TARANAKI DISTRICT HEALTH BOARD

MATERNITY ANNUAL REPORT

1 JULY 2017 - 30 JUNE 2018

TARANAKI
District Health Board

Taranaki Together, A Healthy Community
Taranaki Whānui He Rohe Oranga

MATERNITY QUALITY COMMITTEE MEMBERS

Belinda Chapman, MQSP Coordinator/ Associate Director of Midwifery

Mary Lawn, Operations Mgr, Women & Child - Clinical Management

Amanda Antoine, Clinical Midwifery Manager

Sharon Howe, Quality Rep and Midwife Educator

Megan Harvey, Acting Clinical Nurse Manager, Neonatal Unit

Lisa Gilbert, CNS - Infection Prevnt Control - 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

Valentina Shaw, Obstetrician/ Gynaecologist - Obstetrics & Gynaecology

TE AHU

TARANAKI DHB VALUES

Partnership
WHANAUNGATANGA
We work together to achieve our goals.

Safety
MANAAKITANGA
We provide excellent service in a safe and trusted environment.

Courage
MANAWANUI
We have the courage to speak up and advocate for each other.

People matter
MAHAKITANGA
We value each other, our patients and whānau.

Empowerment
MANA MOTUHAKE
We support each other to make the best decisions.

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Taranaki District Health Board Vision, Mission, Aims, Values

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 / Te Ahu Taranaki

Partnership / Whanaungatanga
We work together to achieve our goals.

Courage / Manawanui
We have the courage to do what is right.

Empowerment / Mana motuhake
We support each other to make the best decisions.

People matter / Mahakitanga
We value each other, our patients and whānau.

Safety / Manaakitanga
We provide excellent service in a safe and trusted environment.

Maternity Services Vision

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

- HE URUNGA WHENUA
- HE URUNGA TANGATA
- HE URUNGA OHI
- HE URUNGA TARANAKITANGA
- KI TE TAIAO
- MAU TONU

Message from Dr Jeremy Smith (Head of Department), Mary Lawn (Operations Manager, Maternal and Child Health), Belinda Chapman (ADOM)

We have had a busy year since the 2017 report was written. Taranaki DHB remains committed to the Maternity Quality and Safety Programme (MQSP), which continues to assist us in our decision making and monitoring and advancing local quality improvements and quality initiatives.

Our governance group has continued to meet monthly; implementing the work plan as well as reviewing local maternity audits, reports and initiatives with our dedicated consumer continuing to be very proactive within our group. The committee continues to report to the Taranaki clinical Board annually.

As noted in our previous report, we continue to work in the old maternity unit at Base hospital. We have started discussions around the new build.

We now have six medical consultant staff which means we have been able to consolidate and enhance currently service delivery . We are pleased to report that one of our specialists has passed an examination towards gaining an Ultrasound qualification to allow quality in-house scanning. We now have a contemporary scanning machine, and are continuing to make progress towards a "one stop shop" for checking the progress of complicated pregnancies.

Succession planning for senior medical staff has resulted in our recruiting a NZ trained specialist and we wish her and her family a happy future in Taranaki. Our unit continues to be accredited by The Royal Australian and New Zealand College of Obstetricians and Gynaecologists for training of registrars, and the quality of our unit still allows two posts to be available. Accreditation is dependent on many factors, so thanks are given to all the doctors' nurses and midwives, and others who contribute to the smooth running of the Maternity Service

We now also have 5th and 6th year medical students receiving training in the department, a new initiative to try and get more new doctors into the regions.

This past year has seen challenges in recruiting midwives to vacancies of maternity; solutions are being explored unions and management working in partnership to address the ongoing workforce challenges.

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

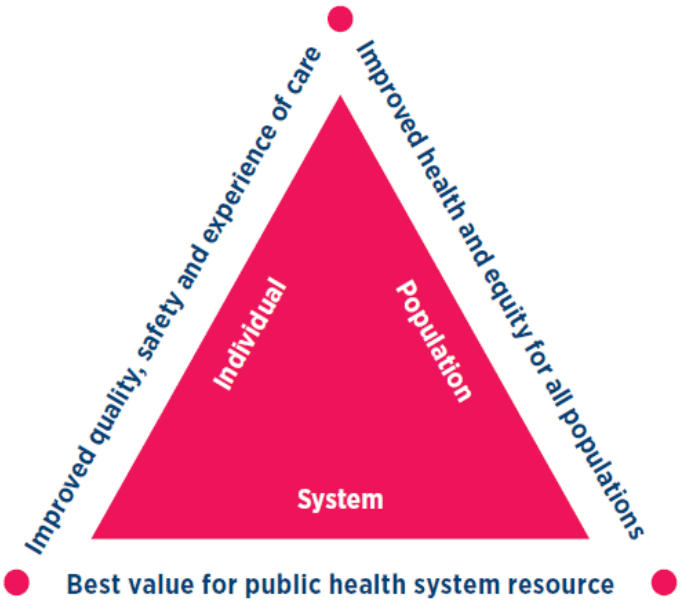
Enhanced patient experience	Improved population health and equity	Improved value for money	Strengthened system resilience
Our population will understand how, when and where to access the right health services and is supported with information to achieve their health goals. Patients will receive integrated services – centred around their needs.	Services are targeted at those most likely to benefit, with the workforce matched to population needs and enabled to support better health outcomes.	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.	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.

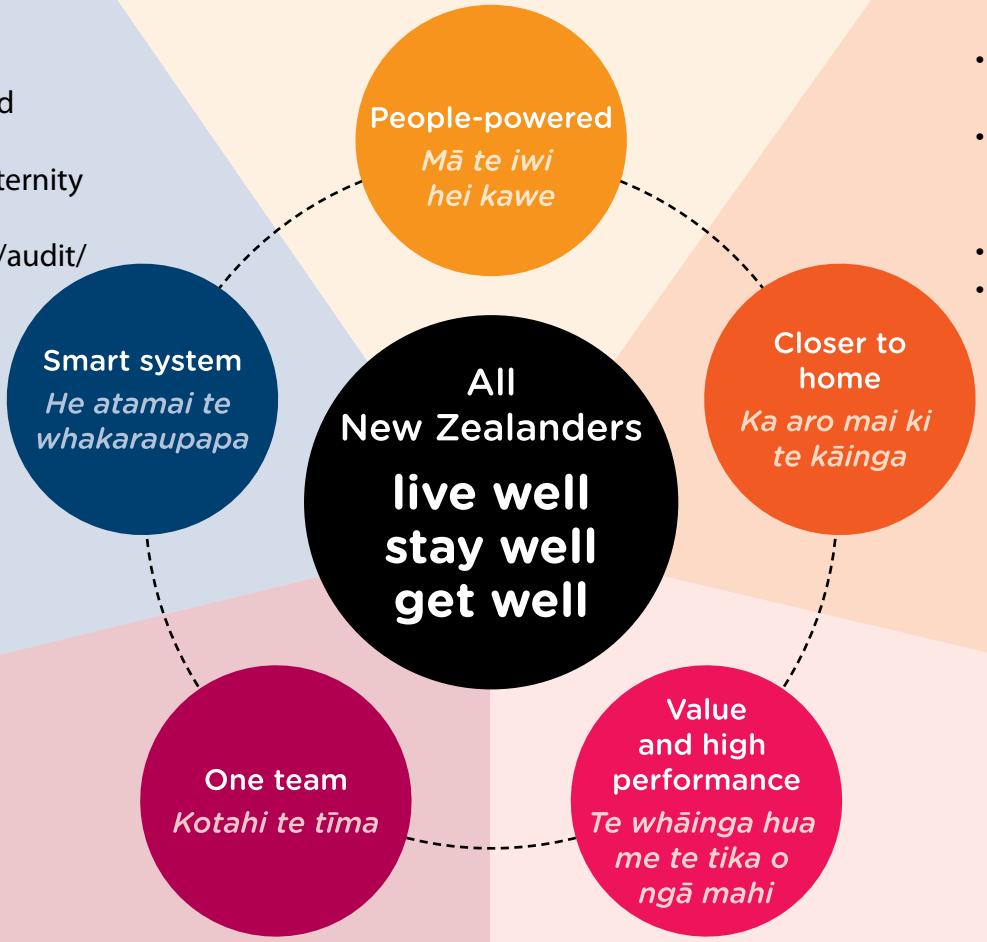


The Triple Aim framework simultaneously considers individual, population and system dimensions of health care

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.

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

The report describes Taranaki DHB's activities undertaken in 2017/18 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 five years and is highly engaged and participates in the programme including improvement priorities and projects. Training and support is integral to the role.
- 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.
- Taranaki DHB meets all of the New Zealand Maternity Standards audit criteria.
- Taranaki DHB continues to develop relationships and alliances with other maternity primary care providers including participation 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 2017/18

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:

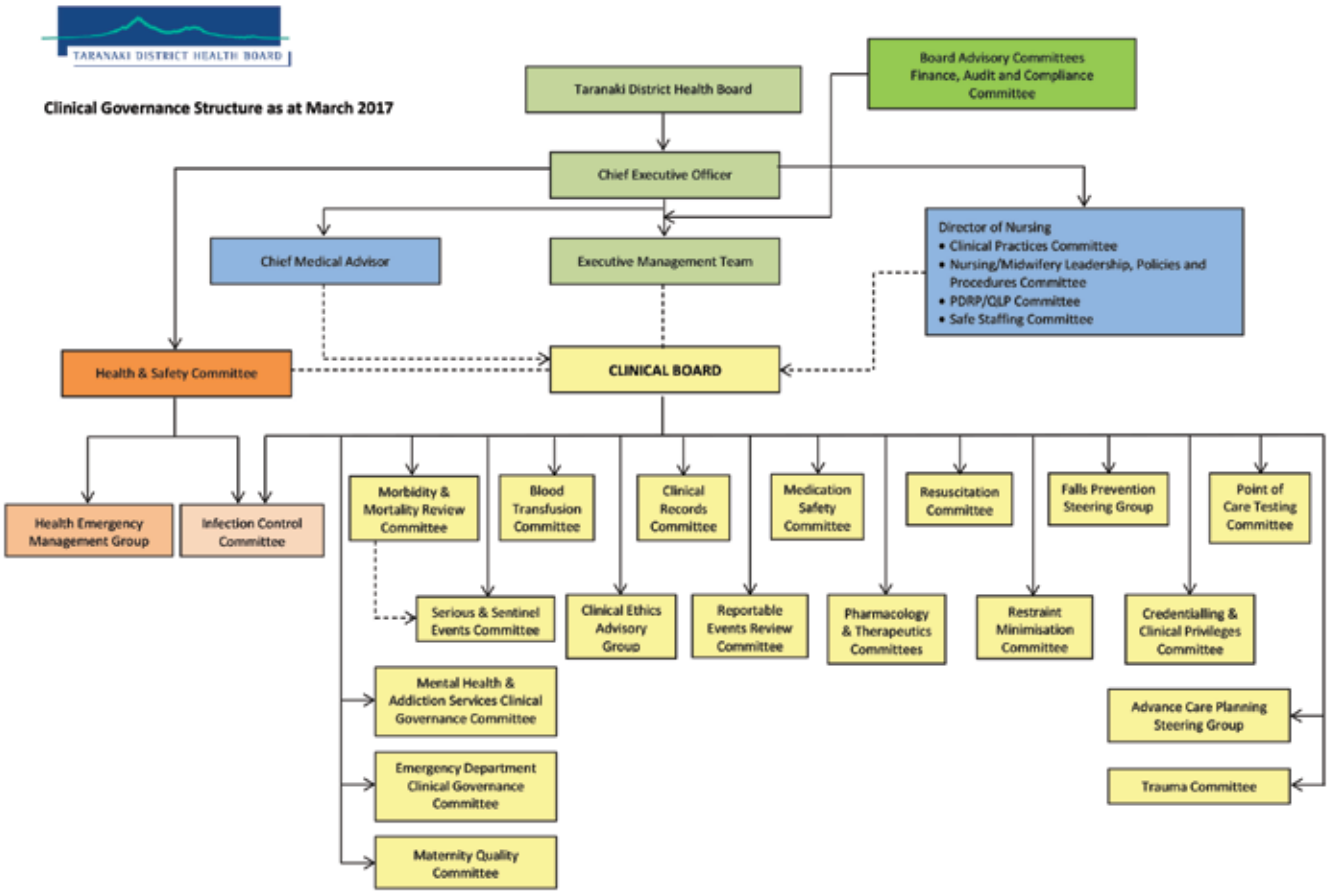
- Monitor and oversee regional and local activities associated with:
  - The National MQSP
  - The National Maternity Standards
  - Maternity Service Specifications
  - The Universal Newborn Hearing Screening Programme

  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
- Operations manager, women and child clinical manager
- Quality and risk advisor
- Midwife educator (ME)/quality risk delegate
- Two LMC representatives
  - Rural
  - Urban
- Consumer representatives
- Core midwife/New Zealand College of Midwives (NZCOM) representative
- Planning & funding maternity portfolio manager/Māori health representative

MQSP national DHB coordinators



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 a member of community maternity consumer groups Active Birth Taranaki, La Leche League and has completed her training as a childbirth educator.

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/Power to Protect
- Oranga Tamariki Child Protection, 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
- Taranaki Stop Smoking Service; 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
- 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 2017/18 Taranaki DHB served a population of 118,965* people.

The Māori population is projected to increase to 22.6% of the total population by 2028. The European, Māori, Pacific and Asian populations have grown since 2006, as at the 2013 Census. Taranaki has 83.9% identified as European and other, 17.1% as Māori, 1.7% as Pacific and 3.6% as Asian.

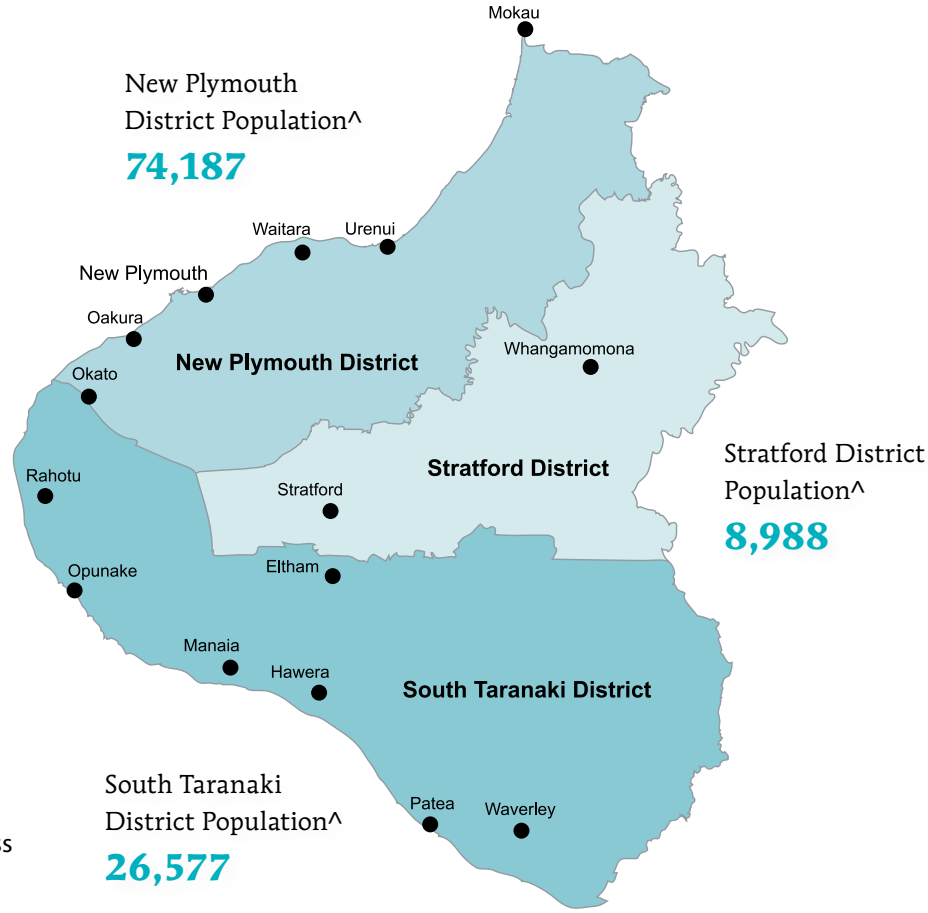
Note: Where a person reported more than one ethnic group, they have been counted in each applicable group. As a result percentages do not add up to 100%.

SOCIO-ECONOMIC INDICATORS

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

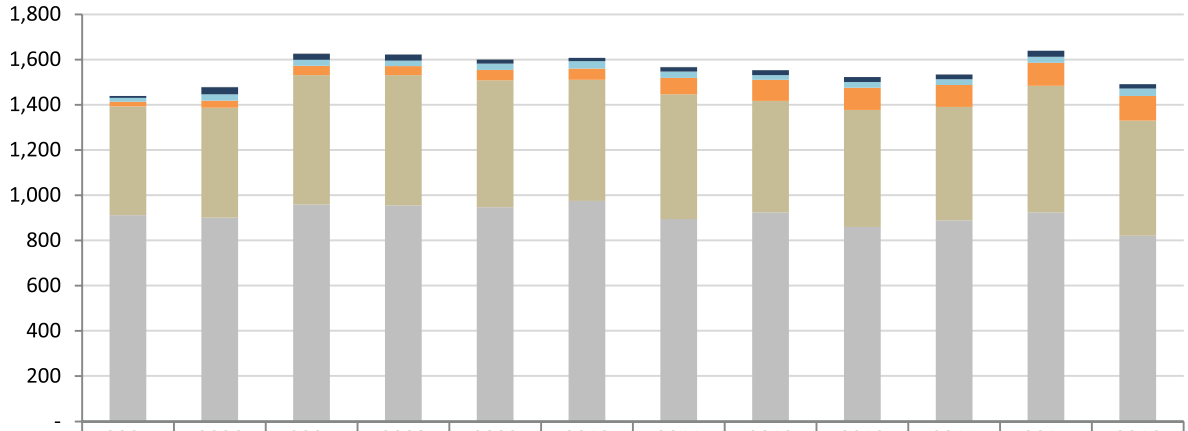
Around 38.8% of the Taranaki population live in NZDEP2013 Decile 6, 7 and 8 compared to 30% nationally. Non-Māori are over-represented in the wealthiest socio-economic deciles and Māori are over-represented in the lowest socio-economic deciles.

Within Taranaki, 32% of Māori live in the most deprived 20% of areas compared to 13% of non-Māori. In contrast, 7% of Māori live in 20% of the most affluent areas compared to 17% of non-Māori. Māori in Taranaki have five to six years less life expectancy than non- Māori.



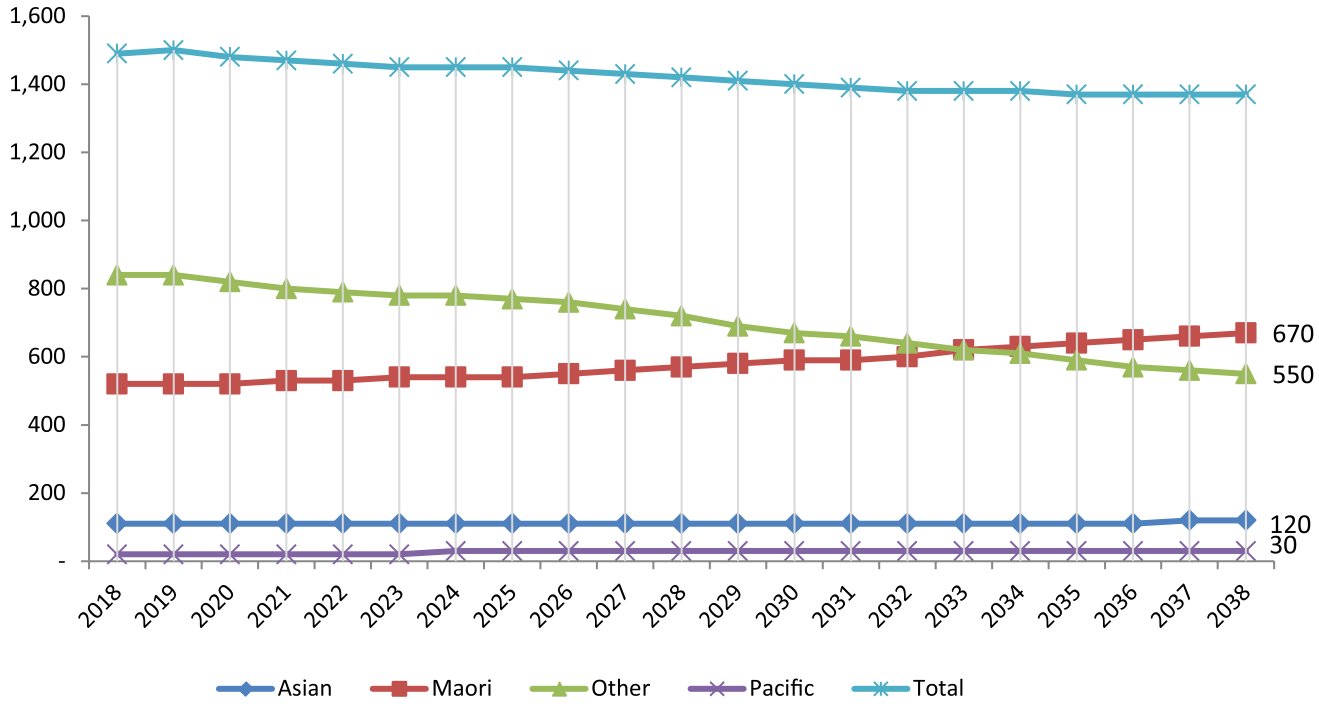
**Based on updated information received from Statistics New Zealand Population Projection released December 2016*
^Based on usually resident population, 2013 Census

Taranaki DHB: movement in live birth rates from 2005 to 2016 (based on registration date)



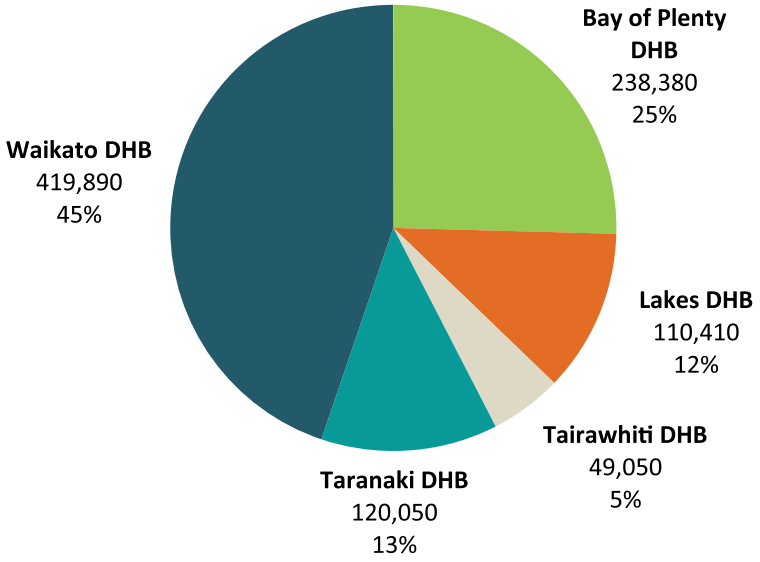
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Not Stated	-	2	2	1	2	-	1	-	-	1	-	-
Other	8	31	26	27	17	15	20	23	22	21	26	20
Pacific	17	28	26	24	28	32	27	20	25	25	27	32
Asian	21	32	41	40	47	50	73	93	98	97	102	109
Maori	481	485	572	577	560	535	551	493	517	502	559	509
European	911	901	959	954	947	975	895	924	860	888	924	821

Projected births by ethnicity for Taranaki DHB 2018-2038

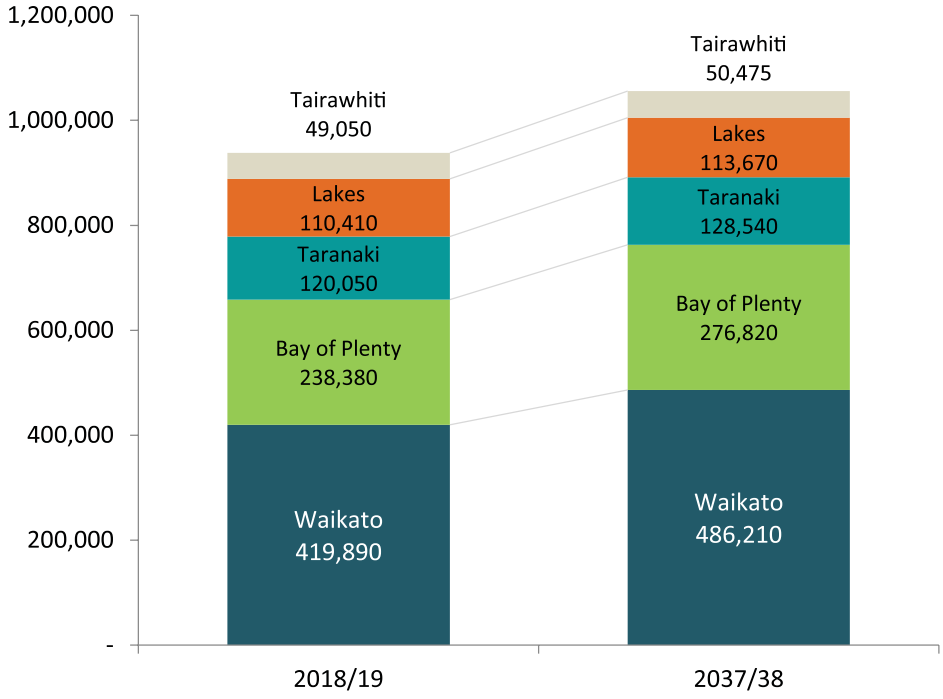


Data source: HealthShare Limited, sourced from MOH 2016 projected population tables by Stats NZ (published Nov 2016)

2018/19 Projected Population for Midland DHBs



Projected change in Midland total population from 2018/19 to 2037/38

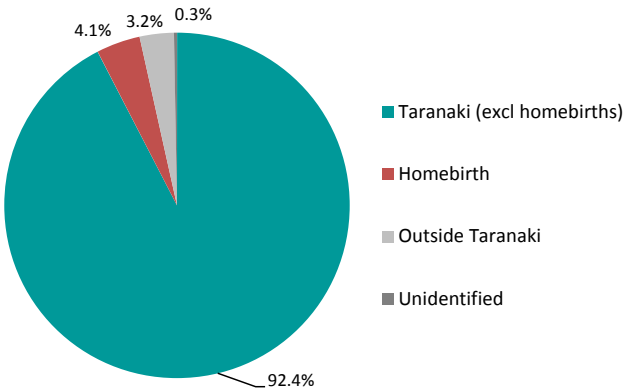


Place of birth, domiciles and deprivation decile 2009 - 2016

Mother Domicile	NZ Deprivation Decile 2013	#	% of Total
New Plymouth			
Barrett	1	17	1.2%
Bell Block	5	79	5.5%
Bowden	3	5	0.3%
Carrington	1	3	0.2%
Egmont Village	2	13	0.9%
Fernleigh	1	6	0.4%
Fitzroy	5	35	2.4%
Frankleigh	6	48	3.3%
Glen Avon	4	8	0.6%
Highlands Park	1	21	1.5%
Inglewood	6	64	4.5%
Kaimata	3	21	1.5%
Kaitake	2	22	1.5%
Kawaroa	7	25	1.7%
Lepperton	2	29	2.0%
Lynmouth	8	24	1.7%
Mangaoraka	2	9	0.6%
Marfell	10	28	1.9%
Marsland Hill	7	7	0.5%
Merrilands	6	37	2.6%
Moturoa	9	43	3.0%
Mount Bryan	6	8	0.6%
New Plymouth Central	7	50	3.5%
Oakura	1	16	1.1%
Okato	6	21	1.5%
Okoki - Okau	5	30	2.1%
Omata	2	5	0.3%
Paraite	4	1	0.1%
Spotswood	7	34	2.4%
Struan Park	6	47	3.3%
Upper Westown	3	19	1.3%
Urenui	7	5	0.3%
Waitara East	9	36	2.5%
Waitara West	10	78	5.4%
Welbourn	6	11	0.8%
Westown	8	55	3.8%
New Plymouth Total		**960**	**66.9%**

South Taranaki			
Eltham	9	29	2.0%
Hawera North	8	28	1.9%
Hawera South	8	122	8.5%
Hawera West	2	7	0.5%
Kahui	5	34	2.4%
Kaponga	9	6	0.4%
Kapuni	5	11	0.8%
Makakaho	6	6	0.4%
Manaia	9	13	0.9%
Mangatoki - Moeroa	5	15	1.0%
Normanby	6	12	0.8%
Ohangai	4	5	0.3%
Ohawe Beach	6	8	0.6%
Okaiawa	6	4	0.3%
Opunake	9	18	1.3%
Patea	10	15	1.0%
Rahotu	7	3	0.2%
Tawhiti	3	4	0.3%
Waingongoro	4	5	0.3%
Waverley	9	14	1.0%
Whenuakura	6	6	0.4%
South Taranaki Total		**365**	**25.4%**

Stratford			
Douglas	4	7	0.5%
Midhurst	6	3	0.2%
Pembroke	4	14	1.0%
Stratford East	8	22	1.5%
Stratford West	8	50	3.5%
Toko	4	15	1.0%
Stratford Total		**111**	**7.7%**
Grand Total		**1,436**	**100.0%**



Taranaki	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Taranaki (excl homebirths)	1,503	1,484	1,468	1,466	1,416	1,399	1,412	1,327
Homebirth	73	67	50	42	54	53	57	59
Outside Taranaki	44	34	29	42	38	51	36	46
Unidentified	11	7	20	8	16	13	9	4
Grand Total	1,631	1,592	1,567	1,558	1,524	1,516	1,514	1,436

Source: National Maternity Collection (MAT), 2018, Ministry of Health

Maternity services in Taranaki

BASE HOSPITAL

PRIMARY & SECONDARY MATERNITY UNIT

Caesarean section
Complex delivery
Inpatient antenatal care
Inpatient postnatal care
Lactation consultant 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

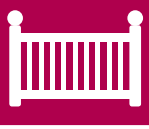
ANTENATAL CLINIC

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

POST NATAL WARD

16 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

People-powered

All maternity staff

We have...

