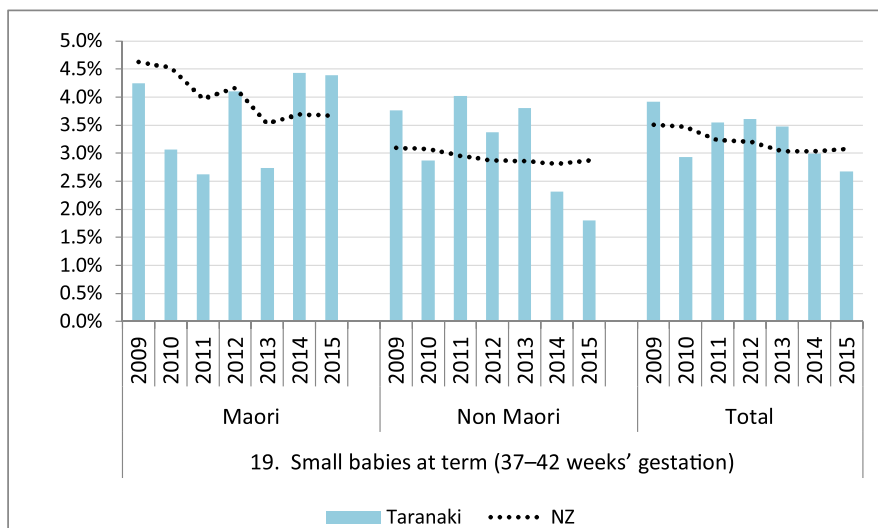
Indicator 18: Premature births (delivery from 32-36 weeks)

DECREASED: Taranaki has a decreased rate 7.2% (national rate 7.3%) down from 8.2% in 2014, 7.8% in 2013, 8.5% in 2012 and 5.9% in 2011, 6.1% in 2010, 5.7% in 2009; the national average is fairly consistent at 7.3%. An audit was undertaken in 2014/2015 and the NNU manager continues to monitor the rate of preterm births. Fetal Fibronectin testing is undertaken in TDHB and early tocolysis where appropriate is administered.



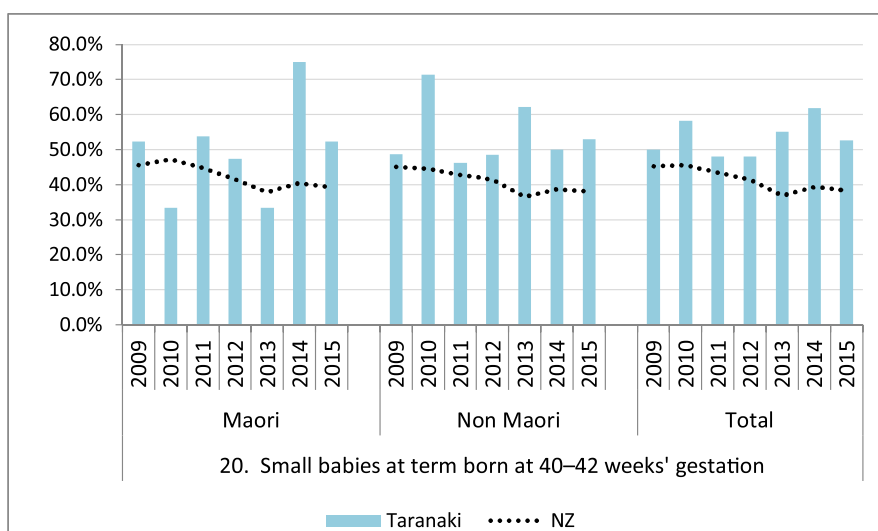
Indicator 19: Small babies at term (37-42 weeks gestation)

Taranaki has a reduced rate of 2.7% in 2015 down from 3% in 2014, 3.5% in 2013 with an overall national rate of 3.1% in 2015. We are encouraging the use of the GROW tool in pregnancy and the use of the birth weight centile calculator on the newborn weight to help identify babies at risk. We are also monitoring undiagnosed SGA babies in the weekly case review/ maternity obstetric outcomes monitoring meetings. The rate is now below the national average of 3.1%.



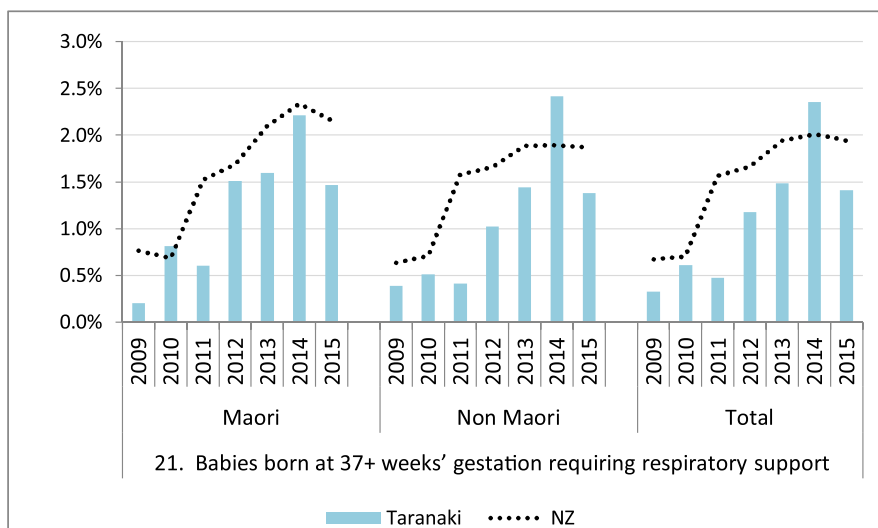
Indicator 20: Small babies born at term (40-42 weeks gestation)

CONTINUE TO INVESTIGATE: Taranaki continues to have the highest rate in the country but has decreased from 61.9% in 2014 to 52.6% in 2015 (Taranaki base is 48.6% not the highest in the country); 55.1% in 2013. The national average has risen to 38.4% in 2015. This rate requires continued monitoring. The expectation is that diagnosed SGA are likely to be induced before term. Also SGA can be linked with smoking in pregnancy. Carbon monoxide (CO) monitors have been purchased to use as a tool to help pregnant women quit in pregnancy. We are currently reviewing all undiagnosed cases of SGA that are identified in the weekly case review sessions to try and help identify any trends/ areas that can be improved. An audit has been completed. The GAP programme is currently being introduced in Taranaki; all practitioners have been offered e-learning for this and face to face education is planned for October 2017. Having the GAP programme will allow access, audit and on going monitoring of SGA to ensure best practice guidelines are followed.

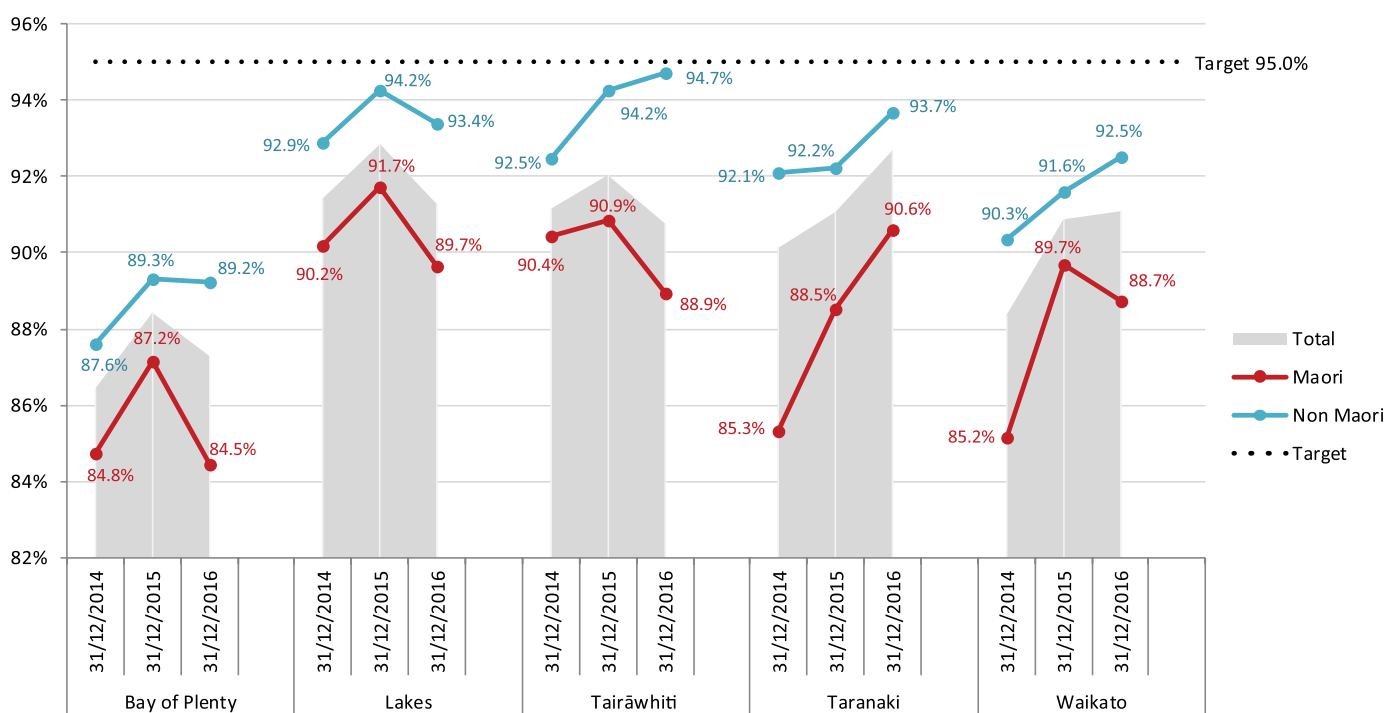


Indicator 21: Term babies requiring respiratory support

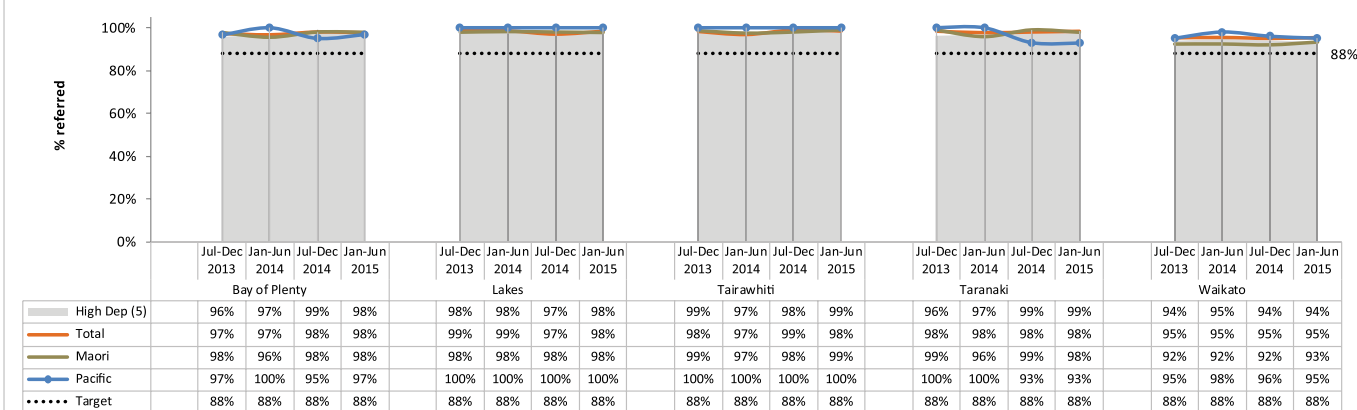
Taranaki has an decreased rate of 1.4% in 2015 down from 2.4% in 2014, 1.5% in 2013. It is now below the national average of 1.9%. The number is small, however all unexpected term baby admissions to the Neonatal Unit are case reviewed.



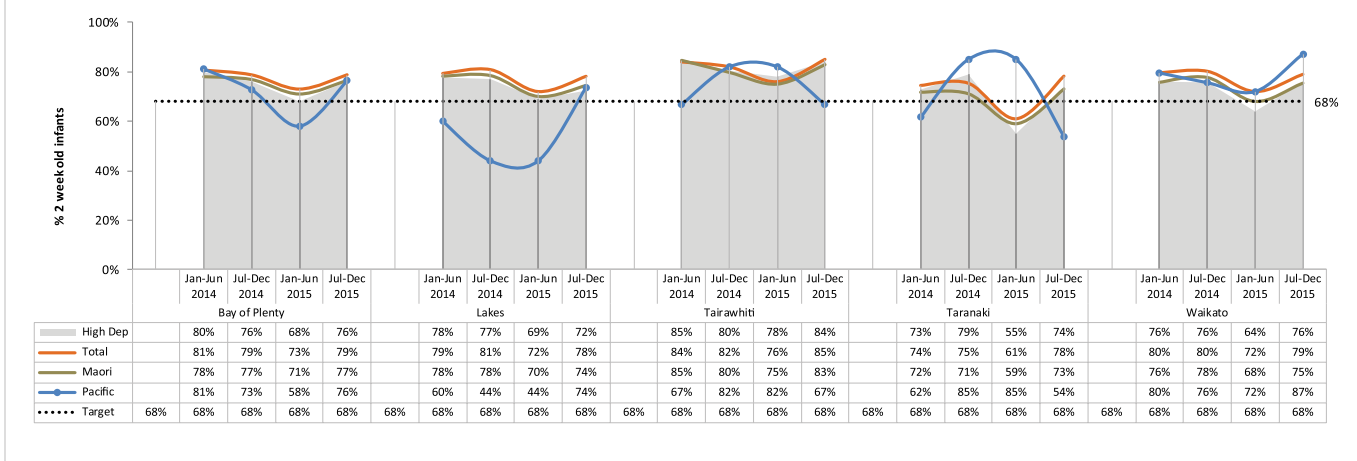
Immunisation rates at eight months (annual result at Dec each year) by ethnicity



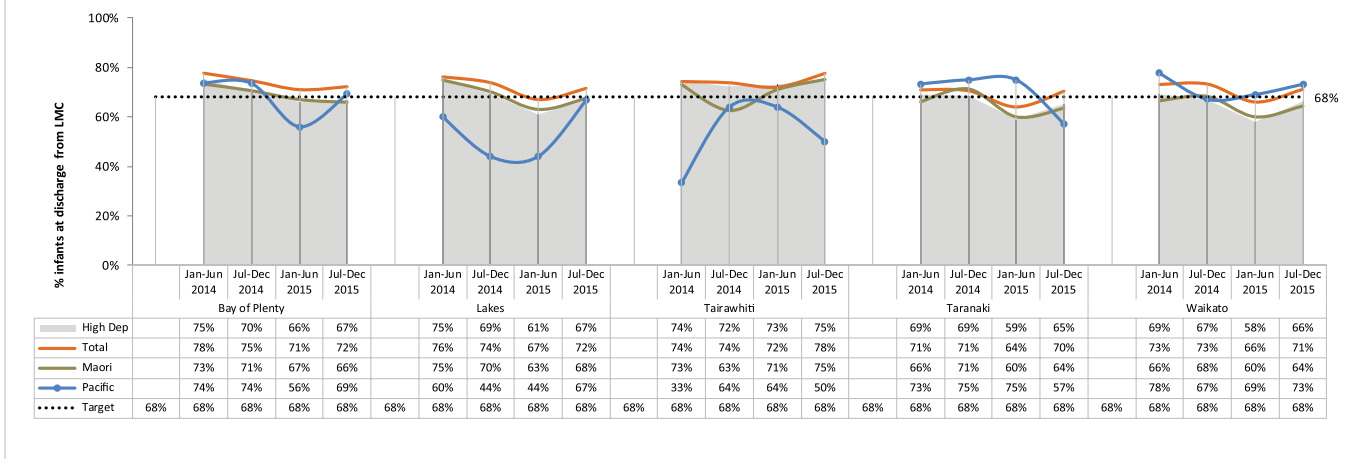
WCTO Indicator 2: Percentage of families and whanau referred by LMC to WCTO



WCTO Indicator 11: Percentage of infants exclusively or fully breastfed at two weeks



WCTO Indicator 12: Percentage of infants exclusively or fully breastfed at discharge from LMC



Summary of 2016/17

- Presentation to the Taranaki DHB Clinical Board on the activities and progress of the Taranaki MQC
- Continued to improve the environment of Hawera primary maternity unit
- Completed the Hawera maternity unit brochure
- Updated the consumer information on the maternity external internet site
- Improved relationships with the local baby loss/SANDS consumer group
- Provided a pregnancy and parenting Hub at WOMAD
- Safe Sleep initiative, pepi pod distributions and safe sleep consumer day
- Maternal Mental Health guidelines and initiatives
- Breast feeding initiatives including the breastfeeding welcome here project
- Waitara district Maternity Services Roadshow
- Perinatal mortality and neonatal encephalopathy focus
- Set up of a risk register for maternity
- Long active reversible contraception (LARC) service
- Midland Maternity Action Group regional protocols, education and quality initiatives
- Continued to monitor the maternity 777 calls and level 1 caesarean section calls
- Implement the virtual obstetric consultation service for non urgent consultations/advice for LMCs
- Standardised neonatal resuscitation trolleys have been implemented in all neonatal areas and the operating theatre
- Information on better help for pregnant women to quit smoking
- NCHIP implementation
- Alliancing project with community midwives
- Education sessions in relation to clinical indicators, outcomes and changes to CYFS/Oranga Tamariki
- Audits identified in the 2015/16 work plan
- Quality improvements
- Midwifery staffing trial and workforce planning.

Rural and primary maternity facilities and primary LMC services:

A marketing leaflet on the maternity services available in Hawera maternity unit was completed to help promote its use for women who are considered low risk. The unit has also received new furniture and furnishings with a focus on it becoming a more whānau/family friendly environment.

Hawera's primary unit's birth rate has remained much the same despite the closure of the primary maternity unit in the Stratford District. It was hoped that the women suitable to birth in a primary unit from the Stratford district would choose to birth in Hawera rather than in Taranaki Base Hospital.

Work has continued in Hawera to promote collaboration and communication with other services such as the St John ambulance service and the Emergency Department (ED) in Hawera Hospital. Both the local ambulance and ED personnel are invited to participate in the local Practical Obstetric Multi-Professional Training (PROMPT) sessions held in Hawera maternity unit. This has been well received with positive feedback on the training programme and the opportunity to work together as a team, enhancing local relationships.

The rural ED, ambulance service, maternity unit, senior midwifery/obstetric and medical teams have worked together to produce and implement two emergency response procedures:

CURT - Critically Urgent Road Transfer.

A TIME-CRITICAL PROBLEM - e.g Massive PPH, Cord Prolapse, Unwell pre-eclamptic or Eclamptic patient.

NERT - Neonatal Emergency Response Team.

A SKILL-CRITICAL PROBLEM - a retrieval team is dispatched from Taranaki Base Hospital to Hawera maternity with specific skilled staff e.g. paediatrician confident in neonatal intubation/resuscitation to help with stabilisation and transfer of the neonate between hospital sites.

One of the senior midwifery team attends Hawera maternity unit on a weekly basis for meetings with core and/or rural LMC's to present educational sessions or to discuss any issues, review any cases with either the educator, clinical midwife manager or associate director of midwifery.

Patient safety



Alliancing Community Midwives

There are five leadership midwives who have been trained by the New Zealand College of Midwives as part of the alliancing pilot project who meet monthly with the Associate Director of Midwifery. The Purpose of the meetings is to support Community Midwives to have a voice within the DHB, to represent Community Midwives at meetings or on groups where representation is required and to report back to all Community Midwives via the monthly College of midwives meetings. Progress has been made and quality improvements have been initiated. Community midwives now have access to WIFI within the DHB and all have access to concerto which includes laboratory results, policies and protocols, documents and discharge letters.

The current challenges for our community midwives is gaining access for consumers for nuchal translucency scan services and access to female sterilisation services for women in need which we are trying to progress. We have worked together on interface issues and produced the handover of clinical responsibility flow chart:

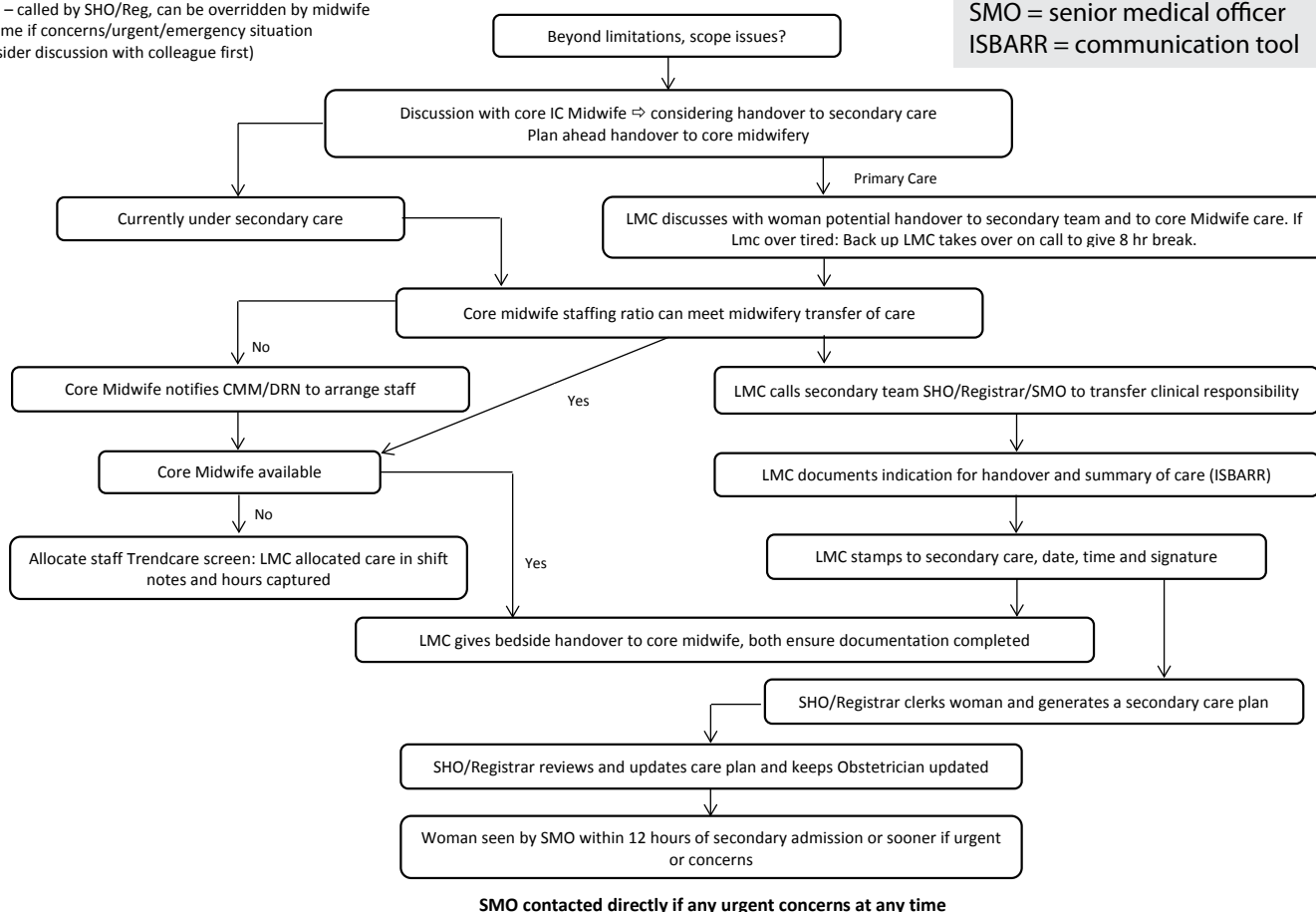
Medical roles:

SHO/Reg – accepts handover of care, clerks and communicates findings to SMO; agreed secondary care plan documented in records

SMO – called by SHO/Reg, can be overridden by midwife anytime if concerns/urgent/emergency situation (consider discussion with colleague first)

Handover of Clinical Responsibility Midwife Lead Maternity Carer(LMC) to Core Midwifery

IC = in charge
CMM = clinical midwife
DRN = duty resource nurse
SHO = senior house officer
SMO = senior medical officer
ISBARR = communication tool

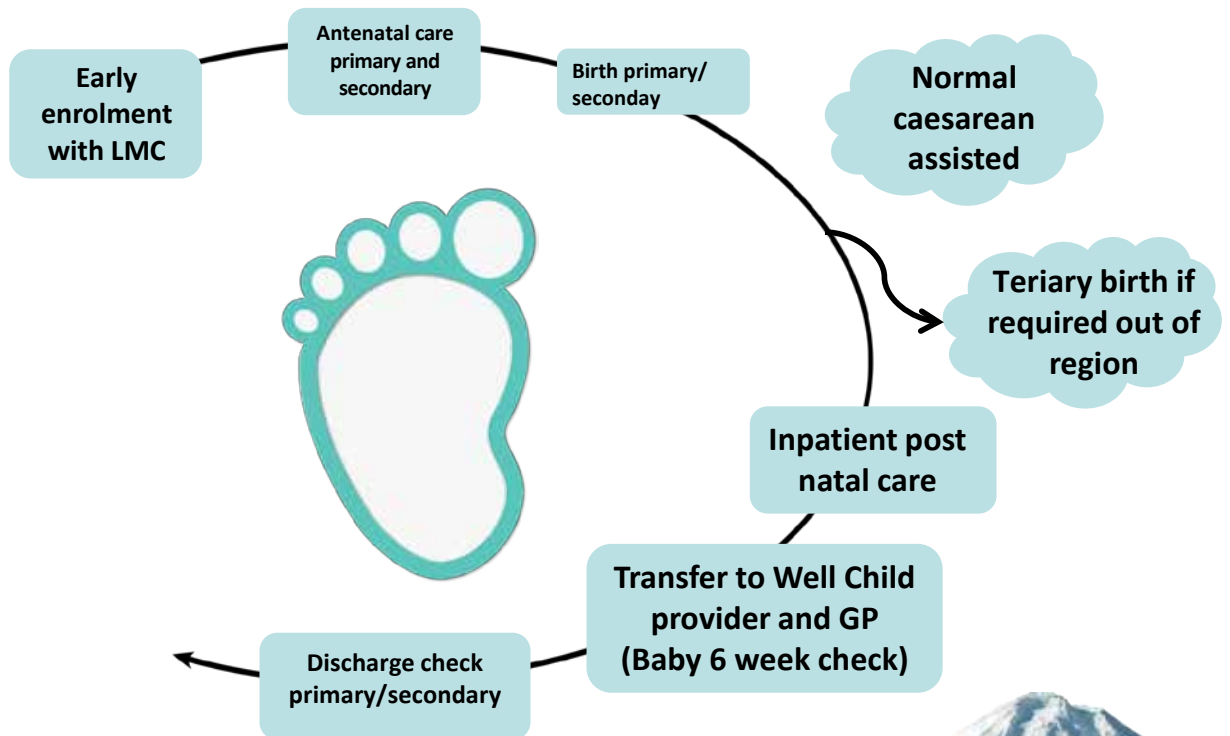


Long Acting Reversible Contraception (LARC)

Jadelles are inserted by trained RMOs on the postnatal ward if requested by the woman after discussing with their LMC. Depo provera is also available on the ward.

There is a Contraception Clinic provided in Gynaecology Outpatients every week for women who have difficulty or barriers to accessing contraception or difficulty using contraception. This used to be the female sterilisation' clinic but has evolved into more of a LARC clinic as many women opt for a LARC instead (following discussion), or do not have enough points for a publicly funded female sterilisation procedure. The clinic is run by an Obstetric and Gynaecology Medical Officer.

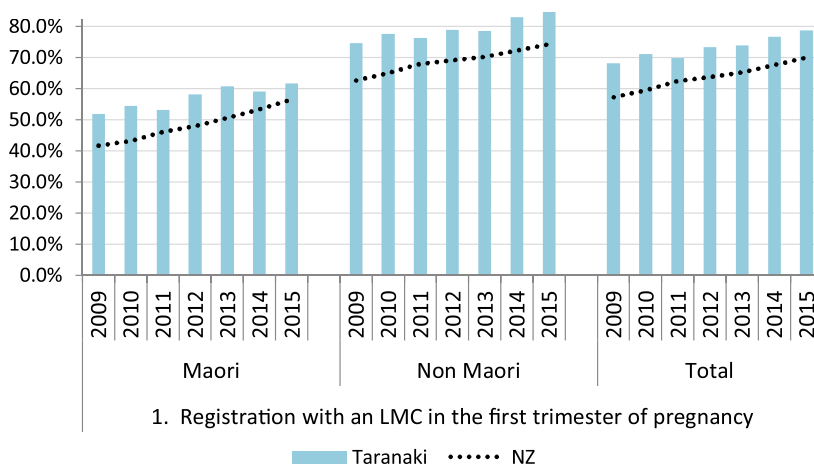
Maternity Pathway



Registration with a Lead Maternity Carer and early pregnancy care

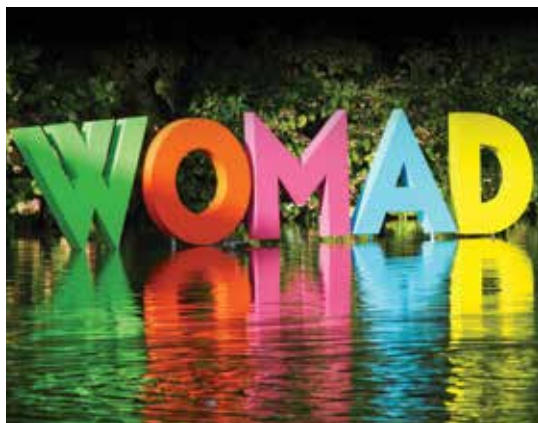
Initiatives that Taranaki MQC have participated in 2016/17:

- Updating of the pre and post pregnancy services directory twice yearly
- WOMAD pregnancy and parenting tent
- Super Mama toolkit
- Maternity Services Roadshow in Waitara district



WOMAD

The success of manning the pregnancy and parenting tent at the World of Music Art and Dance (WOMAD) in 2016 led to the request that Taranaki maternity services again provided this in 2017. This was again a great opportunity to advertise the importance of the top 5 things to do in the first 10 weeks of pregnancy and mix with consumers, parents and potential future families to utilise our maternity services and another successful promotion.