One team

O&G = Obstetrician/Gynaecologist

Workforce and staffing

Maternity staffing has continued to be challenging for 2017/2018 both at Taranaki Base maternity Unit and the rural primary maternity unit in Hawera. It is disappointing that Midwifery in Taranaki has been removed from the Voluntary Bonding Scheme (VBS) given the challenges we have had in attracting midwives to the region in the past year, especially in the rural area of Hawera.

Medical staffing has seen an increase in both Senior Medical Officers and Registered Medical Officers (RMO) with the implementation of a roster for RMO's so they no longer are on call overnight but rostered for duty.

Midwives and nurses:

There continues to be stability in the Māori workforce and a marked increase in the percentage of our workforce 55years and older to 45%. This will be a priority for future succession planning to ensure we have enough skilled and trained midwives and nurses to provide maternity care in Taranaki long term.

The Auckland University of Technology (AUT) satellite midwifery training programme has continued to train undergraduate midwives locally which has assisted in retaining and filling local midwifery positions. This last year Taranaki retained three out of the four new graduates and attracted another new graduate from another region who returned to her home town.

Taranaki Base Hospital Maternity Unit:

The challenge is for staffing to meet the high and low acuity times in maternity care. Having the ability to draw from Taranaki DHB's staffing pool resource has assisted greatly in filling rostering gaps.

The staffing trial completed and evaluated in 2016/17 along with the initiation of a collaborative maternity forum meeting has led to the future implementation of a flexible shift roster of 8 and 12 hour shifts, due to start in August 2018.

With the progress in utilisation of the staffing acuity tool Trendcare the reports and data have become increasingly more reliable/valid. It is delivering information on our maternity staffing, rostering, leave and other reports providing information for future staff planning.

Hawera Maternity Unit:

Hawera has seen an increase in Lead Maternity Carers (LMC) however attracting and recruiting into the core midwifery positions has proved difficult. New Midwives in Taranaki have a contract for both Hawera and Base Hospital with the intention to be able to provide staffing support for each other when there are roster gaps. This has not been fully achieved this year as Base Hospital maternity has had increased pressure on their services resulting in times where Hawera maternity facility has been reliant on an on-call midwife when there are no inpatients. Taranaki DHB is continuing to advertise and try to recruit to the vacant position.

Core Midwifery services for private obstetrician

Taranaki DHB continue to provide core midwifery services for labour and birth to one private obstetrician and one primary GP obstetrician.

Access agreement holders:

There are currently 37 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

Medical workforce

The Obstetric and Gynaecology (O and G) service has had a year of significant change and we are seeing many improvements as a result.

We have employed a sixth consultant, welcoming Dr Valentina Shaw to the senior staff. Valentina had been a senior registrar with us prior to her appointment, so fitted into the workforce very smoothly.

We are going from strength to strength as we have additional time to continue developing the service, as well as increasing our in service training and learning. We continue to be an accredited RANZCOG training centre, and our increased staffing level means we will be able to improve on some areas of our registrar training that will enable further periods of accreditation.

We also have fifth and sixth year University of Auckland medical students learning in the department, under the nurturing care of Dr Edward Williams.

Our ultrasound capability is improving all the time, and Dr Gian Luca Ventresca is working towards the DDU higher qualification.

We have had a period of unprecedented stability for around four years now, which has assisted creating a high workforce morale.

We now eagerly await the new build and ability to further improve our service to our community.

Education of staff and Quality Leadership Programme (QLP)

The sharing of education templates and programmes with the other Midland DHBs has continued with the midwifery leaders and midwife educators by working together to improve, access, equity, efficiency and quality of education programmes. A copy of the maternity education calendar can be found in Appendix 3.Taranaki DHB has coordinated and worked with the Midland DHBs to complete the regional QLP guideline and processes for application and assessment.

In 2017/2018 60% of our midwives achieved the confident or leadership domains which is an increase of 10%.
Two midwives have also submitted their portfolios for assessment.

Maternity workforce

Table 1: Age Distribution of Midwife Workforce								
Age Group	2015		2016		2017		2018	
	n	%	n	%	n	%	n	%
18-25	0	0.00%	1	2.27%	1	2.27%	1	2.17%
26-35	8	21.05%	10	22.73%	6	13.64%	5	10.87%
36-45	8	21.05%	9	20.45%	9	20.45%	12	26.09%
46-55	14	36.84%	13	29.55%	14	31.82%	11	23.91%
56-65	8	21.05%	11	25.00%	13	29.55%	16	34.78%
66+	0	0.00%	0	0.00%	1	2.27%	1	2.17%
Grand Total	38	100.00%	44	100.00%	44	100.00%	46	100.00%
Inclusion criteria: Active employees with a position title of "Midwife"								

Table 2: FTE and Age statistics of Midwife Workforce										
Unit Name	2015					2016				
	n	FTE	Avg Age	Min Age	Max Age	n	FTE	Avg Age	Min Age	Max Age
BMU Base Maternity	30	22.2	45.27	28	60	33	23.8	45.30	23	61
Hawera Maternity Service	4	2.2	53.25	44	58	4	2.7	54.25	45	59
Pool/Casual Staff	4	0	53.25	42	64	7	0	48.86	32	65
Grand Total	38	24.4	46.95	28	64	44	26.5	46.68	23	65

Unit Name	2017					2018				
	n	FTE	Avg Age	Min Age	Max Age	n	FTE	Avg Age	Min Age	Max Age
BMU Base Maternity	29	20.5	45.48	27	62	28	20.5	47.64	31	63
Hawera Maternity Service	5	2.7	54.00	46	60	4	3.3	53.50	45	61
Pool/Casual Staff	8	0	54.25	33	66	12	0	48.17	25	66
Grand Total	42	23.2	48.17	27	66	44	23.8	48.32	25	66

Table 3: Age of Maternity Workforce								
Age Group	2015		2016		2017		2018	
	n	%	n	%	n	%	n	%
18-25	0	0%	1	2%	0	0%	1	2%
26-35	10	19%	11	19%	7	12%	5	9%
36-45	8	15%	10	17%	10	18%	13	22%
46-55	20	37%	17	29%	17	30%	13	22%
56-65	15	28%	18	31%	19	33%	23	40%
66+	1	2%	2	3%	4	7%	3	5%
Grand Total	54	100%	59	100%	57	100%	58	100%
Inclusion criteria: BMU Base Maternity Unit, Hawera Maternity Service, pool/casuals who have a position title of midwife, registered nurse, enrolled nurse, health care assistant, ward administrator, lactation consultant and associate director of midwifery								

Table 4: FTE and Age Statistics of Maternity Workforce										
Unit Name	2015					2016				
	n	FTE	Avg Age	Min Age	Max Age	n	FTE	Avg Age	Min Age	Max Age
BMU Base Maternity	44	33.3	47.86	28	65	46	34.20	47.84	23	66
Hawera Maternity Service	6	3.55	55.83	44	66	6	3.65	56.83	45	67
Pool/Casual	4	0	53.25	42	64	7	0.00	48.86	32	65
Grand Total	54	36.85	48.84	28	66	59	37.85	48.90	23	67

Unit Name	2017					2018				
	n	FTE	Avg Age	Min Age	Max Age	n	FTE	Avg Age	Min Age	Max Age
BMU Base Maternity	42	30.9	48.5	27	67	41	30.55	50.45	31	69
Hawera Maternity Service	7	3.7	56.6	46	68	5	3.30	54.60	45	61
Pool/Casual	8	0.0	54.3	33	66	12	0.00	48.17	25	66
Grand Total	57	34.6	49.7	27	68	58	33.85	50.91	31	69
Inclusion criteria: BMU Base Maternity Unit, Hawera Maternity Service, pool/casuals who have a position title of midwife, registered nurse, enrolled nurse, health care assistant, lactation consultant, ward administrator and associate director of midwifery										

Table 5: Ethnicity Statistics for Maternity Workforce								
Ethnicity Status	2015		2016		2017		2018	
	n	%	n	%	n	%	n	%
Maori	9	16.67%	11	18.64%	8	14.04%	10	17.24%
Non Maori^	45	83.33%	48	81.36%	49	85.96%	48	82.76%
Grand Total	54	100.00%	59	100.00%	57	100.00%	58	100.00%
Inclusion criteria: BMU Base Maternity Unit, Hawera Maternity Service, pool/casuals who have a position title of midwife, registered nurse, enrolled nurse, health care assistant, ward administrator, lactation consultant and associate director of midwifery ^ Non Māori includes those who did not disclose ethnicity status								

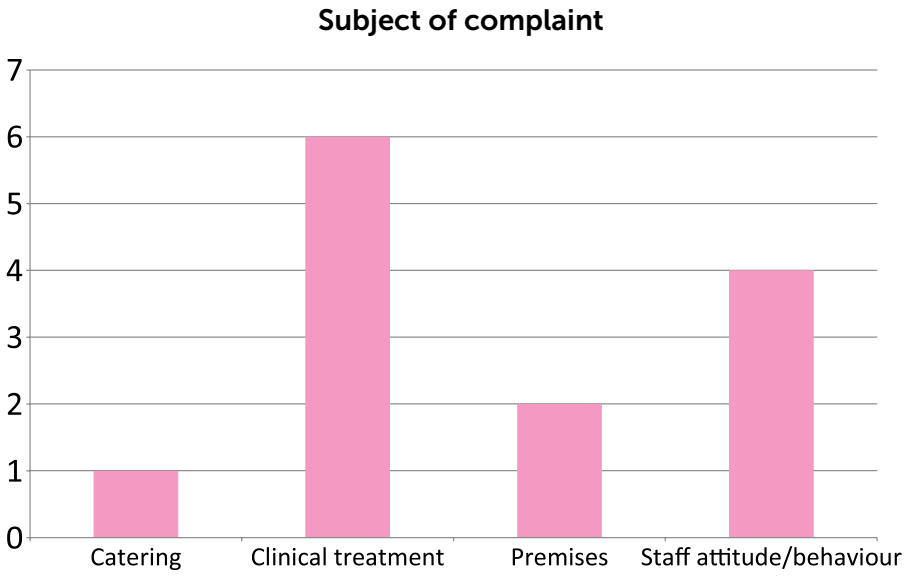
Complaints

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 is for clinical treatment, followed by staff attitude and behaviour.

All complaints are fully investigated by the clinical midwife manager or operations manager and the complainant is responded to in writing or personal contact. The focus when investigating complaints is to review how our consumers journey through our services could be improved with a focus on quality, safety, competency and implementing change where indicated.

A new Datix reporting system was implemented to Taranaki DHB in December 2015. This system captures and registers complaints received; work is still 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. All feedback is relayed to personnel specifically involved in the care or service provided.



Compliments

Really great friendly service, made me feel welcome and any questions and requests were answered with a happy tone. I was reassured when nervous about pre and post caesarean. My partner was also well looked after and all his questions and concerns were met and addressed. Thank you.

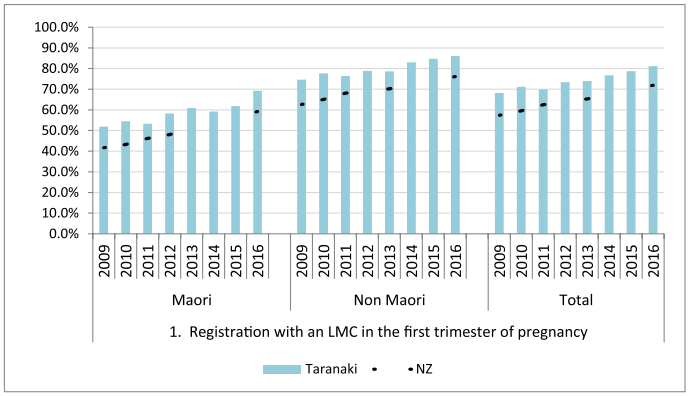
I would like it known how wonderful and amazing the theatre, obstetrician and midwives on Ward 15 were during my stay. I was made to feel like a person, and the genuine care and consideration for me and my feelings has been an experience that I will always remember and hold dear. Considering the two experiences I had in Auckland with the birth of my older children, this time at Base has put my faith back in good bedside manner and a positive experience being in hospital. Thank you so much to the theatre nurse that kept my dignity, the three midwives on Ward 15 that cared for me so genuinally and the obstetrician that was amazing in explaining and keeping me comfortable throughout.

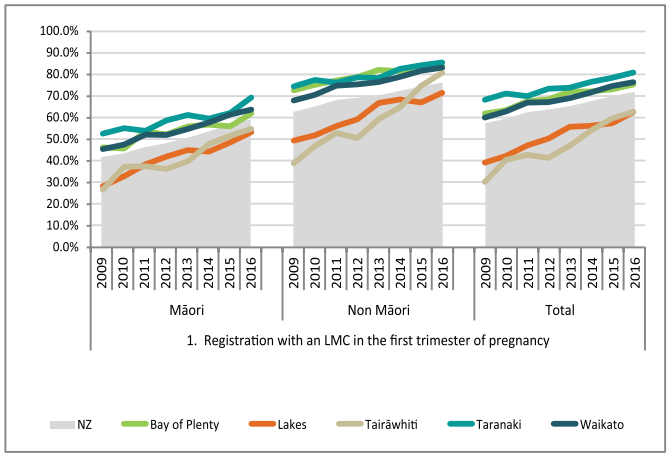
Compliments to the wonderful midwives I had during my time up in post natal. It made the situation a lot easier and I was glad they backed me up as a patient and how I felt.

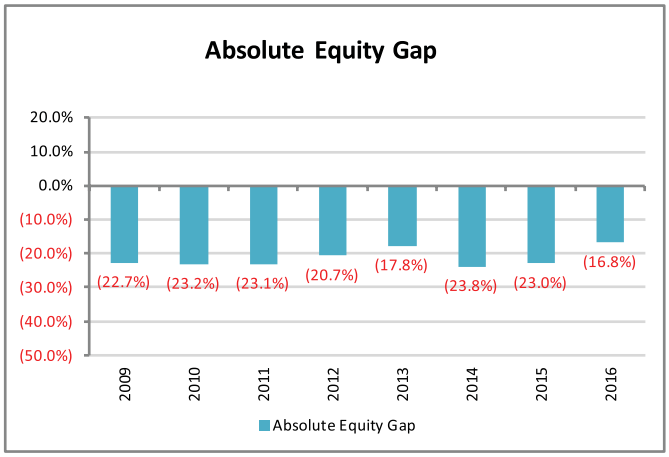
Performance against clinical indicators

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

STRENGTH: Taranaki has increased rates over the last five years - 98% of women are registered under an LMC. The national rate has increased to 71.9%. Taranaki Base has a rate of 81.2% in 2016 up from 78.7% In 2015, 76.7% in 2014 73.7 in 2013, and 73.4% in 2012. There is still a focus on inequity between Maori and non Maori. Initiatives are continuing to focus on achieving equity/narrowing this gap. The Super Mama campaign and the Hapū Wānanga workshops are examples of this.

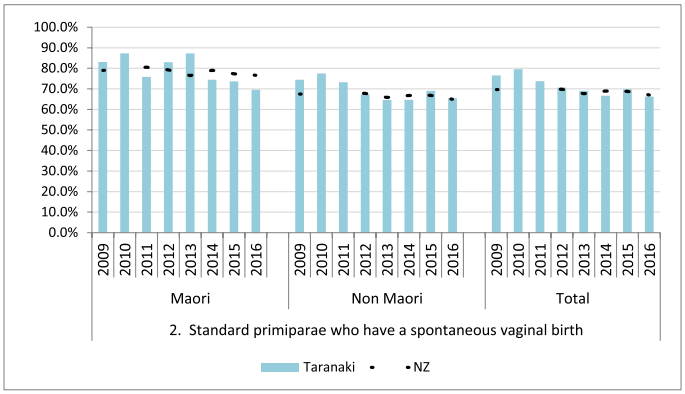


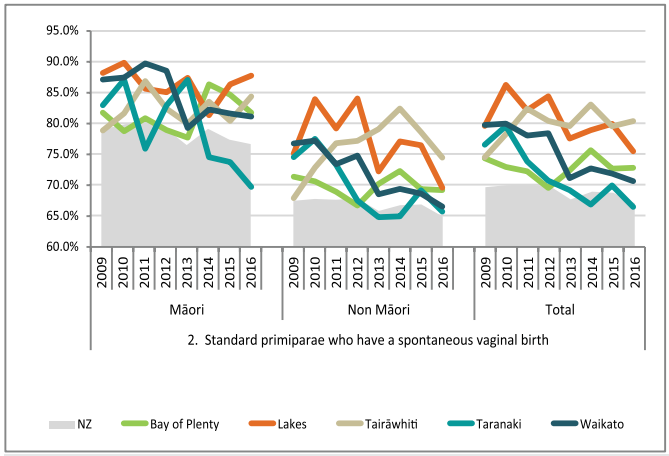


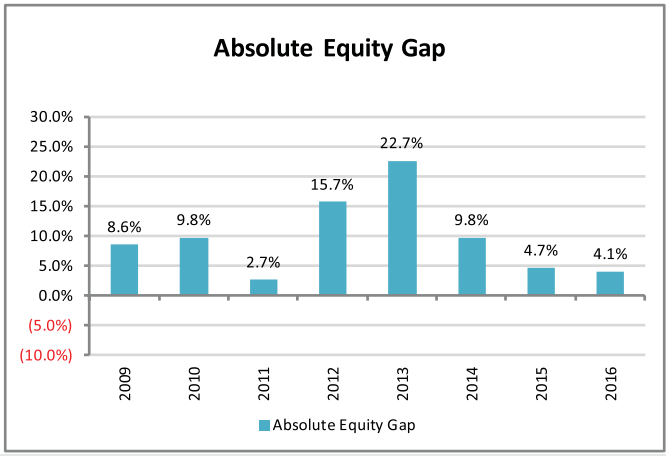


Indicator 2: Spontaneous vaginal birth

Nationally and locally decreasing: The national rate in 2016 was 67% down from 68.7% in 2015. Taranaki's overall rate has decreased to 66.2% (63.6% at Taranaki Base hospital) which is around the national median rate. Previous rates are; 69.8% in 2015, 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. Maori and non Maori are showing similar rates, in the past Maori had higher rates.







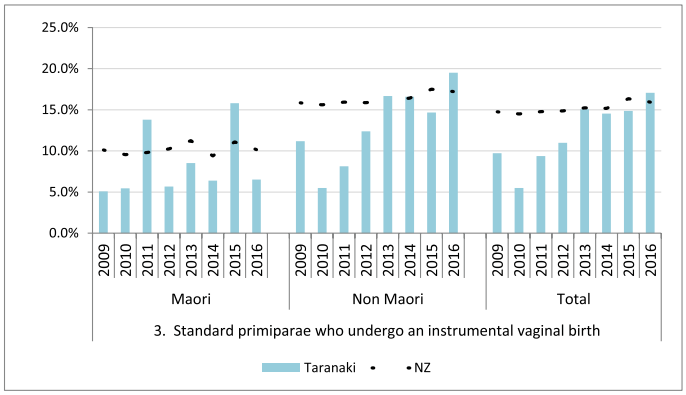
ABSOLUTE EQUITY GAP GRAPHS

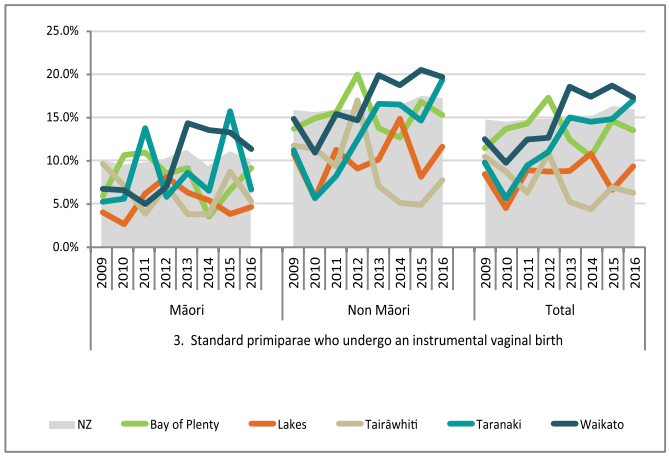
The absolute equity gap shows the net difference between the two results. All absolute equity graphs indicate:

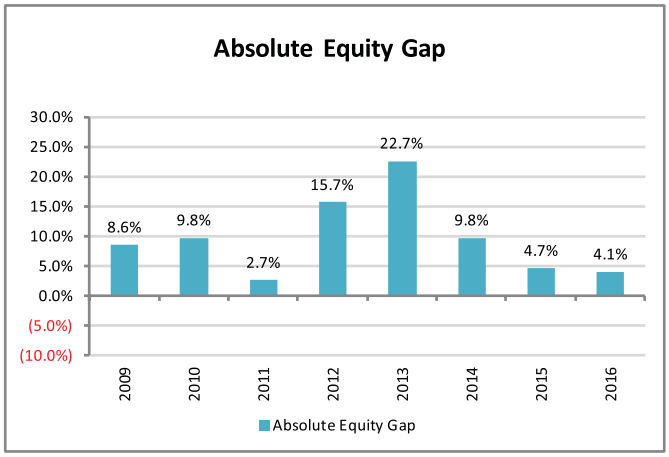
Above 0%	Māori result is better than Non Māori result
At 0.0%	Māori and Non Māori results are equitable
Below 0%	Māori result is poorer than Non Māori result

Indicator 3: Instrumental vaginal birth

INCREASED: Taranaki has an overall rate of 17.1% (just under the 75 percentile in 2016 (18.4% in Taranaki Base hospital). National the rate is 15.9%. Past data: 14.9% in 2015, 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. The rise is more in non Maori compared to Maori ethnicity.

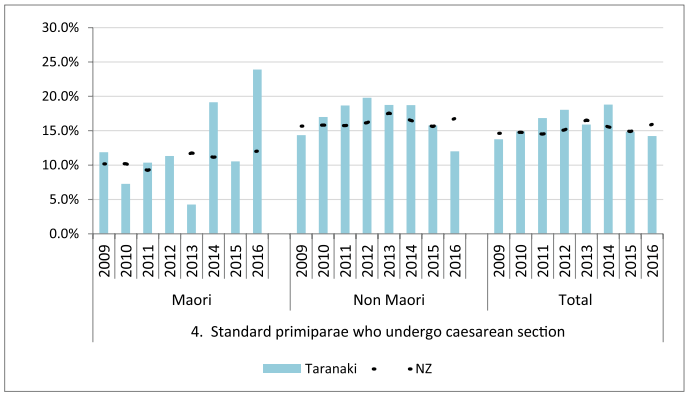


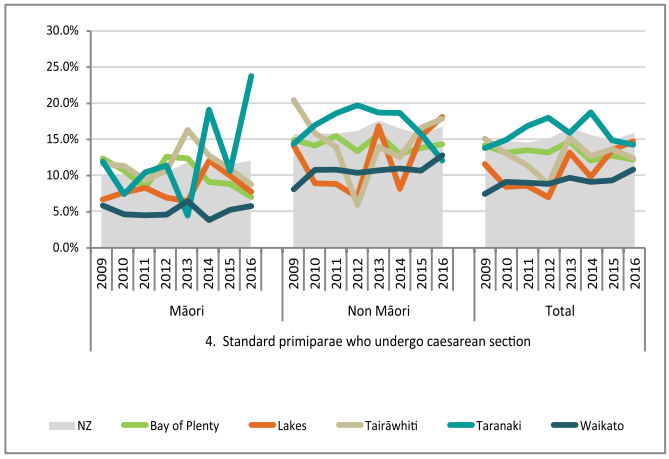


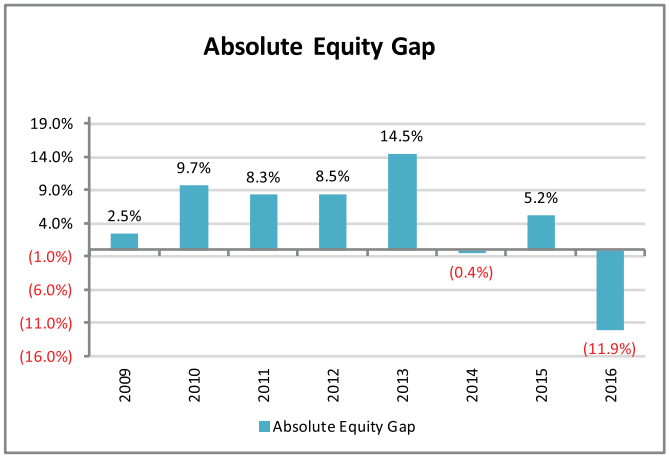


Indicator 4: Caesarean section among primiparae

DECREASED: Taranaki has continued to decrease to 14.2% (15.4% at Taranaki Base), this is below the national median of 15.9%. Previous year's data show: 14.9% in 2015, 18.8% in 2014; 15.5% in 2013, 18.3% in 2012, 17.4% in 2011, 15.3% in 2010
and 14.6% in 2009. We continue to case review all category one caesarean sections. Looking from an ethnicity lens non Maori have reduced significantly but Maori have increased significantly, this should be a focus to explore why this has occurred especially as the Maori birthing population is anticipated to rise and the non Maori decline in Taranaki.