Super Mama

As part of the Ministry of Health's "better public service" target, Taranaki DHB has developed an informative video for young mothers on how to keep themselves and their baby healthy during pregnancy. The target by 2021 is to have 90% of pregnant women registered with a lead maternity carer in the first trimester, with an interim target of 80% by 2019.

The video features a Māori super hero named Super Mama, who offers important advice to pregnant mothers in the first 10 weeks of pregnancy and beyond.

There are a range of Super Mama resources available to download on the Taranaki DHB website. You can also add 'Super Mama Taranaki' as a friend on Facebook to get ongoing support and advice directly to your Facebook news feed.

Video



Facebook



Twitter



Instagram



www.tdhub.org.nz/services/maternity/supermama.shtml



Quit 4 Two – Smokefree Pregnancy

Quitting smoking during pregnancy is one of the best decisions a woman can make for her, and her baby.

The TSSS Team is serious about reducing smoking in pregnancy by increasing the number of pregnant women who are supported to access a quit programme designed just for them. Our Quit Coaches are trained to work with pregnant women, and can provide nicotine replacement therapy medicines such as nicotine patches, gum or lozenges. These medicines will help ease the cravings and are far safer than smoking. We want to ensure pregnant women and their whānau have the quickest access to support. To make this happen email stopsmoking@tuiora.co.nz or call 06 759 7314

'Just having that support and not being judged and told oh you need to do this. You know it was more like this is the service we provide...I didn't feel like I was being pressured.'

'Committing to giving up was really scary and I think Tui Ora took a lot of the scare factor away.'

'It's not a challenge to actually fill out the paperwork and send it off, I guess the biggest challenge is to get somebody engaged in wanting to quit, so to keep asking the question.'

Feedback

'Knowing that I have got nother life growing inside me, I need to be there for them.... I think just putting that in my head and knowing this is what I want for me and my family has given me that strength'

'Just knowing that she is only a text away and that she is so approachable. She is like a friend instead of a health provider.'

'You've got to strike while the iron is hot. If someone's going hey I want to give up smoking, you've got to actually do something now, because by tomorrow, or by even later that day, they have decided that they don't want to make that decision.'

Feedback from people in the programme and referrers.

Smoking Cessation Referral Pathway

- 1** Refer the person via best practice (GPs), smoking cessation form (TDHB) or TSSS referral form (all other referrers)
- 2** Tui Ora will acknowledge receipt of the referral
- 3** The Taranaki Stop Smoking Service contacts the person to enrol in the programme
- 4** The Quit Coach will see the person to talk about the programme, how to prepare for quitting and ways to fight urges

Smoking in pregnancy

		2016/17			
		Q1	Q2	Q3	Q4
Percentage of pregnant women who identify as smokers at the time of confirmation of pregnancy in general practice are offered brief advice with support to quit.	Māori	100%	100%	96%	
	Non-Māori	100%	100%	100%	
	Total	100%	100%	98%	

Smoke screening and referrals within the DHB

The below data is from the Health Target 'Better help for smokers to quit Secondary' which is the rate of smoking cessation advice and support provided to identified smokers who are hospitalised.

		2016/17			
		Q1	Q2	Q3	Q4
Providing smokers with smoking cessation advice and support - hospitalised	Māori	97%	98%	97%	95%
	Non Māori	98%	97%	98%	97%
	Total	97%	97%	97%	96%

Tui Ora are now the lead providers of the only face to face smoking cessation service for the Taranaki region. The Taranaki Stop Smoking Service is a completely free service, the stop smoking practitioners are qualified and they can provide nicotine replacement therapy and a tailored quit programme for all pregnant mums and their whanau.

The stop smoking team completed a research project to better understand people who are accessing Stop Smoking services and what it is like for providers that are referring them and were very interested to hear and understand the experiences from a referrer's perspective. One of the objectives was to learn what obstacles were met by the referrers and if there were any opportunities for improvement. It was a really useful process, a lot of good feedback was obtained and it was discovered that the Taranaki DHB smoking cessation referral form needed updating as there were many versions in circulation, contained non-existent provider details and disconnected phone numbers. This form has now been updated and can be faxed, emailed or a direct phone call can be made if a mum wants to stop smoking and you need to book an appointment straight away, for example if the pregnant

mum does not have access to phone or contacts. Once the client has met with the stop smoking practitioner and she has enrolled with the service feedback to the referrer will be provided including when she completes or exits the programme.

Education has been provided on the use of the carbon dioxide (CO) monitors and it is intended to have local providers recommence education and training on asking pregnant woman about their smoking status, giving brief advice to stop smoking, referral to cessation support and quit coaches and also be able to administer nicotine replacement therapy.

The maternity unit now has two midwives who have a special interest in championing this interest and are currently devising an information leaflet in consultation with Tui Ora; progress of this is dependent on having down time within their current working time.

Taranaki DHB website has been updated to ensure local service provider details are available.

Waitara Road Show

Our consumer assisted in organising the maternity services roadshow in the Waitara district of Taranaki. This was the first maternity roadshow which is intended to be held annually in different rural communities of Taranaki. The road show is an opportunity to engage with local communities to ensure the message of the top 5 things to do in the first 10 weeks in pregnancy reaches pregnant women and their families. The roadshow also brought all the local stakeholders and consumer groups together with the maternity services which was a great success in promoting relationships, communication and information."

Meet your Maternity Services

ROADSHOW

3 AUGUST 2016
9:30AM – 12:00PM
KNOX CHURCH, WAITARA

Are you a new mum? Pregnant? Planning a baby?

Engaging with a midwife as soon as you know you are pregnant will help give your baby the best start in life.

There are a wide range of free and low cost services available to support you during pregnancy, birth and in your child's early years.

Join us at the Meet Your Maternity Services roadshow for a light morning tea provided by Waitara Community Kaumatua, and the opportunity to meet maternity service providers in your area.



TOP 5 things to do in the first 10 WEEKS of pregnancy

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

Find a Lead Maternity Carer by scanning this QR code or go to www.tdhub.org.nz and search "LMC"



SERVICES

TARANAKI DHB SERVICES: Midwives ■ Smoking Cessation ■ Health Promotion ■ Newborn Hearing Screening ■ Immunisation ■ Secondary Antenatal Clinic ■ Breastfeeding Welcome Here ■ Lactation Consultant

WELL CHILD / TAMARIKI ORA: Plunket ■ Tui Ora ■ Ngati Ruanui

COMMUNITY GROUPS: La Leche League ■ Baby Wearing ■ NNU Play Group ■ SANDS ■ Parents Centre ■ Home Birth Aoteroa ■ Breast Feeding Peer Support

SUPPORT SERVICES: Pregnancy Help ■ Women's Refuge ■ MSCC - Maternity Services Consumer Council

FOR MORE INFORMATION

Christine.Strydom@tdhb.org.nz
Belinda.Chapman@tdhb.org.nz



Outpatient antenatal services

Services provided by the antenatal clinic

1. Antenatal clinics

There has been an increase in antenatal clinics due to the appointment of a fifth obstetric consultant. There are now six to seven outpatient antenatal clinics per week.

Dr Viner, Dr Ventresca, Dr Chukwujama, Dr Williams and the antenatal clinic coordinator have weekly clinics.

Dr Smith and Dr Chukwujama have fortnightly clinics in both New Plymouth and Hawera Maternity Units.

2. Vaccination clinic

Flu and whooping cough vaccination clinics are now weekly instead of fortnightly due to demand.

3. Fetal assessment unit (FAU)

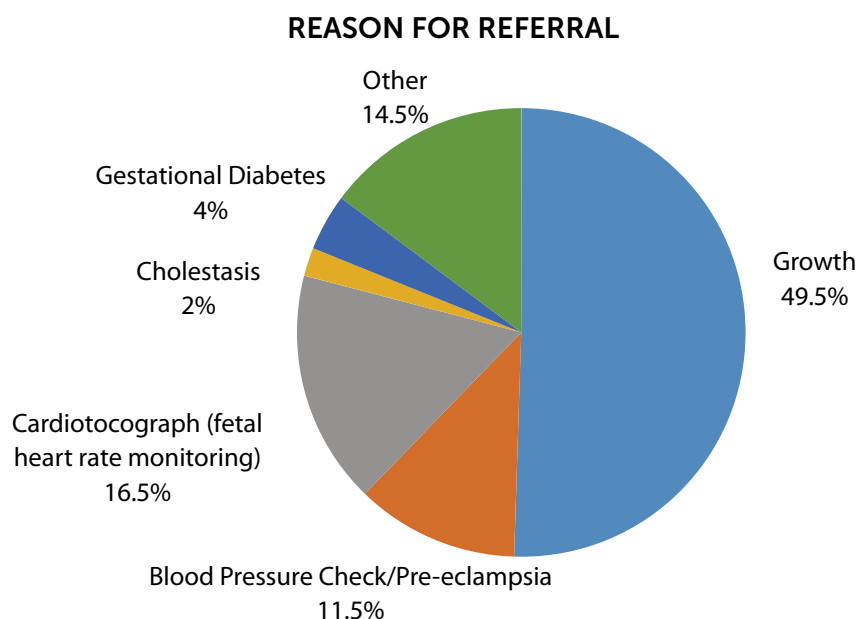
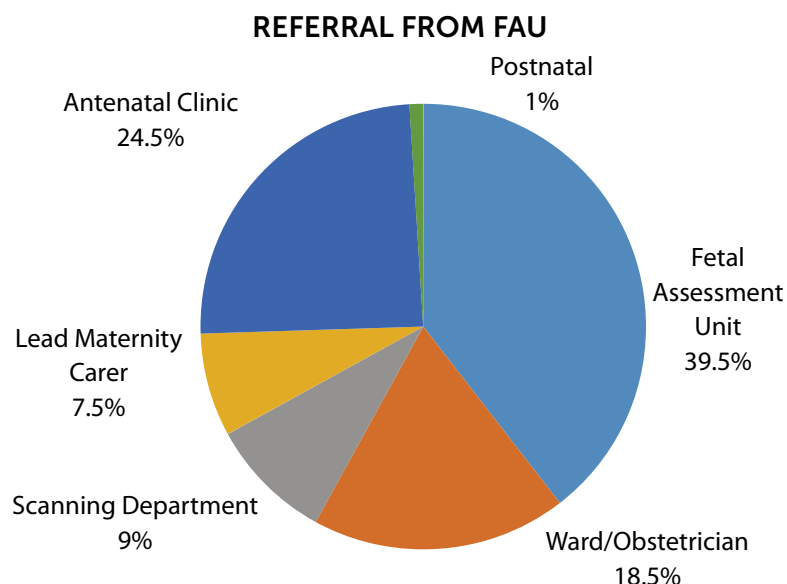
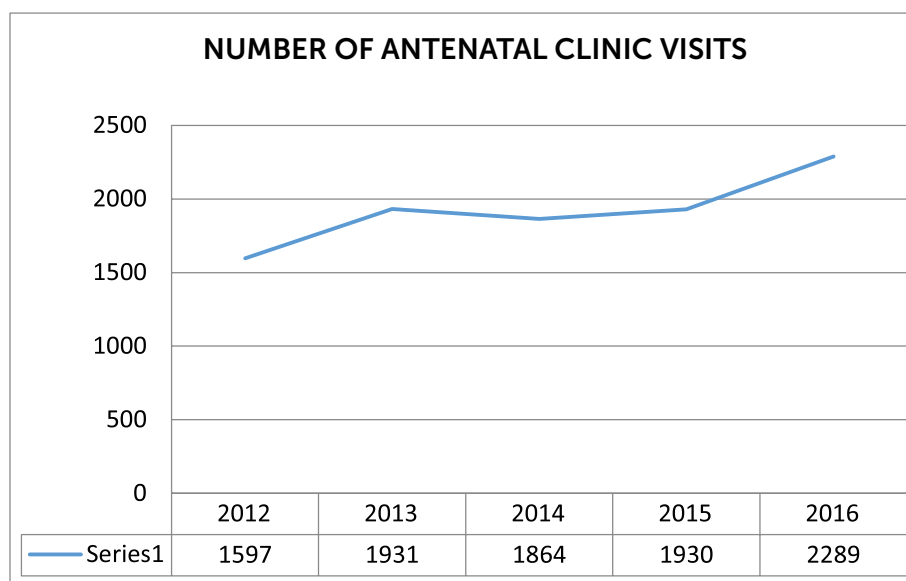
This clinic started in March 2014. It is held every Wednesday and is run by a midwife and an obstetric registrar. The number of women seen in this service continues to increase; there is a call for it to be held twice a week particularly on the days when complex obstetric scans are performed at Fulford radiology.

4. Outpatient hip check clinic

This clinic is held twice weekly.

5. Amniocentesis service

This service is now provided in Fulford Radiology by Dr Ventresca. This is an improvement as there is a radiographer present to assist, also the quality of the ultrasound scanner is far better than the one we use on the Maternity Unit.



Improvements made and what's going well

1. Vaccination Clinics

115 women have been vaccinated against flu and/or Whooping cough June 2016-June 2017. Antenatal clinic again achieved cold chain accreditation

2. TV and DVD player available in the antenatal clinic waiting room for antenatal education purposes.

3. The increase in hours of the ward administrator for Antenatal clinic, continues to streamline the service by having a methodical system to process referrals and records. Also having the same ward clerk helps with continuity and getting to know the women.

2. The need for a **clinic for women with gestational and pre existing diabetes** is still there. It was attempted in 2013 with Dr Viner but wasn't well attended by the diabetic educators, it was therefore discontinued. The concept of a diabetic liaison midwife was proposed last year but this has not gone forward. Taranaki DHB have supplied a midwife to collect the data for the TARGET (optimal glycaemic targets for gestational diabetes) research project with a special interest in healthy eating, exercise and diabetes. Data/details on this type of position has been sent to our clinical services manager with a request to support this proposal

3. The **clinic FTE has now increased** to 0.8FTE due to the increase in the amount of antenatal clinics. The current role is 0.7FTE.

4. **Hawera Antenatal Clinic** needs a permanent midwife position to run the weekly clinic which currently has 17 high risk cases

3. **Establish relationship via video conferencing** with Jay Marlow in Wellington to avoid women travelling out of Taranaki.

4. Ideally a role for a **Diabetic Liaison Midwife** to run a clinic for women with Type 1 and 2 diabetes for the ever increasing number of women with Gestational Diabetes

5. **An increase in FTE** for an extra antenatal clinic midwife to:

- cover the rise in clinics/complex women coming through the service
- establish a VBAC clinic – something that was discussed two years ago but time constraints has not allowed us to do it
- continue with roadshow's to GP practices to cover how to access an LMC in the first, trimester, early pregnancy screening and secondary antenatal clinic services.

What could improve

1. **Lack of access to local Maternal Fetal Medicine (MFM) services** for the Women of Taranaki continues. Dr Michel Sangalli and Dr Jay Marlow MFM specialists in Wellington are too busy to attend Taranaki. Women still have to attend Tertiary hospitals in Auckland and Wellington for appointments. This is disruptive for the woman and family and costly to TDHB. In previous times a visiting MFM specialist came to Taranaki 1 day per month to run MFM clinics. It is hoped that telemedicine consultations could be developed in the future.

Plans for 2017-2018

1. **Continue with the Fetal Assessment Unit** with the possibility of introducing a cervical ripening clinic for post mature women
2. **Continuity of care for high risk women.**

HbA1c (diabetes in pregnancy screening) screening at booking

1 January 2016 – 31 December 2016

Total initial antenatal screens
1870

Antenatal HbA1c number of requests
1539

82% of total initial antenatal screens have a HbA1c request.

Variation in gestation of birth

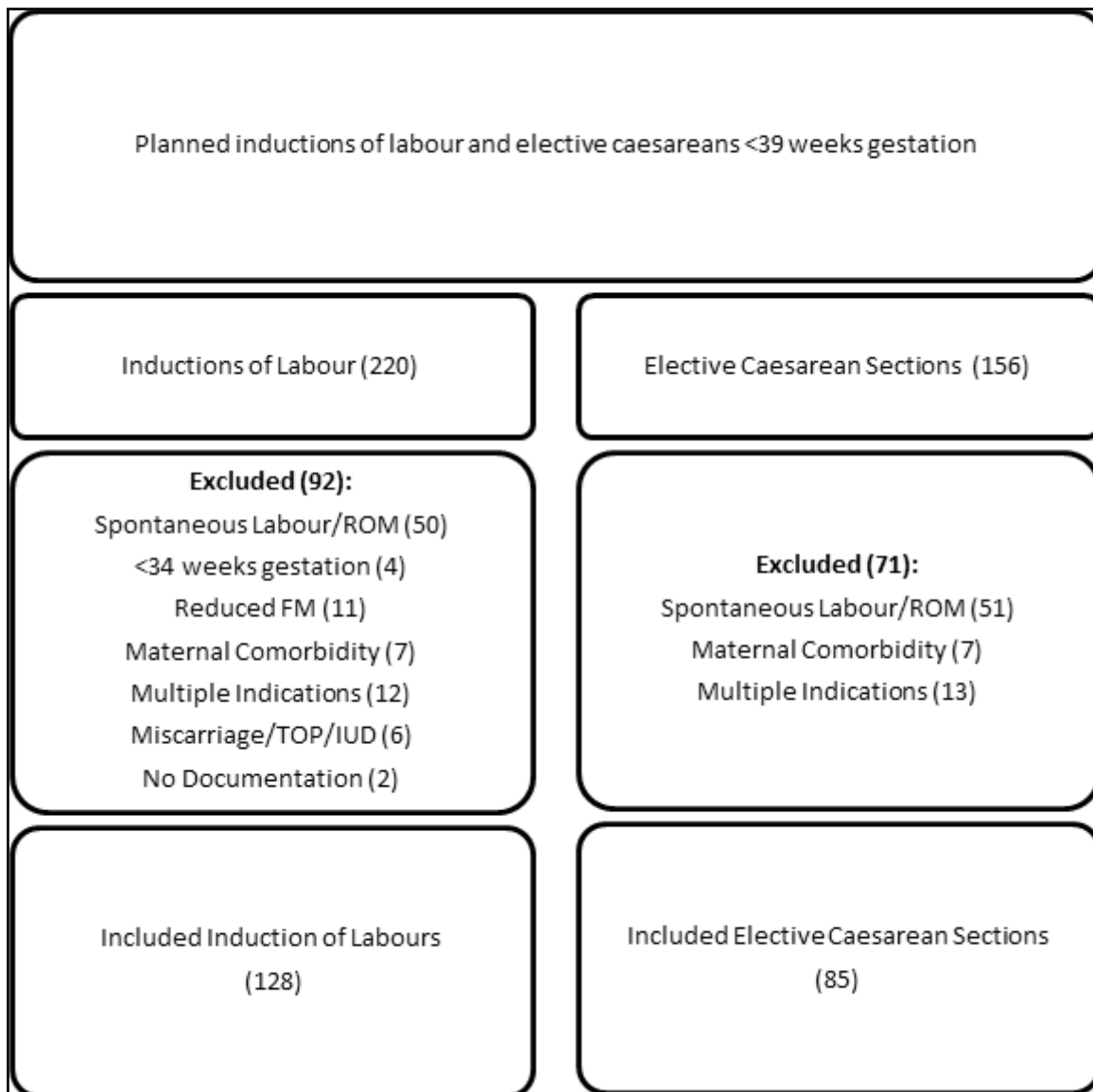
An audit was carried out and the below is a summary of the audit findings and recommendations.

Induction of Labour (IOL) and Elective Caesarean Section (ELCS) before 39 weeks at Taranaki DHB

Medical Students: Samantha Ellis and Michelle Henderson

Index Categories: Maternity - Intrapartum, Antenatal, General

Sample inclusion/exclusion methodology and numbers



Results:

A total of 376 women were identified as having an IOL or ELCS before 39 weeks gestation between 2014 and 2015. 163 were excluded based on the criteria outlined above. Of the 213 cases included, 128 were IOL and 85 were ELCS (Appendix 2).

Table 1: Demographic Data

	Gestation weeks/days (Range)	Age (Range)	Ethnicity (%)			Smoker (%)	BMI Mean (Range)
			NZ European	Māori	Other		
IOL	37 ⁴ (34 ² - 38 ⁶)	29 (18-45)	87 (68%)	27 (21%)	14 (11%)	31 (24%)	28 (18 - 49)
ELCS	38 ¹ (35 - 38 ⁶)	31.6 (18-41)	46 (54%)	19 (22%)	20 (24%)	14 (16%)*	28.9 (18 - 54)**
All	38¹ (34²- 38⁶)	30 (18-45)	133 (62%)	46 (22%)	34 (16%)	45 (21%)*	28.6 (18 - 54)**

*Smoking data for three patients unavailable

**BMI for four patients unavailable

Induction of Labour (IOL) Results

Table 2: Indications for Induction of Labour before 39 weeks gestation

Indication for Delivery									
Gestation weeks/days	Twins*	APH**	Prev. IUD	IUGR/SGA	PET/HTN	GDM***	Cholestasis	Other	Totals
34 ⁰ - 34 ⁶				1 (25%)	3 (75%)				4 (3%)
35 ⁰ - 35 ⁶				3 (60%)	2 (40%)				5 (4%)
36 ⁰ - 36 ⁶	3 (25%)	1 (8%)		2 (16%)	4 (33%)	1 (8%)		1 (8%)	12 (9%)
37 ⁰ - 37 ⁶	4 (10%)		1 (3%)	14 (36%)	10 (26%)	3 (8%)		7 (18%)	29 (23%)
38 ⁰ - 38 ⁶	4 (6%)		3 (4%)	17 (25%)	17 (25%)	12 (18%)	11 (16%)	4 (6%)	68 (53%)
All	11 (9%)	1 (1%)	4 (3%)	37 (29%)	36 (28%)	16 (13%)	11 (9%)	12 (9%)	128 (100%)

*Dichorionic diamniotic twins only

**APH of unknown origin

***Macrosomic babies included in this category

APH = antepartum haemorrhage
IUGR = intra uterine growth retardation
SGA = small gestation age
PET = preeclamptic toxemia
HTN = hypertension

Graph 2: Indications for Induction of Labour before 39 weeks gestation



- 54% of suspected SGA/IUGR included cases had planned IOL before 38 weeks
- Preeclampsia (PET) or essential hypertension (HTN) in pregnancy was the sole indication for 28% of cases, 25% of these were induced prior to 37 weeks
- Three of 11 cases of twins (27%) were induced prior to the recommended 37-38 weeks with an absence of documentation suggesting additional indications.
- Obstetric cholestasis made up 9% of the planned, all between 380- 386
- 13% of planned IOL were documented with the sole indication being for GDM
- Previous IUD was the sole indication for 3% of all planned IOL before 39 weeks.

Elective Caesarean Section

Table 3: Indications for Elective Caesarean Section before 39 weeks gestation

Gestation	Previous LSCS	Previous complications	Breech	Patient request	Maternal complications	Fetal complications	Obstetric complications	Totals
350- 356						1		1 (1%)
360- 366					2		3	5 (6%)
370- 376	4	3		1	5	1	7	21 (25%)
380- 386	38	3	5	3	4		5	58 (68%)
Totals	42 (49.9%)	6 (7.1%)	5 (5.9%)	4 (4.7%)	11 (12.9%)	2 (2.4%)	15 (17.6%)	85 (100%)

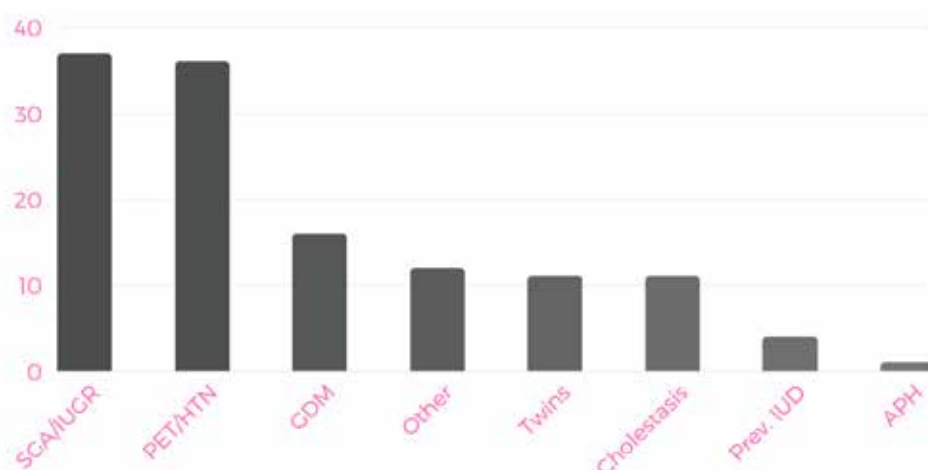
*Previous complications: IUD, perineal tears, ectopic

**Obstetric complications: Twins, increased risk of abruption, APH/previa

***Maternal complications: PET/EHTN, abdominal pain, GDM

**** Fetal complications: IUGR, polyhydramnios

Graph 1: Indications for Elective Caesarean before 39 weeks gestation



- A minimum of 43 cases (50.1% of all cases reviewed) are compliant with RANZCOG standards.
 - All cases in which maternal, fetal and obstetric complications have been documented as the indication for ELCS comply with the current standards set out by RANZCOG.
 - Of the 58 ELCS done in the 38th week of gestation, a total of 15 were done at 38 weeks + 6 days gestation and may therefore comply with the current RANZCOG recommendations.
- Of the 57 cases that may not comply with the RANZCOG standards:
 - Eight were carried out in the 37th week of gestation.
 - A thin lower segment was documented for three of the 43 cases where previous caesarean section was the sole indication for ELCS; all three were carried out at 38 weeks + 1 day gestation.
- No pattern could be identified for gestation at delivery based on BMI, maternal age or number of previous caesarean sections.

Limitations:

- The validity of the audit is dependent on reliable and consistent documentation of rationale for planned IOL and ELCS – There was no consistent standardised document to describe the indication in many cases, the documentation often varied between midwifery and medical staff, and there were large numbers of cases with no discharge summaries, no electronic documentation and limited scanned records.
- Discrepancies between gestation dates obtained from clinical documents and that provided in the data set were found on multiple occasions, reliable coding of data may further impact the validity of the audit

ELCS = elective caesarean

RANZCOG = Royal Australian/New Zealand College of Obstetricians and Gynaecologists

IOL = induction of labour

- Validity of the ELCS component is further dependent on the interpretation of obstetric, maternal and fetal complications, and of recommendations to carry out ELCS “at approximately 39 weeks gestation”.
- Specific guidelines for ELCS and IOL in cases with multiple complications do not exist; clinical judgement is more heavily relied upon in these cases and it is therefore difficult to determine if these cases meet current standards.
- Changes to standard practices within Taranaki DHB have occurred since 2015; therefore the results presented may not be applicable to current local standards.

Interpretation of Results

Planned Induction of Labour

- Current recommendations state women with suspected SGA/IUGR babies should be offered IOL at 38 weeks [2,3], earlier induction has not been shown to improve neonatal outcomes [3] however 54% of cases in Taranaki DHB were <38 weeks
 - Must be interpreted in the context that detailed doppler studies influence clinical judgement (not included in this audit). Not routine at TDHB in 2014, increased frequency 2015.
- Recommended that women who develop PET be induced at 37 weeks and those with HTN also induced at this time are less likely to develop maternal complications – Most inductions appropriate and rationale generally based on clinical judgement.
- All cases of twins were dichorionic, diamniotic suggesting 3 of 11 inductions were not appropriate or had additional undocumented complications.
- All cases of obstetric cholestasis were appropriate between 380+ - 386+
- No indication for early IOL in GDM unless there is associated macrosomia [2], only 2 of 16 cases actually documented macrosomia as the indication
- Risk of subsequent stillbirth is increased with previous IUD, but no specific guidelines around timing of delivery therefore heavily influenced by clinical judgement
- Increased BMI, advanced maternal age, IVF and previous caesarean section alone are not indications for IOL before 39 weeks [2], there were no cases identified where these were documented indications.

Elective Caesarean Section Interpretation

- Limited theatre allocations for obstetric cases could be contributing to the number of ELCS done in the 38th week of gestation.
- RANZCOG guidelines state that myometrial thickness evaluated by ultrasound is not predictive of rupture or dehiscence and may not be useful in clinical practice.
- Inaccurate coding of data may have inflated the number of cases not compliant with current guidelines.
- Due to the heavy reliance on clinical judgement in the RANZCOG guidelines for gestation at ELCS, it is noted that additional factors not considered here may have informed many of the decisions to carry out ELCS prior to 39 weeks.

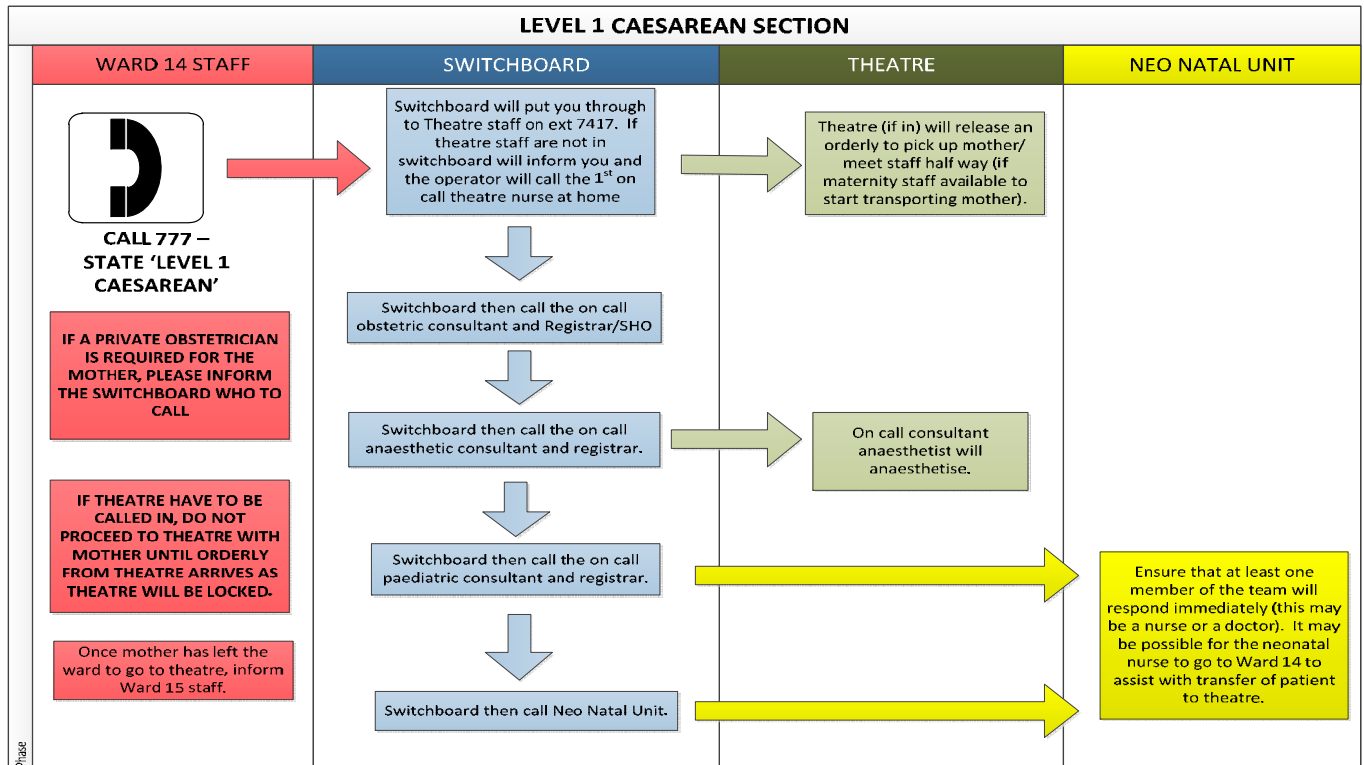
Recommendations:

1. Implement a standardised documentation pathway for all elective deliveries at TDHB, detailing BMI, smoking status, and indications for IOL/ELCS, to be completed on booking and/or arrival to the maternity unit.
2. Clearly document obstetrician rationale of planned delivery <39 weeks in above standardised documentation.
3. Ensure the correct documentation of a specific indication for planned delivery, rather than the condition pre-disposing to the indication (i.e. GDM rather than macrosomia).
4. Familiarisation with current guidelines/evidence for all medical and midwifery staff, particularly recommendations for:
 - IOL for SGA/IUGR and GDM
 - ELCS for previous caesarean.
5. Random audits on documentation (booking sheets, theatre notes and discharge summaries) to ensure clear and comprehensive recording of indication/timing.
6. Consider the development of a local guideline for the timing of elective caesarean section.
7. Liaise with theatre services to ensure bookings for ELCS are made as close to 39 weeks as possible, and/or increase obstetric theatre availability if necessary.
8. Review the value of conducting ELCS before 39 weeks gestation due to findings of thin lower segments and adjust clinical practice according to the findings.
9. Comprehensive reviews for those 8 cases in which ELCS was carried out in the 37th week of gestation to determine causes and prevent similar instances in the future.

Level 1 caesarean section calls 2016

EMERGENCY CAESAREAN DIRECTIVE

LEVEL 1 CAESAREAN; Immediate threat to the life of the mother and fetus, e.g. cord prolapse, massive APH, etc. This is an audited process and the standard is birth within 30 minutes of calling a level 1.



LEVEL 2: Maternal and fetal compromise which is not immediately life threatening, e.g. failure to progress. This is an audited process and the standard is birth within 75 minutes of calling a level 2. **Action taken;** On call Obstetrician will activate Level 2 call out. Ward staff will inform Ward 15 and Neo Natal Unit.

There were 14 Level 1 caesarean section calls made in 2016, however four calls were stood down:

- three resulted in a vaginal birth in the ward
- one was down graded to a level 2 caesarean section.

10 of the 14 cases in 2016 were considered a level 1 caesarean section:

- one case was upgraded from a level 2 to a level 1
- one case although documented in the operation note as a level 1 may have been down graded to a level 2. This case took 79 minutes from decision to delivery, a spinal anaesthetic was administered, however there was no evident documentation of any down grade or indication if any delays had taken place.

Comparing this figure to 2015 where there were 24 level 1 caesarean section calls, and 36 calls in 2014. There has been a reduction by 14 cases of level 1 caesarean section calls (58% decrease) in 2016 compared to 2015. This directive is now embedded into our service, all calls were made via the 777 alert systems, unlike previous years where caesarean section may have been deemed a level 1, however emergency alert processes were not followed.

Table 1. Time in minutes from decision to delivery

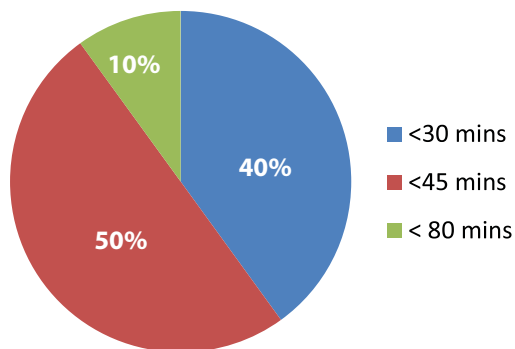
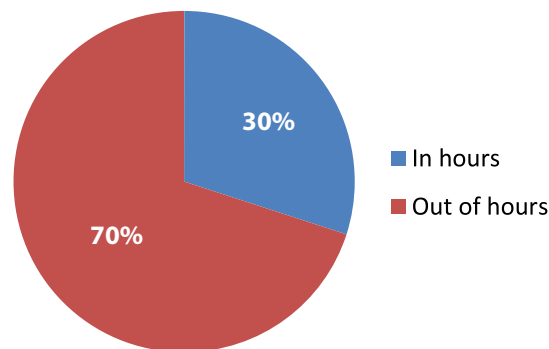


Table 2. In hours 08.00-16.00hrs Monday-Friday and out of hours 16.00-08.00 weekdays and 08.00-08.00 weekends and public holidays

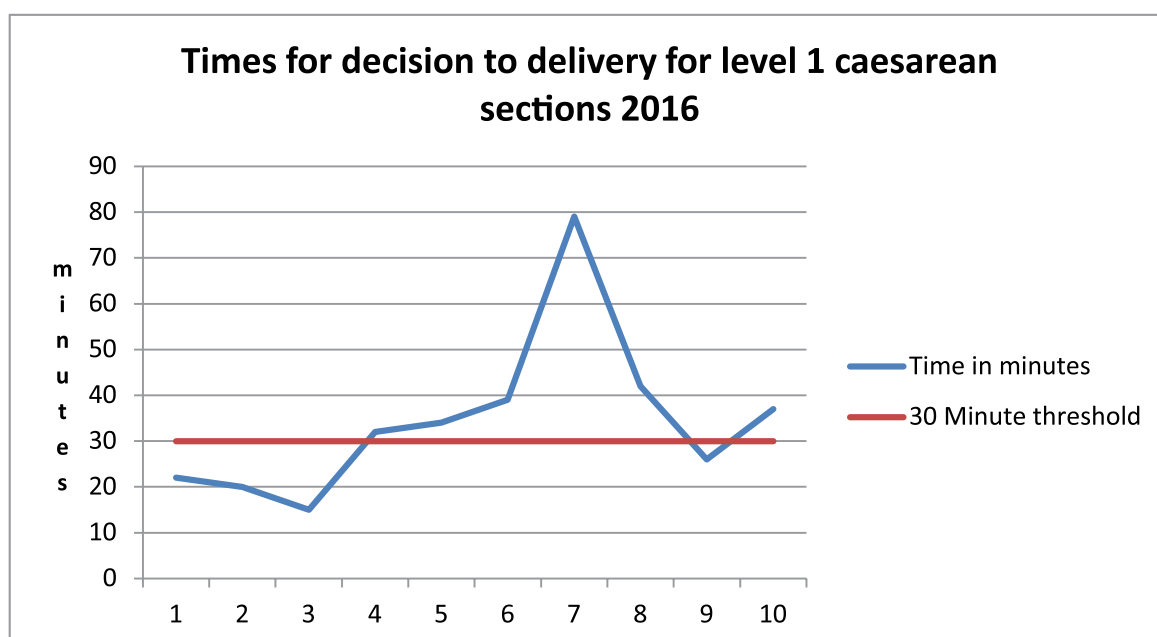


The above table shows that the rates of level 1 caesarean section calls are made “out of hours”; where staffing levels are less. Additionally theatre staff are called in, this may affect achieving the audit time of 30 minutes. However there has been an improvement in timings; in 2015 70.4% were taking longer than 45 minutes from decision to delivery time.

2017 has seen a change to resident doctor’s hours who are now rostered on duty out of hours rather than being on call and off site. This may have a further impact in the future in reducing our rates and improving timings of decision to delivery.

All level 1 caesarean section calls are reviewed as part of our maternity obstetric outcomes protocol to monitor the systems, processes, care delivered and outcomes including condition of the mother and baby and the time taken from decision for caesarean to delivery of the baby.

Reason for Level 1 caesarean section	Number of cases
Placental Abruption	1
Non reassuring CTG/Bradycardia	9



777 calls from maternity

There were a total of twenty one 777 calls made from Taranaki Base and Hawera Maternity in 2016 this includes a case of uterine inversion from Hawera maternity hospital. Since this case a new directive has been initiated for critically unwell patients in Hawera hospital, which includes maternity patients Critically Unwell Requiring Transfer.

Reason for 777 call	Number of cases
Level 1 caesarean section	14 (resulted in 10 level 1 caesarean sections; 4 calls were stood down)
Obstetric emergency	=5 PPH -4 Shoulder dystocia-1
Maternal cardiac Arrest	=2 Eclamptic Fit-1 Uterine Inversion -1 (Hawera)

The 777 call directive from the maternity unit has been narrowed to the following directives only:

Emergency 777 Call Directive in all birthing rooms next to the phones	
EMERGENCIES	
777	Obstetric Emergency (State if anaesthetist needed)
777	Maternal Cardiac Arrest (See Peri Mortem Protocol)
777	Level 1 Caesarean Section
0	Duty Obstetrician

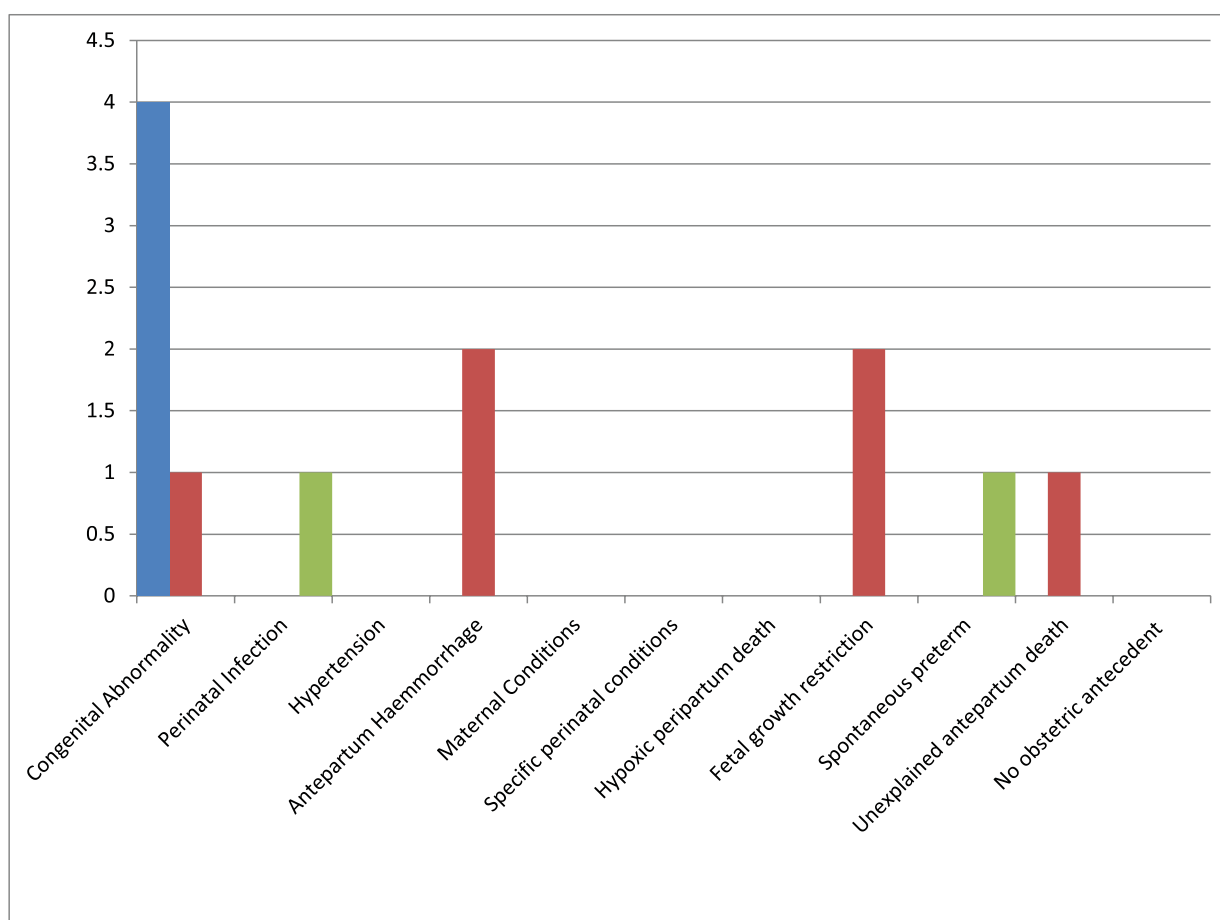
This was following confusion caused to the telephonist if other language is added such as “maternal collapse, eclampsia or shoulder dystocia”.

Neonatal emergencies are alerted through the delivery suites individual intercom systems where direct contact is made with Neonatal staff to summon help. In Hawera the Neonatal Emergency Retrieval Team (NERT) call is made.

Taranaki DHB perinatal related (PMMR) deaths by primary perinatal death classification 2016

All cases of stillbirth and perinatal death are reviewed at the local PMMR meetings and any recommendations are implemented.

Perinatal death classification	Termination of pregnancy	Stillbirths	Neonatal deaths	Perinatal related deaths
Congenital abnormality	4	1	-	5
Perinatal infection	-	-	1	1
Hypertension	-	-	-	-
Antepartum haemorrhage	-	2	-	2
Maternal conditions	-	-	-	-
Specific perinatal conditions	-	-	-	-
Hypoxic peripartum death	-	-	-	-
Fetal growth restriction	-	2	-	2
Spontaneous preterm	-	-	1	1
Unexplained antepartum death	-	1	-	1
No obstetric antecedent	-	-	-	-
TOTAL	4	6	2	12



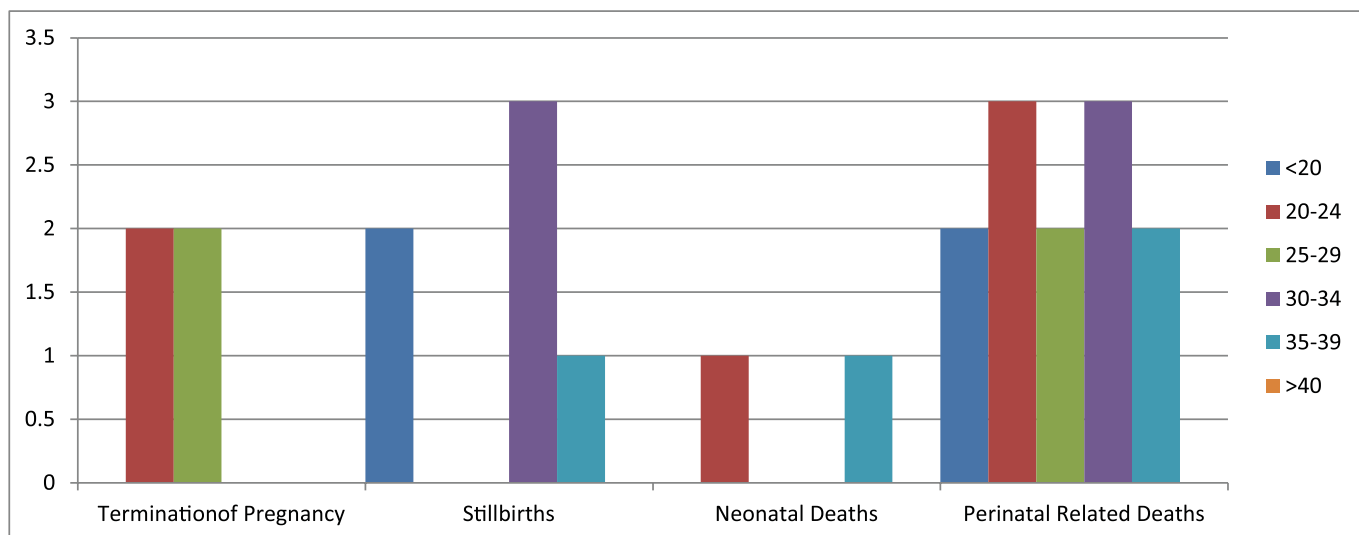
■ Termination of pregnancy

■ Stillbirths

■ Neonatal Deaths

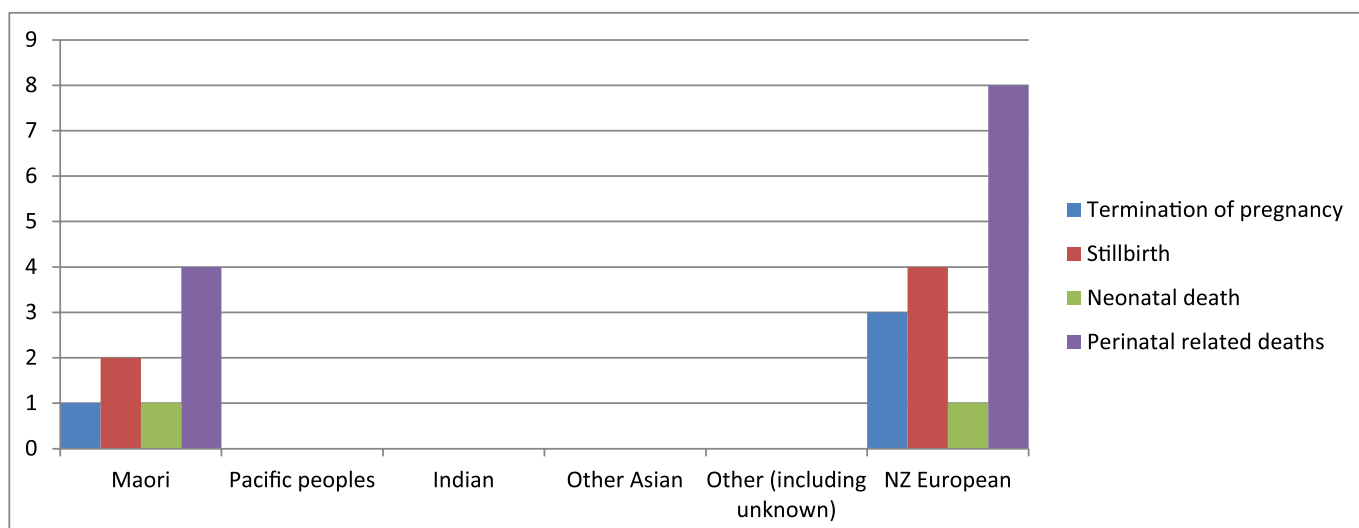
Perinatal related deaths by maternal age 2016

Maternal age	Termination of pregnancy	Stillbirths	Neonatal deaths	Perinatal related deaths
<20	-	2	-	2
20-24	2	-	1	3
25-29	2	-	-	2
30-34	-	3	-	3
35-39	-	1	1	2
>40	-	-	-	-
TOTAL	4	6	2	12



Perinatal related death rates by maternal prioritised ethnicity 2016

Ethnicity (mother)	Termination of pregnancy	Stillbirths	Neonatal deaths	Perinatal related deaths
Māori	1	2	1	4
Pacific peoples	-	-	-	-
Indian	-	-	-	-
Other Asian	-	-	-	-
Other (including unknown)	-	-	-	-
NZ European	3	4	1	8
TOTAL	4	6	2	12



Neonatal Encephalopathy (NE)

The 11th Perinatal and Maternal Mortality report released in June 2017 which is based on data collected in 2015 recommends that district health boards found with rates of Neonatal Encephalopathy (NE), significantly higher than the national rate, which includes TDHB, review the higher rate of mortality in their area and identify areas for improvement.

Examination of the data shows there has been no cases of NE in TDHB since May 2015 (there were two cases in 2015). It also identifies the peak of NE cases were in 2012, these cases were likely responsible for Taranaki DHB's overall findings. This aligns with a number of Health and Disability Commissioner (HDC) complaints we received that same year.

Taranaki DHB introduced the maternity obstetric outcomes protocol in 2013/4; a key indicator for case review is unexpected admissions to Neo Natal Unit (NNU), therefore all local cases of NE are captured and reviewed as part of this protocol. A case review summary, key learning points and any recommendations are entered into the adverse obstetric outcomes report. Any actions or quality improvements identified are entered onto a work plan to ensure these are completed.

Additionally the following quality improvements and initiatives have been introduced:

- **777 call directive** for Obstetric emergency, level 1 caesarean and maternal cardiac arrest to enable prompt assistance and treatment in any cases of concern.
- **Practical Obstetric, Multi-Professional Training (PROMPT):** This was initiated in Taranaki DHB in August 2012 after two Midwives, an Anaesthetist and a Senior Medical Officer (SMO) attended training in Auckland. Since then we have facilitated two trainings per annum at Taranaki Base Hospital. Each training day includes the multidisciplinary training of two Anaesthetists, two Obstetricians, two Registrars or House Surgeons and four Midwives.

Since 2015, Taranaki DHB has also introduced an annual PROMPT training programme in the Taranaki DHB primary maternity unit at Hawera Hospital. This allows multidisciplinary training of four Midwives, two Emergency Department Doctors, two Emergency Department Nurses and two ambulance staff/ Paramedics and has received very positive feedback. The expectation is for all practitioners involved in intrapartum care at Hawera and Base maternity units complete the course at least once in every three years (additional to this our Midwives attend annual emergency day training as laid out by the Midwifery Council Recertification Programme).

- **Fetal surveillance training:** Between 2011 and 2015, Taranaki DHB offered Intrapartum electronic fetal monitoring training (K2) free to all maternity practitioners who provide intrapartum care and/or require skills in cardiotocography (CTG) interpretation. This included Lead Maternity Carer's (LMC) in the region.

From (2016), it was decided to change to the RANZCOG fetal surveillance training which includes an assessment of learning. The first annual training session was held in April 2016 and involved as many practitioners that were available to attend with the remainder of the staff covering the ward clinical work. The intention is that all core Midwives providing intrapartum care should be certified to at least Level 2. Staff that do not achieve Level 2 training are advised to get fresh eyes/ checking of CTG interpretation and attend training on an annual basis; they are also offered additional support/education. Those achieving Level 2 or higher are recommended attendance at least three yearly. This training is open to LMCs and hospital staff.

- Doctors involved in Neonatal and intrapartum care, neonatal nurses and core midwives are expected to attend the full day newborn life support training (NZRC) once every three years; nurses and midwives also attend a refresher course annually in the years in between, additionally new born life refresher training is also provided as part of the PROMPT course and midwives emergency refresher day.
- Since December 2016 obstetric doctors (SHO and registrars) have been rostered to work night shifts rather than be on call from home. There has been an increase from one to two obstetric registrars employed on the RANZCOG training scheme and an additional senior medical officer has been employed. This has provided an improvement in the on call roster for Senior Medical Officers (SMO) as well as support to SMO's and midwifery staff for complex cases and intrapartum care.
- **Local NE by the ACC NE taskforce:** Was held on 28th April 2017, and facilitated by ACC to:
 - Inform everyone about the work the NE Taskforce is doing
 - Outline the planned initiatives and obtain feedback from practitioners
 - Identify and discuss ways to overcome any obstacles to implementing these approaches
 - Help reduce the number and severity of NE cases in NZ
 - Discuss ways to engage others in helping to prevent NE

Taranaki DHB will continue to monitor and review any NE cases, as the numbers are very small it is difficult to identify any specific trends, however we will continue to review all cases and implement quality improvements where indicated.

Taranaki DHB have requested feedback from the NE taskforce from information gathered at its Taranaki road show, they are scheduled to return on 3rd October for this purpose.

Baby loss / SANDS New Plymouth – working with consumers

SANDS (pregnancy, baby and infant loss support) works in the community providing peer support in the loss of a pregnancy at any gestation and the death of a baby as a newborn or infant and no matter how the baby died.

Sands NP is part of Sands NZ, we are a registered charity made up of volunteers (all bereaved parents) who have been providing support in NP since 2007. Sands has been operating in NZ for 30 years and have a wealth and depth of knowledge on baby loss and supporting bereaved parents, families and whanau.

Sands NP has several committee members that have been trained through Vicki Culling Associates in the area of support and advocacy for bereaved parents. Sands NP has been working together with Belinda the Associate Director of Midwifery (ADOM), Sadie the bereavement midwife champion and the TDHB and in 2016 our SANDS support members obtained ID cards and access to the birthing suite. This has helped further establish and cement the ongoing relationship between Sands NP and the hospital health professionals as both look to provide the very best support and advocacy for bereaved families.

For those of us running Sands NP we are really open about our losses and the impact this has had on our lives and how we have woven our babies stories and lives into our own. We are fine to meet with families in the initial days of loss to provide memory making opportunities, provide information or simply provide support. With one in four pregnancies ending in a loss it is so important to provide the best support possible for both families and health professionals.

As members of Sands NP we often meet parents at the most raw times of grief. One common thing stands out; this is that the care and support families receive during

the time of loss whether that be an early miscarriage at ED, birthing a baby that has died in utero or birthing a baby not expected to live, sets up the course their journey will take. The opportunities provided to these families, the support and follow up after the birth can add to or ease the life long grief journey these families are on.

At Sands NP we place a huge importance on companioning families through their loss journey and also use a 3 point model of care which promotes active parenting, slowing down and making memories.

This past year particularly we have been pleased that midwives and health professionals have been contacting us and also providing our information to families using the Willow suite/baby loss room at TDHB. Our feedback from the families who have had initial contact with us at the Willow suite has been amazing and we believe we are able to provide something very special through both shared experiences and tangible memory items.

As bereaved parents ourselves we are so passionate about making sure families are provided with as many opportunities as possible to actively parent their baby in the short time they have them with them physically. We (where possible) provide free hand and foot castings, professional photos, memory items and one on one support. We are just a phone call away and can generally make ourselves available at very short notice to assist families.

The Willow Suite: Sands NP has put a lot of fundraising and time into outfitting the Willow suite to be a special space for families during the loss of their baby. It is designed to be self sufficient for families and also have room for extended family to comfortably be there. There is special linen, duvets and towels all provided by Sands.

We are also so fortunate to have been donated a cuddle cot to the Willow Suite.

In the community we have a support meeting on the first Monday of the month, and these are very well attended. This is one of our main contacts in the community and has been a real lifesaver for many families to know they have support and know they are not on this journey alone.

For any further information about Sands phone or text 0278626977 email sandsnewplymouth@yahoo.co.nz or find us on Facebook Sands New Plymouth or www.sands.org.nz

Support for vulnerable pregnant women and families

The maternity wellbeing and child protection multi agency group meetings (MAG) continue to meet fortnightly, having received 73 referrals in 2017. Referrals were received from: social workers, lead maternity carer's, Well Child/Tamariki Ora providers, Oranga Tamariki (CYF), police, maternal mental health services, GPs and other stakeholders.

Main reasons for referral:

Family/domestic violence concerns, substance abuse, child protection issues, homelessness, mental health concerns, not engaging with care.

The group provides an opportunity for the team that provides direct care to the pregnant woman to work closer together to ensure the woman and her whānau have access to all the services available in relation to what she may need.

Family start and the leap service:

From 1 October 2016 Barnardos started the new LEAP service and no longer provide a generic Family Support Service.

Barnardos LEAP service

LEAP is a new Barnardos service to help vulnerable families better meet the needs of their children so they can reach their potential and flourish.

The service is designed to keep vulnerable children safe and to reduce the risk of maltreatment particularly where there are complex and multiple needs. The service keeps vulnerable children safe and reduces maltreatment through a social work case management approach which includes: the holistic assessment of the child's needs, and individually tailored service interventions that respond to the underlying causes of vulnerability and address the impact of trauma.

LEAP is a 'needs'- led service, meaning they can work with each family to develop a plan and supports that are unique to them. The package might include:

- Safety planning work to keep children safe from violence
- Working with parents around the matters that impact on their children, like better ways to deal with anger
- Building better relationships between caregivers and children
- Direct work with children to address their individual needs
- Group programmes with other families on parenting or boundary setting

- Supporting families to access resources and develop supportive connections in their community

Who is eligible for the service?

The primary client group for the LEAP service are vulnerable children and their families who are being impacted by:

- family violence
- parental mental health
- alcohol or drug use
- neglect or emotional abuse
- significant child health/disability needs
- risk of or actual Statutory involvement

Barnardos are only able to provide the LEAP service where one or more of these needs are evident at referral.

Where is the LEAP service available?

Barnardos LEAP service is currently available throughout the Taranaki region.

How long does the LEAP service work with a family?

Barnardos can offer the service in two sizes depending on the need:

LEAP - Intensive

- Provides an individually tailored assessment and service intervention where there are complex and multiple needs.
- Up to 40 hours of worker time
- Likely to be 8-12 weeks work

LEAP – Targeted

- Provides a short-term focused support to vulnerable families and children to address a specific development, social or parenting need.
- Up to 10 hours of worker time
- Up to four weeks work

WHO CAN GET HELP?

Family Start is designed specifically to work with families who struggle with problems that make it harder for them to care for a baby.

If you or the child's other parent/caregiver are experiencing any of the following challenges and this is making parenting harder, Family Start may be able to help.

- Mental health issues
- Alcohol and drug issues or gambling too much
- Abuse when you were a child
- Serious problems with your partner or family/whānau
- Don't know how to make sure your child is healthy and growing strong
- Your child has a disability or needs special care
- Ministry for Vulnerable Children (CYF) are or have been involved with your family/whānau
- You are a young parent with other challenges and need extra support.
- You have a combination of other issues in your life that make parenting your baby especially hard.

WANT TO KNOW MORE?

Family Start is available throughout Taranaki.

Talk to your doctor, midwife, Well Child nurse, or any other service involved with your family, or contact your local Family Start provider. They will be able to fill in a referral form with you.