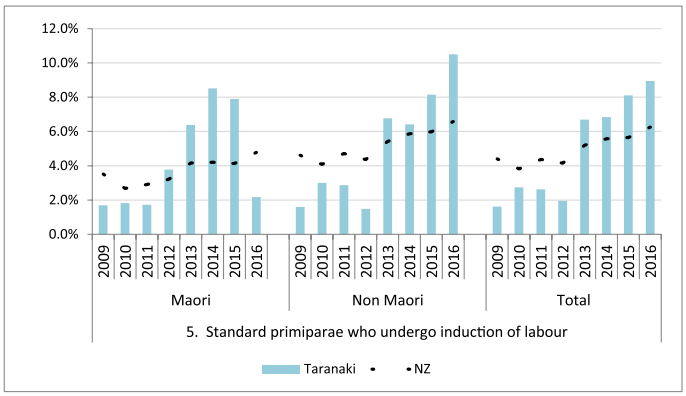


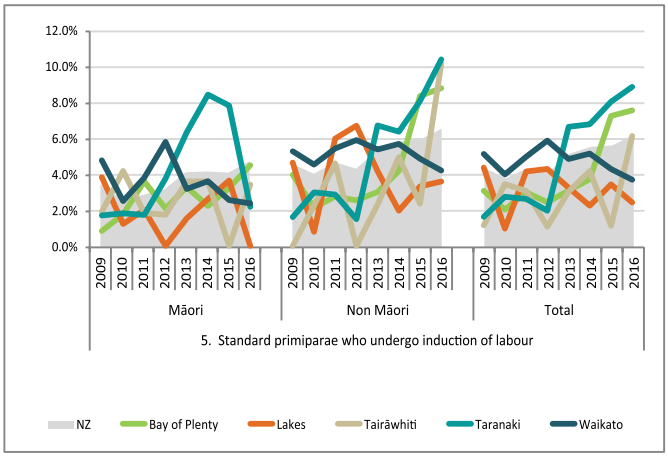


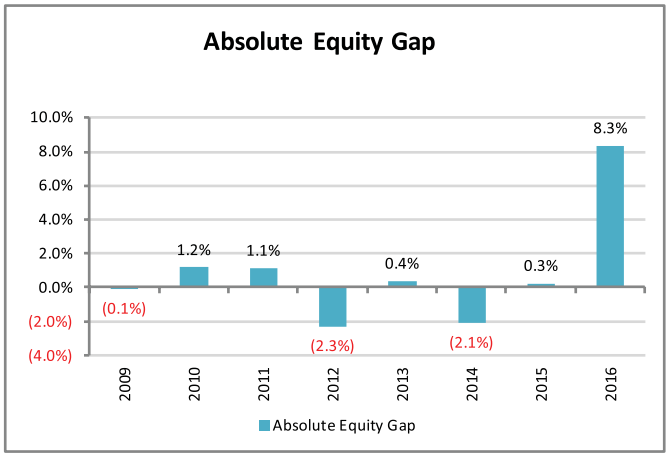


Indicator 5: Induction of labour among primiparae

INVESTIGATE: Taranaki is above the national 75th percentile and is continuing to rise in particular among non Maori. The national rate is 6.3%, Taranaki Base Hospital rate was 10.1% in 2016 increased from 9.8% in 2015, 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 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 reducing the clinical indicator 20 data may have increased the induction of labour rate.

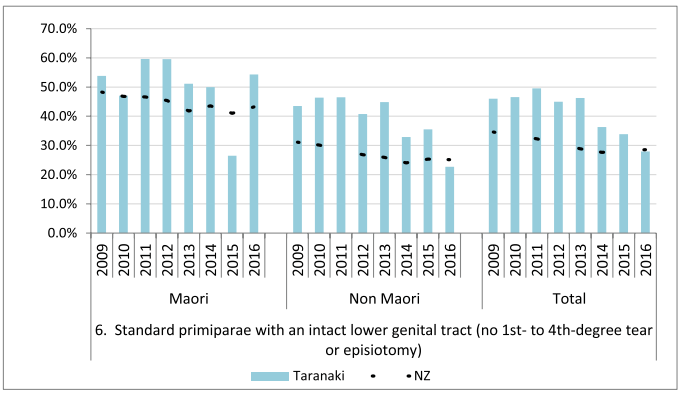


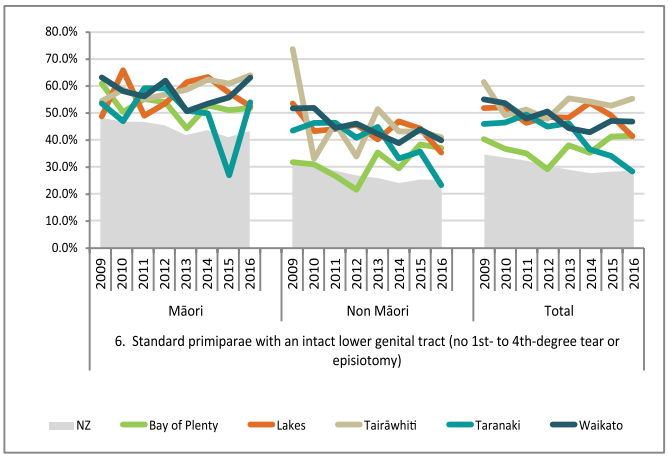


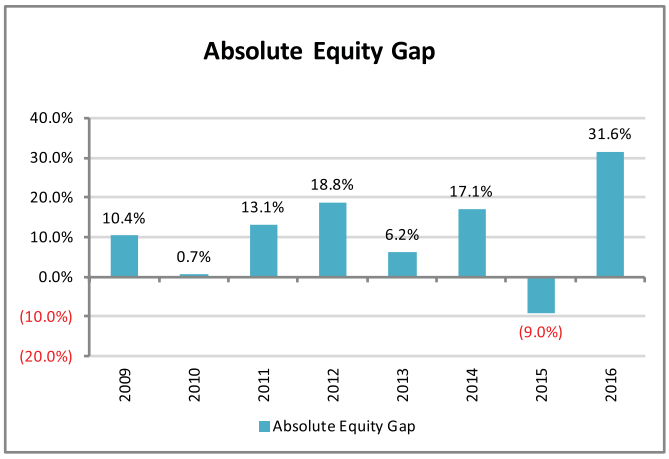


Indicator 6: Intact lower genital tract among standard primiparae giving birth vaginally

INVESTIGATE: Taranaki is sitting below the 50th percentile nationally with a rate of 28% for 2016. Previous years rates were much higher 29.6% in 2015, 36.3% in 2014, and 41.4% in 2013. The most significant drop is in non Maori women

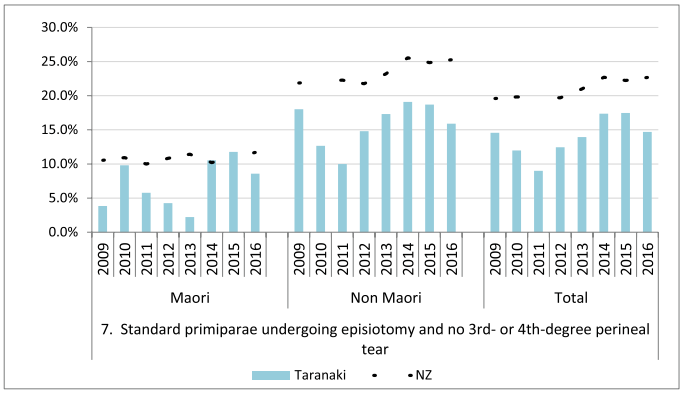


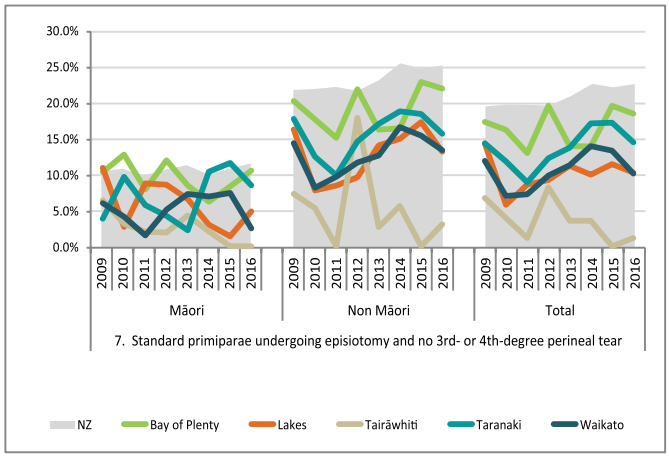


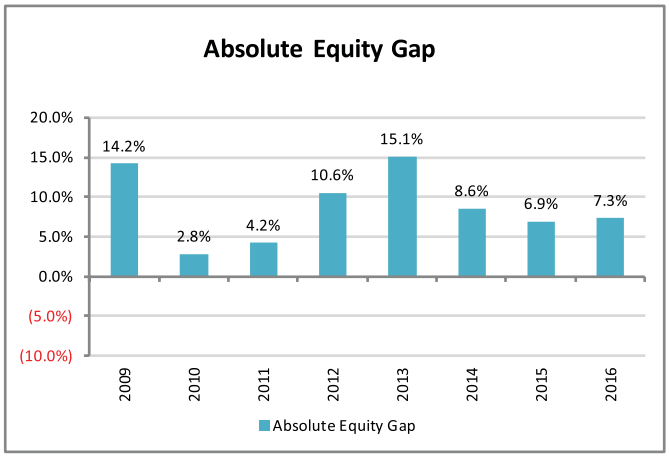


Indicator 7: Episiotomy and no 3rd or 4th degree tear

STRENGTH: Taranaki has a decreased rate of 14.7% (15.5% in Taranaki Base Hospital) down from 17.5% in 2015, 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 22.7% and sits around the 25th percentile. Maori have less episiotomy than non Maori.

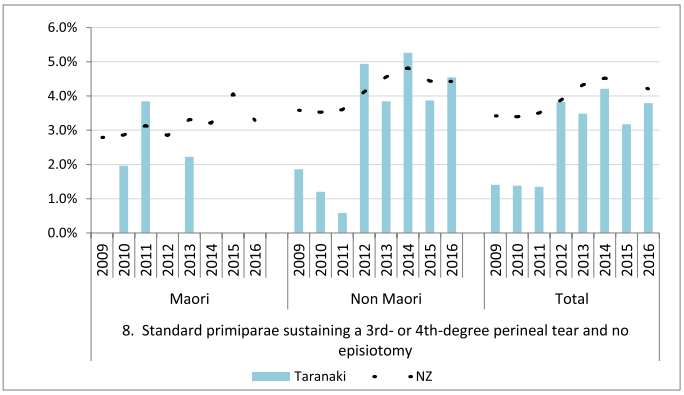


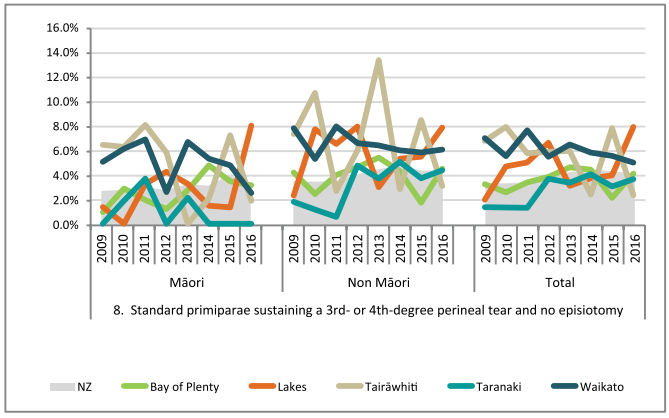


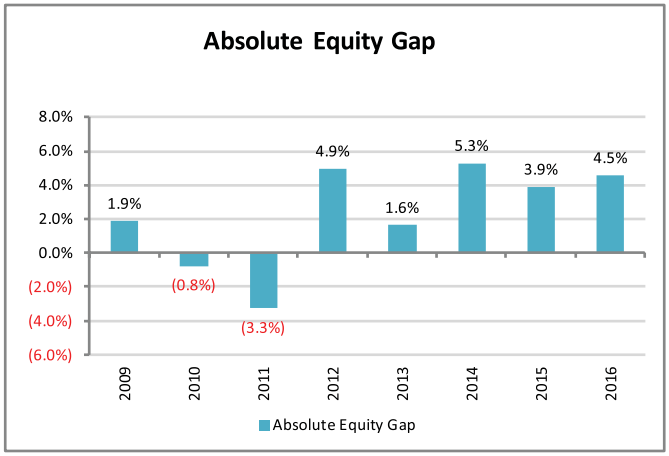


Indicator 8: 3rd or 4th degree tear sustained with no episiotomy

Taranaki has a rate at the median of 3.8% (4.1% in Taranaki Base) in 2016 compared to 3.2% in 2015 (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 4.2%. In 2016 Numbers are low so confidence is low. Most cases were of non Maori descent. There are no cases in Maori in 2014, 2015 or 2016.

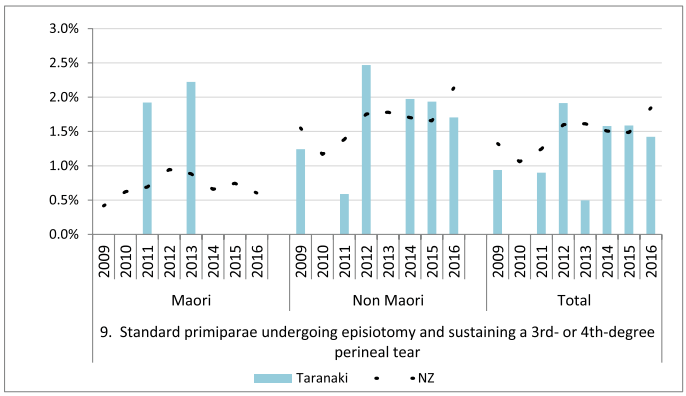


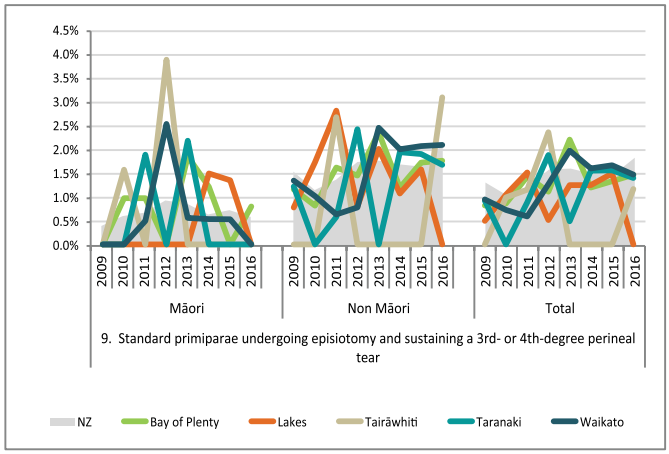


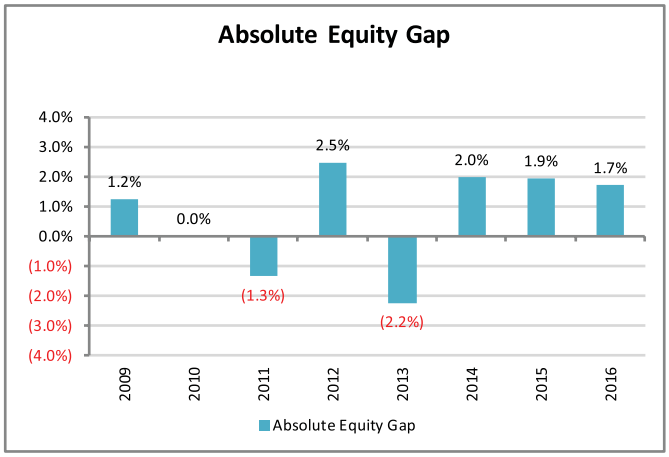


Indicator 9: Episiotomy and 3rd or 4th degree tear sustained

Taranaki has a rate of 1.4% in 2016 (Taranaki Base hospital 1.6%) similar to 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 1.8% in 2016 means Taranaki is sitting around the median. Numbers are very small to have confidence in these figures but will be highlighted to the practitioners.

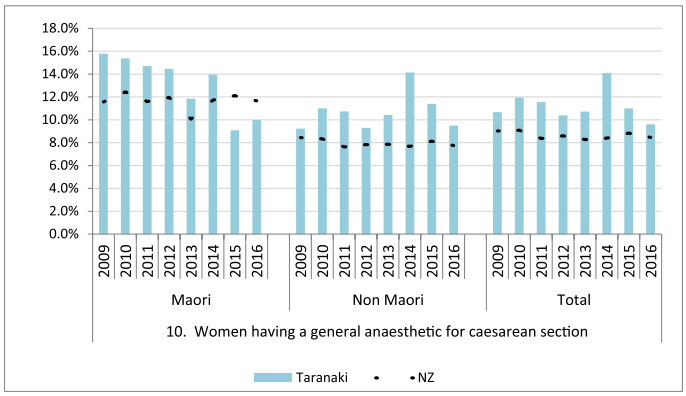


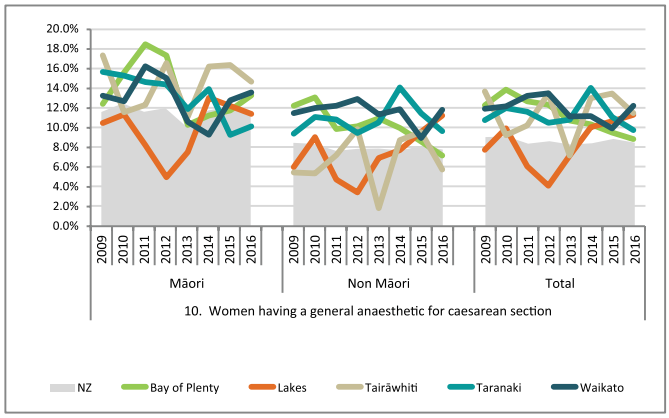


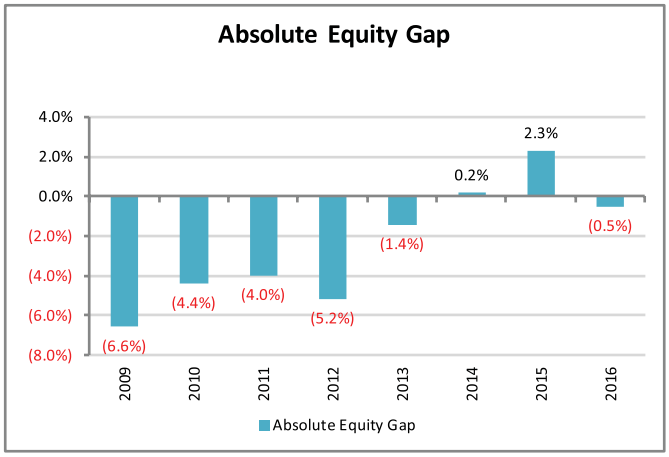


Indicator 10: General anaesthesia for all caesarean sections

Decreased: Taranaki has continued to lower the rate to 9.6% (Taranaki Base hospital 9.3%), the national median being 8.5%. The rate was 10.6% in 2015, 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. 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 initiatives and raising awareness have impacted on the rates. Rates have reduced in Maori and non Maori.

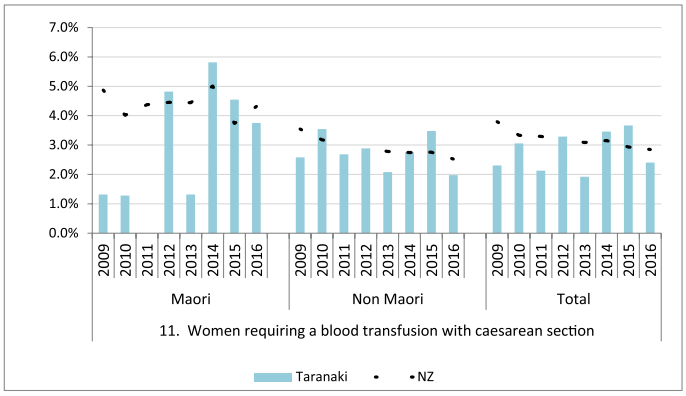


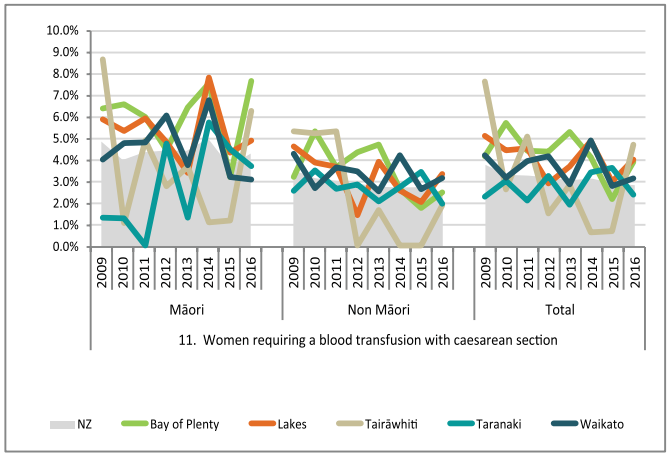


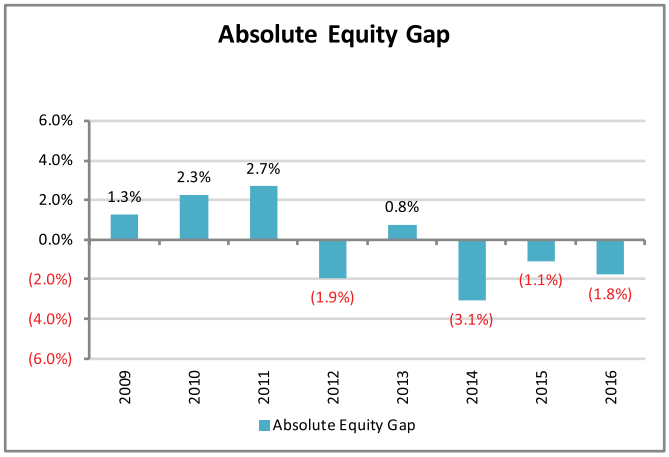


Indicators 11 Postpartum haemorrhage (PPH) blood transfusion after caesarean section birth

DECREASED: Taranaki has a decreased rate of 1.9% at Taranaki base hospital (2.4% overall) down from 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. The national average is static at 2.9% in 2016. Numbers are low to be able to have confidence in these rates however PPH has been audited in 2015/16 and 2016/17 and an external review of PPH was completed in November.

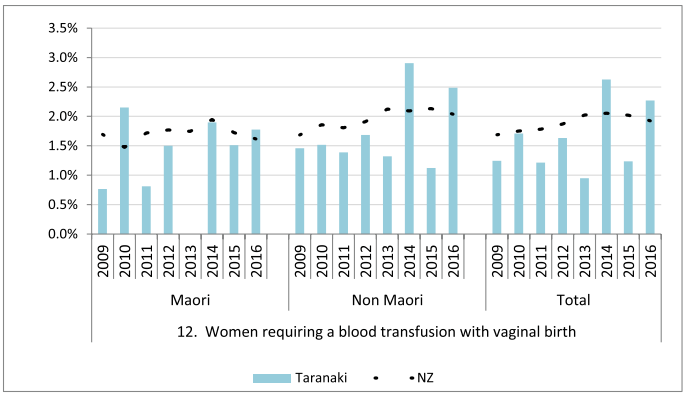


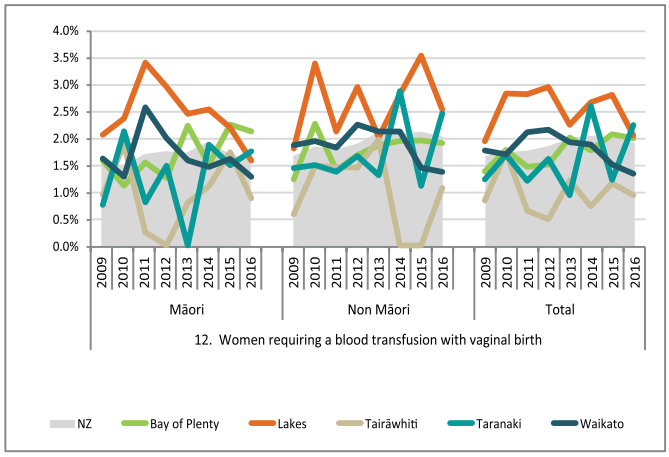


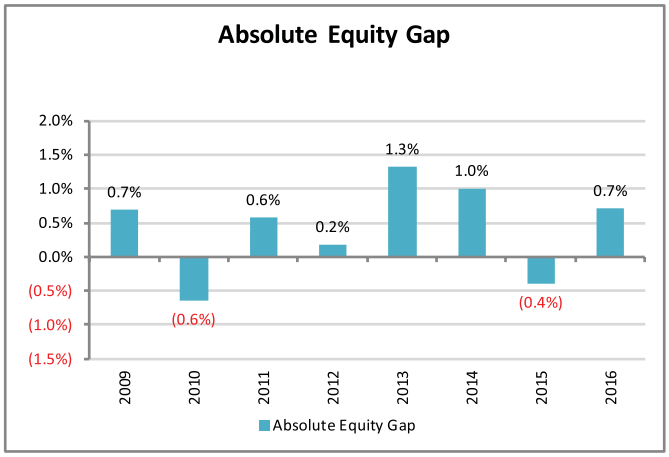


Indicator 12: PPH and blood transfusion after vaginal birth

INCREASED: Taranaki has an increased rate of 2.3% in 2016 from 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 1.9% in 2016. Taranaki DHB had an external review of their PPH rates in 2017.







Indicators 13-15

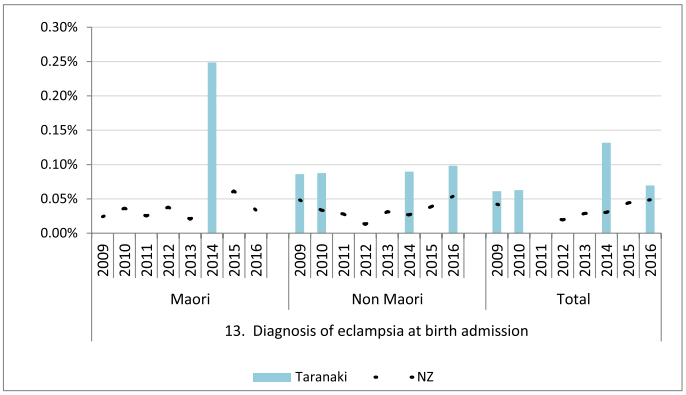
Of women giving birth nationally in 2016:

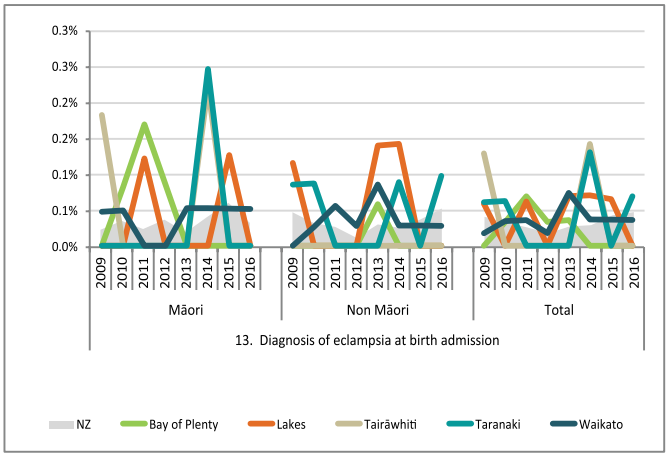
- 29 were diagnosed with eclampsia during the birth admission
- 25 had a peripartum hysterectomy
- nine were admitted to ICU and required over 24 hours of mechanical ventilation at some time during their pregnancy or postnatal period.

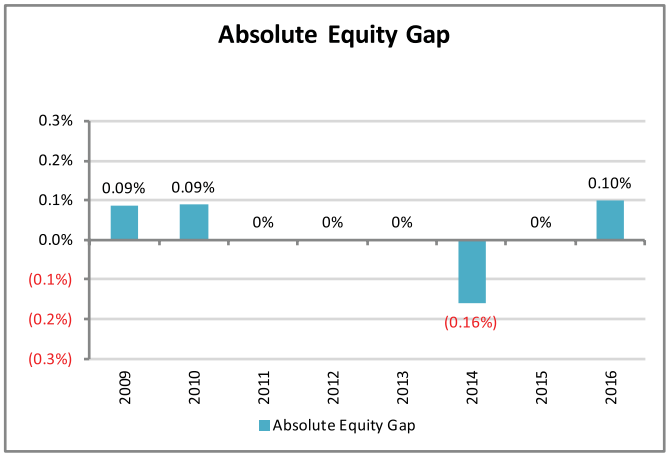
District health boards with cases pertaining to these indicators should investigate each case to confirm the accuracy of the data and to determine whether there were opportunities for prevention. All of these criteria meet the criteria for local case review to ascertain these points.

Indicator 13: Diagnosis of eclampsia at birth admission

Taranaki had 1 cases in 2016, no cases in 2015 two cases in 2014 and no cases were reported in 2013.