For further information please contact
Elaine Nicholls
Family Start Team Leader
(06) 968 8533 or 027 234 3812
elaine.nicholls@barnardos.org.nz
or
Barnardos Taranaki
06 753 3484

Barnardos
AN OTTERANGA NEW ZEALAND
S.K.I.P.
family & community services
routage & whānau, & hapori
Support to the Ministry of Social Development

Family Start
Giving children the best start in life...

Barnardos



SAFE SLEEP

Taranaki Safe Sleep and Pepi Pod Audit 2016

Taranaki District Health Board (TDHB) is committed to reducing the post perinatal mortality rates in Taranaki, as a part of this TDHB joined the pepi pod programme in 2013. This programme is valuable in identifying at risk babies and opening the doors to difficult conversations around safe sleep, gentle handling, smoking cessation and the importance of breastfeeding and immunisations. The combination of these conversations, education and Pepi pods saves vulnerable babies lives.

In December 2016 TDHB held its first successful buggy walk for safe sleep day; we had a fantastic turn-out. This is the start of an annual event that helps to spread the word about safe sleep and we look forward to this year's event. TDHB are still seeking funding for pepi pods and/or replacement mattresses and linen for any returned pepi pods we have been lucky enough to get back from the community. This was aided by an amnesty in conjunction with Tui Ora offering supermarket vouchers to mums who had a pepi pod not in use that brought the pepi pod back in good condition.

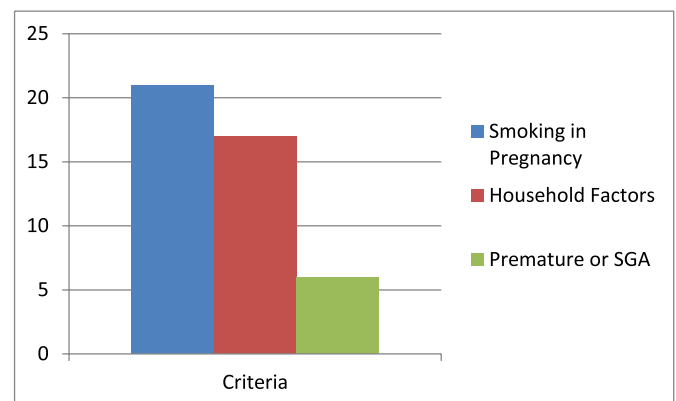
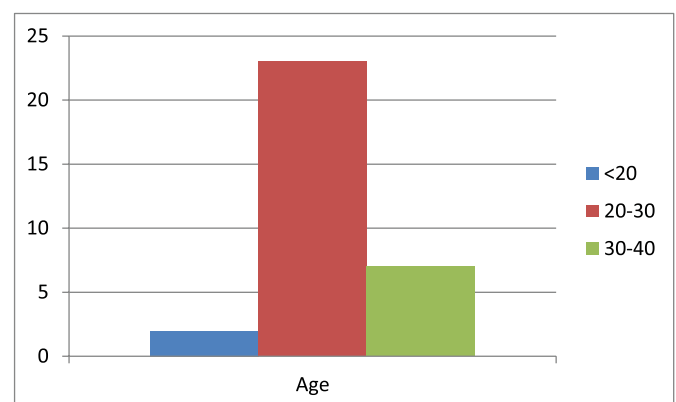
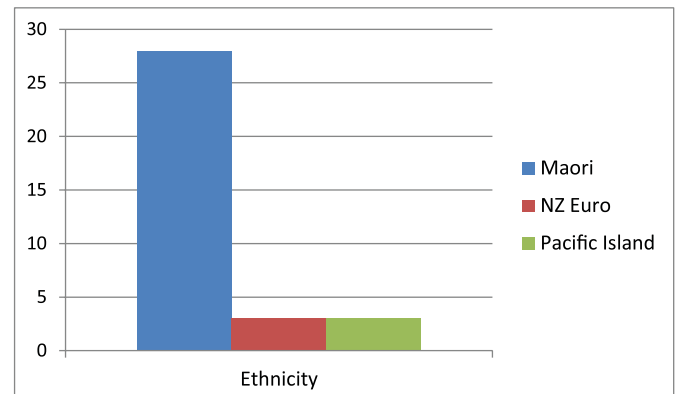
In 2016 TDHB gave out 33 Pepi pods;

The referral criteria to receive a fully funded pepi pod are;

Newborn (unless referred by paediatrics or NICU) and two of the following -

- NZ Māori
- Exposed to smoking in pregnancy
- Premature (<36 weeks) or low birth weight (<2500 grams)
- Regular smoking, drug use or alcohol in the baby's household

The following is a breakdown of referrals received:



Audit of notes:

21 sets of notes audited; 5 from Hawera 16 from Base
 17 (80.95%) notes there was safe sleep discussion
 6 (28.57%) notes included safe sleep discussion and a pepi pod assessment
 4 (19.05%) notes had no discussion on safe sleep or pepi pod assessment

A further 17 sets of notes were audited of women who received pepi pods;

8 from Hawera and 9 from Base
 14 (82.3%) notes there was a safe sleep discussion

Recommendations:

- That women are screened antenatally by their LMC for a pepi pod and subsequently referred for a pepi pod if meets criteria in the antenatal period.
- That all postnatal inpatients get screened for a Pepi Pod and subsequently referred for a pepi pod if meets criteria.
- More antenatal education on safe sleep.

Highlights - supporting safe sleep practices

MIDLAND SAFE SLEEP PROGRAMME

Midland Maternity Action Group requested from Change for Our Children an update report on the Pēpi-Pod Programme being coordinated in the Midland region's five District Health Boards.

Midland Pēpi-Pod Programme Update (July 2013-October 2016)

Excerpt from conclusion:

'In Midland, the Pēpi-Pod programme was applied consistently and appropriately by distributors, Portable Sleep Spaces (PSSs) were acceptable to and used appropriately by recipient families, and safety advice was reflected in snap shots of infant care. Post-perinatal death rates (7 days to 1 year, all causes) have fallen since the start of the intervention period in 2011, especially for Māori. This fall has continued for Māori infants and stabilised for the region as a whole. While cause and effect cannot be claimed it is likely, given the reach and impact described here, that the sleep space programme has made a significant contribution to mortality changes in the region.'

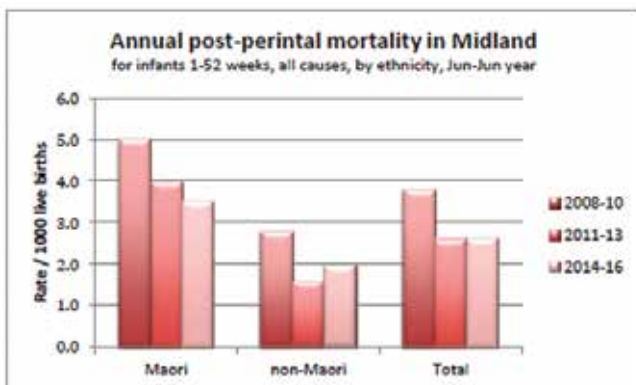
"I really liked our pēpi-pod and so did our baby. He doesn't sleep in it any more so we have given it to my sister to use for her baby that is due in a few days.

I didn't know much about SUDI when I had our baby and I didn't know about how bad smoking during my pregnancy was for our baby and how it is a massive risk.

The midwife who gave me the pēpi-pod was really understanding and gave me a lot of information and some patches and gum to help me to stop smoking, and I can tell you now that I have QUIT."

- Māori mother from the Bay of Plenty

Annual post-perinatal mortality rates for Midland, by ethnicity and for the June-June year



Source: Midland Pēpi-Pod Programme Update (July 2013-October 2016)

MIDLAND SAFE INFANT SLEEPING (BIRTH TO 1 YEAR) POLICY

The regional policy was implemented in 2013 and covers all Midland DHBs' facilities, and contracted facilities and is currently being reviewed, led by Waikato DHB Lactation Services. The regional policy is due for its three yearly review to ensure it is informed by the latest research findings and supports best safe sleep practice.

This comprehensive regional policy provides additional information and resources to support staff and families, ie:

- risk factors for Sudden Unexpected Death in Infancy (SUDI)
- discharge planning
- example of infant safe sleep risk assessment
- example of safe sleep message and safe sleep space sticker alert, and
- UK UNICEF's updated resource 'Caring For Your Baby at Night - a Guide for Parents, and a Guide for Health Professionals'

The Midland region is in a strong position to contribute to the Ministry of Health's new National SUDI Prevention Programme (NSPP) to be implemented from 1 July 2017. Lakes DHB will lead the coordination of the Midland Regional SUDI Prevention Programme, on behalf of the Midland DHBs.



Pēpi-Pod® Programme Report

Period: 1 Jan 2017 - 31 Mar 2017

Summary of distribution, follow-up and feedback data, by DHB region, for records entered into the programme database in the first quarter (Q1) of 2017

Region	Distribution (N=584)								Follow-up (N=278)				Feedback* (N=57)	
	Total to 2017	Q1 2017	Maori		Smoking in Pregnancy		Uses CS Card		Yes		Want to keep pod		People spoken with	Total to date
	n		n	%	n	%	n	%	n	%	n	%	n	n
Auckland	172	102	27	26	30	29	32	31	12	12	12	100	92	3
Bay of Plenty	1161	56	45	80	46	82	39	70	28	50	28	100	145	0
Canterbury	76	7	3	43	3	43	4	57	4	57	4	100	10	0
Counties Manukau	200	8	7	88	2	25	4	50	8	100	6	75	34	8
Hawkes Bay	1877	84	41	49	47	56	39	46	57	68	57	100	149	0
Hutt Valley	44	1	0	0	1	100	0	0	0	0	0	0	0	2
Lakes	657	29	23	79	18	62	15	52	9	31	9	100	35	2
MtCentral	166	24	14	58	17	71	18	75	12	50	12	100	56	5
Northland	497	24	22	92	21	88	18	75	9	38	7	78	47	0
Southern	77	14	7	50	7	50	9	64	12	86	11	92	49	14
Tairāwhiti	338	25	19	76	14	56	10	40	8	32	8	100	28	0
Taranaki	267	3	3	100	3	100	1	33	1	33	1	100	10	0
Waikato	2202	76	61	80	38	50	46	61	20	26	19	95	61	5
Waitemata	548	54	24	44	25	46	37	69	34	63	33	97	124	9
West Coast	6	1	1	100	1	100	1	100	0	0	0	0	0	0
Whanganui	339	76	49	64	35	46	48	63	37	49	36	97	269	9
Total	8639	584	346	59	308	53	321	55	251	43	243	42	1109	57
Mean: 5.0 others														10%

High rating (7-9/9) for overall idea (52/57) 91%

NB: This is provisional data from participating DHBs. Variations exist in service size, start dates, duration and data entry lag times. Percentages are of total respondents (*some missing data).

Snapshot of infant care at 4-6 week follow-up for Pepi-Pod babies

SAFE SLEEP

Always/usually:

	N	%
on back	266	96
firmly tucked	273	98
in pod when in risk locations	240	88
in same room as carer at night	269	97

STRONG BABY

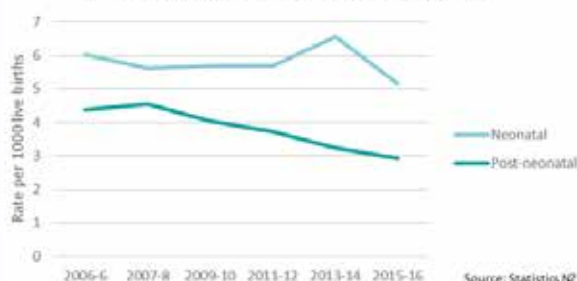
exclusive - fully breastfed	125-42	60
smokefree - receiving support	114 - 83	71
immunisation started - booked	120 - 31	55
showed others gentle handling	270	98
Enrolled with GP/Primary Care	243	88

Note:

There has been a recent fall in neonatal deaths (0-4 weeks) as well as post-neonatal (4-52 weeks) which is encouraging.

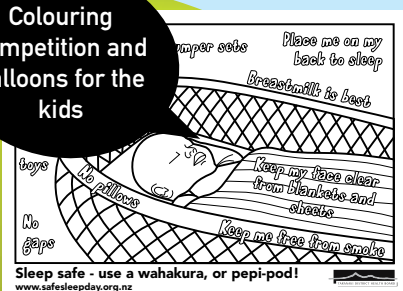
Statistics NZ data for the completed 2016 year has been delayed due to the Kaikoura earthquakes.

Total Infant Mortality by Age Group: all causes, neonatal and postneonatal, Sep-Sep year

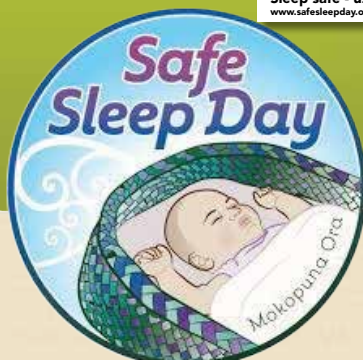


BABY BUGGY WALK

Colouring competition and balloons for the kids



Display of Pepi Pod/Wahakura and weaving of Wahakura



EAST END BEACH TO PUKEARIKI LANDING
Friday 2 December 10am – 2pm



Pregnancy Help Taranaki donation



Taranaki DHB Maternity were the lucky recipients of kind donations. A cart load of hand-knitted woollens for newborn babies were donated to our Maternity Ward thanks to Pregnancy Help Inc. Taranaki Branch. The pregnancy help service provides practical support and advice for families who need assistance to prepare for parenthood te tautoko me te tohutohu awhina mō te mātuatanga. They work collaboratively with other organisations including TDHB maternity services to enhance each other's work .

Family violence (FV) training and screening

The 2016 FV routine enquiry for the past six months (antenatal and post natal Intimate Partner Violence (IPV) enquiries) result found a 60% routine FV enquiry rate.

Monthly reports on the Post Natal ward: Routine enquiry rate shows evidence of 60% enquiry of combined ante and post natal inpatients. Positive IPV disclosures are round 6%

Core VIP Training percentage of Community LMC Midwives = 80%

Maternity Ward staff = 90%

The FV coordinator is working with Human Resources to be able to draw a report on staff training - by designated VIP services

Perinatal mental health

The community perinatal mental health team leader and midwife educator have continued to present education on the Edinburgh Post Natal Depression Scale (EPDNS) screening tool and Taranaki DHB outpatient referral pathway at the midwives practice day.

A new guide: Mental Health Screening and interventions during pregnancy and perinatal period has been collated and circulated by Dr Yariv Doron. This guide specifies the processes and forms involved especially around Acute Risk / Mental Health Act . Education sessions are planned already to inform referrers.

Referrals to the perinatal mental health team for 2016 were around 15% of number of babies born in Taranaki. Around 40% of these referrals are triaged as not requiring or declining perinatal mental health assessment. Customer satisfaction surveys of those under our perinatal mental health team consistently reflect a high level of satisfaction with our team. Surveys of those who decline or are declined by our service have yet to be done. Also a satisfaction survey of our referrers would be helpful to identify any referral process/outcomes issues.

The medical director and service manager have notified referrers that a completed assessment tool must accompany all referrals. Referrals are being returned to referrers if they are incomplete and practitioners are advised to amend and include the screening tool if they are not included in the original referral. If the client's score is in the mild to low end of moderate and the practitioner is still clinically concerned they should annotate the EPDS score as underscored. These referrals will then still be triaged. Referrals need to identify the symptoms being experienced by the client as highlighted in the in service education sessions.

Plunket/Well Child Tamariki Ora are completing an EPDS if their initial screening tool (PHQ-3) is positive for post natal depression (PND).

Refreshers on the use of screening tools, the referral pathway and the signs and symptoms of perinatal mental health problems will be ongoing annually and available for individual practitioners if their need arises.

The Midlands region infant perinatal clinical network has endorsed a perinatal support worker core competency learning package. This has now gone live as funded by the MOH.

The return of Child and Adolescent Mental Health Services (CAMHS)/inpatient CAMHS to the Community Mental Health (CMH) fold has strengthened the links with perinatal mental health. Cross referrals are taking place and staff attend our meetings on an ad hoc basis.

The forum between maternity and perinatal CMH teams will continue to meet monthly. With the establishment of the MAAG group for cases of cross discipline concern the Terms of Reference (TOR) for this forum should be able to be finalised and signed off by the departmental heads. A revised TOR should be ready shortly for the medical director and service manager of PMH for their input/approval.

Access to mental health services for pregnant women and new mothers (see Appendix 5 for Perinatal Mental Health Referral Pathway)

- The 0.6 FTE acute perinatal registered nurse (RN) position was successfully appointed in May 2015. After an extended period of orientation the role has impacted very positively in the numbers of clients being referred to the perinatal team. The acute component of this role in providing brief intense intervention has been assisted by the acute home based team who do intensive work over a two week period.
- The Midlands' five DHBs are working together through the Midlands 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 Midlands 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 Midlands Regional Network Team to produce a Primary Mental Health-Primary Care Map of Medicine Pathway and this is currently in draft format.
- 2017/18 Taranaki DHB will continue to promote integration with maternity services, Drug and Alcohol, WCTO and PNMH services.
- Client satisfaction surveys have commenced via our consumer advisor. Real time feedback has gone live. Clinicians are using an ipad to allow the clients to complete a comprehensive electronic satisfaction survey. The use of modern media means that this can take as little as three minutes.
- The patient information leaflet is now in print and has been distributed to all patients.

- We have initiated a draft referrer information Leaflet which we will distribute to all referrers.
- We continue to monitor where the referral includes the data:
 - 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
 - referral problem
 - age
 - ethnicity
 - referred source
- This monitoring is currently done manually – we hope to have a report which will extract this data from the patient management system by June 2018
- We have adapted our referral tracking system to include some targets around time till first contact, time to be seen. However the volume of referrals has made it difficult to achieve the targets.
- A review of our perinatal mental health team was completed in 2016. We await the changes which have been highlighted by that review.

Our Philosophy

During pregnancy and the first year after a baby is born, difficulties can occur in the life of any woman. Many things can contribute to different types of mental distress that affect mother, baby and a family.

The Perinatal Mental Health Team aims to reduce this distress by working together with you and any other health professionals involved in your care, to support, and promote mental well being.

Mental Health and Addictions Services
Taranaki District Health Board
Private Bag 2016
New Plymouth 4342

Hours
Monday to Friday 8am till 4.30pm.
Ph: 06 753 7749 ext 8963 or ext 8745 or phone your keyworker.

For after hours urgent support contact the hospital operator on 06 753 6139 or 0508 277 478 and ask for the Acute Brief Care Team.

Other services
Plunket: 0800 933 922
Tamariki Ora - Tui Ora Ltd 06 759 4064
Mindfulness Apps: 'mind the bump' 'headspace'
Trauma and Birth Stress: <http://tabs.org.nz>
www.mothersmatter.co.nz

Published: Communications Team
Responsibility: Mental Health
Date Published: February 2017
Last Reviewed: February 2017
Version: 1

TARANAKI PERINATAL MENTAL HEALTH SERVICE

www.tdhib.org.nz

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

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga

Welcome to Perinatal Mental Health Service

We are a specialist mental health team covering the whole of Taranaki.

We provide support to:

- Women who are experiencing mental distress related to pregnancy and the post natal period, up to one year after the baby is born.
- Women who have had previous experience of severe post natal depression / psychosis / anxiety / Post Traumatic Stress Disorder.
- Women with mental illness, requiring specialist consultation pre-pregnancy.

Our team

Consists of a team leader, registered nurses, social worker, psychologist, occupational therapist and psychiatrists.

A registered nurse providing Kaupapa Māori services is also available through Tui Ora Ltd.

How to access the service

A referral to the service needs to be made. The following health professionals can do this with you:

- GP
- Midwife
- Obstetrician
- Paediatrician
- Plunket
- Tamariki Ora nurses

What happens next?

When you come into our service an assessment will take place with you. You can bring your family and whānau or support people with you.

We use the information from the assessment to work with you to decide the best way we can support you. One of our team members will oversee your care.

What we do

- Specialist care by an individual keyworker.
- Regular home visits or hospital based appointments.
- Education and support.
- Referral to other community maternal, child health and family services.
- Psychology support.
- Joint care for women already receiving other adult mental health services.
- Consultation / liaison and education to other healthcare providers and community groups.
- 12 session group programme 'Adjustment to Parenthood' for post natal illness (Anxiety, Depression, Post Traumatic Stress Disorder).

"Being a new parent can be a struggle. I was suffering from depression, anxiety and other distress. Perinatal services supported me through a tough time. If you think you aren't coping and the feeling doesn't go away, it's OK to reach out and ask for help."

Holly - Supported by the Perinatal Mental Health Team

"Asking for help was the best thing I did for myself and my family. The perinatal team were very supportive, respectful and understanding of what I was going through. Anxiety and depression doesn't have to make sense. It can happen to anyone. Asking for help can be the hardest thing to do, but so worth it, please don't suffer alone."

Kate - Supported by the Perinatal Mental Health Team

www.tdhib.org.nz

Taranaki Together, a Healthy Community
Taranaki Whānui He Rohe Oranga

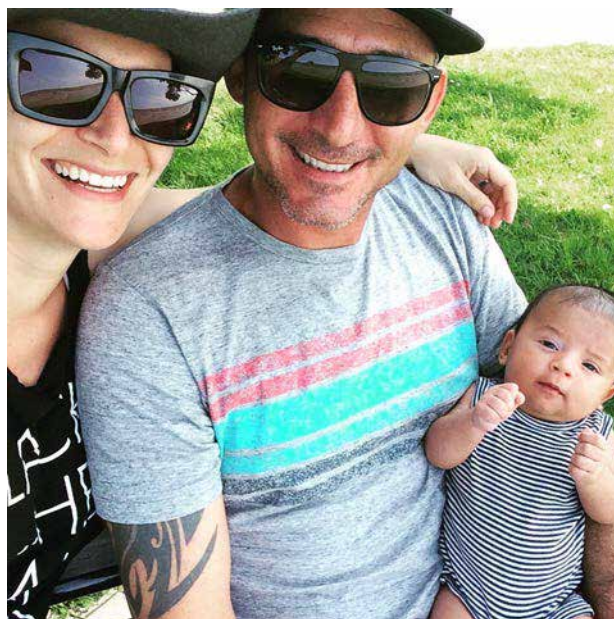
Highlights - supporting maternal mental health

Midland perinatal mental health seminars

The Midland Maternity Action Group supported seven seminars held across the Midland region over March – June 2017, facilitated by Carla Sargeant from Voice for Parents, Hamilton. The seminars were open to primary maternity and Well Child Tamariki Ora providers and maternity staff.

The seminars focused on perinatal mental health and the impacts of a traumatic birth experience. The roles perinatal practitioners play in supporting women who experience perinatal mental health issues, and in decreasing the likelihood of a traumatic birth experience taking place was the overarching theme. Specific seminar content was developed with each Midland DHB's maternity leadership to meet their local needs.

The seminars have been well attended and encouraging feedback has been received on the content covered.



"I just wanted to say a big thank you for running your 'Perinatal Mental Health and the Impacts of a Traumatic Birth' workshop here at Gisborne. The information and stories you shared impacted on every health professional attending that day and gave us all 'food for thought' about how we practice and how we phrase what we say when caring for women.

We have shared what we learnt with the rest of our team and forwarded the information on including the article you referred to on 'consent and coercion' which is a great read for anyone providing maternity services. The feedback from the midwives, LMCs, antenatal educator, mental health psychologist, child development nurses, and consumer who attended has all been very positive.

I would recommend your workshop to all health professionals providing maternity care and include obstetricians, Well Child and Plunket."

Liz Lee-Taylor, Director of Midwifery Director of Midwifery & Clinical Midwife Manager, Hauora Tairāwhiti

Baby Friendly Hospital Initiative

The 2016 BFHI annual surveys for Taranaki Base Hospital and Hawera Maternity Unit have been completed.

The NZ Breastfeeding Alliance collates the national data and forwards a report to Ministry of Health.

The annual survey requires recent annual feeding data and progress on recommendations from the previous external audit.

The next external audit is due 2019.

Taranaki Base Hospital

Exclusive breastfeeding rate on discharge: 83% (2015: 84.6%)

The slight change may reflect the increased management of late pre term infants in Post Natal.

Hawera maternity

Exclusive breastfeeding rate on discharge (including women who transferred in exclusively breastfeeding): 86.8%. (2015: 80.7%)

This indicates a favourable increase for exclusive breastfeeding on discharge.

Of the mothers transferring in partially breastfeeding many left fully breastfeeding which indicates good support.

The Midlands breastfeeding framework

The framework offers a clear direction on how different sectors can work together to provide services and initiatives that could turn the tide and increase breastfeeding rates across the Midland region.

The framework offers targeted approaches that have been shown to support the needs of Māori, it is hoped that equity is achieved through prioritisation and sustainable funding of integrated services that work well.

Offering tools, with practical check lists the framework outlines the evidence behind the recommendations to support service improvement and development.

The framework can be used as a guideline for planners, funders and service leaders to look across the whole system to provide a fully integrated service that will improve breastfeeding rates in the Midland region.

Spotlight on Hawera mothers' focus group

Six mothers participated in group

Key findings were:

- Determination was a key word that was used frequently in this group. The mothers felt it was their personal determination that kept breastfeeding going for them.
- Most mothers decided they were going to try to breastfeed during the antenatal period. Three mothers referenced that they made their decision during antenatal classes.
- The attitudes of others can influence the eventual breastfeeding outcome (duration). In particular, this group sighted the influence of the mother-in-law as being negative, but not necessarily changing their breastfeeding outcome. This group mentions husbands and partners as being a key person in supporting breastfeeding outcome and practices.
- Five out of six mothers had downloaded and actively used the BreastFedNZ app. They had actively shared the app with other mothers. All mothers search online for information and support (e.g. Facebook groups)
- Hawera mothers would like greater access to breastfeeding support services, there is a delay in access because they live rurally (less provision than in New Plymouth.
- All six mothers were interested in the peer support service and would have used it if they had known about it. They suggested including it in the bounty pack information.
- All mothers thought that a general awareness around breastfeeding and support services that are offered needed to be better promoted.
- Access to tongue tie release services was raised as a local issue for two mothers. They both travelled outside the district to receive release services. The mothers sighted 'along waiting list' as to why they travelled outside the district.
- Returning to work was sighted as a key reason was discontinued.
 - One mother continued to express during work hours when she returned to work. The mother stated she had to "educate the day care about expressed milk"
 - One mother reduced her feeds to morning and night when returning to work.
 - One mother planned to cease breastfeeding altogether when she returns to work next month.
 - One mother resigned from her job so she could continue breastfeeding.
 - Two mothers could take their infant to work with them. One found this difficult and the other found it made breastfeeding easier.

Highlights - supporting breastfeeding

MIDLAND BREASTFEEDING FRAMEWORK

The Framework was approved by the Midland Maternity Action Group at its meeting in May 2017 and forwarded to the Midland DHBs for implementation when planning services to support breastfeeding.

The Framework provides the knowledge, insight and practical tools to implement a comprehensive and equitable range of initiatives and services that support breastfeeding in the Midland region. Stakeholder focus groups with mamas, maternity staff and service providers have commenced across the region.



Photo of some of the attendees at a recent breastfeeding focus group workshop held in Tairāwhiti

The Framework diagram (right) provides a visual overview of the integration of services and initiatives, and displays the layers of services and initiatives required to positively influence population breastfeeding outcomes- namely breastfeeding according to the Ministry of Health guidelines.

The macro level components of the **Midland Breastfeeding Framework** support the mother/infant dyad which should be at the heart of all service design. Each component is likely to have a more dominant effect on either of the two main components of breastfeeding outcomes; initiation and duration. This further emphasises the need to plan and fund the whole system of services and initiatives to make a difference to breastfeeding rates.

A fully funded service that aims to increase breastfeeding rates would include:

- 1) Settings based public health initiatives; supportive environments, policy and early awareness raising
- 2) Antenatal education, both from primary practitioner (LMC) and quality antenatal classes
- 3) BFHI accredited maternity facilities
- 4) Integrated breastfeeding peer support programme and community lactation service
- 5) Specialist services
- 6) Ongoing workforce development

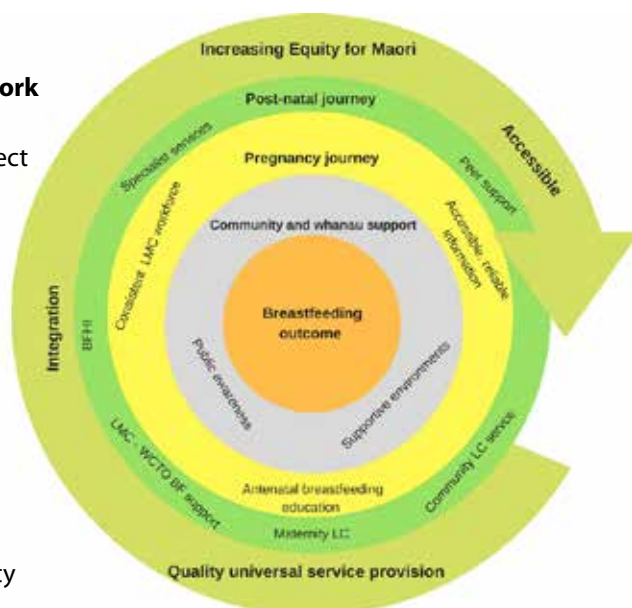


"The Midland Breastfeeding Framework offers a clear direction on how different sectors can work together to provide a suite of services and initiatives that could turn the tide and increase breastfeeding rates across our Midland region."

By adapting current services to meet the needs of the 'millennial mother' and planning for a wrap-around of well equipped services and initiatives, it is hoped that we can positively change the breastfeeding statistics for our future generations."

Corli Roodt
Chair, Midland Maternity Action Group

Midland Breastfeeding Framework diagram



BREASTFEDNZ SMARTPHONE APP

The Waikato Hospital Antenatal Clinic focused on championing the BreastFedNZ app over a two week period.

The banner was displayed in the antenatal clinic waiting room and pregnant women were actively being given the BreastFedNZ app wallet cards.

The key message is to:

"Encourage women to download the app onto their phone during pregnancy. This will help to support an early decision to breastfeed and enable the women to become familiar with the app so they can learn about breastfeeding."