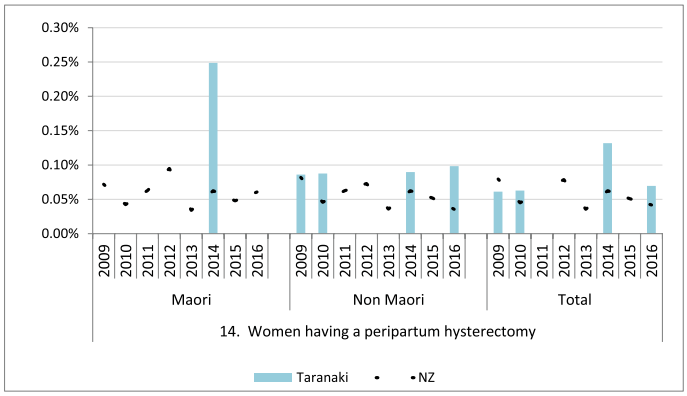


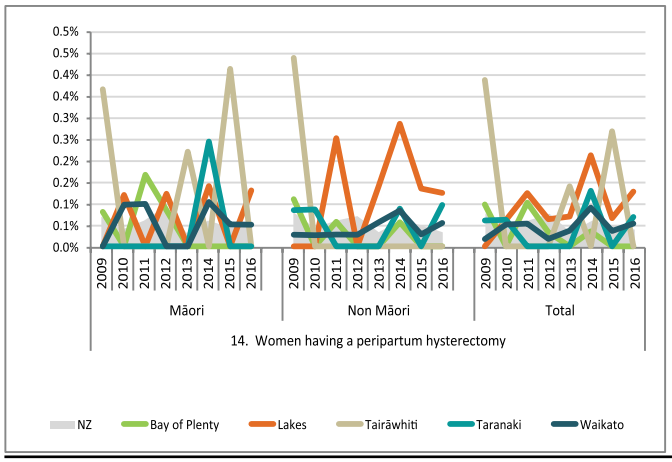


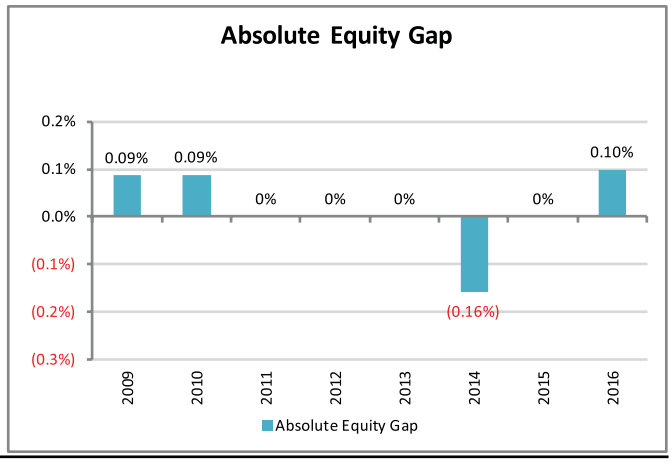


Indicator 14: Peripartum hysterectomy

Taranaki had 1 case in 2016 however no cases at Taranaki base Hospital so this case likely birthed in another DHB. There were no cases in 2015, 2 reported cases in 2014 and no cases were reported 2013.

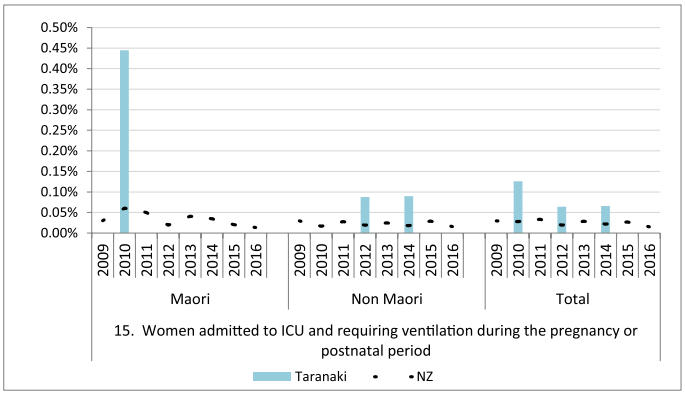


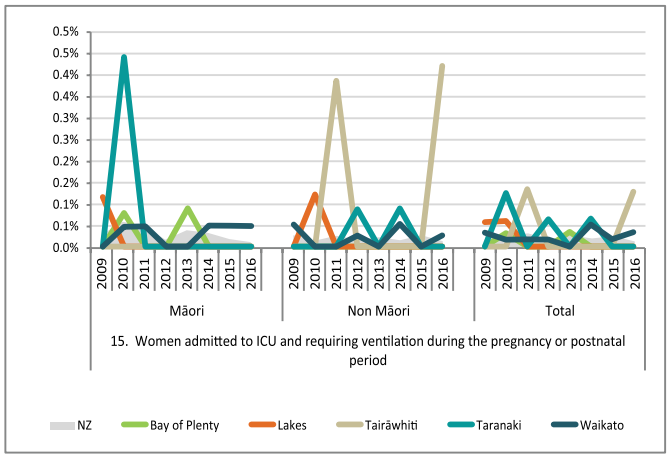


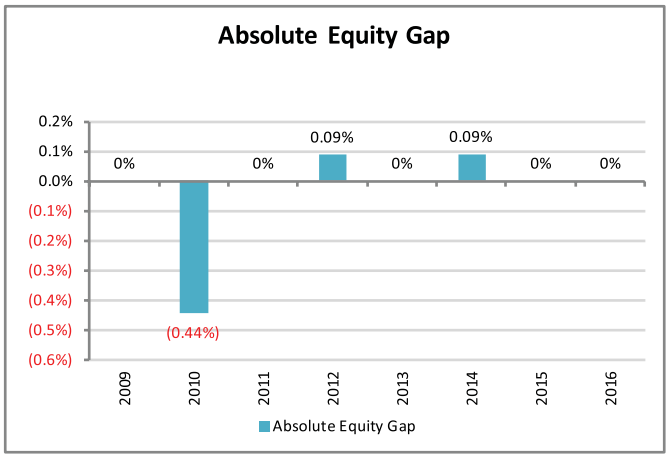


Indicator 15: Mechanical ventilation during pregnancy or postnatal period

Taranaki had no cases in 2016, 2015, one case reported in 2014 and no cases in 2013.

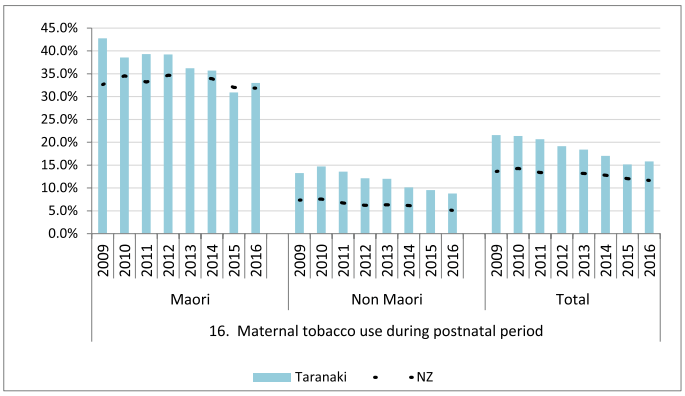


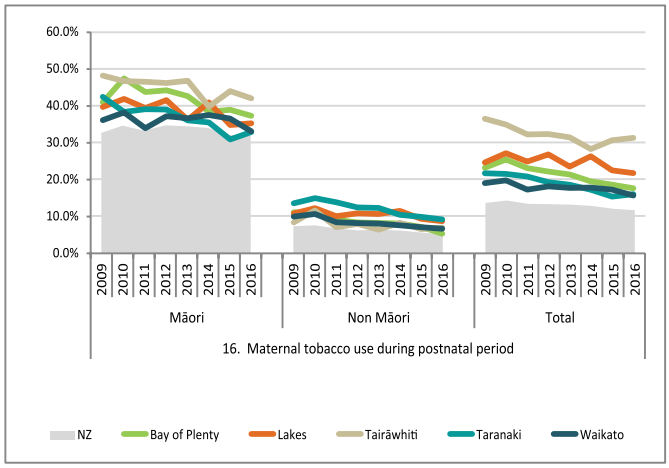


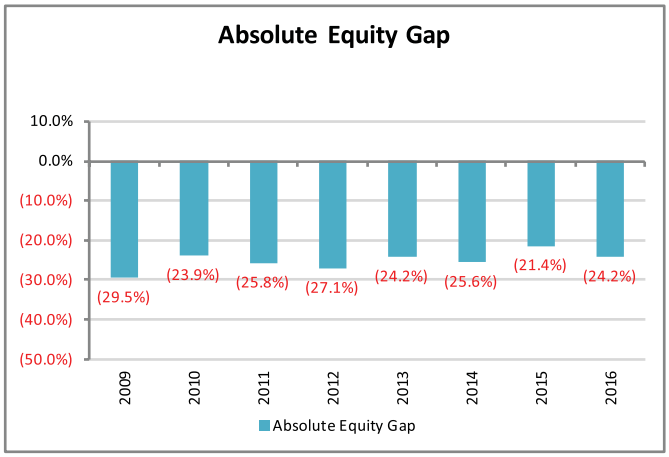


Indicator 16: Maternal tobacco use during the postnatal period

STATIC: Taranaki has a rate of 15.8% (14.4% at Taranaki Base Hospital) compared to the national rate of 11.7%. 2015 rate was 15.1% (13.7% in Taranaki Base) down from 17% in 2014, down from 18.3% in 2013 and 19.1% in 2012. Smoking in pregnancy is more prevalent amongst Maori women and is a key indicator to focus on improving both the number and reducing inequity.

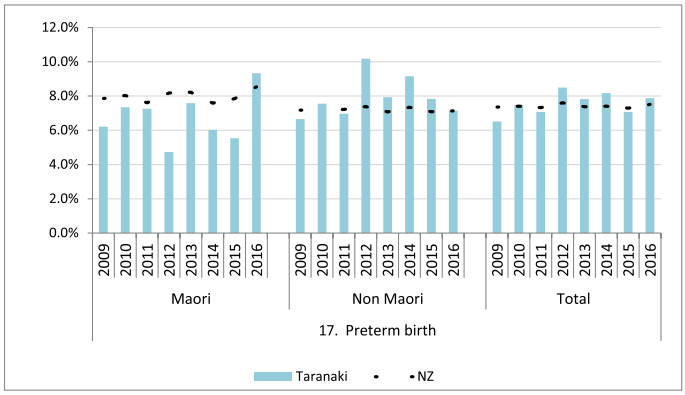


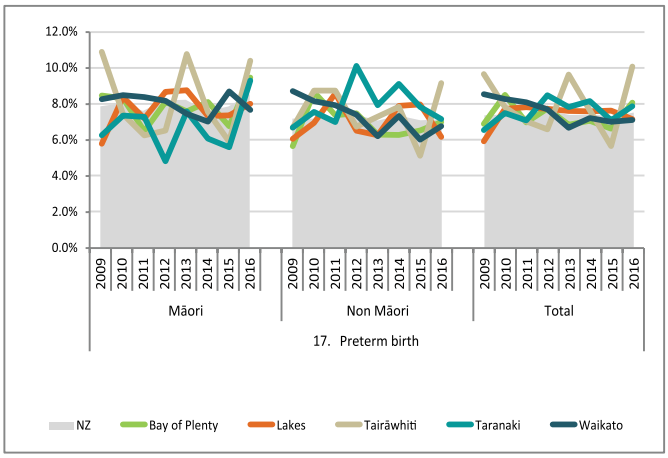


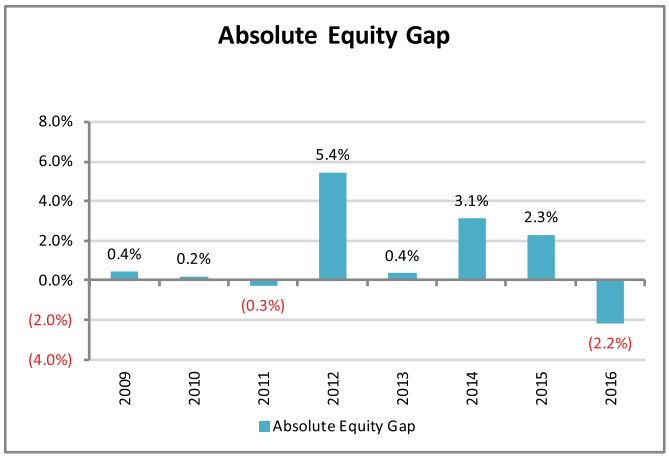


Indicator 17: Premature births

STATIC: This may be the change of definition. Taranaki has a similar rate of 7.9% (Taranaki Base Hospital 7.5%) compared to the national average rate of 7.5% in 2016. Data for 2015 was 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; we continue to monitor the rate of preterm births via our analytics. Fetal Fibronectin testing is undertaken in TDHB and early tocolysis where appropriate is administered.

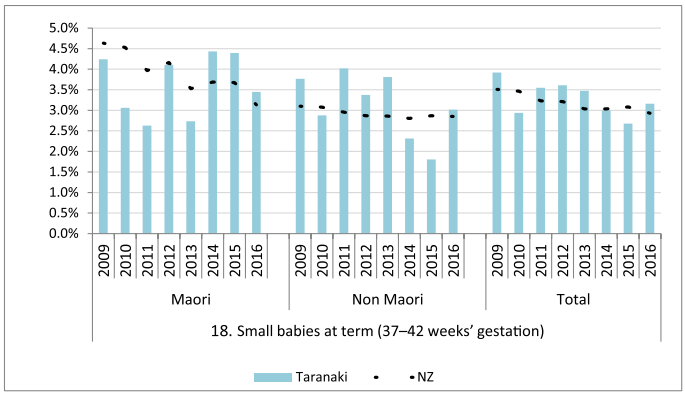


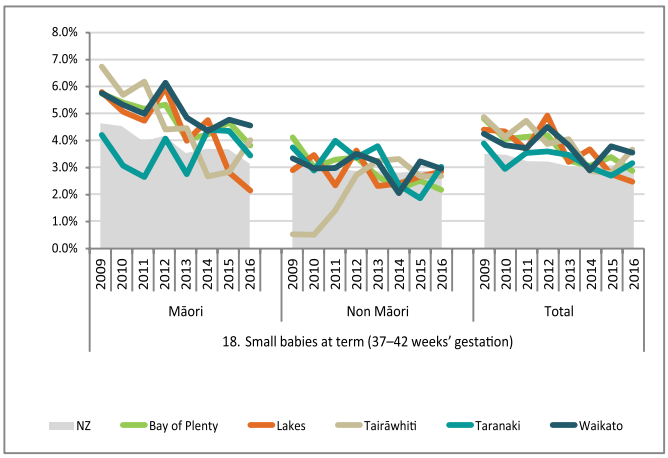


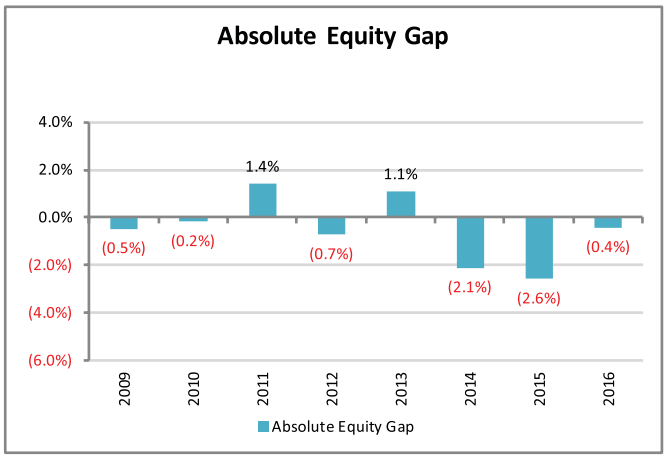


Indicator 18: Small babies at term (37–42 weeks' gestation) (SGA)

Taranaki has a rate of 3.2% in 2016 compared to 2.7% in 2015, 3% in 2014, 3.5% in 2013. The national rate was 2.9% in 2016. We have had local education sessions and adopted the Growth Assessment Protocol (GAP) and 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.



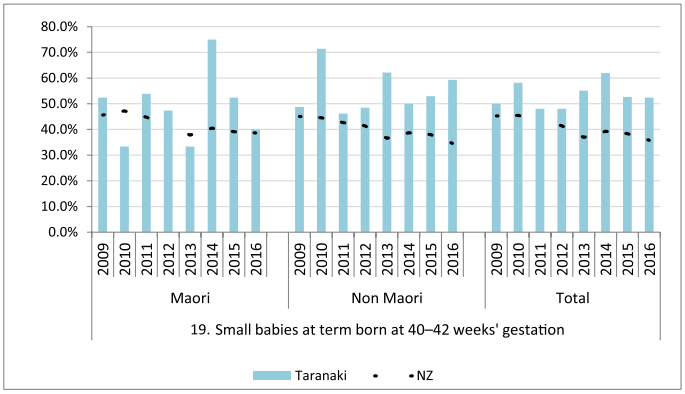


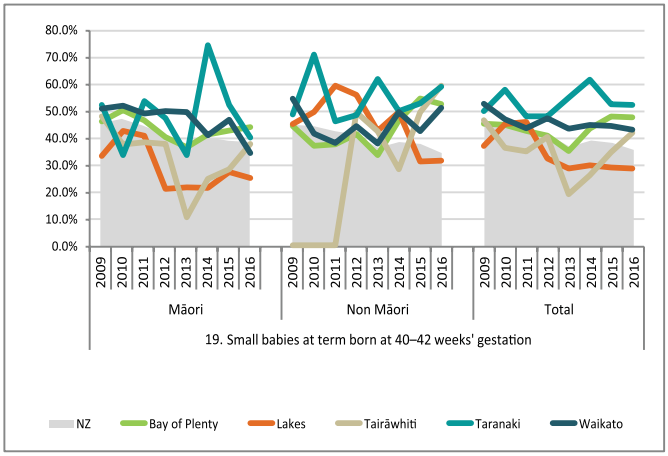


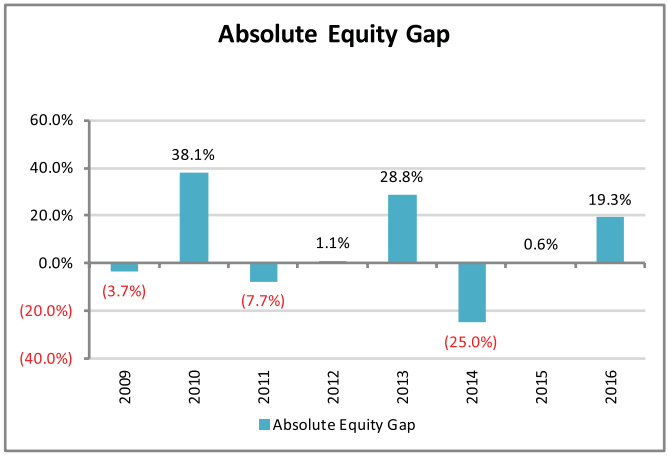
Indicator 19: Small babies born at term (40-42 weeks gestation)

CONTINUE TO INVESTIGATE: Taranaki continues to have the highest rate in the country but has decreased to 52.4% (Taranaki Base Hospital 56.1%) in 2016 from 61.9% in 2014, 52.6% in 2015; 55.1%in 2013. The national average is 35.8% in 2016. 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. 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 has been introduced to Taranaki; all practitioners have been offered e-learning, face to face education was completed in October 2017. Having the GAP programme allows access, audit and on going monitoring of SGA to ensure best practice guidelines are followed.

Taranaki DHB GAP team

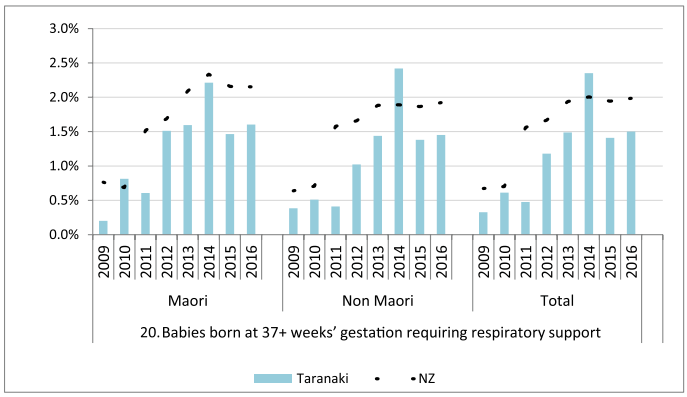


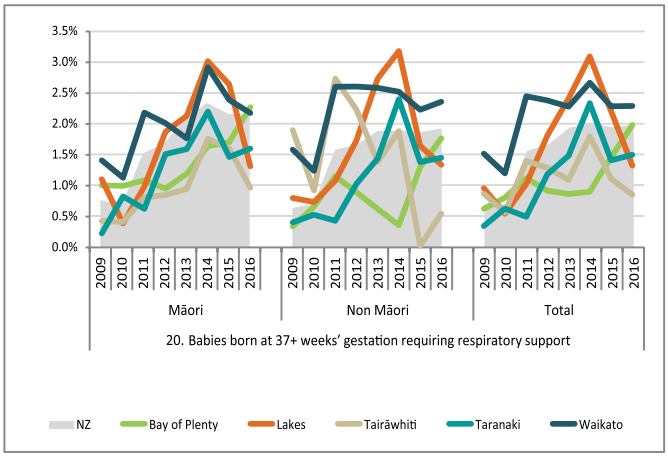


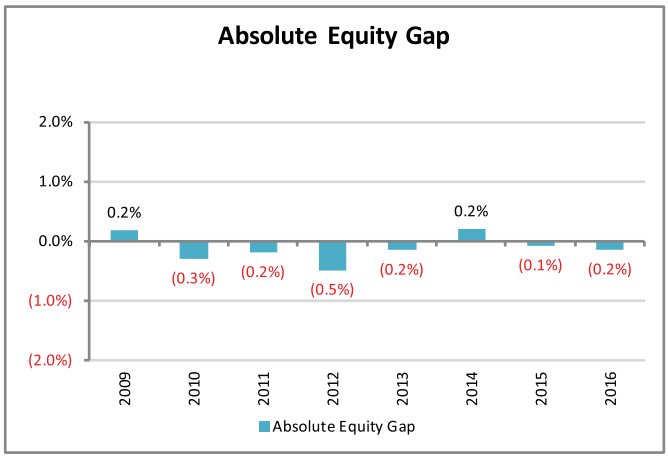


Indicator 20: Term babies requiring respiratory support

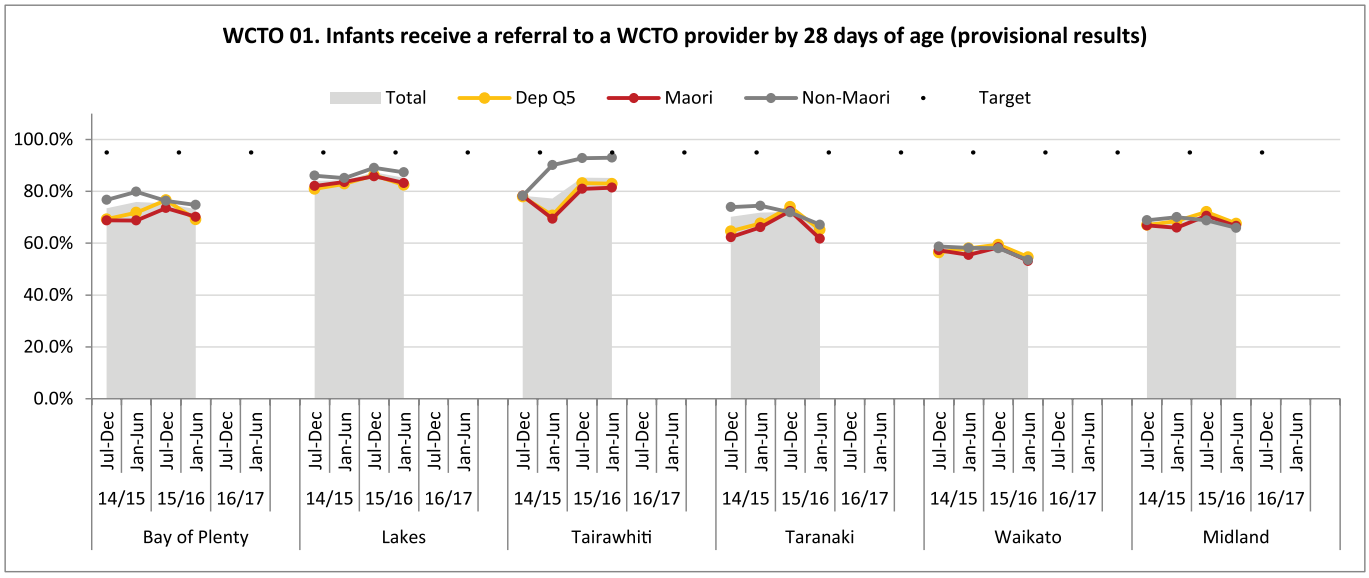
Taranaki has a similar rate of 1.5% (1.4% at Taranaki Base Hospital) in 2016 compared to the rate of 1.4% in 2015 down from 2.4% in 2014, 1.5% in 2013 It is now below the national average of 2%. The number is small, however all unexpected term baby admissions to the Neonatal Unit are case reviewed.