New developments and innovations

- BreastFedNZ now includes Midland Well Child and Pregnancy + Parenting providers on a GPS activated map (Hauora Tairāwhiti to provide information)
- 'Quick Find' has been added to the app home screen to assist in searching topics
- A complete chapter-by-chapter review of the app contents has been undertaken; informed by a survey of consumers and health care providers on the app.
- Link to the Babble MidCentral DHB app, supporting users with information about what to expect if breastfeeding and newborns
- Hawke's Bay DHB breastfeeding support services now added to BreastFedNZ
- BreastFedNZ flyers will be distributed nationally through the 'Your Pregnancy' Bounty packs.

"Every day I do a 'How to hold, position, and latch your baby' talk. I wave my laminated poster for BreastFedNZ – everyone takes a photo of it, or uses the QR reader link and downloads it immediately! They all LOVE having a NZ app – I'm so grateful you did it!"

- Waitemata Lactation Consultant

"I wish I found this app earlier. Was struggling with feeding my baby in the first week and now everything starts making sense."

Vinh, consumer

"Thank you so much for putting this app together - I really love it."

Rachel, Midwife, Nelson



[iTunes App Store](#)

[GooglePlay app store](#)

QUICK APP STATS:

- 12,000+ APP DOWNLOADS
- 1,000+ FACEBOOK FOLLOWERS



Pictured: Heather Sears, Antenatal Clinic Midwife, and Kirsty Orr, Student Midwife



BreastFedNZ is generating lots of interest and positive feedback on its usefulness as a breastfeeding resource, from both women and health care providers.

The June 2017 target for the number of app downloads was 10,000, which has now been exceeded, with 12,000+ app downloads and 1,000 Facebook followers.

The lead content author, Karen Palmer, Community Lactation Services Coordinator, Pouawhi Ora, Western Bay of Plenty Plunket, has undertaken a review of the chapter contents, following feedback received from consumers and health care providers.

BreastFedNZ will be updated with new photos, content, and useful links (see BreastFedNZ website for updated chapter contents).



"Bounty is delighted to sponsor the Breastfed app, by helping to make it available to 99% expectant parents throughout New Zealand" (Audited by PwC)

MIDLAND USE OF DONOR BREASTMILK PROTOCOL

Consumer information leaflet

Protocol aim

To guide practice within a hospital setting on the use of donor breastmilk for an infant. It is anticipated this need will be primarily for secondary and tertiary units, but not exclusively.

The five protocol objectives:

1. To provide options for babies to receive donor breastmilk as a preferred option to infant formula when the biological mother is unable to provide adequate breastmilk, for any reason.
2. To provide a process of informed consent for the parties donating and receiving breastmilk.
3. To provide guidelines of safety with the use of donor breastmilk in the absence of pasteurisation.
4. To provide guidance to staff with supporting this option for infant feeding.
5. To reduce the risks of unsafe donor milk being given to a baby.



Supporting Midland DHB maternity services with an updated breastfeeding resource

The Bay of Plenty District Health Board's A2 postnatal breastfeeding poster resource was updated and shared with Midland DHBs for use in their facilities.

BreastFedNZ app resource information was added; new photos and modern illustrations of hand expressing breastmilk were also added.

The updated poster has been shared with the five Midland DHBs.





Sherrie Adlam holding her newborn son Jaxon Maxwell, one of the first babies to be registered on NCHIP (photo: The Daily News)

Children benefit from better coordinated health services

Around 8,000 Taranaki have just had all their key health milestones entered onto the new National Child Health Information Platform (NCHIP), with help from Child and Youth Coordination Services (CaY-C).

Becky Jenkins, Taranaki DHB General Manager Planning, Funding and Population Health said, "NCHIP is about improving the health of our children and enables early childhood health services to be delivered in a more coordinated way so that no child falls between the cracks."

Launched in June this year, NCHIP began back loading health information on children aged 0-6 years in October and is now successfully up to date. This

information includes midwife checks, Well Child/Tamariki Ora assessments, immunisations, hearing and vision checks, oral health checks and B4 School Checks. The CaY-C service is assisting in the tracking and tracing of children lost to providers so that no child misses out.

All Taranaki newborns will be automatically registered onto NCHIP. Amanda Antoine, Taranaki DHB Clinical Midwife Manager said, "NCHIP fills important gaps and helps streamline processes right from when a baby is born. We are embracing NCHIP as it will ensure we keep mothers and their babies at the centre of their health care."

A competition was held within Taranaki DHB to encourage LMCs to enter information onto NCHIP during the first three months, with Independent Midwife Alison Jennings winning a \$200 My Food Bag voucher for being the top user.

Taranaki is the third Midland region DHB to implement NCHIP, with successful roll outs already in the Waikato and Tairāwhiti.

Marnie Reinfeld, Portfolio Manager - Population Health, presents Alison Jennings with her prize for entering the most information on NCHIP in the first three months.



Benefits of using NCHIP

- Track and deliver shared view of children aged 0-6 years, their chosen health care providers and their status for scheduled health milestones
- Integration with provider I.T systems
- Ensure children are enrolled with core providers and systems
- Ensure children are receiving health checks/milestones
- Support providers to find children whose data has not been entered
- Support for families to find and access core providers
- Resolving issues in these processes



The postcard delivered to around 8,000 Taranaki families to inform them of NCHIP.



Summary of the Taranaki DHB Universal Newborn Hearing Screening and Early Intervention Programme 2016/17

Background

The Universal Newborn Hearing Screening and Early Intervention Programme (UNHSEIP) aims to identify permanent congenital hearing loss that is likely to impact on the development of a child's speech and language so that:

- they can access timely and appropriate interventions;
- inequalities are reduced; and
- the outcomes for these children, their families, whānau and communities, and society are improved.

The goal is for all babies in New Zealand to have a hearing screen completed before the age of one month, diagnostic audiology testing for those without a clear response by three months, and early intervention services initiated by six months.

The Taranaki Newborn Hearing screening programme is managed by the UNHSEIP Coordinator and is part of the Allied Health, Scientific and Technical Service.

Staffing

Recruitment to a 0.4 FTE vacancy for a screener occurred in October 2016 following the resignation of Rebecca Davis. Sue McEwan, who has a background as an Audiometrist, was employed and successfully completed the newborn hearing screening specific training and is screening independently. The service is fully-staffed.

National Audit

In November 2016 the service submitted documentation to the National Screening Unit for auditing of systems and structures in place to support the effective delivery of UNHSEIP and Taranaki DHB. This audit was a desktop review of documentation and reports provided by the DHB.

Taranaki DHB was compliant with 37 of the 45 criteria assessed (82%), partially compliant with three criteria (7%) and non-compliant with five criteria (11%).

The audit report noted that Taranaki DHB has good systems in place at both an operational and strategic level and has a strong focus on using information to drive service delivery. A number of examples of good practice were identified and the newborn hearing screening team were commended for working hard to ensure they continue to deliver a high quality service.

Ten low or moderate priority corrective actions were identified for Taranaki DHB with these focusing on clarifying processes and procedures and confirming training requirements have been achieved.

Work to meet all corrective actions has commenced.

**Table 1: Total newborn hearing screens completed for the period by DHB,
1 January to 31 December 2015 (latest national report)**

DHB of birth	Completed total ¹	Live births ²	Percentage complete within period %	95% confidence interval
Northland	1691	2140	79.0	(77.2, 80.7)
Waitemata	6825	7622	89.5	(88.8, 90.2)
Auckland	5578	5937	94.0	(93.3, 94.5)
Counties Manukau	7065	8253	85.6	(84.8, 86.3)
Waikato	4738	5319	89.1	(88.2, 89.9)
Lakes	1396	1520	91.8	(90.4, 93.1)
Bay of Plenty	2353	2796	84.2	(82.8, 85.5)
Tairāwhiti	696	741	93.9	(92.0, 95.4)
Taranaki	1463	1528	95.7	(94.6, 96.6)
Hawke's Bay	1763	2010	87.7	(86.2, 89.1)
Whanganui	754	816	92.4	(90.4, 94.0)
MidCentral	1934	2131	90.8	(89.5, 91.9)
Hutt Valley	1898	1979	95.9	(94.9, 96.7)
Capital & Coast	3603	3561	101.2	
Wairarapa	431	462	93.3	(90.6, 95.2)
Nelson Marlborough	1392	1426	97.6	(96.7, 98.3)
West Coast	287	358	80.2	(75.7, 84.0)
Canterbury	6176	6262	98.6	(98.3, 98.9)
South Canterbury	604	667	90.6	(88.1, 92.5)
Southern	3335	3444	96.8	(96.2, 97.4)
Total	53,982	58,972	91.5	(91.3, 91.8)

¹ Sourced from UNHSEIP national database

² Sourced from National Maternity Collection

Future Plans

- Implementation of NHIMS (Newborn Hearing Information Management System) is planned, following the implementation of MCIS.
- Succession-planning for the UNHSEIP Coordinator role is in progress.

SUMMARY OF AUDITS 2016-2017

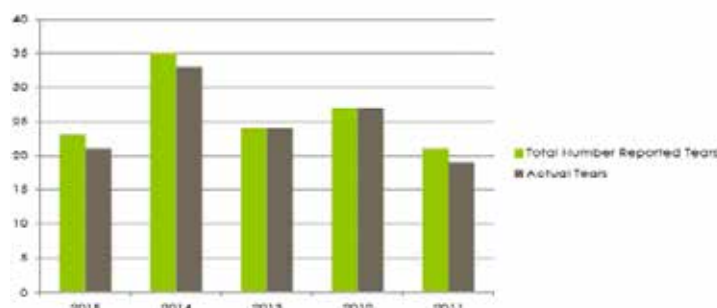
1. Third & Fourth Degree Tear Audit (Dr Beth Thompson and Dr Stephanie Luoni)

Audit Purpose

To elucidate overall incidence of Obstetric Anal Sphincter Injuries (OASIS)

- To elucidate proportion of OASIS by Mode of Delivery
- Appropriate management of OASIS
- Pre-operative Documentation of Vaginal, perineal and rectal examination
- Documentation of Analgesics, suture material, method of repair and grade of operator
- Post-operative advice and follow up

Data Analysis: Total number of reported OASIS vs Actual number of OASIS



Summary of findings

- Incorrect coding increases our reported number, true numbers are slightly less
- Majority of women with third and fourth degree tears are NZE, normal BMI and Nullips having NVD without episiotomies and delivered by midwives
- Very long and very short second stages appear to be associated with tears
- More severe tears appear to be decreasing
- Majority of tears are repaired by consultant
- Improved documentation of examination, but continued poor documentation of sutures used and type of repair
- Increased use of OT for repair
- Improved post operative care in all areas across the past 5 years

2. Small for Gestational Age (SGA) Audit (Steva Rumsey & Ariel Chung (TI's))

Objective

What was the incidence of SGA babies born at 40-42 weeks and the proportion of these cases that were unrecognised or sub optimally managed?

Audit sample

- Block sample of SGA coded births from 2013 and 2014 from TDHB and Ministry of Health records
- Review of infant and maternal case notes

Findings

- Risk assessments completed well
- Use of GROW charts unknown
- When SGA pregnancy suspected → appropriate referral and management instigated
 - Important for identifying SGA prior to birth
 - 73% and 74% primiparous women
- Growth scans
 - 2013: 30%
 - 2014: 45%
 - 40% (2013) and 72% (2014) were reported normal
 - Normal umbilical artery dopplers on all the scans
- Only a few had serial scans until birth of baby
- Intrapartum care

- All that were identified as SGA had continuous cardiotocograph (CTG), ppaediatric review at birth and blood sugar levels (BSL)
- Many had continuous CTG but for other reasons
- Postnatal Care
 - Neonatal blood glucose: 39% (2013) 64% (2014)
 - Not recognised as SGA at birth
 - Guidelines for BSLs <2500g
- Neonatal Unit(NNU) admission: 4% (2013) 36% (2014)

Recommendations

- Collaboration of midwifery notes
 - Especially universal scanning of GROW charts into computerised notes
- Serial scanning in high risk women until delivery
- Improved hypoglycaemia screening in newborns
 - Obtain birthweight percentile within 6 hours
 - To screen all under 10th centile
- Protocol for consideration of delivery before 38 weeks as per NZMFM
- Follow up audit
 - On the mothers identified from 2013-2014
 - Investigate management of subsequent pregnancies

3. Documentation, protocol and process checks as follow up from Datix (Belinda Chapman & Sharon Howe)

Objective

To determine if the correct Taranaki DHB documentation, protocols and procedures are followed by all Maternity Core Staff, O&G and LMC's, by examination of all records that are case reviewed at the weekly Maternity Obstetric Outcome case review sessions.

Findings

Interpretation of results:

- There were 12 transfers of clinical responsibility identified out of the 15 clinical notes audited
- The secondary team were aware of the clinical transfer in 10 cases
- 11 cases clinical responsibility evident by documentation eg stamp or referral
- 13 cases women were clerked by the secondary team (one clerked although was not transferred to secondary)
- 11 women were seen by a specialist within 12 hours of admission
- 10 clinical sets of notes had a secondary care plan to follow
- 12 clinical sets of notes it was clear if a primary or core midwife was providing care
- 10 Sets of notes showed evidence of the first stage of labour protocol being followed, four cases were not applicable and one the first stage of labour protocol was not followed
- In one set of clinical notes it was evident that the MEWS protocol was followed for secondary women antenatally and postnatally in the body of the notes and not in the chart, it was followed correctly in nine clinical notes and four sets of notes the midwifery early warning score (MEWS) was not followed or escalated
- Overrides were completed with seven sets of notes
- ISBARR communication tool was used once, 10 cases the ISBARR tool could have been used but wasn't and not applicable in four clinical sets of notes viewed
- 10 sets of notes had a fluid balance chart completed to standard-5 were not
- 11 sets of notes had signed medication charts and IV charted
- nine medication charts were not completed correctly
- Epidural received in one of the 15 clinical notes viewed, O&G informed and correct monitoring etc
- six clinical sets of notes viewed had partograms initiated, but three times it would be recommended but wasn't used
- Weights of the women were only recorded in four sets of the clinical notes
- Urinalysis was only recorded in six sets of the notes

- Electronic Discharge Summary (EDS) for 10 sets of the clinical notes (12 were transfers to secondary, so two not completed-ward administrator coding concern?)
- Appropriate stamps used in eight sets of clinical notes viewed
- Demonstrated breast feeding handover plan in 12 sets of notes viewed
- nine handover sections were completed from labour to postnatal on the Maternal Care plan
- Comments on deviations were:
EM C/S=1
Good Partogram
Nil comment x3
H2O temps & maternal temps not completed
Admission Cardio Toco-Graph (CTG) in primary unit
Undiagnosed until labour breech birth
Maternal collapse called! 777 called

Recommendations:

Areas requiring further investigation/future quality initiative topic recommendation:

1. Further education on transfer of clinical responsibility to secondary
2. Documentation education for midwives and performance improvement plans
3. Ward administration coding
4. Use of stamps in notes if ward admin not utilizing them
5. Further Partogram education
6. Further fluid balance education
7. Further medication chart education
8. Further MEWS education
9. Follow up with staff/LMC regarding secondary team transfer process

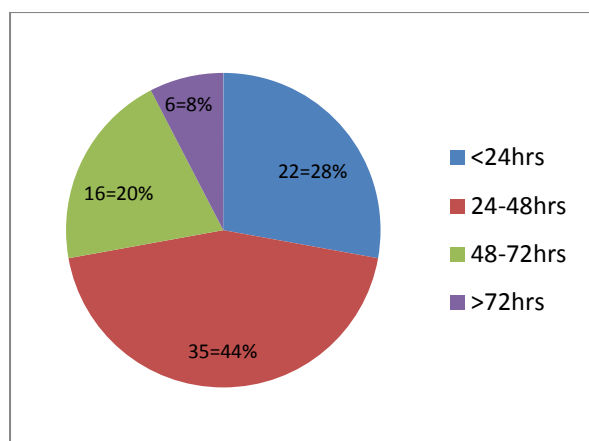
4. Length of Stay Postnatally at TDHB (Carol Wells, Helen Hall)

Objective

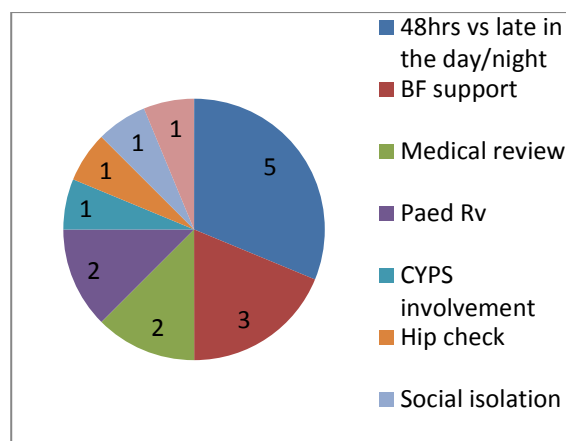
To determine the reasons for patients having an extended length of postnatal stay beyond 48 hours, if the mother was under primary care and the reasons for prolonged stay beyond 72 hours for secondary care, over a 4 week period.

Findings

Length of postnatal stay of 79 women audited



Reason documented for 48-72hour postnatal stay



Reasons for the six women with more than 72 hour length of postnatal stay documented

4 women stayed because of elevated blood pressure (B/P) and adjustment of medication.

1 woman stayed because of unstable blood sugars

1 woman stayed because of paralytic ileus and other medical complications.

Comments and recommendations:

- Almost all of the issues causing elongated stay whether primary or secondary appear to be legitimate under the maternity service specifications.
- It was sometimes difficult to find the reason due to incomplete or inadequate documentation - correct use of the transfer primary/secondary stamp would be helpful especially for the coders.
- Further education for staff around these issues would be helpful.
- An additional sign-off line in the care plan where both LMC and core staff sign already could alert staff to ensure "circling and stamping " has been completed.
- All postnatal notes could be checked by nominated staff, before going to clerical discharge so correct stamping has been done.
- On a number of occasions there has been no stamp to secondary, by the LMC, at time of instrumental delivery, PPH, or 3/4 degree tear.
- Staying a day longer for hip check or hearing screening is to be discouraged unless remote rural. Staying a few hours over can still happen if the woman is discharged at the appropriate time and waits in her room (if bed not required) or in the lounge if it is, until the check/screening is done.
- Review by the paediatric team is often a timing issue as they have prioritised visits in NNU and WD 2 to complete before getting to the postnatal ward very often they arrive late morning or early afternoon and then request ECGs, bloods or other checks to be done before allowing discharge. This often delays discharge until evening.
- In the given four weeks of this audit there were no instances of late pre-term babies extending the length of stay, this has been an issue in the past, discharging the mother at 48 hours if appropriate, than admitting the baby as a secondary patient under Paeds may solve this, provided we can accurately reflect this on Trendcare.
- It would be possible to extrapolate further information from the audit around parity, geographic location, mode of delivery etc if required—the above meets the primary objectives of the audit.

4. Documentation Audit (Sharon Howe)

Summary 10 maternity woman's clinical notes

1. Audit remains complicated by difference between documentation expectations between SEM and Core (eg SEM do not have to fill in Partogram). LMC/CORE Midwife added to bottom of documentation
2. All core staff advised needed to complete on line effective midwifery documentation audit-CMM looking into how many have completed their effective documentation.

Positive points noted

- Notes were sequential in all
- All entries timed and dated except one
- Allergy status marked clearly on all front sheets
- Parents ethnicity-mums documented on all booking-dads on only 3
- Changes in woman's diagnosis or condition updated in all applicable
- Frequency of documentation suitable in all cases.
- Smokefree form completed in all bar one-improvement of 2 from last year
- Only 1 set of notes did not have label on each page (3 last year)
- 1 set of notes had consent for 3rd stage management
- 3 set of notes only had Vitamin K consent-only 1 last year
- Only one of the notes had a completed booking sheet-half last year
- Partogram's not used by LMC when commenced by core for abnormal labour
- Stamps were only used correctly in 1 set of notes
- Medication charts noted to be not being completed-special care and supplementary charts are not being ticked for no or comments added if yes-same as last year

Recommendations

- Repeat Audit 2017
- Performance manage Core staff not meeting expected standards after second notice-competency plan sent to CMM for this and documentation noted during case review compilation weekly sent to CMM for staffing notification
- All core staff to complete Effective Midwifery online documentation package
- Email regarding legibility of signatures to go to Community midwives and Core
- Staff not meeting expected standards to undertake documentation workshop and have notes checked? what basis until effective documentation maintained
- MEWS training by Raechel Goodhue (Sept) completed
- SEM midwives not following TDHB guidelines for documentation will have this discussed with ADOM as part of the TDHB access agreements
- Audit collation findings to be sent to all core and community midwives and O&G via newsletter

5. Variation in Gestation at Birth (Michelle H & Sam Ellis (TI's))

OBJECTIVE

Standards:

All uncomplicated singleton pregnancies should be delivered at 39 weeks gestation or later to reduce neonatal morbidity (Royal Australia New Zealand College of Obstetricians & Gynaecologists, (RANZCOG 2006) with the following exceptions:

- The Auckland consensus guideline (2014) provides evidence based indications for induction of labour (IOL) before 39 weeks.
- Where the risk of neonatal respiratory morbidity is weighed against the risk of labouring prior to elective CS (eICS), RANZCOG recommends carrying out elective CS "at approximately 39 weeks gestation".
- RANZCOG guidelines (2006) state eICS before 39 weeks may be indicated in the setting of maternal, obstetric or fetal complications based on clinical judgement.

FINDINGS

Interpretation of results:

Planned induction of labour

- Current recommendations state women with suspected Small for Gestational Age (SGA) /Intrauterine Growth Retardation (IUGR) babies should be offered IOL at 38 weeks. Early induction has not been shown to improve neonatal outcomes, however 54% cases in TDHB were <38 weeks
 - Must be interpreted in the context that detailed Doppler studies influence clinical judgement (not included in this audit). Not routine at TDHB in 2014, increased frequency 2015.
- Recommended that women who develop pre eclampsia (PET), be induced at 37 weeks and those with HTN also induced at this time were less likely to develop maternal complications. Most inductions appropriate and rationale generally based on clinical judgement
- All cases of twins were di-chorionic, diamniotic suggesting three of 11 inductions were not appropriate or had additional undocumented complications.
- All cases of obstetric cholestasis were between 38⁰- 38⁶, clinical judgement recommended for timing
- No indication for early IOL in Gestational Diabetes Mellitus (GDM) unless there is associated macrosomia, only two of 16 cases actually documented macrosomia as the indication
- Risk of subsequent stillbirth is increased with previous IUD, but no specific guidelines around timing of delivery therefore heavily influenced by clinical judgement
- Increased Body Mass Index, advanced maternal age, In Vitro Fertilisation (IVF) and previous caesarean section alone are not indications for IOL before 39 weeks and there were no cases identified where these were documented indications.

Elective caesarean section interpretation

- Limited theatre allocations for obstetric cases could be contributing to the number of elective CS done in the 38th week of gestation.
- RANZCOG guidelines, state that myometrial thickness evaluated by ultrasound is not predictive of rupture or dehiscence and may not be useful in clinical practice.

- Inaccurate coding of data may have inflated the number of cases not compliant with current guidelines.
- Due to the heavy reliance on clinical judgement in the RANZCOG guidelines for gestation at elective CS, it is noted that additional factors not considered here may have informed many of the decisions to carry out elective CS prior to 39 weeks

RECOMMENDATIONS

Recommendations:

1. Implement a standardised documentation pathway for all elective deliveries at TDHB, detailing BMI, smoking status, and indications for IOL/elective CS, to be completed on booking and/or arrival to the maternity unit.
2. Clearly document obstetrician rationale of planned delivery <39 weeks in above standardised documentation
3. Ensure the correct documentation of a specific indication for planned delivery, rather than the condition pre-disposing to the indication (i.e. GDM rather than macrosomia)
4. Familiarisation with current guidelines/evidence for all medical and midwifery staff, particularly recommendations for:
 - IOL for SGA/IUGR and GDM
 - eICS for previous caesarean
5. Random audits on documentation (booking sheets, theatre notes and discharge summaries) to ensure clear and comprehensive recording of indication/timing.
6. Consider the development of a local guideline for the timing of eICS
7. Liaise with theatre services to ensure bookings for eICS are made as close to 39 weeks as possible, and/or increase obstetric theatre availability if necessary.
8. Review the value of conducting eICS before 39 weeks gestation due to findings of thin lower segments and adjust clinical practice according to the findings.
9. Comprehensive reviews for those 8 cases in which eICS was carried out in the 37th week of gestation to determine causes and prevent similar instances in the future

Areas requiring further investigation/future quality initiative topic recommendation:

- Indications for planned IOL and eICS for 2016 and 2017
- EICS timing requests on booking and the availability of theatre spaces
- Mothers who received antenatal steroids prior to planned preterm delivery
- Neonates born via eICS or planned IOL before 39 weeks admitted to neonatal unit for complications associated with preterm birth
- Subgroup analysis of indications for planned IOL - i.e. If mothers were induced solely for GDM, or for complications/macrosomia as a result of GDM
- Doppler USS results in IOL for SGA/IUGR babies before 38 weeks
- Analysis of cases with planned IOL/eICS before 39 weeks for multiple indications

6.C/S trolley-Lisa Gilbert

OBJECTIVE

To evaluate the effectiveness and efficiency of the current C/S trolley in maternity

AUDIT SAMPLE

1 trolley

Audit questionnaire left with trolley for maternity staff to complete

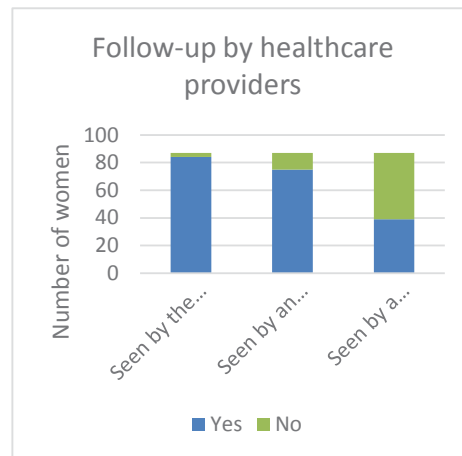
FINDINGS

- 2X- It has the IV medication in an emergency (in elective/semi urgent I get them out of Pyxis)
- The trolley is working well
- It has everything needed for LSCS and performing VE speculum exams
- It is a work surface in the rooms as there are no tables in them

RECOMMENDATIONS

Possible improvements to make

- 6X one drawer for LSCS, one for speculum examinations
- 5X Less is more, don't over stock
- Put dividers in drawers as they are messy
- We need the CS stamp back in the trolley
- 3X querying need for trolley as most thing in room or is a smaller trolley better
- 2X re purposing trolley – make IV trolley into the speculum trolley or make this trolley into Ventouse trolley (its easier to manoeuvre and smaller)
- Why are there bandages here?
- Why are we worrying about a CS trolley when most of our equipment is missing or broken?



Next steps

Discuss outcomes with working group and decide which of the possible improvements are actionable.

7. Compliance and Implementation of the "Screening, Diagnosis and Management of Gestational Diabetes in New Zealand" Clinical Practice Guidelines at Taranaki DHB Audit (Sarah Nam & Emma McCallum (II's))

Objective

To evaluate the compliance and implementation of the "Screening, Diagnosis and Management of Gestational Diabetes in New Zealand" clinical practice guidelines at Taranaki DHB

Standard

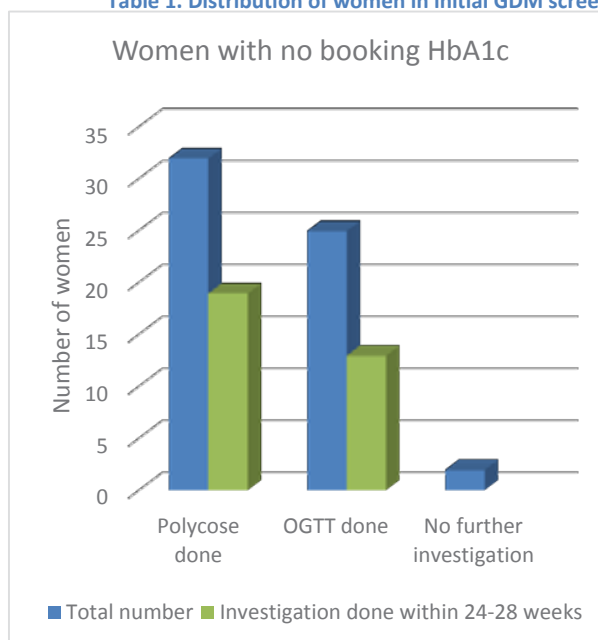
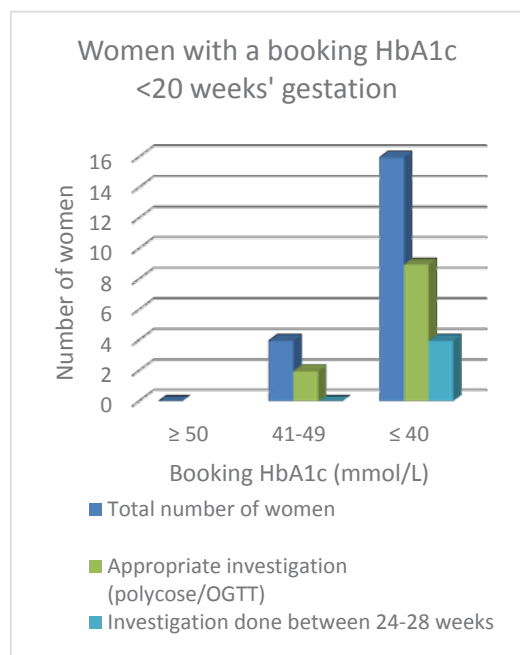
All women with diabetes in pregnancy at Taranaki DHB should be receiving the appropriate screening, diagnosis and management in concordance with current Ministry of Health guidelines for Gestational Diabetes.

FINDINGS

Of the 87 women included in the audit, 25 (28.7%) received a booking HbA1c prior to 20 weeks gestation, 3 (3.4%) had pre-existing diabetes mellitus, and the remaining 59 (67.8%) women did not receive a booking HbA1c within 20 weeks gestation (Table 1).