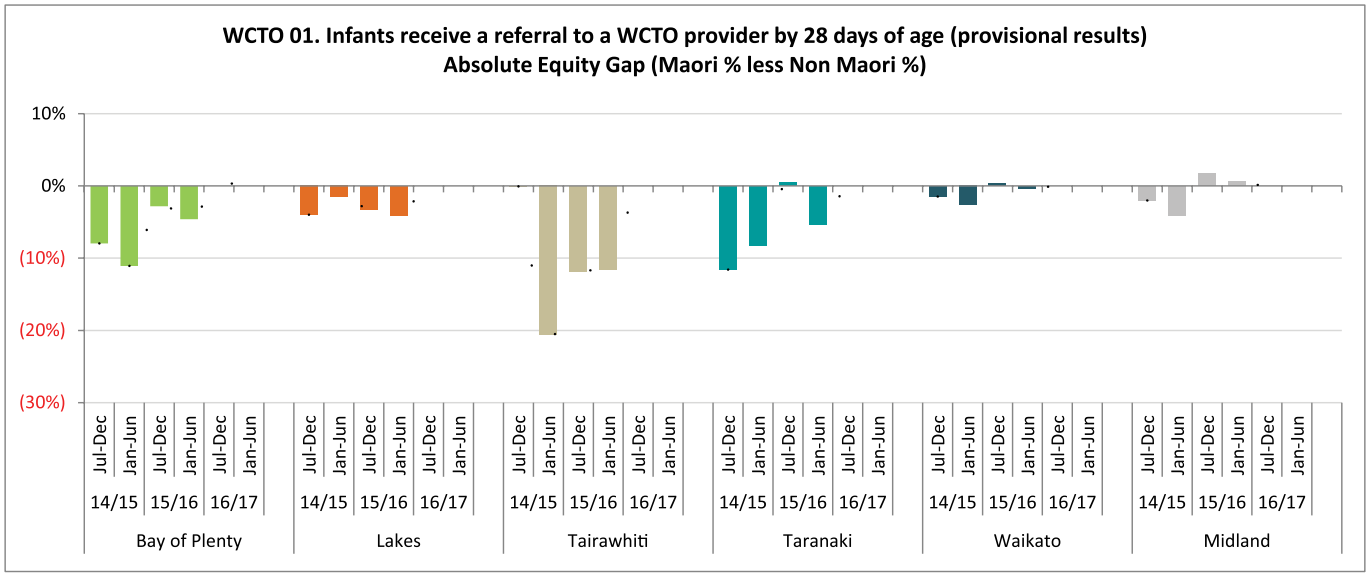


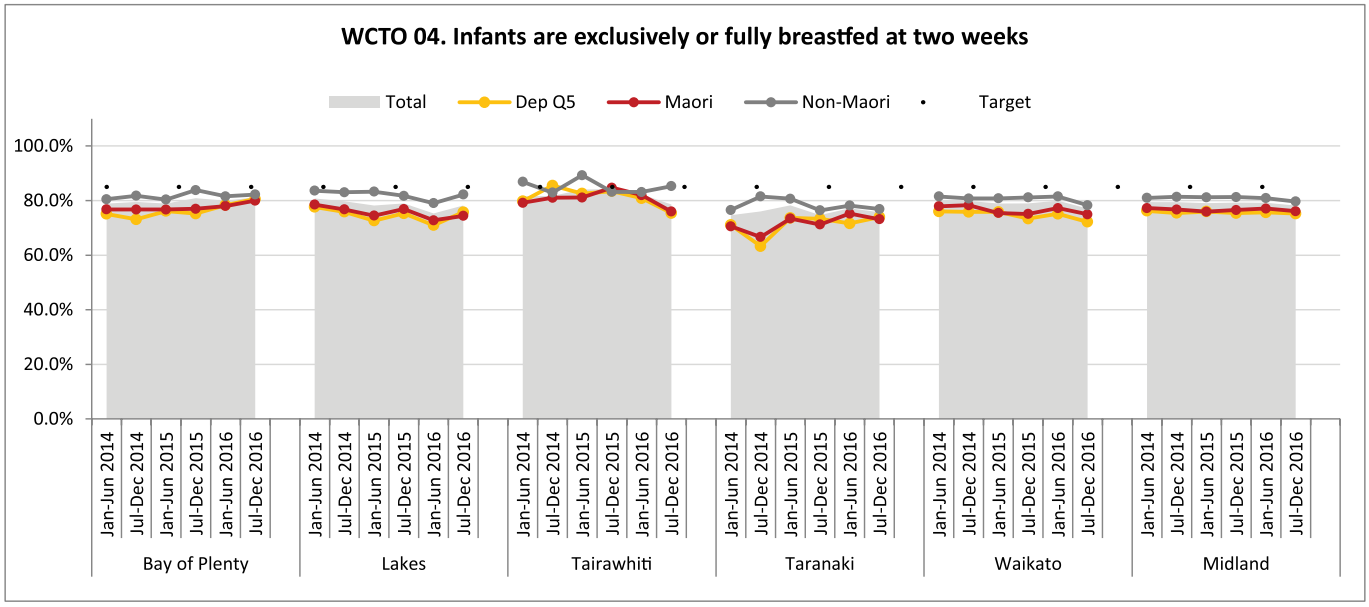




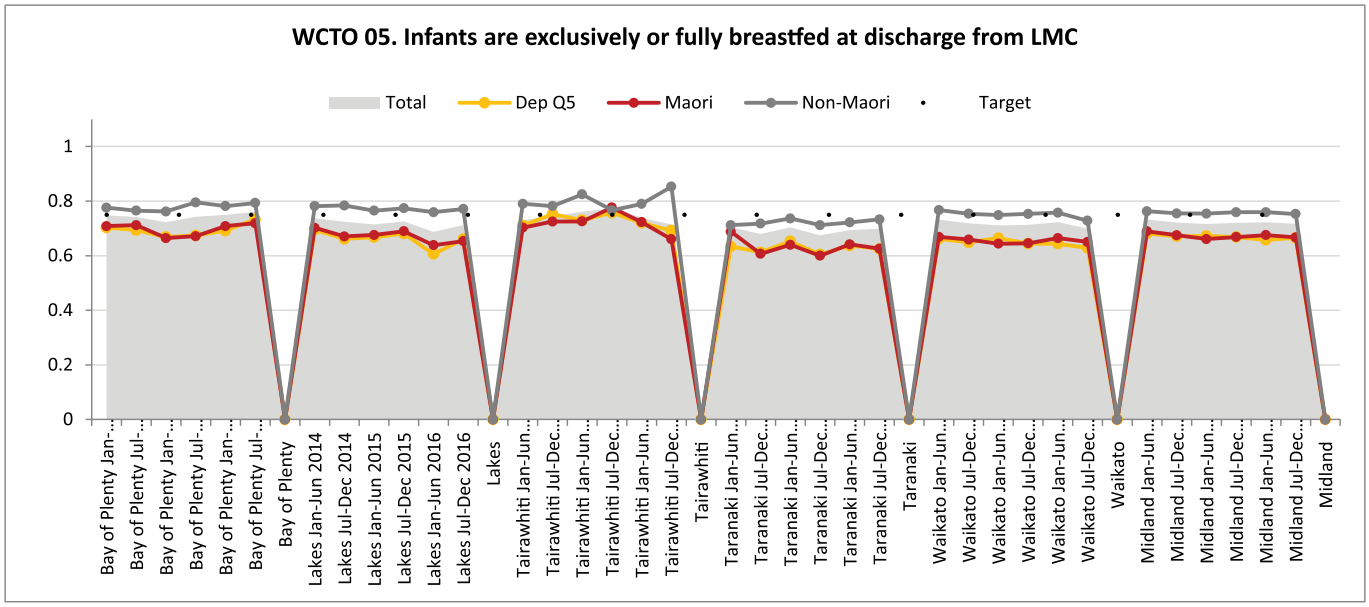
WELL CHILD TAMARIKI ORA (WCTO) INDICATORS

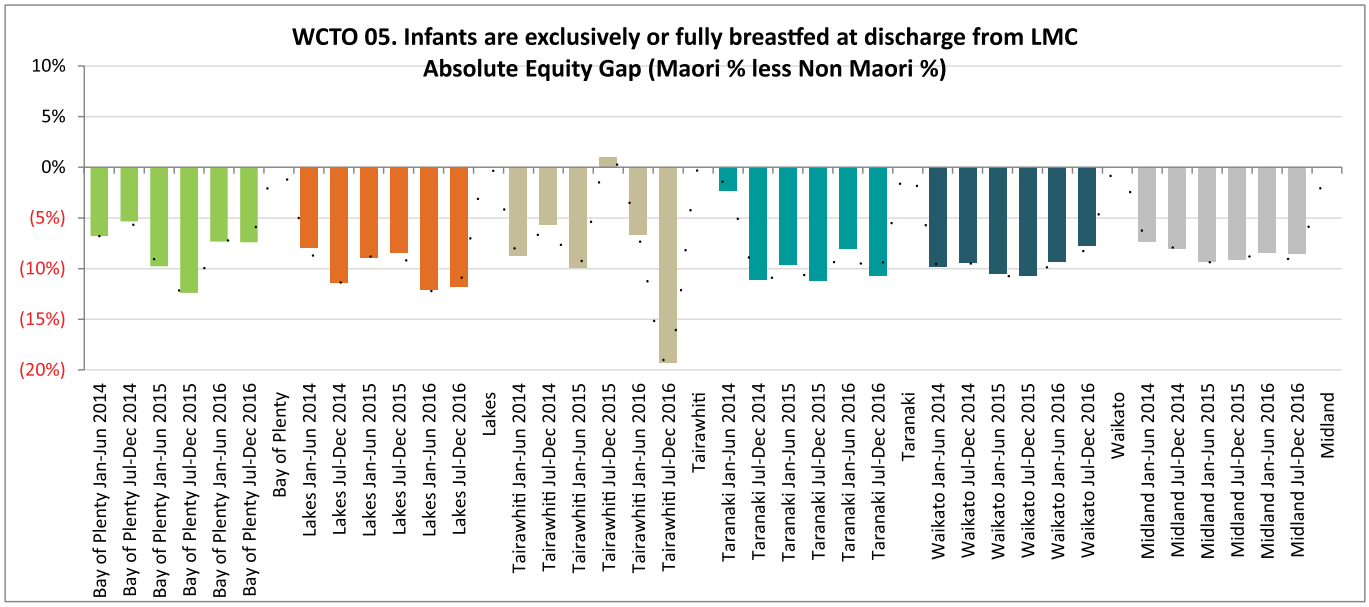






Smart systems





Smart systems

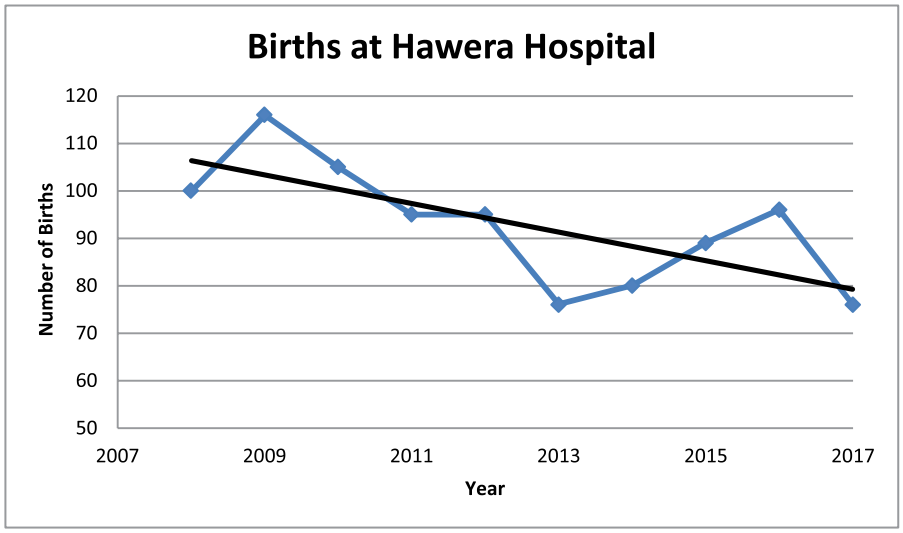
Cultural responsiveness

Taranaki DHB has the following practices and activities:

- All staff newly employed attend a session on tikanga Māori, recommended best practices as part of their induction day which includes a handbook for reference. The expectation is that this is repeated two yearly as part of a refresher day. Taranaki DHB in the future plan to increase monitoring to ensure on going refreshers are attended.
- Taranaki DHB runs a Treaty of Waitangi workshop that is available to all maternity practitioners to attend, with the expectation that new employees register and attend this.
- The Engaging Effectively with Māori workshop has been running for 12 months and will continue to run with two sessions per month being available to all maternity practitioners/DHB employees. Taranaki DHB staff are strongly encouraged to attend.
- Annual breastfeeding educational study day/workshops are available to all maternity and child health practitioners. The study day has a session focused on Māori Health outcomes including data presentation
- The Taranaki maternity annual report breaks down data to ethnicity to highlight awareness, with a health equity focus. The annual report also analyses workforce data including availability of Mâori midwives.
- The Health Equity Assessment Tool (HEAT) is utilised over services. This has been used for Immunisation services and the Breast Feeding Welcome here project to target identified inequity issues and assist in planning for action and improvements in outcomes.
- Taranaki DHB has Māori Health advisors to assist staff in providing advice on cultural, whānau, or engagement issues.
- Taranaki DHB is currently piloting the Hapū Wānanga child birth education programme which is facilitated by Māori midwives and focuses on improving health outcomes including the 0-4year old national Māori Health priorities
- Taranaki DHB has Māori health representation, including Kaiawhina on the Maternal Wellbeing and Child protection multi agency group meetings to provide advice and support to assist in providing wrap around services to families that are identified as being vulnerable in pregnancy.
- Taranaki DHB has recently undergone a restructure; this includes the Māori health team which is currently in the recruitment process for two new roles that will be the key roles to drive cultural competency in our DHB both culturally and with a kaupapa Māori clinical lens. This will include Key Performance Indicators for Māori responsiveness.
- There is Māori representation on the Maternity quality and safety programme governance group with the goal to have a second representative in the future.
- It is the intention to restart the monthly maternity forum meetings between the maternity service and Māori health stakeholders and services. Also the maternity service is to be invited to connect with a Hapū Ora reference group. This group provides Māori advice and support to the sector in delivering services appropriately for Māori women and babies.

Rural and primary maternity facilities and primary LMC services

Table 1



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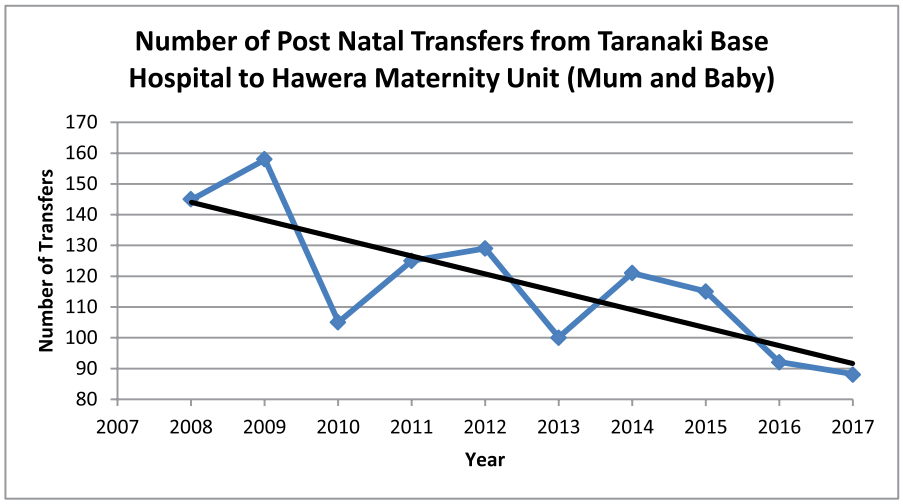

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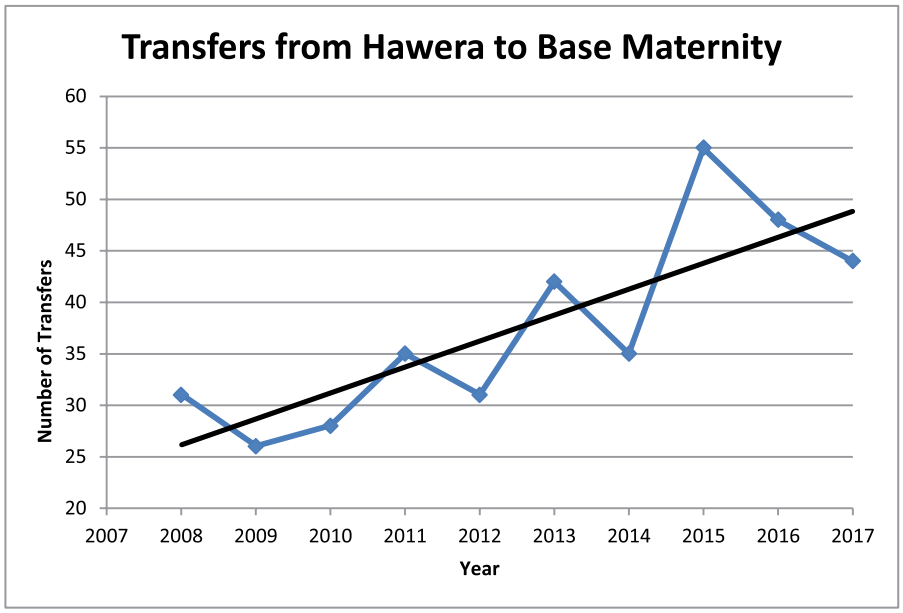


Hawera Primary Maternity Unit

Despite the refurbishment of Hawera Maternity Unit (HMU) and the development of a marketing leaflet, birthing rates in HMU have declined as per Table 1 and transfers from HMU to Base Maternity Unit (BMU) have increased as per Table 3. Preliminary data for 2018 suggests the decline has stabilised with 2018 data indicating the birth rate may be slightly increased on 2017 figures. A decline in the birthing rate in HMU has affected the utilisation and bed occupation rates in HMU and has contributed to the increase at BMU.

A focus on the reasons for transferring to BMU and the outcomes of transfers to base hospital may provide information to focus on in 2018/19.

Additionally a decline in the rate of mothers and babies transferring from BMU to HMU for post natal care has also reduced. Some families are opting to be discharged directly to home but recruitment challenges (see workforce section) may have also contributed to this. A further examination of this in 2018/19 would provide greater understanding as to why this rate is declining.

Summary of 2017/18

Draft Sepsis Resuscitation Guideline

The draft guideline has been formulated in response to the Maternal Morbidity Working groups (MMWG) reported findings following their review of cases of maternal Sepsis around New Zealand. Their findings reported key themes and opportunities for hospital services to improve/review provision of care in cases of maternal sepsis.

The review identified the need to improve knowledge regarding early identification of infection and sepsis in pregnant or recently pregnant women, and expedite appropriate early interventions. It is anticipated that having a specific guideline for Taranaki DHB maternity services will improve recognition, promote immediate management of sepsis and reduce the number of admissions to High Dependency Unit due to maternal sepsis.

Following sign off of the guideline education and scenario based training will take place with local practitioners to ensure local knowledge and awareness.

USE THIS STICKER IF YOU SUSPECT SEPSIS	TICK IF PRESENT ☐ HR > 90 ☐ Temp >38 or < 36 ☐ RR > 20 ☐ New or worsening confusion ☐ WCC >12 or < 4	*ONE TICK OR MORE = CONTINUE WITH SEPSIS SIX BELOW*
	SEPSIS SIX	
	TASK	**NAME AND TIME**
1	**Oxygen:** aim $Sp0_2$ 94 -98% (or 88-92% for COPD and chronic type II respiratory failure) as per Taranaki DHB Standing Order	
2	**Blood Cultures:** take two sets, plus all relevant blood tests	
3	**IV Antibiotics:** Aim for administration within one hour	
4	**Fluid Resuscitation:** if hypotensive give bolus of crystalloid 20ml/kg up to a max of 60mg/kg.	
5	**Serum lactate:** and Hb	
6	**Observe:** reassess vital observations and urine output at least hourly	

DRAFT

NHI Label

Maternal Sepsis Pathway

Greater than 20 Weeks Gestation/Up to 42 Days postpartum

This pathway is intended for the recognition and immediate management of sepsis in the Maternity and Postnatal Setting

RECOGNISE

Are you concerned that the woman could have early sepsis?
Does she have any risk factors or signs or symptoms of infection?

- ☐ Immunocompromised/chronic illness
- ☐ Indwelling medical device-eg IV line/redness
- ☐ Wound infection/cellulitis
- ☐ Recent Surgery/invasive procedure
- ☐ History of fever or rigors
- ☐ Re-presentation within 48 hours
- ☐ Unexplained abdominal pain/distentin
- ☐ Cough/sputum/breathlessness
- ☐ New onset of confusion/altered LOC/ neck stiffness/headache
- ☐ Possible breast or intrauterine infection
- ☐ Dysuria/frequency/odour

Have a higher level of suspicion of sepsis for women with PROM

PLUS

Does your patient have any RED ZONE CRITICAL observations or additional criteria as per MEWS?

- ☐ Temp > 38°C or < 35.8°C
- ☐ HR > 90 or <50bpm
- ☐ RR > 20 or <10rpm
- ☐ Any alteration of mental status
- ☐ O_2 sat < 94%
- ☐ SBP < 100mmHg

Obtain a venous blood gas if available

YES →

The woman has SEVERE SEPSIS OR SEPTIC SHOCK until proven otherwise

- **Sepsis is a medical emergency**
- **Call for a Rapid Response as per local MEWS unless already made**
- **Conduct a targeted history and clinical examination**

RESPOND & ESCALATE

NO

Look for other common causes of deterioration

Sepsis may still be a concern

Initiate clinical care

Repeat observations within 30 minutes AND increase the frequency of observations as indicated by the patient's condition

Re-evaluate for sepsis if observations remain abnormal or deteriorate

NO

Patient may have SEPSIS

Sepsis is a medical emergency

Obtain SMO review within 30 minutes

Conduct a targeted history & clinical examination

NO Look for other causes

Does the SMO consider the patient to be septic

YES

YES

Patient has SEVERE SEPSIS or SEPTIC SHOCK until proven otherwise

Sepsis is a medical emergency

Obtain IMMEDIATE review from a SMO

Expedite transfer to resuscitation area or equivalent

Commence treatment as per sepsis resuscitation guidelines and put completed sepsis pathway sticker in the Clinical Record

Discuss management plan with patient and family and review the newborn for S&S Infection

NHI Label

Maternal Sepsis Pathway

Greater than 20 Weeks Gestation/Up to 42 Days postpartum

SEPSIS RESUSCITATION GUIDELINE

RESUSCITATE & REASSESS

A — **Maintain patent airway**

B — **Give oxygen**
Aim SpO_2 94 -98% (or 88-92% for COPD and chronic type II respiratory failure) as per Taranaki DHB Standing Order

C — **Large bore intravenous access, collect and check results:**
Lactate Blood gas Blood cultures x 2 (separate sites)
EUC Coags CRP
FBC LFTs Glucose

Prescribe and administer antibiotics within 60 minutes time of diagnosis.
If source of sepsis is unknown prescribe 1.5g Cefuroxime and 7mg/kg of Gentamicin, otherwise refer to local guidelines.
DO NOT DELAY INVESTIGATIONS OR RESULTS.

IV fluid resuscitation
Give initial 20mL/kg crystalloid fluid bolus STAT: aim for MAP of > 65mmHg or SBP > 100mmHg. If no response, repeat 20mL/kg crystalloid fluid bolus unless there are signs of pulmonary oedema
If no response **immediately** consult with lead Senior Doctor on duty

D — Assess level of consciousness (LOC) using Alert, Voice, Pain, Unresponsive (AVPU)
If V or less conduct a GCS
If P or U reassess Airway, Breathing and Circulation

E — Examine patient for source of sepsis
Collect appropriate swabs, cultures, ECG, chest X-ray if indicated

F — Fluid balance
Monitor and document fluid input & output - consider IDC
Maintain urine output ≥ 0.3mL/kg/hour

G — Check Blood Glucose Level: if > 12mmol/L consider glycaemic control

MONITOR & REASSESS — Continue monitoring and assess for signs of deterioration:
- Respiratory rate in the Yellow or Blue Zone
- SBP < 100mmHg
- Decreased or no improvement in level of consciousness
- Urine output < 0.3mL/kg/hour
- Increasing or no improvement in serum lactate

REFER

IF NO IMPROVEMENT INTENSIVE CARE MAY BE REQUIRED

- Reassess suitability to continue resuscitation
- Consider consultation with and referral to Intensivists
- Consider baby/fetus and any likely effects
- Discuss management plan with woman and their family/carers

VERSION 1: 2016

DRAFT

WOMAD

2018 saw Taranaki Maternity Services, manning the pregnancy and parenting tent at the World of Music, Art and Dance (WOMAD) again as requested by organizers, following on from wonderful feedback and attendance for previous years. Once again, this was a fabulous opportunity to promote the importance of the Top 5 things to do in the first 10 weeks of pregnancy and to offer advice regarding breastfeeding and parenting.

Self employed and core midwives were joined this year by colleagues from Le Leche League, who passed on their great knowledge of breastfeeding and support networks. All mingled with consumers, present and potential future families to pass on their knowledge and to offer support. Once again positive feedback was received from all in attendance.

Consumer report to Taranaki DHB MQSC for 2017/2018

Reflecting back on the past five years of the Taranaki DHB Maternity Quality and Safety (MQSC) group I am filled with a sense of achievement and progress. Under the stewardship of our chairperson Belinda Chapman and support from Sharon Howe this group has remained steadfast in regular meetings and actively bringing about quality improvements within Taranaki Maternity Services. As a consumer member I am contracted rather than employed by Taranaki DHB, yet this has not been a barrier to myself feeling appreciated as part of the group.

Within Taranaki DHB there is a noticeable change in recognising the importance of seeking a consumer voice, I am enjoying being part of a number of projects. A highlight this year has been a revamp of one the parent rooms at Base Hospital, what once was an underutilized space is now a bright, functional room.

Building on the success from our 2016 Maternity Roadshow in Waitara, I facilitated the 2017 Maternity Roadshow in Stratford. This event was very well attended by providers and community groups from right across the childbearing spectrum, with a total of 25 stallholders attending. The goal behind this event is to increase consumer awareness and engagement with maternal and child health services, anecdotally we have found that stallholders find immense value in networking with each other which is leading to greater awareness and collaboration of services. The next road show will be held further around our mountain in Hawera in early November 2018.

The Taranaki Maternity Quality & Safety Committee Consumer Facebook page is still active currently boasting 195 members. This page is used as a digital notice board for maternal and child health related news and events. Cross posting with the Taranaki District Health Board helps increase members of both pages. I also invite other maternal and child groups both locally and nationally to share, with approval, to the MQSC page.

In my own personal and professional development I am now an active childbirth educator in the Taranaki region. Having regular contact with a number of consumers on the childbearing journey in this time has given me a greater understanding of how consumers experience service delivery. Looking forward I will continue to share my consumer voice so that together we can achieve amazing things. In the next five years I would like to see a new maternity unit for Taranaki.

Meet Your Maternity Services Roadshow 2017 - Stratford

The second Meet your Maternity services roadshow was held 19 October at the Stratford Memorial Hall.

Meet Your Maternity Services Roadshow is about establishing and fostering relationship between consumers and maternity service providers, as well as between service providers themselves.

For this event we invited along a mix of maternity services that consumers can access at very little, or in most cases no cost including health care as well as support services.

Raising awareness of just what is out there is the first step to increasing engagement with services. We know that having consumers engage with services in the first trimester of pregnancy (before 10 weeks gestation) goes great length to more positive outcomes for everyone.

The 2017 Maternity Services Roadshow had 25 providers represented, with an estimated 20 consumers through out the course of the morning.

Marketing of the event was done largely via facebook with each exhibitor sharing the event on their own.

Providers who attended:

Well Child / Tamariki Ora:

- Tui Ora
- Ngati Ruanui Healthcare

Taranaki District Health Board maternity services:

- Maternity Quality and Safety Program
- Immunisation
- Health Promotion
- Newborn Hearing Screening
- Antenatal Clinic
- Lactation Consultant
- Midwives
- Post Natal Ward Co-ordinator
- Midwifery management

Other community and not for profit services:

- La Leche League Taranaki
- South Taranaki Baby Wearing
- Taranaki Neonatal Support Trust
- SANDS New Plymouth
- Parents Centre Stratford
- Active Birth Taranaki
- Breastfeeding Peer Support
- Pregnancy Help Taranaki
- NZ College of Midwives Taranaki Branch
- Taranaki Women's Refuge
- Maternity Services Consumer Council
- Stratford High School Teen Parent Unit
- Great Fathers
- Te Puna Trust - Nuture Taranaki

stuff.co.nz www.stuff.co.nz/taranaki-daily-news/news/98044419/Rural-maternity-roadshow-calls-the-midwife

Antenatal clinics

- There has been an increase in the number of Obstetric **antenatal clinics** at Taranaki Base hospital. There is a marked increase in the amount of referrals which has added pressure onto the antenatal clinic midwifery services. Hawera secondary antenatal clinic operates one day per week. **Vaccination clinic** continues weekly; in the first six months of the year there has already been 62 women vaccinated, this is a projected increase on last year and is a popular service for the women of New Plymouth

- **Hip check clinic** twice weekly.

- **Amniocentesis** service has improved; it can now be done any week day as opposed to just Thursdays in the past. Two obstetricians are skilled to provide this service. We have a new ultrasound scanner which is far superior to the previous one, making the procedure much easier.

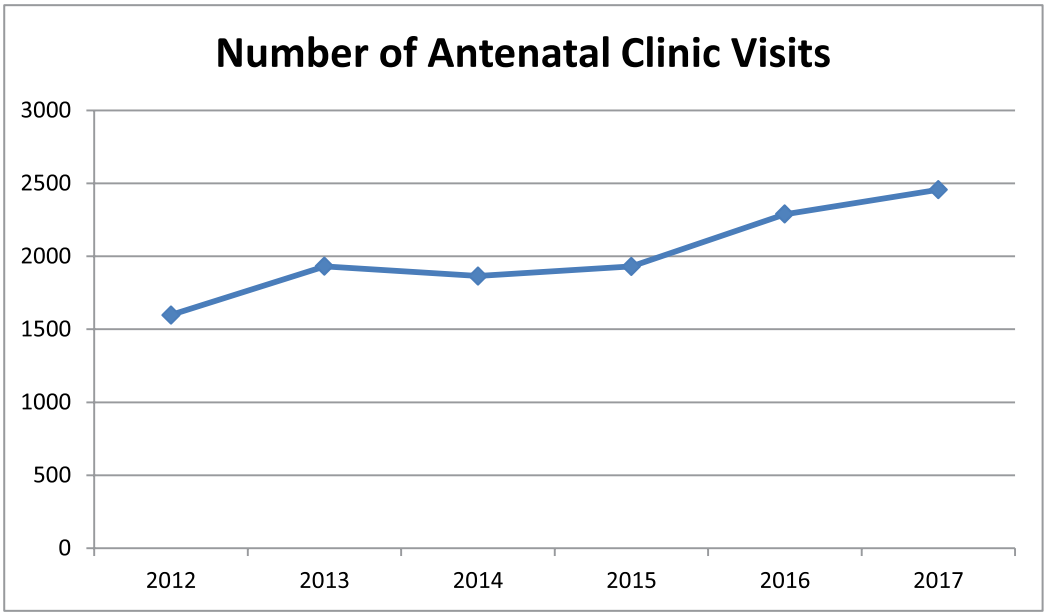
What could be improved/challenges:

- **Antenatal clinic midwifery hours:** The amount of clinic time has expanded under the same clinical midwifery hours. Not only has the amount of referrals increased but also the complexity of the women referred. There are also an increasing number of requests for elective C/S without medical indication

- **Hawera secondary antenatal clinic**: Since July last year Hawera ANC has been unable to recruit a dedicated midwife to run it due to recruitment difficulties for Hawera maternity unit. A midwife from base hospital currently attends to this clinic on a weekly basis ; it is hoped that we can recruit to full FTE in Hawera in the near future.

- Local access to **Maternal Fetal Medicine** (MFM) services for the women of Taranaki: A national shortage of MFM specialists means women travel to Wellington for consultation, in the past we were able to have a visiting specialist one day per month to provide the service in Taranaki. There has been a further increase in the number of women referred to MFM this year. We have had 20 for the first 6 months of 2018; previous annual figures have been lower than this rate.

- We are seeing an increasing number of women with **diabetes in pregnancy**. The need for a clinic for women with gestational and pre existing diabetes was identified in 2013 which was trialled in conjunction with the diabetic educators however this was not successful, it was therefore discontinued. It would be good to revisit this along with the need for a diabetic liaison midwife given the continuing increase of women with diabetes in pregnancy.



The growth referrals have increased probably in line with our increased detection rates of small for gestational rates and local training with the Growth Assessment Protocol (GAP).

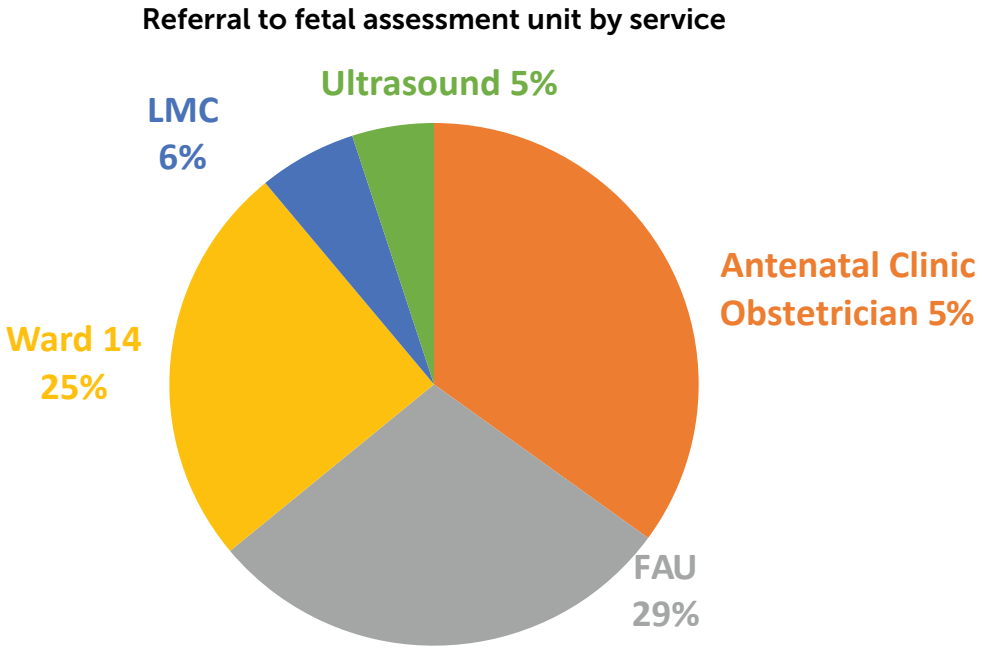
Year	2012	2013	2014	2015	2016	2017
Number	1597	1931	1864	1930	2289	2456

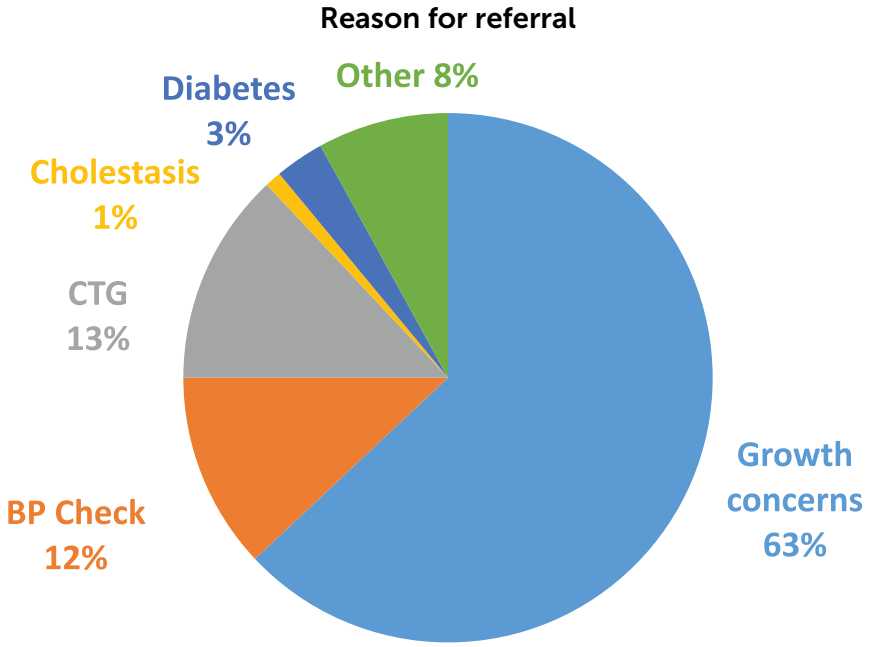
Fetal Assessment Unit Clinic

This clinic is available one day per week (see flow chart for referrals), if there are any urgent reviews required outside of this time these are completed on ward 14.

Reason for referral

Growth concerns are the major reason for referrals. For some cases a woman referred with growth concerns may also be monitored closely for Pre eclampsia (PET). A woman having Cardiotocograph (CTG) monitoring for reduced fetal movements may also have another issue such as prolonged ruptured membranes.



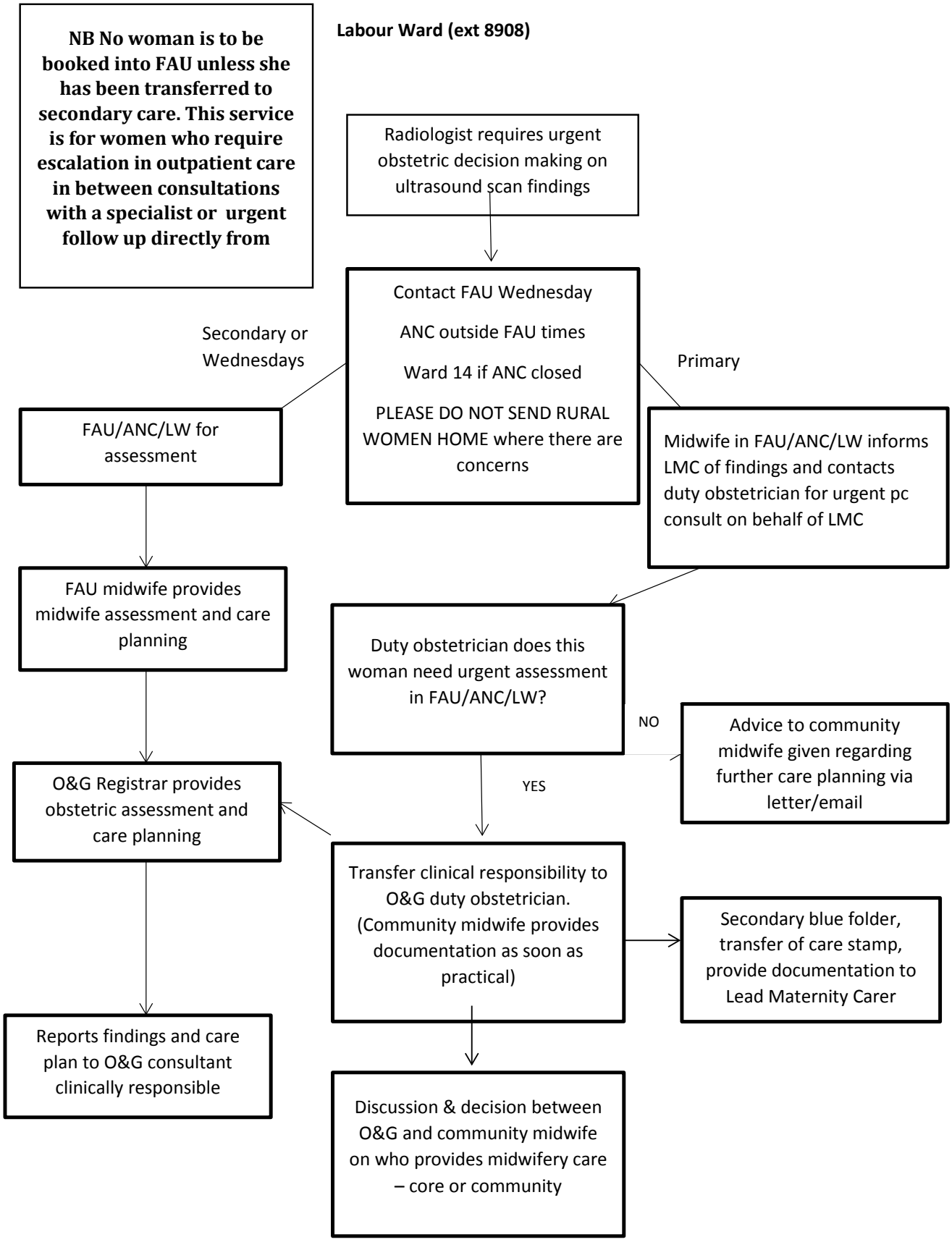


URGENT SCAN REFERRALS TO FETAL ASSESSMENT UNIT (FAU)/ANC or LABOUR WARD (LW)

FAU runs each Wednesday; 08.30-17.00hrs (ext 8044)

Antenatal Clinic Coordinator (ext 8335)

Labour Ward (ext 8908)



Post partum haemorrhage review

Background

Taranaki District Health Board received data from the Health Round Table Ltd that its Post Partum Haemorrhage (PPH) rate became significantly elevated. The hospital itself responded with its own analytical data showing a PPH Rate of 15.76% The multi-disciplinary team started to meet in April 2017 to examine the rate. By July 2017 a PPH work plan was formulated. In response to this an external midwife and obstetrician were asked to conduct the independent review over two days.

Methodology

The reviewers visited the delivery suite and the operating theatres.

They also interviewed the head of department obstetrics and gynaecology, the associate director of midwifery, the charge midwife of delivery suite and the operating theatres. A number of the core midwives, LMC, including the NZCOM representative as well as an LMC in the Leadership Group, the senior medical officer in charge of the analytical data, an anaesthetist, senior medical officer's and a senior registrar.

In addition they reviewed the notes of 12 cases of PPH ranging from losses of 500mls to 4500mls. As well as reading various protocols including PPH and the third stage of labour.

Results/findings

The reviewers acknowledged the efforts made by staff and management in recognizing this issue and for taking steps to improve maternal outcomes from the outset. The management of PPH when it occurs is very good. Measures have been put in place for accurate measurement of blood loss. This equates to information on the dry weight's of items used in this event being extrapolated from the total loss.

The use of a PPH bag that allows collection of the fluid at the time of the event is used for further accuracy. It appears from the case notes that identifying quickly in the room when the incident is happening, good team work and the adherence to the protocols for the management of PPH including early recourse to Tranexamic Acid, are evident in this review. The use of the PPH checklist/proforma is available in all delivery rooms and for most of the cases reviewed was filled in completely.

From the interviews it was acknowledged that the rate was rising. Their understanding of why this was happening came through in our discussions during the interviews and will be reported below as well as what we will go on to recommend. Of note the responses to the rationale for the increase did also correlate with the analytical data that were being collected at the time.

Of the 12 cases reviewed using a modified SAMM (Severe Acute Maternal Morbidity) technique six were deemed avoidable, two in which management could have been improved and four in which were deemed unavoidable. The two major issues identified in this review that became apparent over the two days was the avoidance of PPH occurring, not in the management once it had occurred, although further improvement is always of benefit with this event. Secondly the distance from the delivery suite to the operating theatres.

The analytical data showed the women at greatest risk of PPH were those women whose labour was induced, whose labour was augmented with oxytocin, and those women who had a prolonged second stage of labour.

The discussions during the interviews from staff suggested the increase in induction of labours (IOL) required further attention to look at the indication and consistency of criteria for IOL. Additionally pre-empting the risk of PPH when these women have protracted labours or prolonged second stage could be anticipated with prophylactic measures put in place..

Recommendations/possible solutions

For women whose labour is induced, augmented and who have a prolonged second stage:

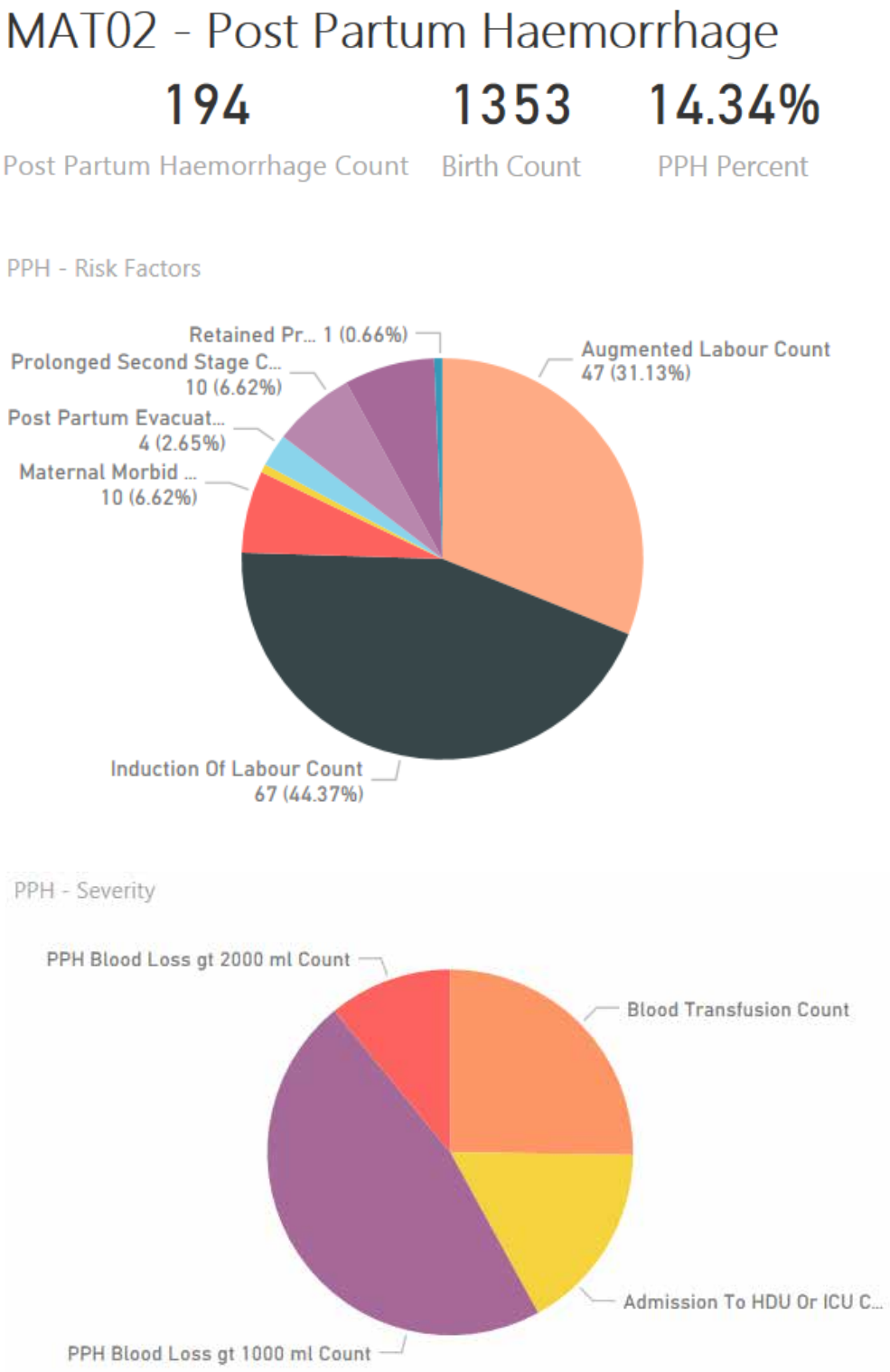
- It is suggested that for these women be administered Syntometrine 1ml instead of 5IU of oxytocin I.V. or 10IU oxytocin I.M. (Unless hypertensive disorder)
- It is also suggested that these high-risk women should also be given a 40IU infusion of oxytocin prophylactically.
- Consideration of a vaginal pack in cases of trauma while awaiting transfer to the operating theatre.
- To examine the criteria for Induction of Labour to see if it is evidence based and indicated.
- To try and get a consistent research based approach to the process of Induction of Labour. Review Cervidil and Prostin methods of IOL and use one or the other.
- The consideration of a shift co-ordinator, particularly after hours, to facilitate coordination and supervision of people, systems and resources. Which will ensure service delivery is effective and efficient achieving a 'helicopter view' of what is happening. With a fresh eyes approach to the situation, they will take a clinical lead in any emergency event.
- Supervision of junior doctors and early escalation to SMO.

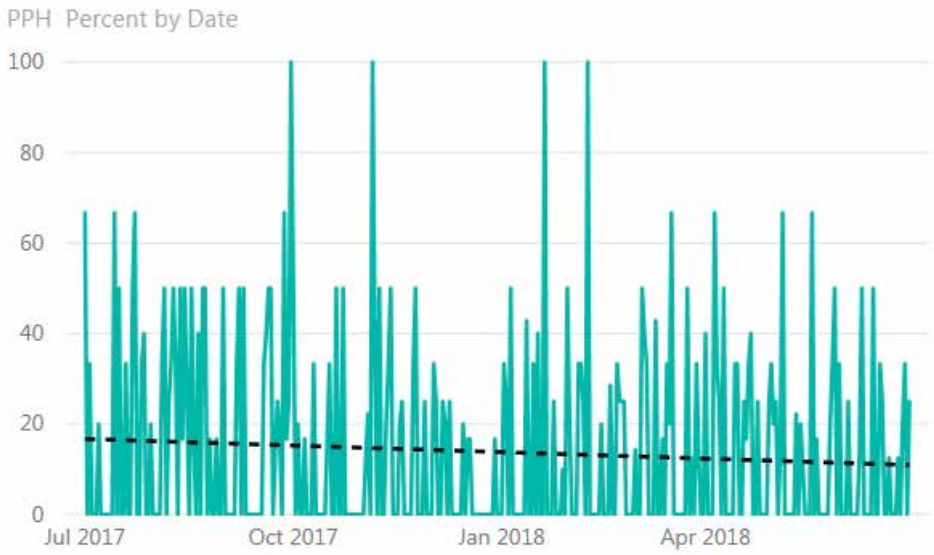
- To ensure that the PROMPT courses have both senior medical officer and resident medical officer participation and involvement.
- In regards to future planning it would be of benefit to have he delivery suite, antenatal and postnatal all on one level (this would allow easier facilitation of staffing) as well as having it adjacent to the Operating Theatres.
- The consideration of a midwife in the Post Anaesthetic Care Unit (PACU) when there are mothers and babies present.

Areas for further investigation

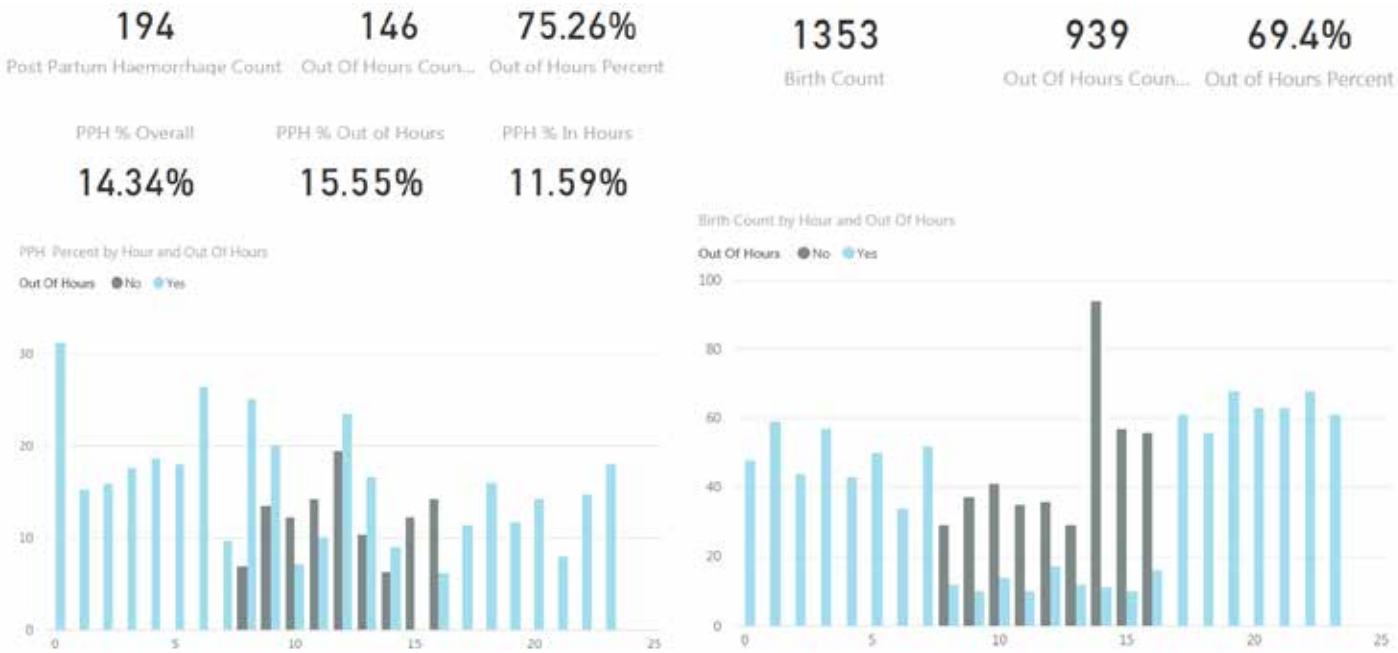
It is also suggested in this review to use the analytical data to further extrapolate the data for the causes of PPH in relation to the four T's (Tissue, Tone, Trauma, and Thrombin) and also for instrumental deliveries. This may give further assistance to the elevation in these rates.

At the time of the review Taranaki DHB was seeing a decline in the rates of PPH probably in relation to some of the initiatives that had already been put in place but are continuing to strive to reduce rates further.





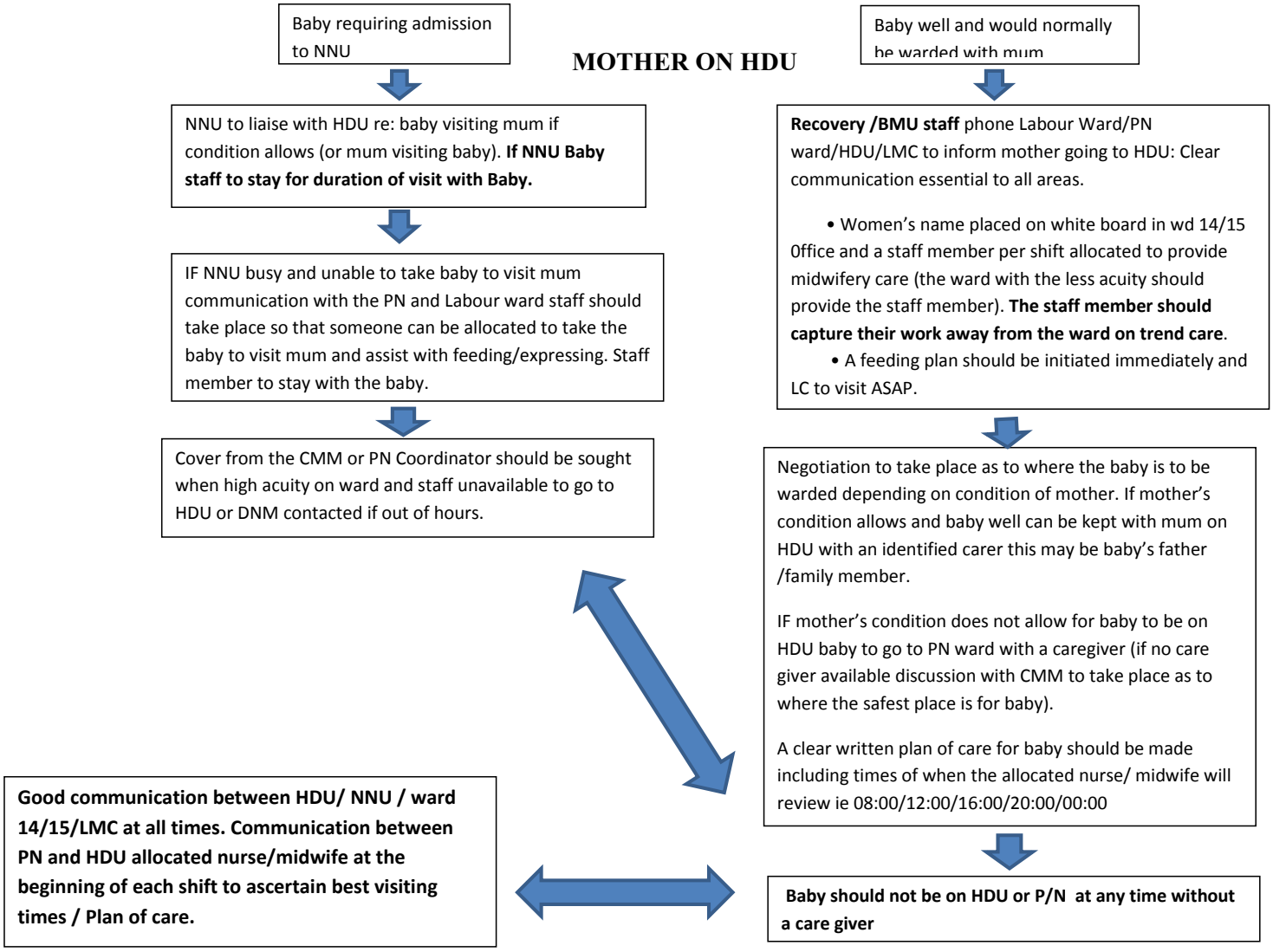
MAT02 - Post Partum Haemorrhages and Births - Out of Hours Analysis



High dependency flowchart

A High Dependency Flowchart was devised as a result of an maternal HDU admission audit to ensure care and safety responsibilities were clear for the maternity and Neonatal Unit staff.

The objective is to ensure the mother and newborn baby receive optimal care to promote skin to skin, early bonding and assist with feeding and early new born and maternal care on an individualized basis.