Booking HbA1c done <20 weeks?	Number of women	Percentage
Yes	25	28.7%
No	59	67.8%
N/A (pre-existing DM)	3	3.4%
Total	87	100.0%

Table 1. Distribution of women in initial GDM screening



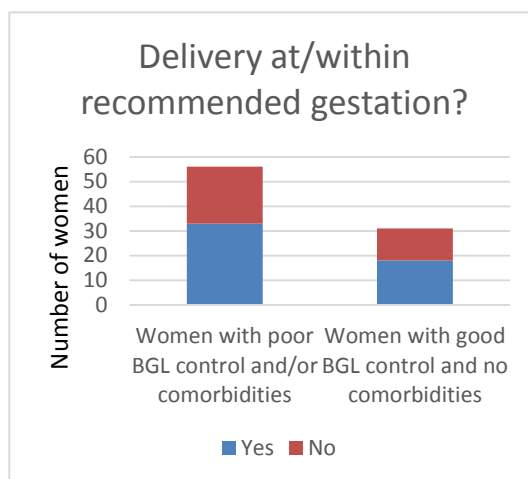
DOCUMENTATION RECOMMENDATIONS

Adequacy of blood glucose control in pregnancy

	No of Women	Percentage
Yes	44	50.6%
No	32	36.8%
Unclear/No Information	11	12.6%

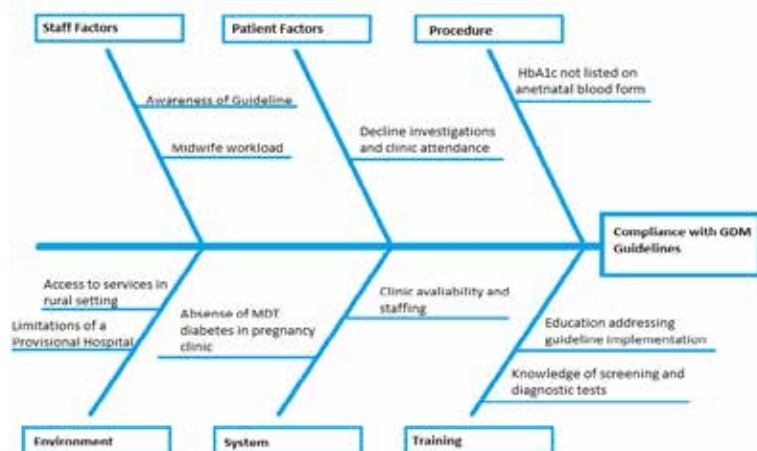
Was ultrasound growth scan performed between 36 and 37 weeks?

	Number of women	Percentage
Yes	36	41.4%
No	45	51.7%
<36 weeks	29	
>37 weeks	5	
No growth scan	10	
N/A (delivered prior to 37 weeks)	6	6.9%
Total	87	100.0%



Was HbA1c checked post partum?

	Length of time post-partum	Number of women	Percentage
Yes		57	65.5%
Median	4 months		
Minimum	1 month		
Maximum	10 months		
No		30	34.5%



Ishikawa Diagram Demonstrating the Contributing Factors to Guideline Compliance

Recommendations

- Incorporate HbA1c into the standard antenatal booking blood form.
- On birth booking form, incorporate a section for HbA1c results with prompts for further investigations/referrals for diabetes testing.
- Establish multidisciplinary clinics which incorporate diabetes team, obstetricians and dieticians.
- Regular education sessions regarding appropriate investigations for diabetes in pregnancy.
- Identify the appropriate health professional (i.e. GP vs LMC) to organize and follow-up post-partum HbA1c.

Future quality initiative topic recommendation

- What proportion of all pregnant women, are receiving appropriate screening for diabetes in pregnancy?
- What proportion of women diagnosed with diabetes in pregnancy do-not-attend (DNA) specialty clinics? Furthermore, is there an ethnic disparity in this cohort of women?

8. What is the Successful Vaginal Birth after Caesarean-section (VBAC) Rate at Taranaki District Health Board (TDHB)? (Rohit Katial & Hamish Ko (Ti"i))

Objective

To compare the success rate of VBAC in women with uncomplicated pregnancies to the rate quoted in the TDHB VBAC guidelines.

Sample Size

143 women were candidates that met the exclusion and inclusion criteria.

Results

VBAC discontinued during Labour

Indication	Number	%
FTP	21	65.6%
APH	1	3.1%
CTG Abnormality	1	3.1%
PET	3	9.4%
IUGR	1	3.1%
Other	5	15.6%
Total	32	

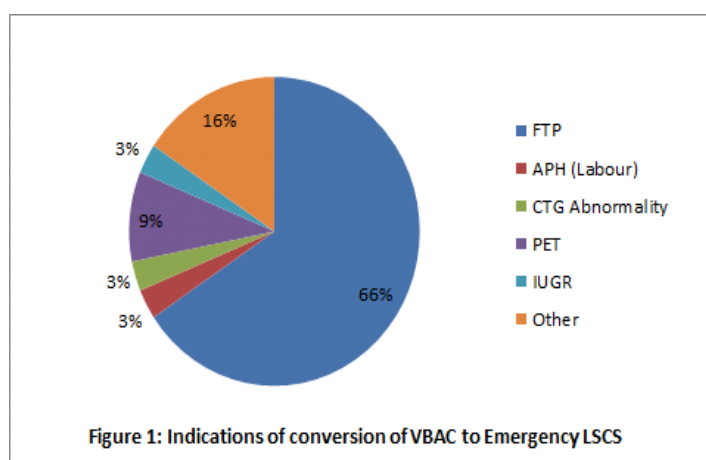


Table 1: Indications for conversion of VBAC to Emergency LSCS during Labour.

VBAC Declined Prior to Onset of Labour

Indication	Number	%
Maternal Preference	51	72.8%
Breech	9	12.8%
PET	2	2.8%
APH	2	2.8%
Large for Gestational Age LGA	1	1.4%
Depression	2	2.8%
Other	3	4.2%
Total	70	

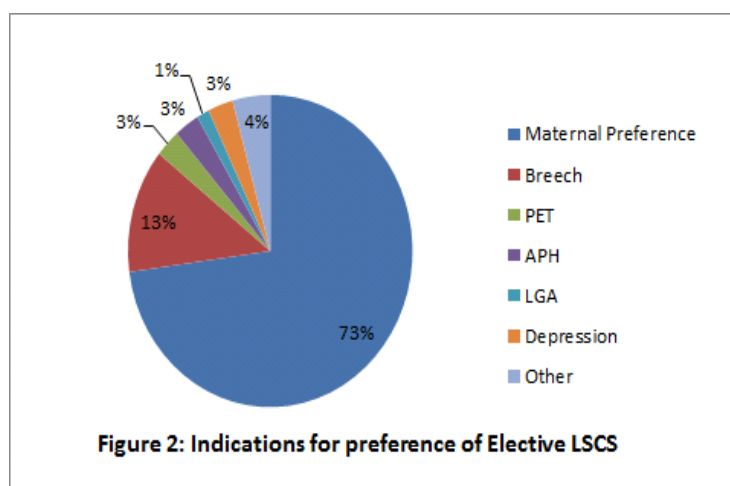


Table 2: Indications for preference of EICS decision made during Antenatal Clinic.

Total Eligible for VBAC	143
Successful VBAC's	41
VBAC converted to LSCS for medical indications	32
Total VBAC's attempted and reached labour	73
%Successful VBAC	41/73 = 57%

Recommendations

- Adequate electronic documentation with a model template that Registered Medical Officer's (RMO) can use for their discharge summary to include all vital information such as gravidity and parity.
- Future audits can be done to find the percentage of a successful VBAC over the years of 2000-2014 to note the trend to see if the rate is increasing or decreasing.
- Future audits to determine why there is a lower than expected rate of VBAC success.
- Consultants should inform the RMO staff about the admissions of their private patients so that they complete an electronic discharge summary of their maternity care in the public health system database (Concerto).
- All women should have their 6 week post-natal follow-up with an obstetrician regarding VBAC vs another repeat LSCS.
- Continued encouragement of midwifery staff to ensure all VBACs are coded in the ICD-10 system.
- The results of this audit should be reviewed in the future in accordance with RANZCOG guidelines.

9. Antenatal Colostrum Expressing (ACE) Audit (Ongoing Audit) (Glenda Martin)

Objective

To assess the use and information given for ACE at Taranaki DHB (TDHB) using feedback forms.

Findings

Parity	First baby 10 Multiparous 6
Referrals made by:	LMC: 12 Hospital Midwife: 1 Secondary Service: 1 Lactation Consultant 1 Self Referral: 1
ACE Commenced	35 2 36-7 12 38+ 2
Reasons for Initiating Ace	Gestational Diabetes Mellitus (GDM) + Breast Feeding (BF) History 2 Previous BF History 1 Diabetic + Previous delayed lactation 1 Gestational Diabetic 7 Gestational Diabetic plus cleft lip/possible palate 1 Twins 1 Back up plan 1 Insulin Dependent Diabetes Mellitus (GDM) 1 Read Info on Facebook 1
Length of time women expressed prior to delivery.	1 week 4 2 weeks 3 3 weeks 3 4 weeks 4 5 weeks 2
Adequacy of written information? Scoring 1 for Poor - 5 for Very useful	Score 5: =8 Score 4: =6 Score 3: =1 Score 2: =1
Adequate guidance on how to hand express	Yes=16

Difficulty hand expressing	Yes=1 One breast only=1 No=14
Positive Experience	Yes=16
Collect again in future pregnancies	Yes=16
Gestation at birth	35/40 =1 36/40 =0 37/40 = 1 38-40/40 = 8 40/40+ =6
NNU Admission	Yes=6 No=10
Reason for NNU admission	GDM mum=4 Late Preterm=11 Twins=1
Approximate mls expressed	10 mls or less = 4 15-30 mls = 4 40-50 mls = 4 70 mls =1 100+ mls = 3
ACE milk given to baby in the first few hours after birth	Yes =13 No = 3
Need for formula and did staff discuss the reasons and get consent	Formula=3 babies (1 twin and two with GDM mum) No written consent obvious in body of notes

Recommendations

- Women were very positive about the benefits of ACE and they would do it in the future.
- Small number of feedback forms only but the number of women starting ACE has increased significantly since the commencement of the programme at Taranaki DHB.
- Some women are not using ACE, who would benefit from it
- Suggest we encourage every woman to consider ACE, especially as women have more complications and feeding challenges are not uncommon.
- The importance of providing women with appropriate advice on the process of hand expressing with the reminder that some women may need more guidance than others.
- Care taken in our conversations as to how formula is portrayed-for some women it is their personal choice and for others it is required short term for their baby's health.
- Guidelines have been updated following comments received.
- The audit will continue.

10. Baby feeding time from initial Breastfeed Audit (Sharon Howe)

Objective

To evaluate if babies are allowed to sleep for 6hours undisturbed if no concerns or stipulations in a plan of care due to small for gestational age, (SGA), gestational diabetes mellitus (GDM), prematurity etc

Findings

Only 1 baby was woken inappropriately or the protocols not adhered too

Recommendation

To enquire as to why the baby was given dextrose gel when blood glucose level was 2.6mmol and EBM was available as this does not follow protocol.

11. High Dependency Unit (HDU)/Intensive Care Unit (ICU) Admissions Audit 1 June 2016- 31 May 2017 (Glenda Martin)

Objectives

To ascertain

- The reason why women are admitted to ICU/HDU from maternity.
- If mother and baby were separated during the admission to ICU/HDU
- To inform TDHB Maternal and Child Health Service Manager, Associate Director of Midwifery (ADOM), Head of Department (HOD) Obstetrics & Gynaecology (O&G), Midwife Manager, Intensive Care Unit/High Dependency Unit (ICU/HDU) Nurse Manager, Maternity Quality Safety Committee

(MQSC) and Maternity practitioners of findings and identify any changes or improvements in practices required.

Summary of findings

- Length of stay was not determined in this audit
- Need to follow up maternity input
- Mum and baby were separated in six instances of the HDU admissions-clinically indicated in two cases, not clinically indicated for the baby for four cases. With the use of an apnoea mattress, the HDU staff feels more secure around having a baby in HDU with a support person present.
- Post partum haemorrhage (PPH) was the main reason for HDU admissions
- Admissions for maternal cardiac conditions was due to lack of telemetry function in maternity
- Five women were admitted antenatally-sepsis x2, 1x DKA (diabetic ketoacidosis)
- Six women in labour were admitted to HDU (cardiac telemetry)
- 15 women were admitted in the postnatal period
- Documentation incomplete regarding visits to HDU by core staff and lead maternity carer (LMC)

Recommendations

- Maternal HDU flow chart/policy to be developed-working group to be established to work towards reducing the mother/baby separation
- Telemetry coverage to be improved for maternity to enable women to be monitored in labour ward-this will reduce the amount of staff on call, anxiety for staff and the mother and whanau of birthing in HDU (facility in HDU for labour and birth is not conducive to birthing eg sound proofing, privacy and not en suite bathroom facility.
- Mother on HDU to be visited by Registered Midwife/Registered Nurse/Lactation Consultant at least once a shift
- Documentation essential when woman visited in HDU
- Every woman to have a secondary appointment to discuss events postnatally.
- Omit did the LMC continue postnatal care as this is difficult to find, thus inaccurate

Clarification on how often staff need to visit an antenatal woman in HDU. It may be on a case by case basis but needs to be documented in order to know if the audit criteria have been fulfilled appropriately.

12. Hawera Maternity Unit (HMU) Water Immersion during Labour and Birth (WILB) Audit April 2017 (Sharon Howe)

Objective

To determine if the policy/protocol pertaining to water immersion and birth were followed for women admitted to Hawera Maternity Unit

Results

A total of 174 sets of clinical notes were reviewed –mother and baby notes as they were all classified from coding as having been admitted to HMU in the period 1/10/16-31/3/17 and the results as per table 1 below.

Of these notes, **87 sets** = Mother notes

87 sets = Baby notes

41 women actually birthed at HMU

12 women were identified as having water immersion for labour and birth

5 women were identified as having birthed in water

Recommendations

- Midwife Educator to complete one on one education with all Hawera Maternity Core staff and self employed midwives who access Hawera Maternity, regarding water immersion during birth and labour and following protocol
- Associate Director of Midwifery to discuss with self employed midwives accessing Hawera Maternity the documentation and recording's required if women is labouring in water or births in water

13. Midwifery Early Warning Score (MEWS) Spot Audit April 2017 (Sharon Howe)

Objectives

To determine if the Policy/Protocol Pertaining to Midwifery Early Warning Score (MEWS) was followed for Women who were admitted to Base Maternity Unit (BMU) or Hawera Maternity Unit (HMU).

Interpretation of Results:

- 65% of notes had MEWS scores totalled
- 75% notes had relevant observations completed
- 75% notes had MEWS algorithm activated for score above 1
- 100% notes who had MEWS 1-3 had midwifery evidence documented in notes
- 100% notes had midwifery documentation to say MEWS 4-5 activated in clinical notes
- 12.5% notes that required a change in parameters had clear documentation on front of MEWS chart
- 50% of notes had the MEWS override documented on front of MEWS chart
- 100% notes did not have the MEWS being discontinued documented

Recommendations

To follow up

- 1 MEWS education to all staff in HMU and BMU-with emphasis on the interpretation of results/findings and also Intensive Care Unit Nurse Support on back page
- 2 Findings and recommendations from audit into weekly newsletter and feedback to Maternity Quality Safety Committee, Quality Risk director, Director Of Nursing, ward staff, Lead Maternity Carer and Obstetricians & Gynaecologists
- 3 Further MEWS inaccurate documentation noted will be forward to Clinical Midwife Manager for follow up discussion and then Midwife Educator to do Education support plans

Areas requiring further investigation/Future QI topic recommendation

- Repeat audit one month after education complete to identify staff requiring education support plans.

14. Postpartum Haemorrhage (PPH) Audit 2017 (Reagan Humphrey & Jessica Fulton TI's)

Objective

To audit all women who birthed at Taranaki District Health Board (TDHB) Maternity Unit during the period 1 January 2017 and 30 April 2017 who experienced a Postpartum Haemorrhage (PPH). To determine if the National consensus guidelines were followed, three years after the National Consensus Guidelines were released, TDHB Maternity Unit has been identified in the new Health Round Table data as having a higher than average PPH rate

Interpretation of Results

- Postpartum haemorrhage an important issue for TDHB, with Roundtable Health data showing continual underperformance in the region's rates of PPH. In accordance
- Single-sheet Proforma created in 2015 to help guide staff through the steps of managing a PPH. An audit in 2015 found very low use of this form attributed to its complexity - obviously a labour-intensive documentation job is not appropriate for an emergency situation.
- Simplified form in 2017, our audit was created to see if any changes had come into effect in comparison to 2015.
- Overall there were very few differences found across comparable variables
- Improvements-teams were much better at calling for help, with the medical team notified in 94% of cases, compared to 83% in 2015. There were also fewer blood transfusions required (6% down from 10%, although the sample size is small for this variable).
- More risk factors were identified and analysed than the 2015 audit, based on the RANZCOG PPH information. A positive thing to see was that, of the 14% of cases with a physiological third stage, all were in low-risk patients. This shows that identification of at-risk women is happening during pregnancy to help prevent PPH.
- Follow the PPH Proforma recommendations

- Otherwise, we found no significant difference in terms of the use of active versus physiological management of the third stage, or in the rates of retention of products or perineal trauma, or in the overall estimated blood loss

Future QI topic recommendations:

- New Proforma is only just beginning to be circulated-follow-up of the use of this document would be recommended.

15. Postpartum Haemorrhage (PPH) Admission to HDU Documentation Audit 1 June 2016-31 May 2017 (Sharon Howe)

Objective

To audit the 10 women admitted to HDU at TDHB with PPH to see if MEWS chart, Partogram, Fluid Balance Chart and Medication Charts were completed.

Was the Partogram commenced and complete if the woman was under Secondary care?	4 x Under Secondary care and Partogram completed 4 x under primary care-so no Partogram 1 not applicable as was 19 days postnatal when PPH occurred 1 x was secondary care and no Partogram
Was MEWS Completed?	MEWS was not scored completely in 10 sets of notes
Were there Blood Products Transfused?	6 x PPH were treated with blood products 4 x no blood products
Was the PROFORMA USED and if yes old or new (old did not have space to chart medications)	Proforma was used x 4 (all old ones as new one not in use at these times) 2 x Proforma not able to be used as ED and ICU only 4 times not used

Recommendations

- Midwife educator to provide face to face fluid balance chart, medication chart and Partogram education to all employed and self employed midwives
- Midwife Educator to continue post partum haemorrhage ongoing education
- Implementation of new PPH Proforma
- Ensure all secondary antenatal women have a plan documented by doctors for active third stage management

16. Protocols for Preterm Birth at TDHB during 2016 (Marcel Fernando & Chinmay Pandit TI's)

Aim

The aim of this audit was to review the management of patients presenting with pre-term labour who met the requirements for the guidelines as set by Taranaki DHB, over the year of 2016. Originally this included fetal fibronectin testing, magnesium sulphate administration, steroid administration, in-utero transfer, and tocolysis. During the audit, the topic was narrowed to focus specifically on the administration of steroids and magnesium sulphate in the context of preterm birth.

Results

Steroids

25/32 births $\leq 34+6$ weeks gestation received two doses of antenatal corticosteroids Of the patients not receiving two doses of steroids, there were 2/7 cases where it was not appropriate to consider this intervention. This is because one baby was born still-born with the mother presenting to hospital with reduced fetal movements. Another patient delivered in hospital, 1 hour & 2 minutes after the first initial call to the midwife; therefore there was not sufficient time to consider steroids.

Magnesium Sulphate (MgSO₄)

Of the 85 births reviewed, 3 births qualified for magnesium sulphate. Of these, 1 patient received the appropriate protocol dose of magnesium sulphate. In the case of the other 2 patients, 1 was a stillbirth with fetal demise noted on bed side ultrasound. The third presented with spontaneous rupture of membranes and imminent labour, fully dilated in the emergency department. In both of these cases there was no opportunity to complete the magnesium sulphate infusion. This is not explicitly discussed or noted in the clinical notes but is evident from the discharge summaries.

Interpretation of Findings

- It is clear from this audit that in pre-term births occurring before 35 weeks, there is both the consideration and the administration of two doses of antenatal corticosteroids.
- In cases where two doses have not been able to be given, it is evident that this is the result of obstetric complications occurring, such as placental abruption or mothers going into advanced spontaneous labour before the doses can be given.
- For one patient, documentation did not establish the cause for the second dose of steroid not being provided. A potential, and immediately executable, recommendation could be to ensure such documentation is on the discharge summary for the mother or made explicit in the clinical notes.
- An area for further investigation could be the use of repeat corticosteroids. For example, if women have received two steroid doses in a pregnancy, then a repeat single dose should be given, if it has been greater than 7 days since their last dose and they have not yet given birth.
- It would be worthwhile investigating whether these repeat doses had been given.
- Due to the sample of only 3, the magnesium sulphate component of the preterm birth protocols cannot be conclusively reviewed in this audit.

Future quality initiative topic recommendations

This audit considered preterm protocol with a variety of outcomes; as such it was difficult to determine the appropriate sample size for each. With the specific intention of auditing MgSO₄ prescription for neuroprotection, a larger audit of pre-term births spanning more years could be done. This is particularly relevant given the inconclusive results of this audit with regards to MgSO₄. In addition to this, there could be an audit to determine if the District Health Board is meeting standards for repeat doses of steroids. In addition to our primary outcomes we summarily noted use of fetal fibronectin, tocolysis and in utero transfer in our original appraisal. Ultimately these were not considered in this audit but are potential outcomes for which later Trainee Medical Interns could perform as an audit.

Alignment with the aims and objectives with the national priority and recommendations

Multidisciplinary review process/meetings that have been coordinated

- Monthly MQC meetings
- ADOM monthly meetings with community leadership alliancing midwives (rural and urban)
- Maternity obstetric outcomes case review meetings weekly
- Fortnightly maternity service management meetings
- Fortnightly core maternity staff meetings
- Monthly perinatal mental health liaison meetings
- Midland Maternity Action Group meetings-quarterly includes sub groups for breastfeeding, educators, midwifery leaders
- Perinatal mortality meetings two to three times per year
- Taranaki immunisation strategy group meetings
- Breast feeding case reviews and terms of reference
- Maternity wellbeing and child protection multi agency meetings, including terms of reference, memorandum of understanding and set templates
- Child Health Service Level Alliance Team (SLAT)
- Attendance at National MQSP meetings
- Attendance at regional Maternal Morbidity Working Group reviews (HQSC)

Changes in clinical practice and quality improvements driven by MQSP

- Super Mama advert
- ADOM and midwife educator accepted onto HQSC SAMM National Panel
- Update colour PPH Proforma
- Maternity obstetric outcome newsletter
- Maternal cardiac arrest pager for O&G team so O&G get the pager at the same time as the cardiac arrest team
- Three new maternity resuscitairs
- Three new Neopuff, newborn life support oxygenators
- Maternity Roadshows
- Hawera Maternity renovations and revamp
- Hot box for maternity and OT
- Second consumer for MQS

New maternity Initiatives

- Towel and woollen warmer (hotbox for the operating theatre)
- Hotbox for maternity for towels and woollens
- Updated Post partum haemorrhage Proforma
- Weekly education newsletter
- Pyxis access to ward 14 and 15 for anaesthetists
- Maternal cardiac arrest pager for O&G team so O&G get the pager at the same time as the cardiac arrest team
- Postnatal unexpected maternity outcome debrief in secondary clinic with consultant at two weeks
- Maternity Obstetric Outcome Newsletter
- Obstetric emergency process for telephonists update
- Antenatal clinic panic button for emergency situations
- New caesarean menu for postnatal women
- Oxytocin and syntometrine nightly PYXIS check for quantities
- 16g IV cannula prompt for IV trolleys for Base and Hawera
- Mother and baby car parks for maternity
- Laminated MGSO4 maternity IMED pump settings guide for top of eclamptic box
- Laminated IMED pump settings for Maternity MgSo4 for eclamptic box at Base Maternity and Hawera
- Extra baby labels in resuscitaire in OT
- Documentation sample packs on Ward 14 and 15
- Addition of professional development planner to midwives orientation booklet
- Breast feeding case reviews
- Maternal ICU trolley update

Midland Maternity Action Group (MMAG)

Midland Maternity Action Group 2016-17 Work Plan

Chair:	Corli Roodt, Associate Director of Midwifery, Waikato DHB
Project Manager:	Suzanne Andrew
1. Develop a Midland Breastfeeding Framework to inform and prioritise breastfeeding initiatives in the Midland region	
<ul style="list-style-type: none"> Key themes will be underpinned by specific priorities and can add value to the current and future work plans, and also support information sharing and learning across DHBs in the Midland region. 	
2. Midland Breastfeeding App – BreastFedNZ (goal: 10,000 downloads of the App is achieved)	
<ul style="list-style-type: none"> Interest in the BreastFedNZ app content is maintained Post implementation review of BreastFedNZ app completed Implement the ‘Midland Use of Donor Breastmilk Protocol’ and information leaflet. 	
3. Smoke-free pregnancies	
<ul style="list-style-type: none"> Explore training video demonstrating a discussion of benefits of a smoke-free pregnancy, how to incorporate the use of a CO monitor into a consultation (note: CO monitors were distributed as part of MMAG’s 15/16 work plan) Smoke Free Pregnancy Tupeka Kore Framework (Waikato MQSP initiative) – look to implement across Midland maternity providers (<i>to be confirmed by Waikato MQSP/ Māori Health Team and Midland DHBs</i>). 	
4. Sudden Unexpected Death in Infancy (SUDI)	
<ul style="list-style-type: none"> Undertake a three yearly review the Midland Safe Infant Sleeping (Birth – 1 Year) policy, update safe sleep e-learning package on Moodle Audit against the Midland Safe Infant Sleeping (Birth – 1 Year) protocol (note regional protocol due for review 2017). 	
5. Maternal mental health, including alcohol and drug addictions	
<ul style="list-style-type: none"> Support training opportunities in Midland for perinatal anxiety and depression workshops across maternity and WCTO providers Share information, resources, and screening tools to help identify women with modifiable risk factors for perinatal related death, and identify areas where MMAG can work collectively to address these (PMMRC 9th Report 2015, recommendation 1). 	
6. Healthy weight gain in pregnancy /management of the bariatric pregnant woman	
<ul style="list-style-type: none"> Ongoing implementation of the MoH childhood obesity package, namely initiatives 4, 6 and 7: <ul style="list-style-type: none"> guidance for healthy weight gain in pregnancy, gestational diabetes guidelines, and referral pathways to Green Prescriptions for pregnant women (at risk of gestational diabetes) for LMCs to access via regional pathway tools Implement the ‘Midland Management of the Bariatric Pregnant Woman Guideline’. 	
7. Primary and rural birthing for women in the Midland region	
<ul style="list-style-type: none"> Share resources on how to reduce risks and interventions Review findings of Wintec research project on the experiences of women and LMC using primary facilities in the Waikato to identify learnings across Midland. 	
8. Coding in Midland maternity services	
<ul style="list-style-type: none"> Explore coding issues across Midland maternity services and work with DHB coders to find a resolution to support improved quality in the reporting of maternity data. 	