777 calls from maternity 2017

There have been 43 777 calls made throughout Taranaki DHB (this includes both Base and Hawera Hospital) in 2017. Of these 43 calls:

Reason for 777 call	Number of cases
Level 1 caesarean section	20
Obstetric emergency	12
Maternal cardiac arrest	7
Neonatal emergency response team (Hawera)	3
Paediatric resus	1

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

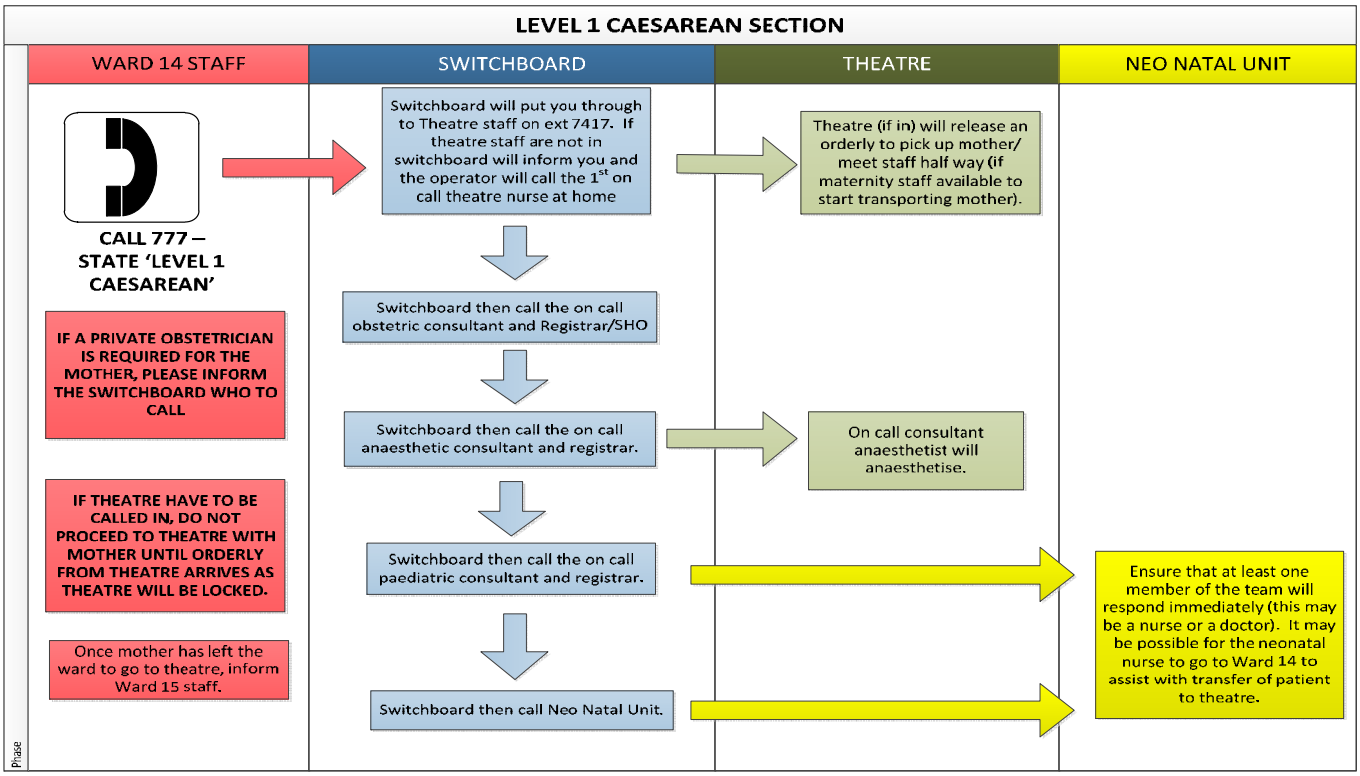
EMERGENCIES

777	**Obstetric Emergency** (State if anaesthetist needed)
777	**Maternal Cardiac Arrest** (See Peri Mortem Protocol)
777	**Level 1 Caesarean Section**
0	Duty Obstetrician

Level 1 caesarean section

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.



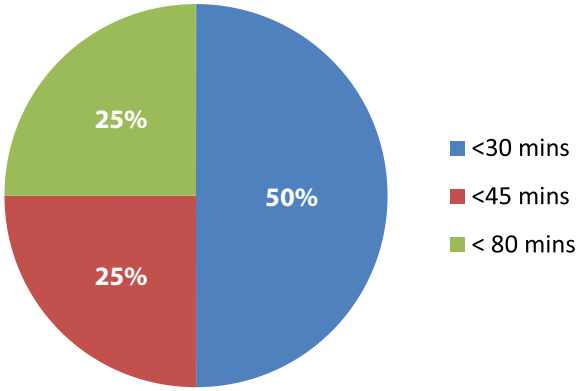
LEVEL 2: Maternal and fetal compromise which is not immediately life threatening, e.g. failure to progress. This is an audited process and the standard is birth within 75 minutes of calling a level 2. **Action taken**; On call Obstetrician will activate Level 2 call out. Ward staff will inform Ward 15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

Of the 20 calls for Level 1 caesarean section, four were stood down due to babies delivering in the delivery suite; two of which were breech vaginal deliveries. There was one call for a Level 1 that had been categorized as a Level 2 throughout the clinical notes. This has been excluded from the data. One Level 1 caesarean section may have been downgraded to a Level 2, but this is not clear in the clinical notes.

Comparing the 2017 data, to that from the previous year, there has been a slight increase in the number of Level 1 caesarean sections, from 14 in 2016, to 16 in 2017 (14.3% increase), this is still somewhat lower than 2015 (43% reduction).

Of all Level 1 caesarean sections, from the data provided, it seems that there was one instance where a 777 call was not made, and the operators were only aware of this when they received a call from theatre enquiring if the paediatric consultant had been contacted.

Table 1. Time in minutes from call to delivery 2017

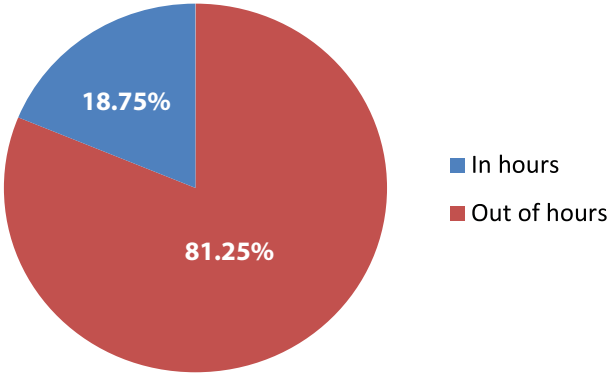


Overall response times (777 call to delivery) have shown improvement in 2017, with 50% of Level 1 caesareans achieving a call-to-delivery interval of <30 min (40% in 2015), a decrease in call-to-delivery interval <45 minutes from 50% in 2016, to 25% in 2017, but a disappointing increase in those taking <80 minutes, from 10% in 2016 to 25% in 2017. Of those taking
>45 minutes call-to-delivery interval:

- Two left the ward within 10 minutes of decision
- One left the ward within 20 minutes of decision
- One had a documentation discrepancy of time of decision at 06.30, but a documented call time of 16.18. This has resulted in the data reflecting that one did not leave the ward until 37 minutes after call, but this may be flawed data.

All the Level 1 caesareans that had call to delivery interval of <80 minutes, took place out of hours, where there may not have been theatre staff within the hospital. Of the Level 1 caesarean sections that did not achieve a call-to-delivery interval of <30 minutes, 87.5% occurred out-of-hours. This corresponds to the overall number of Level 1 caesarean calls, of which 81.25% occurred out of hours, and 18.75% in hours (see table below).

Table 2: In hours 08.00-15.00 Mon-Fri; and out of hours 16.00-08.00 Mon-Fri, and 08.00-08.00 weekends and public holidays.



Data shows a great improvement of call-to-delivery interval of the gold standard <30 minutes, but there is still room for improvement.

Reason for Level 1 caesarean section	Number of cases
Non-Reassuring CTG/Bradycardia	10
APH/Placental Abruption	2
Cord Prolapse	2
Maternal Collapse	1
Pre-Eclampsia/Eclampsia	1

Obstetric Emergencies

12 "777" calls were made to date in 2017 for Obstetric Emergencies. Of these calls:

- 10 of these calls were for PPH (83%)
- One was for CTG concerns with an added concern of acute lower abdominal pain. This case was later upgraded to a Level 1 call after obstetric review.
- One call was made to request Neonatal Resus team due to an unresponsive neonate, but was cancelled soon after as the team arrived.

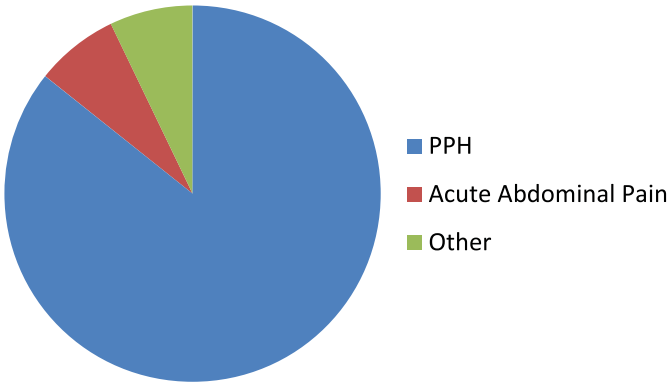
The number of "777" calls made for PPH has demonstrated a significant increase since 2016, this may be in line with the analytical findings of an increase in PPH rates or it could be an improvement in escalating calls to 777 earlier as we seek to reduce the number of PPHs.

Of the 10 calls made, (compared to four in 2016 - 60% increase) eight of these would be classified as a "Major

PPH" with an estimated blood loss > 1500mls. There were two additional PPHs that were called/recorded as "Cardiac Arrest" due to maternal collapse, and have been recorded under that heading. If added to the "Obstetric Emergencies" data, this would show a 77% increase in PPH requiring 777 calls.

This next years education will be focusing on early detection of the deteriorating obstetric mother and or baby as well as prevention, early detection and proactive treatment of PPH.

Table 3: Reasons for "Obstetric Emergency" 777 Calls



Of the total 10 PPHs, eight occurred out of hours (66.7%).

Maternal Cardiac Arrest

In 2016, the 777 call directive was narrowed to include only the following three directives:

Level 1 Caesarean Section
Obstetric Emergency
Maternal Cardiac Arrest

This was to reduce the incidence of confusion when other language was used such as "eclamptic fit, maternal collapse, or shoulder dystocia".

There were seven emergency (777) calls made in 2017 for "Maternal Cardiac Arrest". None of these included actual cardiac arrest but considered an obstetric emergency.

Despite the simplification of the 777 procedure, there still seems to be some confusion as to which call is most appropriate, and with 5 of the 7 of these calls, an obstetric emergency call could be deemed more appropriate. Saying that, if a person is uncertain, such as other staff within the hospital who aren't used to making such calls, an arrest call will get the additional help needed.

Neonatal Emergency Response Team (NERT) Hawera

There were three NERT calls made in 2017 to date. Two calls made from Hawera.

Paediatric Arrest Calls

There has been one documented Paediatric Arrest call in 2017, requested at a Level 2 caesarean section.

The paediatric teams are requested to births where they are needed, or expected to be needed, via the intercom system that is directly linked to NNU. A level 1 caesarean section will automatically request the consultant paediatrician to attend delivery. 777 calls are therefore only made if extended resuscitation and specialist skills are indicated.

Perinatal related deaths by primary perinatal death classification 2017

Termination of pregnancy	Stillbirths	Neonatal deaths	Perinatal related deaths
0	6	1	7

- There were no terminations of pregnancies over 20 weeks gestation in 2017.
- There has been a total reduction of 57% in perinatal related deaths in comparison to 2016, however the numbers are too small to be statistically significant.
- There was one case of neonatal encephalopathy in 2017

SANDS

Sands (pregnancy, baby and infant loss support) Taranaki is so pleased to be able to work with the Midwifery team and other departments at Taranaki Base Hospital to support families facing the loss of a baby at any stage during pregnancy or after birth.

Sands is a voluntary registered charity made up of bereaved parents who have lost a baby/babies at any stage of pregnancy or as a newborn or infant. Sands New Zealand has been supporting bereaved families for over 30 years providing a wealth of knowledge and experience in supporting the baby loss community. Sands Taranaki in its current form has been in the community for over 11 years and has recently expanded the support network to include monthly support meetings in South Taranaki.

In 2017/18 Sands Taranaki have continued to provide memory boxes to parents following the loss of a baby during any stage of pregnancy, from early loss memory boxes in ED and Ward 3B through to memory boxes for babies birthed in the Labour Ward. These memory boxes contain items such as candles, teddy bears, journals, special keepsakes, baby blankets and much more.

As bereaved parents, Sands Taranaki know just how important it is for families to make memories with their precious babies in the short time they have with them. Therefore they offer a hand and foot castings service, free professional photography through Amanda Ritchie, flax burial baskets and other memory items such as handmade quilts, and beautiful handmade clothing items. Their services have been utilised well in 2017/18.

Sands Taranaki has also maintained and provided items to the Willow Suite to make a family's stay there as comfortable as possible and worked with the maternity staff to enable this. Sands Taranaki also offers support in the community by way of regular support meetings, events in October during Baby Loss Awareness week and also work with other community groups such as take them a meal providing the option of meals to bereaved families.

Sands Taranaki Committee members who are actively involved supporting bereaved families have undertaken training and do ongoing training with Vicki Culling Associates to provide the best and most appropriate care possible for families facing such devastating circumstances as the loss of a child. As volunteers our aim is always to make ourselves available to meet any need that arises.

The loss of a baby is something we wish no one had to go through. Unfortunately when families do go through this, having a caring team of health professionals coupled with the option of support from those who have tread the path before them can make the journey a little less lonely.

Perinatal mental health at Taranaki DHB

What's working well in Taranaki DHB for the perinatal mental health:

- Midwives and maternity practitioners have improved awareness of Maternal Mental Health (MMH) issues following increased education sessions. MMH have representation on the local Maternity Quality governance group and information is published locally on MMH in the Maternity Annual Report.
- The introduction of Edinburgh Postnatal Depression scale assessment gives practitioner and woman self assessment/results which assists referrer and the Perinatal Mental Health services (PNMH). This has increased awareness from health practitioners/ midwives and referrals to the PNMH services.
- Taranaki DHB has a direct referral pathway so that Midwives/Health practitioners can refer directly to PNMH services (see Appendix 1).
- The Maternal Wellbeing and Child Protection Group enables early referrals for vulnerable women in the pregnancy to wrap around and support pregnant women and families.
- Taranaki DHB has a Perinatal Mental Health Liaison meeting to enable communication between all services eg maternity, PNMH, maternity social workers, clinical psychologists and includes a hospital/Neonatal tour and birth planning.
- Availability of adjustment to parenthood courses.
- Consumer survey indicates 100% satisfaction from clients who enter the services.
- Specialist PNMH intake role.

What are the challenges:

- Increase in practitioner's knowledge and screening has increased referrals to the service; demand outweighs capacity.
- 10% referral benchmark is doubled.
- Wait times for targets are double, eg. phone call in three working days of referral is actually six working days. Wait time for first face to face meeting target of three weeks is now 4-6 weeks
- 40% of referrals are triaged away (these have not been surveyed).
- Loss of nurturing generations within families.
- Confusion for women on use of antidepressants in pregnancy and breast feeding (not always up to date or evidence based).

What could be done better:

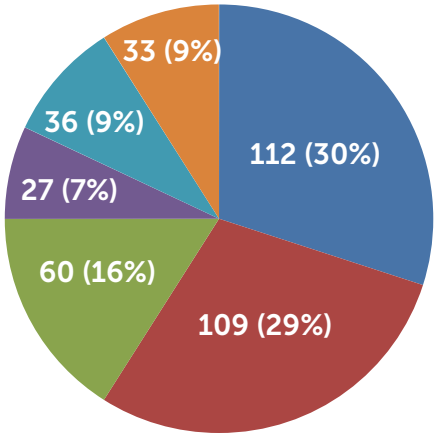
- Better resourced PNMH service with more funding to increase hours to meet targets.
- Better resourced midwifery service for staffing in the community and hospitals to allow more time to be more personal and complete resources/screening.
- Survey the 40% referrals that were triaged away to gain knowledge of what happened and how satisfied they were.
- Train all mental health workers in perinatal mental health.
- Survey referrers.
- Contact and see more timely.
- Have more time to assess .
- Drug and alcohol referral and support services.
- Antenatal education of women to alert them of what new parenting looks and feels like and where to seek early intervention (public health).
- Social support and addressing societal issues eg drugs, parenting, discipline, poverty, abuse, self care eg cooking, budgeting (public health).
- Clinicians participate in annual training on pregnancy and breast feeding in relation to MMH and use of antidepressant drugs and evidence based perinatal mental illness.
- Use of IT to prevent travel of rural women for assessment and consults eg use of skype/VC technology.
- Improve networking of practitioners around the Midland Region to share resources and information .
- Have more primary birthing facilities where care is more homely and not so high paced, more personal.
- Have a Kete centre/hub where women can go to if they are sleep deprived or need advice for parenting in the early days.
- Have an after hours "tuck in" service for perinatal mental health illness to keep women at home.
- Increase understanding of ethnicities and social isolation (ethnically challenged by transient travel and living in different countries/culture); a buddy service.

Perinatal mental health

Taranaki DHB perinatal mental health referral rates since 2012						
Year	**2012**	**2013**	**2014**	**1015**	**2016**	**2017**
Yearly totals	131	137	156	205	218	190
Cumulative data	131	268	424	629	847	1037

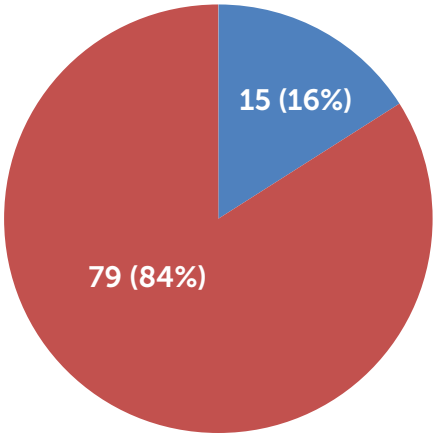
January 2017 - June 2018 Perinatal Mental Health Team (PMHT)

PMHT referrers



- GP
- Well Child Provider
- Hospital non-psych
- Midwife
- Adult Mental Health Service
- Other

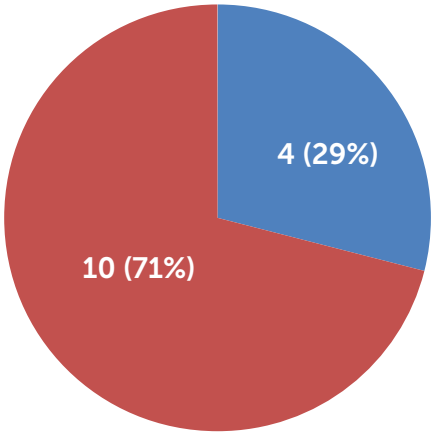
Total number of current active clients by ethnicity*



Māori Non-Māori

*on IBA as at 30th June 2018

PMHT intake by ethnicity*

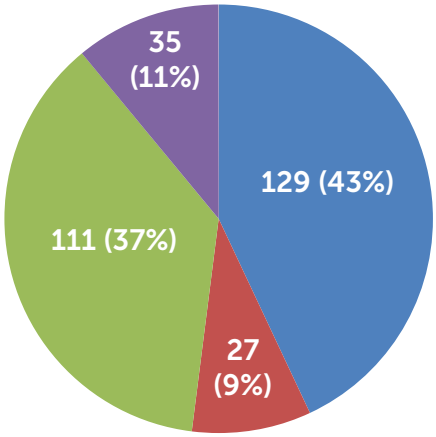


Intake Māori
Intake Non-Māori

*on IBA as at 30th June 2018

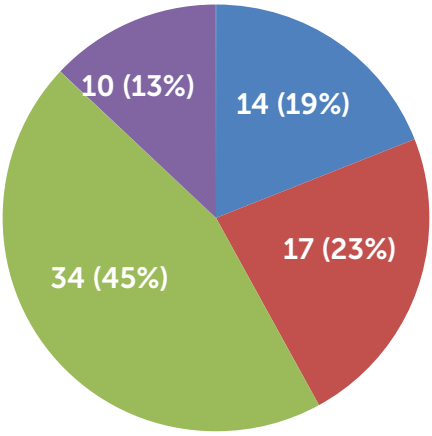
Smart systems

PMHT outcome of referrals of non-Māori clients



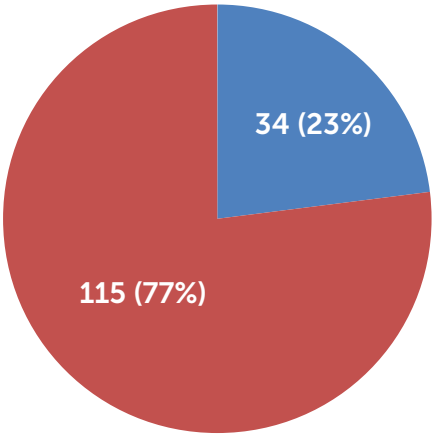
- Taranaki DHB keyworker
- Tui Ora keyworker
- Intake discharge before seen
- Intake discharge other

PMHT outcome of referrals of Māori clients



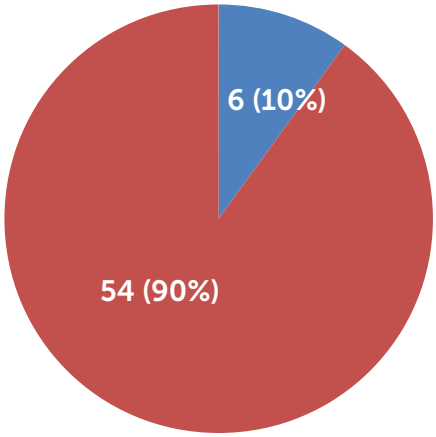
- Taranaki DHB keyworker
- Tui Ora keyworker
- Intake discharge before seen
- Intake discharge other

PMHT clients discharged before seen by ethnicity



- Māori
- Non-Māori

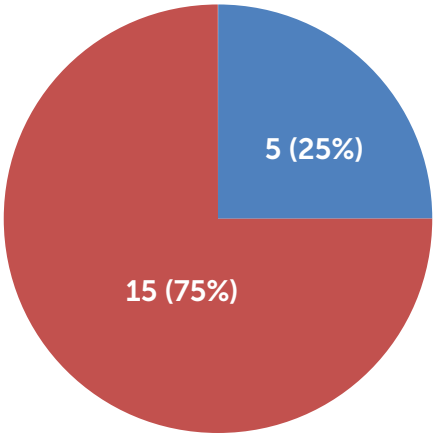
PMHT Taranaki DHB keyworker number of active clients by ethnicity*



- Māori
- Non-Māori

*on IBA as at 30th June 2018

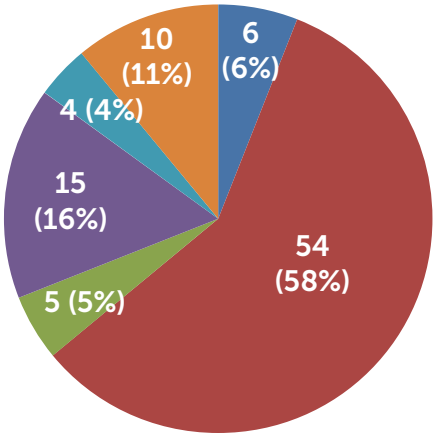
PMHT Tui Ora keyworker number of active clients by ethnicity*



- Māori
- Non-Māori

*on IBA as at 30th June 2018

PMHT total number of current active clients by provider and ethnicity*



- Taranaki DHB keyworker Māori clients
- Taranaki DHB keyworker non-Māori clients
- Tui Ora keyworker Māori clients
- Tui Ora keyworker non-Māori clients
- Intake Māori clients
- Intake non-Māori clients

*on IBA as at 30th June 2018

PMHT total number of clients seen Face to Face (FTF) and average wait time

Total clients seen face to face (FTF)	195
Average days till FTF contact	30

Family violence (FV) training and screening

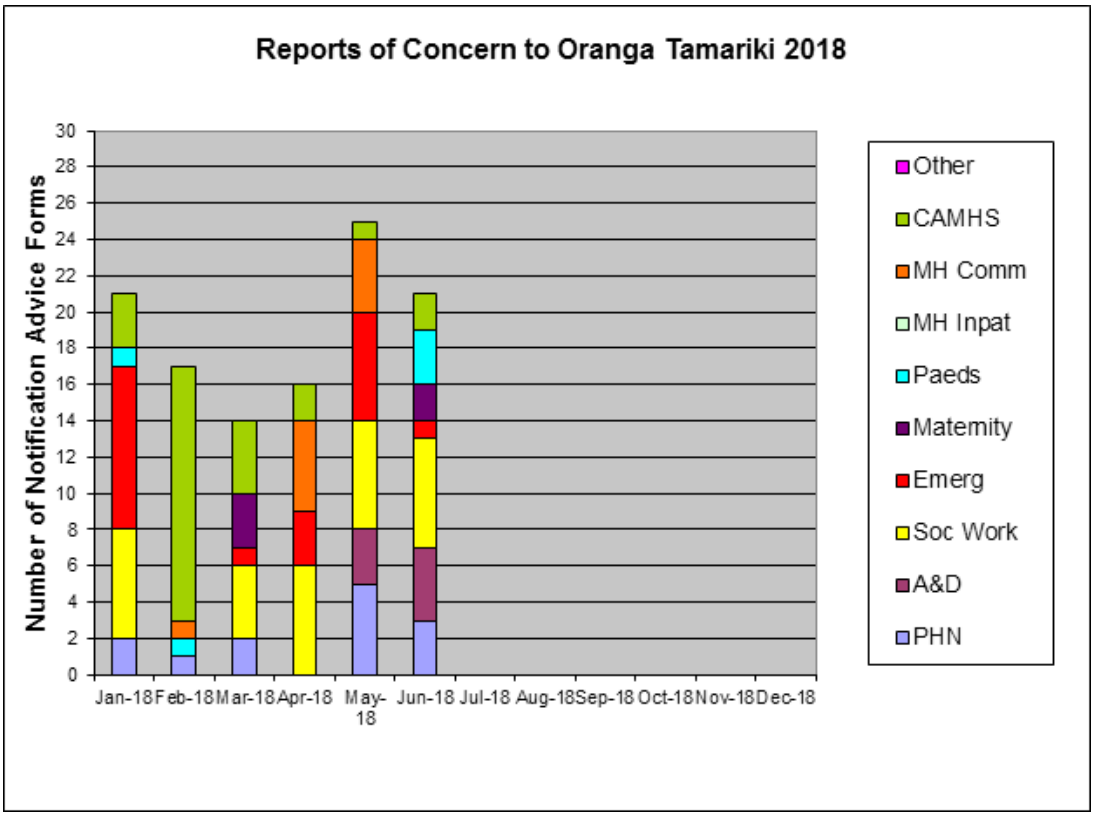
Auckland University of Technology (AUT) completed an audit in 2017 of the number of women who received postnatal questioning about family violence. Checks of 25 randomly selected Maternal Care Plan forms revealed 84% of women were found to have received postnatal family violence questioning.

This is excellent progress working towards reducing further harm to women and children.

The Taranaki DHB Multidisciplinary Advisory Group (MAG) Multi Disciplinary Team (MDT) is now well embedded in the clinical service delivery to pregnant woman. The Child Protection Coordinator attends the fortnightly MAG MDT meetings to discuss concerns about the unborn baby and mother. The MDT has good links with Oranga Tamariki, Police, Lead Maternity Carers and other specialist health services (e.g. Mental Health). Training about MAG MDT is included in core Family Violence and Intervention Prevention training.

118 Reports of Concern have been sent to Oranga Tamariki and 147 Child Protection Alerts placed during 1 January – 30 June 2018. Five were Antenatal Alerts. The MAG meetings, awareness of the vulnerability of pregnant women, and all the hard work of the team (including midwives and social workers), has made a huge difference to protect vulnerable women and infants.

This graph illustrates the 2018 Reports of Concern to Oranga Tamariki (ROCs received from Maternity Service in purple):



This past quarter we have also participated in the planning meetings to re-launch the "Power to Protect" (previous Shaken Baby Prevention) campaign at Taranaki DHB. This is a joint VIP and Maternity Services action plan. We hope to complete this during the quarter July – December 2018. The Power to Protect programme includes information about infant crying and the dangers of shaking a baby. It also provides helpful tips to support parents on what they can do if they are feeling stressed and where they can go to for help. This is delivered through a one-on-one or group discussion. The participants are also given a brochure to take home and they are offered an opportunity to watch a DVD (Never, ever shake a baby: You have the power to protect). The DVD features kiwi families whose lives have been affected by shaken baby syndrome, and gives tips on how to cope with a crying baby. It also includes expert comment about shaken baby syndrome and the consequences of shaking a baby.