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

SUMMARY OF WORK CARRIED OUT, DELIVERABLES AND ACTIONS FOR 2016/17

Maternity Quality Committee (MQC) Work Plan

Chair: Belinda Chapman (MQSP coordinator and 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,
- 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 <i>Carried forward from 2015/16 Continue to Investigate co location of the Maternity and Neonatal units to be nearer to the operating theatre and child health services. Explore what the future maternity services will look like in Taranaki and whether a further primary maternity unit is required</i>	TDHB have sufficient primary, secondary maternity and Neonatal facilities that are conducive to safe birthing and a satisfying experience for women and their Whanau. With a focus on providing continuity of care, integrated, efficient and effective use of staff and equipment.	There has been a recent announcement that stages two and three of Project Maunga, the three-step redevelopment of Taranaki Base Hospital is to go forward which would include a new maternity unit. A Clinical Services Plan (CSP) is to be formulated, however before this can be finalised this point must be decided upon. This will involve extensive consultation with consumers and maternity practitioners to ensure the vision fits with any future maternity service plans with the aim of this being completed by the end of 2017.	To carry over to 2017/18 work plan	M&CHS manager, Quality and Risk, ADOM, CMM
2 <i>Carried forward from 2015/16 Continue to progress the strengthening of the model of care at Hawera primary maternity unit</i>	Provides a safe, low technical homely environment that is whanau/family friendly and meets the needs of the local population for low risk birthing. Continue to promote the use of Hawera maternity unit for low risk birthing To audit, review and reduce the length of stay in base maternity Unit, reaching comparability with other similar size and demographic units	The environment upgrade of Hawera maternity unit has been completed. There has been new furnishings blinds and furniture, including decorating of walls, resources for promoting normal birth such as bean bags and the environment now has posters and information for consumer A leaflet on Hawera primary maternity unit services and facility has been produced and the information is also on the TDHB maternity internet site that can be accessed by consumers Length of stay audit has been completed, please see audit section; led by Helen Hall	Completed	CMM, Leigh Cleland, Jenny James

3	<p>Continue from 2015/16 Inclusion of consumers in the Maternity Quality and Safety programme (MQSP) governance at TDHB to enable consumer informed decision making</p> <ul style="list-style-type: none"> -Commence meet your maternity services road show -Investigate Wahakura weaving parenting sessions -Annual consumer feedback survey and follow up of recommendations from 2015/16 survey -Inclusion of Maori consumer 	<p>Consumers have knowledge and understanding of the maternity services in TDHB</p> <p>Consumer voice is collected via surveys and feedback and informs the future direction of service delivery for Taranaki DHB</p> <p>Consumers in TDHB have a forum/space to share ideas and connect with other maternity consumers to ensure all ethnicities and needs are met</p>	<p>August 2016: Commence meet your maternity services road show</p> <p>Investigate Wahakura weaving parenting sessions</p> <p>Completed. Report presented to MQSC and uploaded to TDHB website, recommendations to be processed</p>	<p>Completed see Engagement with an LMC section</p> <p>Planning and Funding working with Tui Ora and Hapu</p> <p>Wananga now the programme has been received</p> <p>Completed</p> <p>Maori consumer appointed but now resigned to C/F to 2017/18</p>	ADOM/ consumer
4	<p>Continue from 2015/16</p> <p>Improve LMC registration so that access to care is increased-increase the number of women accessing an LMC in the first trimester</p> <p>early engagement with an LMC promotion</p> <p>GP practices are refreshed in assisting women to find an LMC, and early pregnancy assessment and care</p>	<p>Consumers engage in the first trimester with an LMC with an aim of increasing to 78%</p> <p>Progress the video advert on early engagement with an LMC to improve access across all ethnic groups</p> <p>5 Top things to do in the first 10 weeks of pregnancy messages are received</p> <p>Continue the GP road show to communicate with and update GP's on assisting women to find an LMC, and early pregnancy assessment and care</p>	<p>Latest data reports an increase in consumers engaging in first trimester (see clinical indicator section)</p> <p>Advert developed called Supa Mama.</p> <p>Feb 2017: Comms are working on its release to hit the demographics intended</p>	<p>Increase in early engagement in the first trimester</p> <p>Completed and on going</p>	O and G, ADOM and ANC coordinator
5	<p>Carry forward from 2015/16</p> <p>Training of theatre staff on the importance of early skin to skin, breastfeeding and care of the at risk newborn</p>	<p>Theatre staff have the knowledge of the importance of skin to skin and promotion of early breastfeeding post caesarean section where medically appropriate</p>	<p>PN coordinator held one in service. Will require to present this on several occasions to capture all staff (scheduled for August 2017). Care of the post op c/section woman in PACU requires revisiting the staffing project and ties in with reducing 37+ week gestation admissions to NNU</p>	Completed	PN coordinator
6	<p>Continue from 2015/16</p> <p>Investigate how to reduce Neonatal admissions by continuing to monitor and explore reasons for admission, and action plan any identified improvements for care and practices</p> <p>Initiate MDT case review meetings to review all cases admitted to NNU from 35 week gestation onwards with a focus on reasons and decision making for admission.</p>	<p>Neonatal Unit admission rate reflects 10-15% of TDHB birth rate.</p> <p>Reduction in separation of mother and babies due to NNU admission</p>	<p>Cases discussed at Tuesday meeting.</p> <p>Continue to monitor</p>	<p>NNU admissions have decreased in this year</p>	NNU manager/ CMM/MQSP coordinator

7	Timing of planned early birth at Taranaki DHB (including elective caesarean sections and inductions of labour). See audit section	Planned Early births <39weeks gestation will be done in consultation with all appropriate parties and within the recommended RANZCOG guidelines, due to the increased risk of respiratory morbidity, surfactant deficiency and pulmonary hypertension for neonates when delivered before 39 weeks gestation.	See audit section for results	Completed	O and G
8	The maternity unit has a risk register.	Corrective actions and identified risks are documented in the register		This is currently being set up and implemented in July 2017	QR
9	Improve screening and services for vulnerable perinatal women, babies and families Investigate FTE to coordinate MWCPMAG (MAG)	Updated pregnancy and parenting directory (in August and February) that is distributed to maternity stakeholders and practitioners There is set FTE to meet the required hours needed to coordinate MAG Maternity staff are educated on the CYFS changes that come into place on 1st July 2016 Information leaflet on the Perinatal mental health services is available for maternal-infant health practitioners and one for clients Perinatal mental health services are monitored to ensure the service meets the needs of local clients and that practitioners are aware of the services available. Improved integration of PNMH, maternity, drug and alcohol and well child provider services	Directory update completed and circulated in September 2016 and in Feb 2017 These two meetings are now combined with administration support. Some fine tuning will occur as the initial meetings happen in terms of attendance, roles and responsibilities. Feb 2017: Increases 0.7FTE CPC position advertised that will oversee the combined PLM/MAG meeting with admin support from CACC PMMH consumer is designing a leaflet Ongoing reinforcement of the need to have EPDS completed as a baseline and both ante natal and post natal for all women under Maternity Services. Referral as per the Perinatal Referral Pathway with accompanying EPDS and referral letter with full obstetric history / identifying Mental health issues related to pregnancy/ baby. Further education sessions as required. Utilise GP practitioner network to include GP's. Further Plunkett Nurse education sessions. For those declined by the PNMH Service - Survey the referrers of clients and consumers themselves. Encourage re-referral if required (currently done in the letter declining service). Q. 6/12 reports of Referral numbers and outcomes 15% births are referred to PNMH	Completed in Feb 2017 Completed September 2016 Completed 2017 Guideline completed, published and presented in July 2017	MQSP coordinator CMM/MCHSM ME PNMH PNMH/MQSP coordinator
10	Vaginal Birth after a caesarean section: Continue to investigate what range of services and support TDHB can offer to women in support of VBAC. Including retrospective audit of potential VBACS	Women that are considered suitable for VBAC have a consultation with a specialist and are counselled and presented with full information on the risks and benefits of VBAC with a focus on promoting confidence to labour where appropriate.	The ANC Co-Ordinator was keen to initiate some education/information re promoting VBAC. Unfortunately the FTE (0.7) for ANC midwife has not allowed time to do this.	Unable to complete	ANC coordinator/OG

11	<i>C/F from 2015/16 Pregnancy Ultrasound: investigate the rising primary and secondary ultrasound scans in relation to equity, access and timeliness and Audit of repeat anatomy scan reasons.</i>	Reasons for escalating ultrasound scans is identified and addressed Referrals for primary ultrasound scans meet the section 88 criteria		Audit commenced in July 2017, results and recommendations not available yet	Fulford/OG
12	<i>C/F from 2015/16 Continue to train maternity staff and community midwives on FVIP screening and assessment. Monitor maternity patients screened for FVIP</i>	100% maternity staff trained for FVIP screening, assessment 70% of women who come through the maternity services at TDHB are FVIP screened	All employed Maternity staff completed.	New FVIP training to be released soon. Released early 2017	FVIP coordinator
13	<i>C/F 2015/16 Continue to monitor the level 1 caesarean section and GA rate in relation to timing and % of level 1 caesarean section</i>	Timing of level 1 caesarean section meets the auditable standard of 30 minutes from decision to delivery time GA caesarean section rate compare to similar geographical units eg Lakes DHB Presentation of data to inform practitioners Educational requirements are met	All cases are monitored, will be presented as per reporting grid All level 1 caesarean sections are case reviewed	2016 data completed See page	MQSP coordinator
14	<i>Antenatal clinic services: Further develop the virtual consultation clinic for cases eg that may require aspirin in early pregnancy or early advice from a specialist C/F from 2015/16: Explore how Gestational diabetes services can be improved by the implementation of a midwife specialist in GDM to work with O and G specialist</i>	Virtual consult clinic is established and utilised GDM women have timely coordinated services for healthy eating, healthy weight gain, exercise, monitoring and treatment in pregnancy with a focus on continuity of care Green Prescription is prescribed and utilised	New virtual consult email address has been set up and in action. This has not gone forward	Completed Not completed to Carry forward	ANC coordinator/ CMM
15	<i>C/F from 2105/16 Continue to review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres</i>	All cases 24/7 have a core midwife/nurse who is responsible to provide early newborn and delivery care in the operating theatre and until transferred to the postnatal ward. Neonatal unit admission rate is reduced and within 10-15% of birthing population	On going, staffing trial did not aid this at night. Staffing trial evaluation completed No further progress needs prioritising with staffing meetings, admissions to NNU. 1.5FTE pool midwifery positions signed off Feb 2017 may assist when pool midwives on shift	Midwifery positions on Pool 1.5FTE 4,8 & 12 hr shift trial in progress	ADOM/ MCHSM/CMM/ NNU CNM/ Paeds

16	Standardisation of Neonatal resuscitation trolleys throughout TDHB	All departments which require to resuscitate newborn babies have standardized resuscitation trolleys to reduce risk and confusion	Completed in July 2017	Tobacco control coordinator/ MQSP
17	<p>C/F from 2015/16 Better help for pregnant women to quit smoking:</p> <p>Updating of the screening and referral form</p> <p>Review the ABC pathway, resources and training</p>	<p>Ensure 95% of all women hospitalised who smoke are asked about their smoking status, given brief advice to stop smoking and are offered/given effective smoking cessation support even if they don't want to quit within the hospital based maternity services.</p> <p>Quality improvements made to the ABC pathway- screening and referral form</p> <p>Resources, internal and external are available including communication of services available eg Quitline and smoking cessation support/providers</p> <p>Induction compulsory training for all new employees to include specific section for maternal and child health</p> <p>Maternity training on screening and supporting women to quit smoking is provided free to all maternity practitioners</p> <p>TDHB maternity stop smoking champion</p> <p>Raise the profile and improve the referral process and pathway for hospitalised pregnant smokers to specialist stop smoking services</p> <p>KPI-quarterly monitoring and reporting</p> <ul style="list-style-type: none"> -Tobacco Health Target -Increase pharmacy NRT use <p>Taranaki data shows a reduction in pregnant women who have quit in pregnancy</p>	<p>Identified 2 smoking cessation champions: Met with Maori Health services, planning and funding and Tui Ora services 22/8/16</p> <p>MQSP coordinator met re the maternity work plan and progressing improvements in the screening and referral process, NRT collection of data and proactive use of within the maternity unit. Also education for breastfeeding, stop smoking support, screening and referral and SUDI and include use of CO monitor. Information on local data so practitioners are aware of the KPI's, screening numbers, numbers referred, numbers stop smoking and numbers of NRT accepted. Awaiting further information from Tui Ora. Inservice 25th May 2017 completed on Co monitor and referral</p> <p>Completed</p> <p>Hospital referral for smoking cessation has been updated.</p> <p>Vaporizes from pharmacy-PN coordinator following this up.</p> <p>Data not available</p>	<p>Tobacco control coordinator/ MQSP</p>
18	<p>Increase access to Nicotine Replacement Therapy (NRT) and smoking cessation medicines within hospital based maternity services</p> <p>C/F from 2015/16 Pregnancy and Parenting education (PPE) services meet the requirements of consumers</p> <p>Devolution of the PPE contract locally from 1 July 2016</p> <p>Work with LMC's and the Te Kawanu Maro Mama, Matua, Pepi, Tamariki services to increase the uptake of PPE</p>	<p>PPE contract is implemented locally</p> <p>30% of Maori/Pacific and teen first time parents complete funded pregnancy and parenting education</p> <p>Hapu Wananga programme is released and utilised in TDHB</p>	<p>No further updates</p> <p>The review of current education services has not happened yet. It is anticipated to be concluded by the end of the financial year. Recommendations around future models of antenatal and parenting education will be an intended outcome of the review.</p>	<p>Pl and Funding/ MQSP</p>

19	Small for Gestational age babies born 40-42 weeks (Clinical Indicator 20): See audit section below	Number of babies born SGA between 40-42 weeks gestation are reduced to 35% Education on recognition of risk of SGA and use of diagnostic tools is implemented	GAP programme e-learning offered to all maternity practitioners including All undiagnosed SGA babies are presented at case review	Audit completed see GAP face to face training in October 2017	OG/ MQSP
20	Clinical coding: Identify and review clinical coding processes to ensure the quality of local data is reliable and accurate.	Errors in coding are identified and actions are implemented to ensure coding errors are minimised	MQC coordinator met with team leader of coding update of birth and newborn summary sheets currently at printers to assist coders	Awaiting printers	Coder manager/MQSP
21	NZ Maternity Clinical Indicators are reviewed and presented to practitioners locally. Acknowledge where local data is excellent and identify actions to improve outcomes where data indicates	All maternity practitioners are aware of local outcomes by presentation of data on local dashboards, newsletters and education sessions All practitioners are engaged in actions for improvements	2017 Fortnightly case review Newsletter circulated and weekly educator newsletter commenced 2017 Dashboard for normal birth /caesareans and assisted birth indicators	On going	MQSP/OG
22	Children's service level alliance team (SLAT): Maternity representation and alliancing to progress SLAT work plan including implementation of National Child Information Platform (NCHIP)	SLAT work plan is progressed NCHIP is implemented and established by September 2016	NCHIP now in operation, individual training offered to community midwives with the aim for it to be established in September 2016. SLAT meeting now disbanded with projects falling out of this becoming business as usual for the teams involved.	Completed	ADOM/SLAT
23	Alliancing project between NZCOM, community midwives, DHB and PHO's	Primary maternity leadership is developed in the community midwifery workforce in TDHB Capacity for community midwifery equals demand Partnerships among community midwives, DHBs/PHOs/GP are evident IT infrastructure is conducive to information sharing between community midwives, DHB and PHO/other primary care providers	5 leadership midwives trained by NZCOM Monthly liaison meetings with ADOM TOR formulated and circulated to all community and core midwives Request for WIFI access from community midwives to assist with information required in urgent cases and communication	Completed Completed Completed	NZCOM chair/ ADOM
24	National Perinatal and Maternal Mortality review committee and National Maternity Monitoring Group recommendations	That all recommendations from both annual reports are noted and communicated to TDHB maternity practitioners and implemented where appropriate	PMMR meeting in September MQC coordinator presented the findings. All cases of PMMR and Neonatal encephalopathy are reviewed ACC NE roadshow to Taranaki in April 2017. Completed awaiting feedback	Completed Completed	

AUDITS:	Purpose				
1	<i>Clinical Indicator 20 SGA 40-42 weeks</i>	To retrospectively investigate the antenatal management of cases of SGA born between 39-42 weeks gestation to see if there are improvements/education and practices that can be identified and implemented to reduce risk and number of cases undiagnosed. Identify if SGA risk was identified in pregnancy and if consultation with a specialist and preventative treatments were implemented eg aspirin Smoking prevalence in SGA cases MSS1 / Low PAPP: were recommended pathways and consultation with a specialist followed Was SGA diagnosed and was appropriate care planning and management instigated	Raw data has been obtained LMC's to generate GROW chart at booking in order to identify an Hx of IUGR and then refer for Obs consult as per referral guidelines. A flow chart (looking at urgent Referrals to FAU) has been completed .	Audit completed see GAP training organised for October 2017	
2	<i>Preterm Birth</i>	To examine local practices in relation to the national PMMR recommendations on preterm birth: Focussing on practices where there is a history of preterm birth: Early consultation, consideration of progesterone treatment, cervical length measurement. Focussing on recommended practices: Fetal fibronectin testing, use of antenatal steroids, tocolysis, magnesium sulphate for neuroprotection and in utero transfer	Audit complete Recommend further audit to cover more years for larger sample size.	Completed April 2017	ME/QR/O&G
3	<i>Syntocinon Augmentation in labour</i>	To investigate how and when the use of Syntocinon augmentation is implemented Ensure Syntocinon augmentation is utilised appropriately To explore if further education is required for the use of Syntocinon augmentation in labour	Not completed to carry forward	Carry forward	O&G/ME/QR
4	<i>Induction of labour/cervical ripening</i>	To evaluate the implementation of the cervical ripening procedure introduced in 2015	CMM to complete	Induction of labour audit completed see	CMM
5	<i>Variation in gestation at birth</i>	Evaluate Induction of labour processes in TDHB with a focus on variation in gestation of birth. Evaluate elective caesarean sections performed before 39 weeks gestation with a focus on variation in gestation of birth	Audit completed	Completed see	ME/O&G/QR
6	<i>Intrapartum Fetal surveillance audit</i>	To audit practitioners pre and post RANZCOG fetal surveillance training as per RANZCOG	Not completed	Not completed to carry forward	ME/QR/O&G

7	Implementation of GDM guidelines Needs circulating to governance and comments/actions decided	Ensure the pregnancy pathway for women who have GDM is followed. Recommended testing in pregnancy is followed eg of HbA1C at booking,	August update: Completed and presented by Medical Interns	Completed see	
9	Length of Stay at BMU	To audit, review and reduce the length of stay in base maternity Unit, reaching comparability with other similar size and demographic units	Completed	Completed see	
	EDUCATION REQUIREMENTS: Educational sessions to be planned as per feedback from case review and audit: • Use of fetal scalp clip; • PPH- identifying risk factors-early recognition and treatment; • SGA recognition of risk factors- diagnosis and treatment		Educator arranged in service for September x 2 PPH: Covered at Midwives Emergency Refresher day annually and by postnatal co ordinator as scenarios. E learning module to be developed if one not in place that is suitable in Ko Awatea E-learning on GROW sent out to all practitioners	Completed Completed Completed	ME

MQSP STRATEGIC PLAN DELIVERABLES FOR TARANAKI DHB AND THE MIDLAND REGION

LIST OF PRIORITIES, DELIVERABLES AND PLANNED ACTIONS FOR 2017/18

Maternity Quality Committee (MQC) Work Plan

Chair: Belinda Chapman (MQSP coordinator and 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	Responsibility
<p>1</p> <p><i>Carried forward from 2016/17</i></p> <p><i>Explore what the future maternity services will look like in Taranaki and whether a further primary maternity unit is required following a recent announcement that stages two and three of Project Maunga, the three-step redevelopment of Taranaki Base Hospital is to go forward which would include a new maternity unit.</i></p>	<p>TDHB have sufficient primary, secondary maternity and Neonatal facilities that are conducive to safe birthing and a satisfying experience for women and their Whanau. With a focus on providing continuity of care, integrated, efficient and effective use of staff and equipment.</p>	<p>Project Maunga, (Service Manager, ADOM, CMM, Midwives, Community Midwives, LMC's, Obstetric team, educator and maternity stakeholders, consumers).</p>

2	<p><i>Workforce Development carried forward from 2016/17:</i></p> <p><i>A. Investigate current funded core midwifery model of care and ensure it meets the needs of the service in times of high acuity.</i></p> <p><i>B. Continue to review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres</i></p> <p><i>C. Explore how Gestational diabetes services can be improved by the implementation of a midwife specialist in GDM to work with O and G specialist</i></p> <p><i>D. Lactation Consultant services are accessible and equitable</i></p>	<p>A. Midwifery staffing meets the safe staffing standards and the needs of the service. Providing a model that focusses on providing continuity of care, integrated, efficient and effective use of staff. This includes seamless transfer of responsibility between midwives</p> <p>B. All cases 24/7 have a core midwife/nurse who is responsible to provide early newborn and delivery care in the operating theatre and until transferred to the postnatal ward. Allowing seamless transfer of care between levels of maternity and other health services.</p> <p>C. GDM women have timely coordinated services for healthy eating, healthy weight gain, exercise, monitoring and treatment in pregnancy with a focus on continuity of care between maternity and other health services.</p> <p>D. Review Lactation consultant services to ensure they are accessible and equitable to north, south and central Taranaki breastfeeding women who require advice or assistance with breast feeding</p>	DON, ADOM, service manager, CMM, midwives, MERAS and NZNO.
3	<i>Recruit a second maternity consumer</i>	Consumers in TDHB have a forum/space to share ideas and connect with other maternity consumers to ensure all ethnicities and needs are met	ADOM and consumer/quality rep
4	<i>Carried forward 2016/17</i> <i>The maternity unit has a risk register.</i>	Corrective actions and identified risks are documented in the register	Quality and risk/QR midwife
5	<i>Nuchal Translucency scanning service</i>	There is equity of access to NT scans in Taranaki for 100% of pregnant women who meet the criteria/ who make the informed choice for combined maternal screening, or have a reliable alternative screening available.	ADOM, HOD O and G, service manager
6	<i>HDU</i>	Telemetry coverage to be improved for maternity to enable women to be monitored in Delivery suite-this will reduce the amount of time and events staff are required on call; anxiety for staff, the mother and whanau of elective birthing in HDU (facility in HDU for labour and birth is not designed to birth in eg sound proofing, privacy and not en suite bathroom facility).	Quality and risk, CNM HDU, CMM, service manager.

AUDITS			
1	<i>Syntocinon Augmentation in labour</i>	To investigate how and when the use of Syntocinon augmentation is implemented Ensure Syntocinon augmentation is utilised appropriately To explore if further education is required for the use of Syntocinon augmentation in labour	O and G/QR
2	<i>Induction of Labour</i>	To investigate the rising Induction of labour rate in relation to clinical indication, gestation of birth and clinical outcome and failed induction (Health Round Table data).	O and G
2	<i>Intrapartum Fetal surveillance audit</i>	To audit practitioners pre and post RANZCOG fetal surveillance training as per RANZCOG	O and G
3	<i>PPH</i>	To continue investigating on a month by month basis PPH and accompanying data as per Jan-June 2017, to implement and work toward a reduction in PPH at TDHB by June 2018 to 10 %.	ADOM, Educator, CMM, O and G, service manager
4	<i>SGA</i>	Future QI Topic Recommendation: It would be useful to have a follow up project based on this audit to further investigate whether the mothers of these SGA infants in 2013 and 2014 were appropriately managed in subsequent pregnancies for prevention/early detection and treatment of SGA.	O and G
5	<i>High Dependency Unit</i>	-Replicate audit in 2017-2018 to investigate if there has been any reduction in admission rate and improvement in processes and outcomes -Maternal HDU flow chart/protocol to be developed in consultation- work towards reducing the mother/baby separation (Carried forward)	Core midwife/QR and ADOM
6	<i>Length Of Stay</i>	To Investigate if the postnatal average length of stay (LOS) in Base and Hawera maternity units can be reduced as per Health Round Table data for vaginal and caesarean birth and identify if there are any factors which are a barrier for earlier discharge home.	QR/CMM/PN coordinator/Hawera midwife
7	<i>Group B Streptococcus (GBS)</i>	Investigate the number of cases of GBS positive women who were identified in pregnancy through laboratory testing and if evidence based treatment and practices were followed.	O and G audit team/QR
8	<i>Preterm Birth (recommended further audit from 2017 audit recommendations)</i>	To further examine local practices in relation to the national PMMR recommendations on preterm birth: Focussing on practices where there is a history of preterm birth: Early consultation, consideration of progesterone treatment, cervical length measurement. Focussing on recommended practices: Fetal fibronectin testing, use of antenatal steroids, tocolysis, magnesium sulphate for neuroprotection and in utero transfer	O and G team

9	<i>Third degree tear audit</i>	To investigate the incidence and management of third degree tears in 2017/18 to compare with previous years audit. Identify any improvements in practices / initiatives for prevention (See UK and Southland initiatives).	O and G/QR/MQS
10	VBAC	RecommendationNumber The results of the 2016/17 audit should be reviewed in the future, in accordance with RANZCOG guidelines and compared to VBAC rates over the last 10 years to see if the rate is rising or falling and identify if initiatives can be implemented to increase the rate where appropriate.	O and G/MQC
11	<i>Instrumental birth</i>	To investigate the incidence and indication for assisted birth (Ventouse and forcep) compare rates to previous years and identify if evidence based/best practice was followed in relation to care in labour and birth.	O and G/MQC
	EDUCATION		
	<i>PPH</i>	To maintain continuing PPH education for TDHB staff in relation to investigative outcomes (see audit section)	Midwife educator and ADOM/ O and G
	<i>Signs of the deteriorating maternity patient</i>	To further educate maternity staff on the signs of the deteriorating maternity patient by providing all relevant education eg PROMPT, Midwives Annual Emergency Refresher, Clinical scenarios, recognition of deteriorating patient, MEWS.	Midwife educator/ PROMPT educators
	<i>RANZCOG FSEP</i>	To provide continuing FSEP education for TDHB as part of HDC recommendations for TDHB staff. Booked for 20 April-will be the 3 rd year with this programme for TDHB. Requires an O and G to lead this audit.	O and G
	<i>NZCOM</i>	NZCOM Post Natal workshop to be brought to our region as requested by NZCOM-Safety and Sensitivity as requested by Taranaki NZCOM members. NZCOM local branch to part fund to \$1000 toward bringing the workshop to Taranaki	NZCOM
	<i>Breech</i>	Midland co-operative venture for 2018	Midland Educators

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

LIST OF PRIORITIES, DELIVERABLES AND PLANNED ACTIONS FOR 2015-2018

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	Planned activities	Measure	Work Completed
1 Inclusion of consumers in the Maternity Quality & Safety Programme (MQSP) governance at Taranaki DHB to enable consumer informed decision-making • Consumer engagement survey • Consumer representative for the Maori, Indian and Pacific ethnicities identified and utilised to assist MQC.	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.	Sept/Oct 2015: Pilot survey, conduct 100 surveys per year and collate information and publish findings annually. Consumer conducting face to face surveys, a target of 100 surveys from across Taranaki and across the demography is aimed. The consumer uses this time to increase consumer awareness of the BreastFedNZ app, Pepi Pods and other consumer focussed initiatives Sept/Oct 2015: An advert for a second consumer has been advertised on Taleo and on Facebook for a period of 5 weeks, interview dates to be set with panel member being a consumer, Maori representative, MQS member	100 consumer surveys completed annually Two maternity consumer representatives sit on the MQC governance group	Progress the survey, 60 have been completed so far for 2015 Position advertised and appointed in 2016 but needs re advertising in 2017/18

Project	Expected outcome	Planned activities	Measure	Work Completed
2	<p>Promotion of primary birth campaign (use of primary facility and homebirth)</p> <p>Strengthen the model of care at Hawera Maternity unit-aligning with past Stratford unit.</p> <p>Upgrade of Hawera primary maternity unit</p>	<p>Increase in consumer knowledge of primary birthing.</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>Timely emergency response and skills from St John and base hospital for neonatal retrieval</p> <p>Increase in bookings for primary birthing</p> <p>Upgrade of Hawera Maternity facility is completed</p>	<p>An information leaflet on Hawera Primary maternity unit is to be developed and published</p> <p>Visit other primary maternity units to view facilities with core midwives and present to local LMC, consumer and LMC's to promote engagement in facilitating the upgrade of Hawera maternity unit. Develop a proposal of changes to be made and facility upgrade.</p> <p>Upgrade facility and market the changes and facility</p> <p>Upgrade the TDHB Internet site on maternity services and local information on primary and homebirth</p> <p>Neonatal Emergency Response Team (NERT) process to be implemented in consultation with rural midwives, St John and Taranaki base hospital</p> <p>PROMPT training to be held twice yearly in Hawera primary maternity unit to promote relationships within rural emergency response services</p> <p>Rural midwives and St John encouraged to share orientation of layout of emergency resuscitation equipment and communication</p>	<p>Information leaflet developed by September 2016</p> <p>Proposal development</p> <p>Upgrade of facility commenced by June 2016</p> <p>TDHB Maternity Internet site has up to date information on availability of maternity services in Taranaki and information on homebirth</p> <p>Increase in bookings at Hawera Maternity unit to 120 by June 2018</p> <p>NERT response is implemented</p> <p>PROMPT training is implemented and held twice yearly</p> <p>Staff member identified to lead this project-completed in 2016</p> <p>Visit to other primary units has been completed and proposal drawn up in Oct 2015.</p> <p>Awaiting facilities management-completed 2017</p> <p>Work commenced in Maternity</p> <p>Internet information update in Oct 2015-completed in 2016 and on going</p> <p>NERT response flow chart implemented in July 2015</p> <p>PROMPT training presented annually</p> <p>CURT completed in 2016/17</p> <p>Hawera upgrade has been completed in 2017</p>

Project	Expected outcome	Planned activities	Measure	Work Completed
3. Exploration of a maternal and child health hub for Stratford and surrounding districts following the closure of Stratford primary maternity unit	A completed investigation and report on the feasibility of having a maternal and child health hub for Stratford and surrounding district	<p>Key stakeholders and community groups identified</p> <p>Draft project plan by June 2015</p> <p>Agreed governance structure and participation By beginning of July 2015</p> <p>Establish a governance group structure and participation</p> <p>Assess feasibility for hub by :</p> <p>Engaging the Bishops action foundation trust to run the scoping project for a hub</p> <p>Develop Project Scope Including</p> <ul style="list-style-type: none"> • Project timeframes and milestone • Linkage with the wider Stratford health services integration project • Liaison with other services, PHO and Healthcentre • Intersectoral Focus – Role of Other Agencies • Improving access to services • Consider visiting other sites with similar models of care • Future proofing • Appropriate process for engagements with mothers and families about services for the area <p>Complete a report on findings</p>	<p>Scoping project for hub completed by June 2016</p> <p>Report completed by Sept 2016</p>	<p>Draft project plan and governance structure completed in June 2015</p> <p>Completed in 2016. Bishops action foundation were contracted to survey the providers and Stratford community on the interest of a child/maternal hub. As a result of limited feedback, the DHB is no longer progressing a hub</p>
4. Review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres	<p>All Caesarean section (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 <24hrs</p>	<p>Project group to be formed with representation from quality and risk, operating theatre, NNU, maternity, service manager and consumer</p> <p>Investigate feasibility of implementing a midwife or RN to follow through women and babies undergoing caesarean section birth. Include benefits and risks of current service and future services, what will be required to implement change including staffing, education and training</p>	<p>All women undergoing caesarean section have a core RN/RM present to care for mother and baby before, during and following caesarean section by 2017.</p> <p>Reduction in babies admitted to NNU <24hours by 20%</p>	<p>Sept 2015 project group initiated</p> <p>October 2015 admission to NNU < 24hrs old examined and costed</p> <p>Staffing options explored Oct 2015</p> <p>This is on going in 2017/18</p>

Project	Expected outcome	Planned activities	Measure	Work Completed
5 Stop smoking support and NRT therapy for pregnant women, partners and whanau is available and executed in a timely manner	<p>All pregnant women are screened for smoking in pregnancy and are given brief advice and offered referral to smoking cessation support and NRT therapy</p> <p>Posters initiated, distributed and displayed around Taranaki promoting pregnant women and families to quit smoking</p> <p>Purchase of 3 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> <p>Reduction in number of small for gestational age babies (SGA) born in Taranaki at term</p> <p>Reduction in rates of SUDI in Taranaki</p>	<p>Monitor 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 admissions</p> <p>Monitor the number of pregnant smokers to specialist stop smoking services</p> <p>Develop and establish a referral process and pathway for hospitalised pregnant smokers to specialist stop smoking cessation services by April 2016</p> <p>Enable training around best practice to support attainment of quit smoking support indicator for all pregnant women within Taranaki</p> <p>Provide training to maternity practitioners in use of CO monitors to use as a tool to encourage pregnant women to stop smoking</p>	<p>95% or > pregnant women who identify as smokers are screened for smoking, given brief advice</p> <p>100% of women who consent to referral to smoking cessation support services are referred</p> <p>100% of women who are referred are contacted and seen within 7 days of referral</p> <p>2 training sessions per year are presented in Taranaki to engage all maternity related practitioners in smoking cessation training including use of CO monitors</p>	<p>CO monitors received end Oct 2015</p> <p>2017 Data shows 100% women screened in TDHB maternity</p> <p>2017 Training on CO monitors completed</p> <p>New provider and planning and Funding and investigating education provider for 2017/18</p>

Appendix 1 - Welcome to the Secondary Care Antenatal Service brochure



Useful websites

www.treasures.co.nz
www.kiwiifamilies.co.nz
www.diabetes.org.nz
www.pregnancyhelp.org.nz
www.findyourmidwife.co.nz
www.plunket.org.nz
www.parentscentre.org.nz
Financial assistance www.workandincome.govt.nz
Twins or more? www.nzmba.info

Contact us

Antenatal Clinic Coordinator
 Phone: 753 7888
 Email: Antenatal.Clinic@tdhb.org.nz

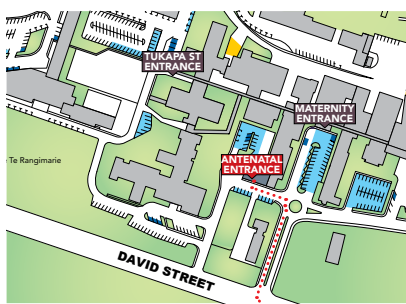
Labour Ward
 Phone: 753 6139 - ask for Labour Ward

Antenatal Clinic Ward Clerk
 Phone: 06 753 6139 ext 8336 or 7139
 (7am-3.30pm, Monday to Friday)
 Fax: 06 753 8687

Please contact the maternity staff at Base Hospital with any concerns about you or your baby's wellbeing. Do not contact the Maternity Unit at Hawera Hospital as all your records and medical cover is at Base Hospital.

Directions

The closest entrance to the Maternity Unit at Taranaki Base Hospital is on David Street. The Antenatal Clinic has its own entrance at the end of the Maternity Unit.




Where can I park?

- Patients / Visitor Parking
- Patients / Visitor Parking (1/2 hour limit)
- All Day Parking
- Mobility Car Parks

How to get to the entrance


Published: Communications Team
 Responsibility: Antenatal
 Date Published: May 2010
 Last Reviewed: November 2016
 Version: 4
 TDHB 11-2016

Welcome to the Secondary Care Antenatal Service



Our goal is to provide quality care for women and their families during their childbearing experience.

www.tdhub.org.nz



www.tdhub.org.nz

Taranaki Together, a Healthy Community
 Taranaki Whānui He Rohe Oranga

Why have I been referred to the hospital for my antenatal care?

You have been transferred to the hospital to be under the care of an obstetrician and the Taranaki DHB midwives. You may also have input from your own midwife, this will be discussed at the first appointment. You may have a medical condition, such as diabetes or a twin pregnancy, which requires close monitoring by an obstetrician.

Referral to the hospital Antenatal Clinic means the specialist and clinic midwife can monitor your blood tests and ultrasound scans, and respond quickly if there are any complications.

Where will I go for my antenatal care?

If you live in the New Plymouth area all antenatal care is undertaken at the Maternity Unit at Taranaki Base Hospital. If you live in South Taranaki you will attend all your Antenatal appointments at Hawera. Your labour and birth will be at Base Hospital, with either your own midwife or the labour ward midwife.

You will usually see the same specialist obstetrician for your care. However, when you come in for the birth of your baby you may be attended by another obstetrician.

What happens at the midwife visit?

The first visit with the Antenatal Clinic midwife occurs after seeing the specialist obstetrician unless you continue to see your own midwife.

During the visit, which takes about an hour, the midwife will discuss your thoughts and plans for the pregnancy and support you to make informed decisions about your labour and birth.

How often do I see a midwife?


Midwife visits happen between visits to the obstetrician and aim to give you a normal focus on your pregnancy.

After the first appointment the following visits with the midwife will enable you make decisions and preparations for labour, birth, feeding your baby and preparing for taking your baby home.

If you are seeing the Antenatal clinic midwife, once you have had your baby you can revert to the midwife that originally referred you for postnatal care. If you didn't have one the antenatal coordinator will help you find a midwife in your area.

You will be given information about antenatal classes and support groups in the community. The Antenatal Clinic midwife coordinates all your antenatal care.

When you come in for labour or for monitoring outside of normal antenatal clinic hours you are cared for by a hospital midwife.



Download the **BreastFedNZ** app to find breastfeeding help, information and support.

Our team in the Antenatal Service


- Obstetricians
- Referral to Maternal fetal medicine specialist in Wellington
- Midwives
- Ultrasonographer
- Ward Clerk
- Social Worker
- Health Care Assistants
- Lactation Consultant

Other services available as referrals

- Dietician
- Physiotherapist
- Maori health advisor
- Diabetes educators
- Speech and language therapist
- Maternal mental health service

Patient satisfaction

Patient satisfaction is important to us and we ask that you provide feedback about your stay in the Maternity Unit. Please ask for a How are we Doing Form.



TOP 5 things to do in the first 10 WEEKS

Expecting Pregnant Hapu

- ☐ Find a Lead Maternity Carer
- ☐ Consider early pregnancy screening
- ☐ Take iodine and continue folic acid
- ☐ Eat well and exercise
- ☐ Avoid smoking, drinking and other drugs

Appendix 2- Helpful questions for community screening

(Taken from presentation notes given in a recent teaching session for midwives)

In all of these symptoms/signs - Too much or too little is a sign of depression/anxiety

- Sleep
- Interest
- Guilt
- Energy – motivation
- Concentration – memory
- Appetite
- Attachment – Bonding
- Psychomotor – ants in their pants / hyper vigilance / staring at the walls / cant get out of bed / OCD
- Suicide – Ideation Plan Intent Attempts – preparatory Acts
- Disclosed thoughts of abandonment/ running away when you have a new baby is an equivalence – sign that they are not happy .
- Disclosed Thoughts of shaking the baby – educate – put baby in cot with the sides up and walk away – deep breaths counting settle down and only return when calm. Tag team partner – phone a friend or relative
- Disclosed baby would be better off without me

For acute mood elevation – consider hypomania/mania/drug induced elevation:

- **Distractibility** – can't focus on one thing easily distracted abnormal intensity (but not to be confused with ADHD pattern)
- **Indiscretion** = excessive involvement in pleasurable activities (does not need alcohol for this) – can be emotionally labile angry/tears in quick succession
- **Grandiosity** – nothing wrong with me I'm better than you
- **Flight of ideas** – thoughts racing from topic to topic - don't feed this with input - cant be reasoned with – least said the better – get help
- **Activity** – cant sit still cant eat or drink – too busy talking thinking – they don't feed this with input - cant be reasoned with – least said the better – get help
- **Sleep deficit** – brain too active - exhausted very quickly – major target is to medicate them enough to catch up on their sleep
- **Talkativeness** – like a flock of budgies – don't feed this with input – can't be reasoned with – least said the better – get help

Regardless of cause (bipolar disorder / drug induced) practical management is the same - limit verbal input and get help ASAP via Ambulance/Police/GP/E.D./ ABC (Crisis) team

Appendix 3 - Expected screening of MH in a pregnant client

- ☐ Past / Current low mood **YES / NO**
- ☐ Past / Current anxiety **YES / NO**
- ☐ Past / Current involvement with psychotherapy, psychiatrist **YES / NO**
- ☐ Past / Current prescription of psychiatric medications (even if prescribed by GP), such as:
 - Anti-depressants **YES / NO**
 - Anti-anxiety medication **YES / NO**
 - Anti-psychotics **YES / NO**
 - Benzodiazepines **YES / NO**
 - Mood stabilizers **YES / NO**
- ☐ Past / Current admission to a MH ward **YES / NO**
- ☐ Past / Current enrollment in community MH clinic **YES / NO**
- ☐ Past / Current use of illicit drugs and/or alcohol **YES / NO**

If you have answered YES to any of the above question, please provide further details and consider referring to the appropriate service.

.....

.....

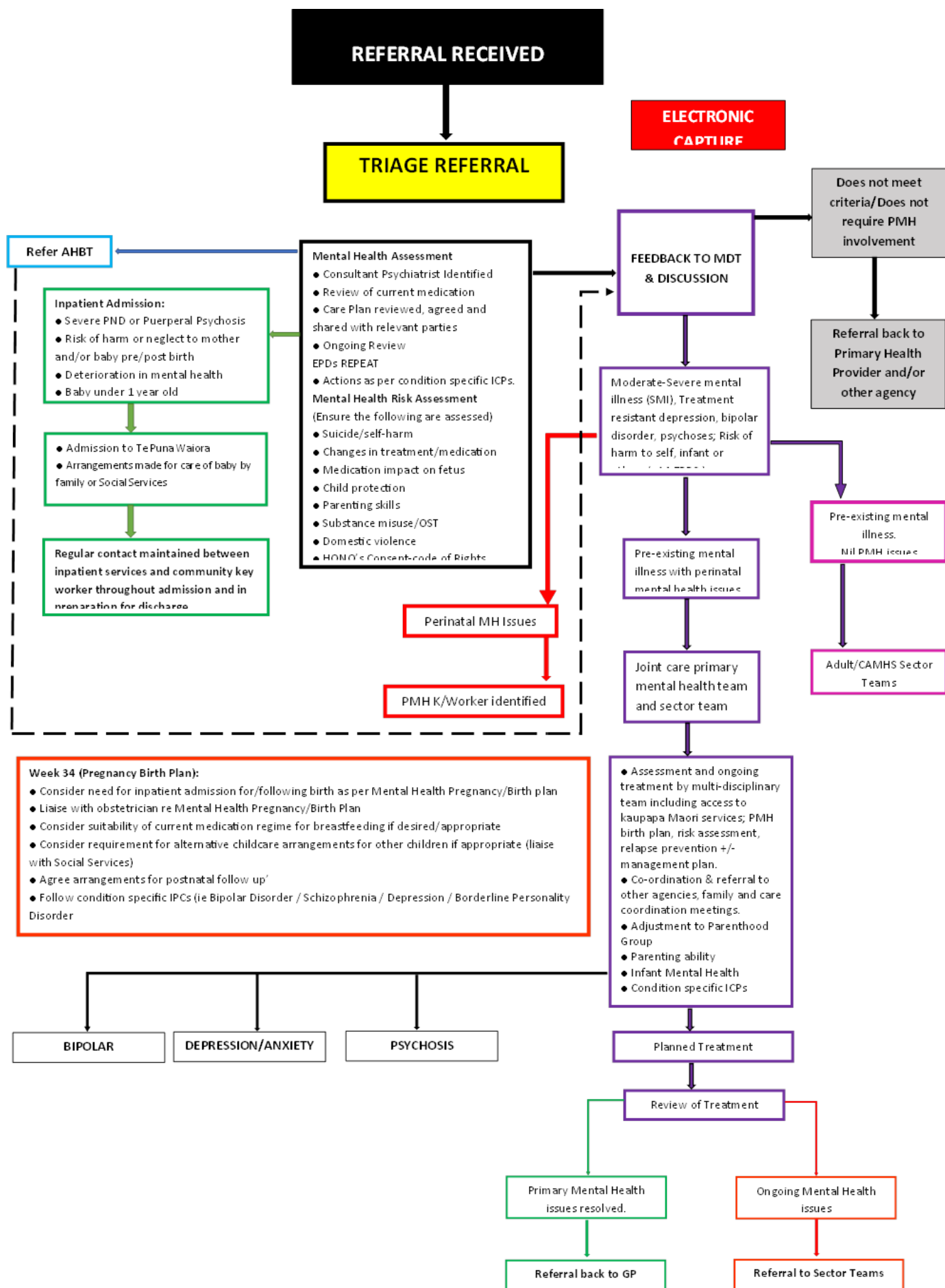
.....

.....

.....

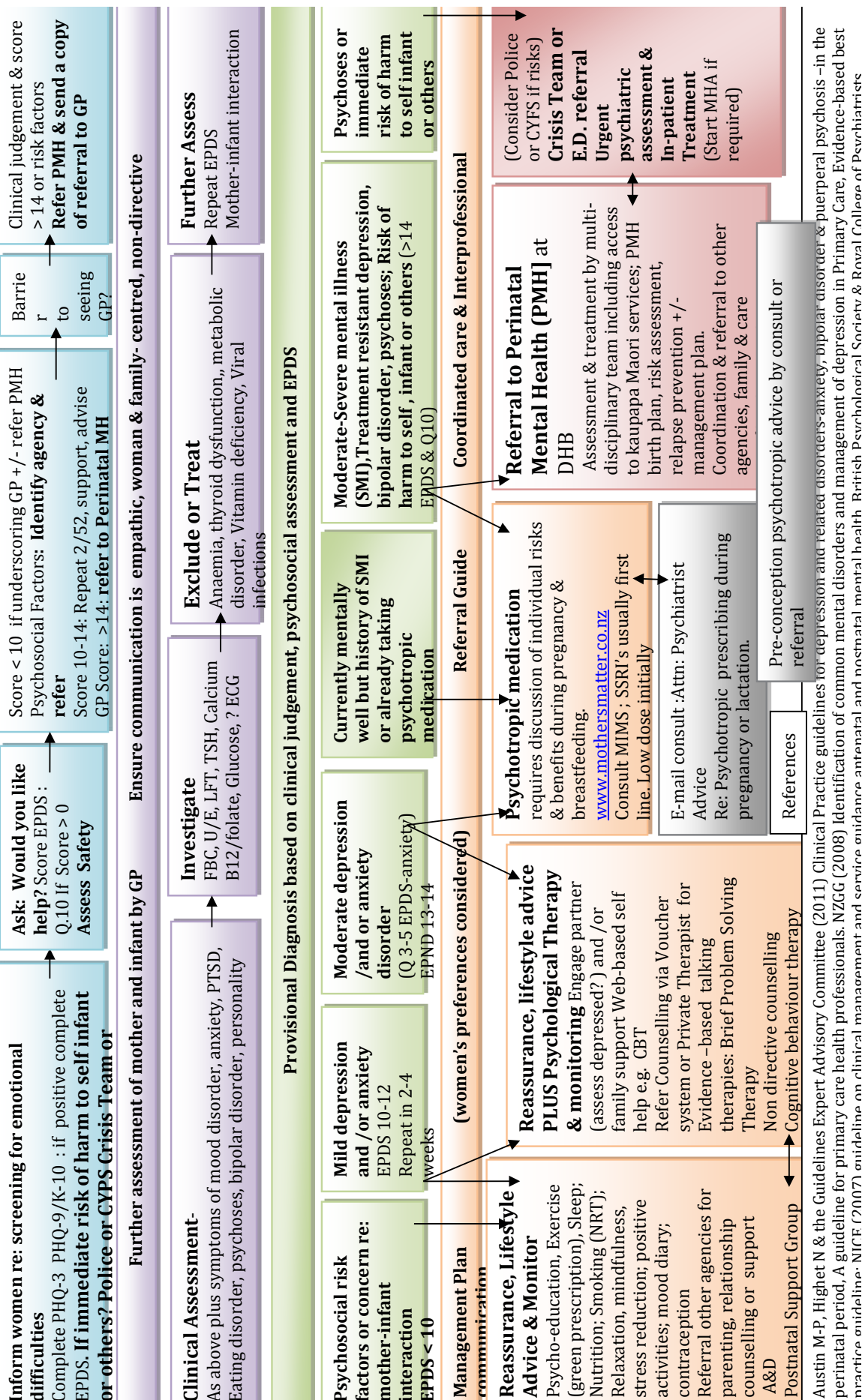
.....

Appendix 4 - Perinatal mental health flow chart



Appendix 5 - Perinatal mental health local referral pathway

All Health Professionals (midwife, Well Child Providers, social worker, psychologist, obstetrician etc) assessing a **woman during pregnancy and up to 1 year postnatally** have the **opportunity for screening for perinatal mental health problems**. This should occur at least once in the ante and post-natal periods, preferably twice.



Appendix 6 - Newsletter

VOLUME 1 ISSUE 14

Education Newsletter

19 May 2017



Kia Ora

Hi everyone. Wet and windy week but it has gone so very fast. I hope you all enjoyed the thunder and lightening! Lots of news and upcoming education for you all-have a great rest of your week. This week we wish Paula farewell as she sets off on her great adventure to TI. We will miss you sunshine ☺



My favourite ever pic of Paula with our lovely school friend Liz taken by our friend Jenny James ☺

Education Updates

Inside This Issue

- 1 Kia Ora & Education update
- 2 Further updates
- 3 Employee Profile
- 4 Birthdays and Anniversaries

*12 days to go before
GROW as we know it
stops!*

*Please make sure that
you all do the online
GROW app work*

PROMPT 23 JUNE

There are two available positions for midwives on PROMPT due to a withdrawal from a colleague. Please let me know if you would like to attend this and you are not rostered to work on this day already. This can be your midwives emergency refresher as long as you have not done PROMPT in last 3 years.

NZCOM JOURNAL ARTICLE

I have attached below the latest journal article from NZCOM titled 'Outcomes of blood loss post physiological birth with physiological management in the third stage of labour at a maternity home in Japan' as not all of you are members of the college. Really interesting read!



Untitled.msg

Latest Maternal Smoking Data

Hot off the press from TDHB's smoking portfolio manager Marnie-looking great team ☺



Copy of Copy of Q2 1617 Maternity smoki
Copy of Q1 1617 Maternity smoking.xls

Audit News

PRETERM LABOUR AUDIT-by C Pandit & M Fernando (TI)

The aim of this audit was to review the management of patients presenting with pre-term labour who met the requirements for the guidelines as set by Taranaki DHB, over the year of 2016.

Originally this included fetal fibronectin testing, magnesium sulphate administration, steroid administration, in-utero transfer, and tocolysis. During the audit, the topic was narrowed to focus specifically on the administration of steroids and magnesium sulphate in the context of preterm birth.

Results

Steroids

25/32 births $\leq 34+6$ weeks gestation received two doses of antenatal corticosteroids. The 7 case who did not receive two doses were due to Em C/S or birthed prior to admin.

MGSO4

85 births reviewed, 3 births qualified for MGSO4. Of these, 1 patient received the appropriate protocol dose of magnesium sulphate. The other 2 patients, 1 was a stillbirth with fetal demise noted on bed side US and the other arrived with imminent birth. So well done TDHB maternity Team-we are doing a great job©

Flowchart-Handover of Clinical Responsibility

The new flowchart for handover to Secondary is now in the cupboards in the birthing rooms and also in Hawera Maternity. The flowchart is the result of primary and secondary interface meetings for the last couple of years.



Handover of Clinical
Responsibility Flow chart

Group B Strep

I have attached the GBS consensus guideline and the Early-onset neonatal group B streptococcus sepsis following national risk-based prevention guidelines study below. The findings were that NZ has halved the occurrence of Group B Strep in babies presenting in the first 48 hours following the release of the GBS guideline in 2014. Great work NZ!



GBS.msg



consensus GBS
guideline.msg

Neonatal Encephalopathy News

Attached below is the March NE taskforce newsletter. We have since had our New Plymouth Workshop



NE Taskforce
Newsletter_March 20

*Education is not
preparation for life.
Education is life itself!*

John Dewey

*Karen Ali and Rachel Way
Xmas Party 2009*



Employee of the Week

Anne Bolton

Not only has Anne received her QLP confident level but she also went above and beyond with her call in on Wednesday. Anne has been a valued member of TDHB Maternity since the 1970's when she qualified as a nurse then Midwife. Apart from time off for children and a wee extended holiday to Nelson! Anne is our longest serving TDHB midwife. Thank you Anne ☺



Blast From the Past

Postnatal Ward 1992-pre decoration & Carpet-Merry posing



Merry and Adie Zeylemaker (Anton's mum) 1992 PN nursery



Antenatal Clinic News

Reminder that drop in vaccination clinic available in Antenatal Clinic Wednesday 2-3. Women on the ward can also attend.

Whakawhetu & Healthy Conversations Workshop in Whanganui

Details attached below for the workshop. PDAC application would apply for transport etc.



Whakawhetu and
healthy conversation:

Upcoming Education Workshops (Red)

New born Life Support Full day Workshop 26 May

IMMAC Vaccinator 4 day Course 30 May

Care of the deteriorating patient-31 May & 27 June

Sue Calvert NZMC Meeting-Compulsory for Core-2 June

PROMPT HAWERA 9 June

Midwives Emergency Refresher 16 June

PROMPT Base 23 June

Upcoming In services (Green)

Birth in the 21st Century-May

Smoke free Tui Ora-25 May

MEWS NEWS-All May-please let Shaz know if you have not had
Face to face training with her for this

Maternal mental health Guideline-27 June

**DON'T FORGET GROW APP FINISHES 31 MAY –LINK
BELOW AGAIN**



FW New GROW-App
for New Zealand.msg

Neonatal Encephalopathy News

Attached below is the March NE taskforce newsletter. We have since had our New Plymouth Workshop



NE Taskforce
Newsletter_March 20

There were a few questions about the NOC/NEWS from some of the participants at the workshop that facilitators couldn't answer on the day. Here are the answers from the ACC team.

1. Are they using this form in the PBU? **Yes**
2. Does everybody need this? The form is to be used for all babies to document observations whether the baby has risk factors or not. The coloured bands enable a flag to the health professional should any of the measures fall outside of what is expected to be normal. They would then process this information in the wider context of the baby's condition and choose to escalate care if they then notice other issues in what was considered in the beginning a normal baby. The chart enables all observations to be batched together to provide an ongoing picture of the baby's progress.
3. Is the NOC form being presented at neonatal conferences? At this stage no but we hope to do this post the audit. There is a conference in CHCH next Paediatric Society which we hope to present something there.
4. MMPO notes- how will it be incorporated to home births. We need to advocate it to be used in all settings including after home birth.
5. Rate of retrieval (Nicola)? Are more babies in the right place? Our rate of retrieval of babies transferred early to a Postnatal facility have halved since the introduction of the NOC/NEWS. We have some clear examples of babies picked up because they had a NEWS score done before transfer.

MAY 2017						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

JUNE 2017						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

MIDWIFERY PROFESSIONAL DEVELOPMENT 2017

Appendix 7 - Midwifery professional development

REGISTRATION: Bookings only accepted once course has been advertised.

COURSE NAME	HOSPITAL RN, MW	PRIMARY SECTOR	DATE(S)	FACILITATOR	APPROX. TIME
Epidural Ko-Awatea on line plus 1hr session practical	RM only	✓	28 February + 24 October	Sharon Howe	1230-1430 TDHB Education Centre
IMMAC 2 day Immunisation Course	MIDWIVES ONLY	✓	26 & 27 July	IMMAC	0900-1700 Barrett's Lounge
IMMAC Vaccinator 4hr update	RN RM	✓	30 May	IMMAC	1730-1930 Lecture Theatre TDHB
NNU Resus - full day	RN RM & Paed & O&G Dr's ONLY	✓	26 May 2017 24 November 2017	Richard Smiley, John Doran, Raimond Jacquemard, Abigail Webber, Belinda Chapman & Sharon Howe	Clinical Skills Lab 0900-1600
NNU Resus - full day Hawera	RN, ED doctors, RM	✓	13 October	Richard Smiley, John Doran, Abigail Webber, Belinda Chapman & Sharon Howe	Hawera board room and maternity 0900-1530
NNU Resus - Refresher	Anaesthetic Dept & OT/PACU	✓	TBA	Richard Smiley, John Doran, Raimond Jacquemard, Abigail Webber, Belinda Chapman & Sharon Howe	TDHB Lecture Theatre 1900-2130
Breastfeeding Workshop	RN RM Paeds, LMC's, Maternity, Well Child Providers	✓	4 July + 21 November	Sharon Howe Debbie Wright	0830-1330
Perineal Suturing; Ko-Awatea on line plus 2 hr practical	RM only	✓	28 March + 30 November	Sharon Howe, Eddie Williams	1230-1430
Perinatal Mortality Meeting	O&G, NNU, Paeds, LMC's, Maternity	✓	21 February, 19 September	Belinda Chapman, Jeremy Smith	1900-2100
PROMPT BASE	RM, Obst, Anaesthetists	✓	24 February, 23 June	PROMPT Faculty-Bill Viner, Emma Patrick, Tom Lupton, Rosemary Darby, Sharon Howe, Belinda Chapman	0800-1630 Corporate Meeting Rm 1

PROMPT HAWERA	RM, RN, ED Dr's, ST John Ambulance	✓	9 June	Rosemary Darby, Sharon Howe, Belinda Chapman, Finola Mooney	0830-1630
Midwives Emergency Refresher Day	RM only Full day, Maternity RN's am only	✓	17 February, 16 June, 18 August, 10 November	Sharon Howe	Clinical Skills Lab 0800-1630
Preceptor Day	RM only	✓	TBA	WINTER	0830-1630
Safe sleep, Smoking Cessation	RM, RN, Child health	✓	TBA	Marnie R organizing	0830-1630
GROW/SGA-GAP programme	RM, RN, Paeds, NNU, Maternity	✓	11 October	Joyce Cowan	0830-1130 1230-1530
RANZCOG FSEP	RM, Obstetricians	✓	11 April	RANZCOG	0800-1630
MMAG Perinatal Mental Health Day	RM, RN, PMMH	✓	7 April	CARLA	0830-1630
NNE Workshop	RM, RN Paediatricians O&G	✓	28 April	ACC	1030-1430

NZMC Midwives compulsory education requires:

- Annual Midwifery emergency skills day which includes adult CPR level 4, Neonatal resuscitation and emergency drill training. PROMPT training day will cover an annual emergency day (once in every 3 years only, remaining 2 years must be emergency day)
- Midwifery focussed education minimum of 8 hours annually (eg may include breast feeding or other focussed education such as fetal surveillance, perineal suturing, water birth and natural birth workshop, GROW etc)
- Midwifery standards review 3 yearly (unless in first 3 years of midwifery practice when it will be at the end of the 1st year and end of the 3rd year, or if review material not complete, reviewers will ask you to return in 2 years)
- Professional activities a minimum of 8 hours per annum (case review attendance, in service attendance, perinatal mortality meetings, protocol development, audits, MFYP etc)

TDHB Core Midwives compulsory education requires

- Newborn life support full day (once in every 3 years)
- RANZCOG FSEP 3 yearly for level 2 and above, or annually until level 2 achieved
- Level 4 adult CPR annually (done as part of Midwives annual emergency refresher workshop)
- RANZCOG FSEP online annually for those who are not attending RANZCOG full day
- Clinical Compulsory Education (once every 3 years)
- Pain management (once every 3 years)
- Family Violence (once every 3 years)

Any questions please contact Belinda Chapman (ADOM) ext 8918 or Sharon Howe Midwifery Educator ext 8257

Appendix 8 - Quality audit and reporting grids

Taranaki DHB Maternity Quality Audit Grid 2017/18

	2017						2018					
	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
MEWS <i>CORE REP</i>	😊						😊					
Customer Satisfaction Survey <i>CONSUMER</i>												
Documentation Audit <i>ME</i>					😊						😊	
ISBARR <i>Postnatal Coordinator</i>			😊						😊			
Appraisals <i>CMM</i>												
Electronic Fetal Monitoring Audit <i>ME</i>	😊					😊						
Midland Referral Guidelines Audit <i>ME</i>												
Safe Sleep Audit <i>Safe sleep champion</i>		😊						😊				
C-sections <i>O&G</i>				😊							😊	

Taranaki DHB Maternity Quality Committee Reporting Grid 2017/18

	2017						2018					
	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
PMMR and case review/trends/great saves <i>ME/ADOM</i>	😊			😊			😊			😊		
Maternal mental health <i>Numbers/Trends – MMH Team Leader</i>		😊					😊					
Neonatal Unit <i>Admissions/ trends/issues CNM NNU</i>			😊			😊			😊			😊
Complaints/ consumer feedback trends <i>Maternal Child Health Manager/CMM</i>		😊			😊					😊		
Wound infections/ general anaesthesia and blood transfusions (caesarean section) <i>CNS – Infection Control</i>				😊					😊			
HDU admissions audit <i>ME</i>						😊						😊
Consumer report <i>Consumer Representative</i>												
LMC registration <i>ADOM</i>											😊	
Newborn Hearing Screening <i>Allied Health Manager</i>								😊				

Acknowledgments

Angela Worthington - Scholarship student (now midwife)
Ariel Chung - Trainee Intern
Belinda Chapman - MQSP Coordinator & ADOM
Dr Beth Thompson - O&G Registrar
Carol Wells - Postnatal Coordinator Midwife
Chinmay Pandit - Trainee Intern
Christine Strydom - Consumer Representative, Maternity Quality Committee
Corli Roodt - ADOM Waikato DHB, Chair Midland Maternity Action Group
Deb Wright - Lactation Consultant
Emma McCallum - Trainee Intern
Finola Mooney - FAU Midwife
Glenda Martin - Core Midwife
Hamish Ko - Trainee Intern
Helen Hall - Core Midwife
Honor Lymburn - Data Analyst, Midland Maternity Action Group
Jane Bocock - Clinical Nurse Manager, Neonatal Unit
Dr Jeremy Smith - Obstetrician HOD O&G
Jessica Fulton - Trainee Intern
Judith Moorhead and SANDS members of New Plymouth
Karen Janes - Antenatal Coordinator
Laura Scholey - PMMR Midwife champion
Lisa Gilbert - CNS Infection Control
Marcel Fernando - Trainee Intern
Marianne Pike - Violence Intervention Coordinator
Marnie Reinfeld - Planning and Funding
Mary Lawn - Child & Maternal Health Clinical Services Manager
Mary Bird - Universal Newborn Hearing Screening Programme
Maternity Quality Committee Governance Group Members
Melanie Clark - Web Admin and Graphic Designer
Michelle Henderson - Trainee Intern
Midland Maternity Action Group Members
Mike Burr and Helen Burley - Customer Services
Rebecca Madden - Safe Sleep Champion
Reagan Humphrey - Trainee Intern
Rohit Katial - Trainee Intern
Sadie Walker - Baby Loss Midwife Champion
Sam Ellis - Trainee Intern
Sarah Nam - Trainee Intern
Sharon Howe - Midwife Educator
Stephanie Cowan - Change For Our Children
Dr Stephanie Luoni - O&G RMO
Steva Rumsey - Trainee Intern
Suzanne Andrews - Project Manager (Midland Maternity Action Group)
Tawera Trinder - Lead Maternity Carer Midwife
Tesa Pilkinton - Antenatal Clinic Coordinator

Report compiled by:

Belinda Chapman - ADOM/MQSP Coordinator.

Melanie Clark – Design.

Sharon Howe - Midwife Educator and Quality Rep.