SAFE SLEEP

Safe sleep

Taranaki DHB and the local safe sleep champion Beki Madden has been promoting safe sleep practices and local public activities/campaigns to increase local awareness in an effort to reduce the number of Sudden Unexpected Death in Infancy (SUDI).

Safe sleep device replacement has been challenging so an amnesty of Pepi Pods was undertaken and now have identified funding for replacement safe sleep devices.

Hapū Wānanga child birth education pilot (please see page 63) also have a strong focus on promotion of safe sleep and a Wahakura is given to each family/whānau that attends the Wānanga.

Pepi-Pod® Programme quarterly report to participating DHBs — **Period: 1 July 2017 - 30 Jun 2018**

Accumulative summary of distribution and follow-up data, by DHB region, for records entered on the programme database between 1st July 2017 and 30 June 2018

Region	Distribution (n=2285)							Follow-up (n=824)					Vulnerable Infants
	Total	Maori /Pacific		Smoking in Pregnancy		Uses CS Card		Yes		Want to keep - yes		People spoken with	Estimated*
	n	n	%	n	%	n	%	n	%	n	%	n	n
Auckland	7	7	100			4	57	6	86	6	100	10	
Counties Manukau	15	14	93	7	47	2	13	15	100	13	87	25	
Waitemata	329	221	67	130	40	53	16	91	28	86	98	317	
Northland	236	186	79	115	49	139	59	93	39	77	85	378	
NORTHERN	587	428	73	252	43	198	34	205	35	182	85	730	4500
Bay of Plenty	373	316	85	254	68	234	63	70	19	68	100	352	
Lakes	113	84	74	50	44	56	50	35	31	33	97	100	
Tairawhiti	43	33	77	22	51	17	40	9	21	8	100	33	
Taranaki	19	17	89	10	53	3	16	5	26	2	50	14	
Waikato	601	460	77	170	28	258	43	114	19	100	94	460	
MIDLAND	1149	910	79	506	44	568	49	233	20	211	139	959	3400
Capital & Coast	53	15	28	8	15	18	34	49	92	29	73	103	
Hawkes Bay	64	31	48	30	47	17	27	60	94	45	75	164	
Hutt Valley	76	44	58	22	29	25	33	62	82	49	91	197	
MidCentral	70	56	80	40	57	37	53	38	54	35	97	137	
Wairarapa	10	5	50	3	30	5	50	8	80	7	88	12	
Whanganui	87	65	75	34	39	47	54	15	17	15	100	37	
CENTRAL	360	216	60	137	38	149	41	232	64	180	78	650	2600
Canterbury	31	16	52	11	35	19	61	23	74	11	50	74	
Nelson Marlborough	17	10	59	8	47	5	29	7	41	7	100	9	
South Canterbury	1												
Southern	134	65	49	45	34	47	35	119	89	65	56	391	
West Coast	6			2	33	4	67	5	83	3	56	12	
SOUTHERN	189	91	48	66	35	75	40	154	81	86	56	486	2000
TOTAL	2285	1645	72%	961	42%	990	43%	824	36%	659	84%	2825	12,500

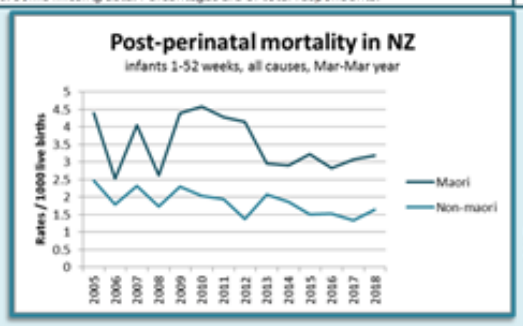
DIFFUSION RATES: 678/770 (88%) people followed up known to have spoken with others about safe infant sleep — Mean = with 4.2 others

*based on smoking in pregnancy rates

NB: Provisional data. Variations in service intensity, duration and data entry lag times. Some missing data. Percentages are of total respondents.

Snapshot of infant care, at follow-up, for Pēpi-Pod babies

CONTEXT	n	%
Device and use		
total wahakura/pepi-pod distributed	204/2086	5/95
used for infant sleep this 'past week'	721	87
Age of infant at follow-up		
≤16 weeks	646	86
>16 weeks	110	14
SAFE SLEEP		
Always/usually:		
On the back	767/810	95
Safe sleep check	770/786	98
In sleep space when in risk locations	647/789	82
In same room as carer at night	786/807	97
STRONG BABY		
Only / mainly breastmilk in past 48hrs	391/170	69
Smokefree and/or receiving support	416/167	73
Immunisation started or booked	545/100	82
Showed others gentle handling	742	96
Enrolled with GP/Primary Care	688	94



Data Source: Statistics NZ (to Mar 2018)

HIGHLIGHTS

Increasing rates of **data entry** from some DHBs
Increasing rates of **message diffusion** and participation by **Maori** and **Pacific**
Increasing rates of distribution to **smoke-exposed** infants
Increasing rates of reported **safe sleep practices** and **GP enrolment** at follow-up

Taranaki District Health Board are currently advertising to recruit into the new role of SUDI Prevention/Maternity Smokefree Coordinator. This role will be responsible for coordinating activities that will influence the two main preventable risks for Sudden Unexplained Death of an Infant (SUDI), which are smoking during pregnancy and unsafe sleep practices as well as try and reduce the inequities of both SUDI and smoking in pregnancy between Māori and non Māori:

- Promote safe sleep practices and smokefree pregnancies across the Taranaki DHB.
- Provide safe sleep and smoking cessation education across the Taranaki DHB.
- Coordinate the "Pepi pod"/safe sleep device programme and distribute safe sleep and smoking cessation resources across the Taranaki DHB region.
- Establish appropriate referral pathways and recording systems for both safe sleep and smoking cessation.
- Maintain, update and audit the Taranaki DHB safe sleep policy.
- Provide data, reports and Key Performance Indicator's relating to safe sleep and smoking in pregnancy.

Call to help save babies' lives

Bry Kopu with a flax-woven wahakura and Beki Madden holds a Pēpi Pod, given to at-risk families for their babies.

Taranaki Health Foundation advertorial in Taranaki Daily News

By Virginia Winder

Taranaki people are being asked to help keep babies safe while sleeping.

Every year, between 40 and 50 babies die from sudden unexpected death in New Zealand and sadly half of those are accidentally suffocated by their parents while sleeping in the same bed.

There is a safe and proven solution – Pēpi Pods, which are similar to a bassinet and are for babies that do not already have their own suitable safe sleep space,.

The Taranaki Health Foundation is seeking funds to buy life-saving Pēpi Pods plus mattresses and safe bedding for each. These will enable babies at risk to sleep safely in their own space. .

Foundation general manager Bry Kopu says the pods were born from the Christchurch earthquake and are now used throughout the country. "They were initially an emergency response."

The pods are free to at-risk families, especially those in a smoking environment, have low birthweight , are preterm and includes parents that do not have a safe sleep space as well as Maori babies who have a higher rate of SUDI.

Midwife and Pēpi Pod co-ordinator and safe sleep champion, Beki Madden says the pods also give babies their own breathing space.

"The babies of pregnant women who live in a smoking environment – it could be their partner who is the smoker – are most at risk."

"These babies come out and they are breathing shallower because they are used to getting less oxygen," Beki says. "So if they are in a situation where they need to breathe more, they can't." There is evidence that an unborn baby's exposure to maternal smoking while in utero reduces the frequency of arousal from sleep after the infant is born.

Beki, says these babies are high risk for sudden unexpected death in infancy, especially if they sleep in their parents' bed. With a Pēpi Pod, the infant has its own space so Mum or Dad can't roll on baby."

The fundraising push for the pods is part of the Foundation's From Hardship to Hope campaign, which supports families and children in need.

Bry adds, there is also the wahakura which are woven harakeke pods, which can be sourced from a national supplier in the Hawke's Bay. "The Foundation is keen to commission a weaver or a collective in Taranaki to make the bassinets."

"It's not just about the Pepi Pods," Beki says. "It's about safe sleep education and advocating for safe sleep practices in every home in Taranaki."

There are four main ways a baby can accidentally suffocate. "Through a covered face, pinched nose, "chin to chest" position of the neck, and pressure on or against the chest."

"When the parents get the pod they get a safety briefing and are taught how to make up the Pēpi Pod to the age of the baby. It should last four to six months," says Beki.

The rules of protection for babies put to sleep in Pēpi Pods are:

- **The babies need to have their feet at the bottom of the pod**
- **Sheets and blankets under the arm pits**
- **On the back, clear face**
- **Only baby in this space**
- **Breastfed, smokefree**
- **Sober carer close by me**
- **Own space, gentle care**
- **Drugs and drinking nowhere near**

People keen to donate to this life-saving cause can go to: www.taranakihealthfoundation.org.nz or phone 06 753 6139 extension 8439.

Amnesty of Pēpi Pods

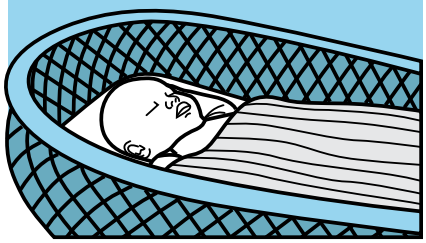
Families in Taranaki are asked to help save lives by handing back Pēpi Pods no longer in use.

Three years ago, 300 pods were given out in the region and only about 20 have come back, says Pēpi Pods co-ordinator Beki Madden.

"Pēpi Pods have gone out all over Taranaki and we would really like to increase the number we get back," Beki says. The death of a baby is devastating. "It's heart-breaking for everyone involved – the family, the midwife, the Plunket nurses – and is something that is so easily preventable."

Taranaki Health Foundation general manager Bry Kopu says the amnesty on Pēpi Pods can have a far-reaching affect. "If you give it back, it will help another family and may even save a life. As mums we need to help each other and advocate safe sleep for others Taranaki wide."

People who have a Pēpi Pod can drop it off to maternity at Taranaki Base and Hawera Hospitals or text 021 1856571 so Beki can arrange a pickup.



Taranaki Health Foundation advertorial in Taranaki Daily News

Knitters sought to make blankets

Safe and breathable blankets are needed for babies in Taranaki.

Taranaki Health Foundation general manager Bry Kopu is calling for people who can knit or crochet to make pure wool blankets for infants using Pēpi Pods.

If people can't knit or crochet, they could donate pure wool or even old woollen blankets, which can be cut up and sewn into pod-sized coverings.

The hand-made blankets need to be 70cm wide and 600cm long.

Safe sleep champion Beki Madden says polar fleece is particularly dangerous for babies. "Put baby on a polar fleece blanket for no-nappy time and see how long the urine takes to absorb – it's about 10 minutes."

If a baby is wrapped in polar fleece and sweats, the moisture will cool down and the baby will get cold and stressed.

Safe sleeping positions, Pēpi Pods, mattresses and pure woollen blankets can greatly help babies' chances of survival.

"It would be amazing if we could get all babies in a safe sleep space of their own and in safe natural materials," Beki says.

People wanting to donate wool or blankets can drop them off at the main reception at Taranaki Base or Hawera Hospitals.

"Community support for this project will help provide protection for our vulnerable infants/pēpē by ensuring each baby has their own safe sleep space and educate families by integrating the message of safe sleeping, smokefree and breastfeeding to reduce the risk of Sudden Death In Infancy (SUDI) and accidental suffocation."

Belinda Chapman RM., RN., DPSM, MMid.
Associate Director of Midwifery
Taranaki District Health Board

"It would be amazing if we could get all babies in a safe sleep possie of their own and in safe natural materials,"

Rebecca (Beki) Madden
Midwife, Safe Sleep Champion & Pepi Pod Co-ordinator, Taranaki District Health Board

"The amnesty on Pēpi Pods can have a far-reaching affect. "If you give it back, it will help another family and may even save a life."

General Manager Bry Kopu
Taranaki Health Foundation

Unstoppable generosity for Taranaki babies

By Virginia Winder

The generosity of Taranaki people is unstoppable, a health charity has discovered.

Taranaki Health Foundation general manager Bry Kopu says anonymous people keep dropping off clothing and knitting for babies and toddlers.

"We have another six boxes full, and the donations keep on coming," she says.

These hand-made gifts will all go towards the **From Hardship to Hope** campaign, which supports families facing tough times during hospital stays. "These clothes will go to the different wards and to families in need."

Part of the campaign is aimed at keeping babies safe at home through the use of Pēpi Pods, which enable new-borns to sleep safely in their own space.

"We want to acknowledge the generosity of people and the fantastic job Beki Madden has done as safe sleep coordinator," Bry said.

She says the knitting donations are wonderful and will be well used. However, the foundation also needs sheet sets for the Pēpi Pods.

There are patterns for these, so people wanting to help can contact the foundation on 06 753 8688 or email **bry.kopu@tdhb.org.nz** for details.

With a display of generous knitted donations are, from left, Viv Lewis, Beki Madden and Bry Kopu.

Safe Sleep Day

Teddy Bears Picnic celebrates Safe Sleep Day

Parents and children attended a Teddy Bears Picnic at Brooklands Zoo on 1 December to support Safe Sleep Day – a national awareness day that aims to reduce the number of babies that die as a result of Sudden Unexpected Death in Infancy (SUDI).

The picnic was also a celebration and thank you to those who have supported at-risk families by providing handmade woollen blankets for baby pepi pods/wahakura.

The Teddy Bears Picnic invite that went out

The Teddy Bears are getting excited!

They have checked their calendars and marked themselves as busy for lunch on:

1 December 2017 at Brooklands Zoo, New Plymouth, 11am till 1pm.

"If you go down to the woods today, you're sure of a big surprise. If you go down to the woods today, you'd better go in disguise."

All teddies young and old are welcome between 11am and 1pm

- Children and parents are encouraged to dress up
- Please bring your picnic basket, blanket and hats for a fun and free event.

Join us to celebrate our wonderful blanket makers and volunteers who provided 320+ blankets to Taranaki DHB's Safe Sleep Programme and help us to promote safe sleep practices for babies, so that every sleep is a safe sleep – for every baby!

If volunteers could RSVP that would be fantastic - viv.lewis@tdhb.org.nz or phone 06 753 8688

For more information phone 06 753 8688 or email or bry.kopu@tdhb.org.nz

TARANAKI HEALTH FOUNDATION
TARANAKI DISTRICT HEALTH BOARD

Community's generosity overwhelms foundation

By Virginia Winder

Piles of donated blankets and bags of wool are warming the hearts of those promoting the From Hardship to Hope campaign being run by the Taranaki Health Foundation.

"We are extremely thrilled with the community's generosity," says foundation general manager Bry Kopu.

"It brings me to tears when I think about people from all over the region showing their kindness and using their talents for the benefit of families that are less fortunate than themselves."

In June, the foundation asked people to knit or crochet blankets, edge cut-up good quality woollen blankets or donate wool or money to buy Pēpi Pods and traditional woven flax wahakura, plus mattresses.

The life-saving pods enable babies to sleep safely in their own space.

Safe bedding, including pure cotton sheets and pure-wool blankets are given out with each Pēpi Pod or wahakura and people have been busy using their crafty talents to make the covers.

"The response is absolutely amazing," says Pēpi Pods co-ordinator and safe sleep champion Beki Madden. "All these donations are going to enable the programme to carry on. It's heart-warming to know that people really care this much."

People have not only knitted and crocheted blankets; they have cut up lovely old woollen blankets and edged them with attractive borders or blanket stitch.

Foundation assistant Viv Lewis is helping to store the donations. "My wardrobe is full of blankets that have been donated to cut up."

Many of the blankets have been made by a women's group called Crafty Yarners, who meet every Friday in New Plymouth.

In Hawera, Gabriele's Alterations has been giving a small discount on wool being bought to make blankets and has been asking people to donate a skein of wool and even bring in unused balls from home.

"As long as it's 100% wool we don't mind where it's coming from," says owner Gabriele Milse. "It's a much-needed cause."

Taranaki Base Hospital meet and greet volunteer Mitty Grant has also been busy. She has crocheted three blankets, has a further two on the go and has taken wool for another.

"I think it's a wonderful cause and I'm always looking for ways to help people," she says. "Sitting at night I have always got to be doing something and I find knitting or crocheting a great way of filling my time."

Bry says that wool, blankets and money donations for Pēpi Pods, wahakura and mattresses are still needed. "It will be ongoing but this gives the region a really good start.

"To work in fundraising is a great honour and people often think it's just about getting cash donations- which is important, but it's also looking at an individual's or family talents, strengths and resources and connecting them to the right opportunity. This is what this project has been a great example of. So thank you to all of the anonymous donors."

People can drop off balls or blankets of pure wool to reception at Taranaki Base and Hawera hospitals and Bry would be grateful if people added their names and addresses, so she could acknowledge them.

"If people want to purchase a pod for families they can contact me or look on the website on how to donate," she says.

For more information go to www.taranakihealthfoundation.org.nz or phone Bry Kopu on phone 06 753 8688.

With just some of wool and blankets donated for at-risk families are, from left, Mitty Grant, Bry Kopu, Beki Madden and Viv Lewis. Photo: Virginia Winder.

Childbirth education

Hapū Wānanga

Hapū Wānanga is a Kaupapa Māori antenatal and parenting programme. Developed by Waikato DHB through input from key stakeholders from the Midlands DHB region, it is underpinned by Māori values, principles and practices.

The purpose of developing this programme is to provide an opportunity for Māori women and their whānau to engage in antenatal and parenting education. It is also to support service engagement so that all participants achieve a safe and healthy pregnancy, labour, birth and beyond.

Hapū Wānanga aims to:

- Deepen knowledge of healthy lifestyles and impacts on Māmā and Pepi
- Demonstrate and deepen knowledge of birthing practices and risk management
- Create and demonstrate a safe and supportive environment for Māori to engage into through Te Ao Māori and traditional birthing practices

The wānanga is run over two consecutive days during the week, consisting of six hours each day. Morning tea and lunch is provided.

The programme is funded and is held on a marae or another suitable location.

During the wānanga, a range of support and educational services are provided, pertaining to childbirth, midwifery and parenting related content and associated issues from Taranaki DHB maternity services based in New Plymouth and Hawera. The Te Kawau Maro provider alliances are a part of these services also.

The programme includes a range of guest speakers on alternate and holistic approaches to women and their journey.

stuff.co.nz

www.stuff.co.nz/taranaki-daily-news/104854592/Birth-education-programme-based-on-Māori-practices-is-launched-in-Taranaki

Hapū Wānanga rack card

These **FREE wānanga** are run over two days at a marae (or similar setting) by Māori midwives Tawera Trinder and Sharron Wipiti.

What to expect:

- The wānanga will go from 9am to approx 3pm
- Morning tea and lunch are provided
- There is transport if needed.

This hands-on wānanga will cover topics including:

- Pregnancy
- Traditional birthing
- Birth options
- Keeping well
- Whānau support
- Life after the birth
- Breastfeeding
- Safe sleep

We encourage you to bring your partner or support person

During the wānanga you will make your own ipu whenua (placenta container). Learn about making muka ties, and other Māori birthing practices in a fun and relaxed setting.

At the end of the two days you will receive your gift packs which include a wahakura and other wonderful goodies.

How do I find out more?

To register or for more information please contact one of the following facilitators/midwifes:

Tawera Trinder 027 727 6657
Sharron Wipiti 021 383 133

"Hapu Wananga Taranaki"

www.tdhb.org.nz

Hapū Wānanga facebook feedback

These past 3days have been the most busy but amazing and educating days of my life Enjoyed it so much ,2days of hapu wananga was the best mean gift packs and highly recommend for new hapu mums and dads to go to the nexted one.....to finish of today proud mum and dad watching our girls at kapas 😍

Big shout out to Hapu Wananga Taranaki for having Ameena & I for the two eventful days 💕 Thankyou for all the gifts and crafty things we got to do, and definitely the food! I encourage all hapu mamas to get amongst it, you learn a lot from two days, from how to make you and your baby safe throughout pregnancy/labour, right through till theyre not your little babies anymore. Also, you learn about how your ancestors went about it and what helped them and the Maori medicinal cures/pain relief. There are many organisations here who help not only the mamas and the babies but the daddy's too, because being a father all you get is "congratulations you're a dad now" and no help or support around the fathers aspect of childbirth/being a father. Made a whole new family within those two days and just wanna say good luck to everyone on their journey of becoming a new Mum or introducing the second/third/fourth (and so on) addition 🙂

WE INVITE YOU TO WIN BIG

NEW YEAR NEW YOU

QUIT FOR YOU, QUIT FOR TWO

Join this stop smoking challenge and be in to win spot prizes & $1000 cash*

Register before 9 February 2018

06 759 7314 or stopsmoking@tuiora.co.nz

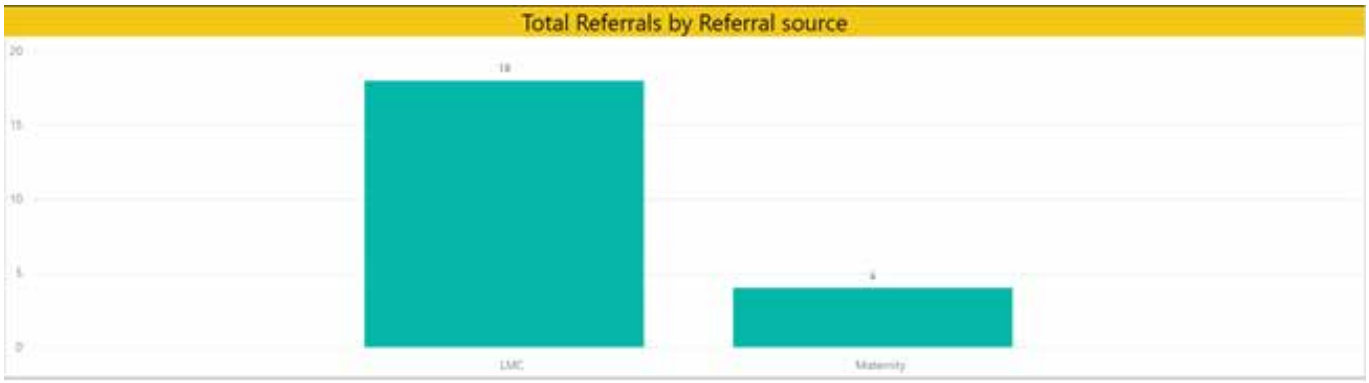
*eligibility for prize draw is subject to a CO validation <9 at 4 weeks post target quit date

Tui Ora LTD
Let Unity Prevail

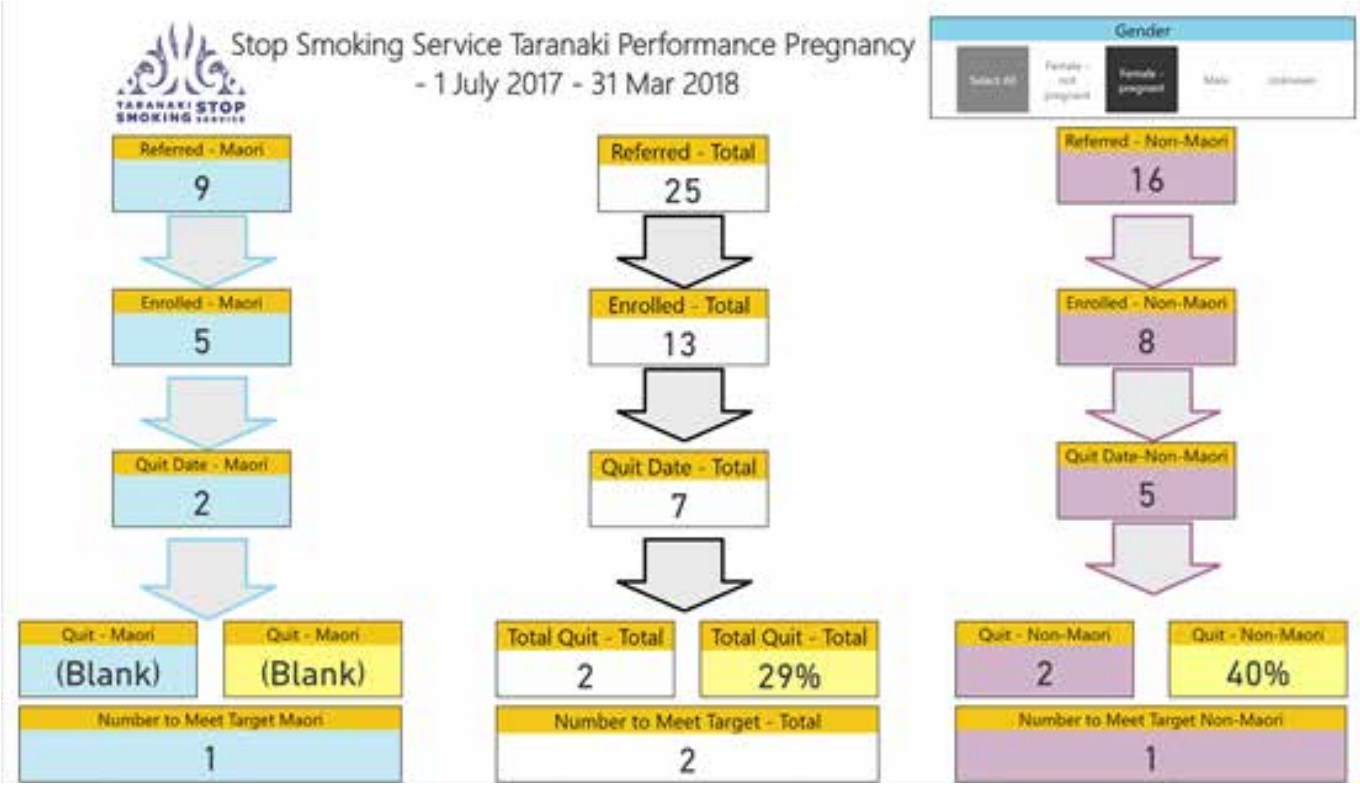
TARANAKI SMOKING STOP SERVICE

Taranaki stop smoking services

Referrals from LMCs or Taranaki DHB Maternity Ward 1 July 2017-31 Mar 2018; still a lot to be done in this area. The two Māori that did enrol, one moved out of the region and the other didn't quit.



Referrals and Outcomes for Pregnant Smokers – 1 July 2017 to 31 March 2018



Target: 90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

What activities have we been doing to increase the number of pregnant women (specifically Māori women) being offered advice and support to quit smoking by their midwife (independent and DHB-employed), as early in pregnancy as possible?

1.

- Asking about smoking at the booking visit or on admission to hospital and documenting this
- Giving Brief advice
- Offering cessation support and Nicotine Replacement Therapy (NRT)
- Referring to cessation support with consent
- The new Hapū Wānanga pilot antenatal education workshops which has a focus on advising and supporting Māori pregnant women to quit (see page 63).

"Being smokefree is the best thing you can do for your pregnancy. If you like I can arrange some support for you today"

Brief advice which focuses on the benefits of becoming smokefree rather than the risks of smoking is a great way to keep the advice positive.

Encourage and provide support

Include a positive message with your advice, such as "becoming smokefree isn't always easy, but there are a number of support options you can try which will greatly increase your chance of success".

In particular, let them know that you can offer them something to make quitting easier and improve their chances of being successfully smokefree.

Smoking increases the risk of pregnancy complications including miscarriage

Being smokefree is best for your and your baby and every step towards that is a good one

Smoking can harm unborn babies. They may not get the oxygen and food they need to grow and develop as they should

Completely smokefree babies have the best chance to be healthy, develop normally and survive

Being smokefree decreases the risk of your baby dying unexpectedly in infancy (SUDI)

Being smokefree means that you're more likely to be able to breastfeed successfully

Stopping smoking is one of the most important actions a woman can take to improve the outcome of her pregnancy and have a healthy baby

2.

What are the barriers to reducing smoking in pregnancy in Taranaki DHB?

Limited resources and time have been a factor however a Smoking cessation Maternity Coordination position has been established which the Taranaki DHB is currently recruiting to. This role will be based in the Maternity Ward and will provide education and support to inpatients identified as smokers, collect data, develop clear and transparent referral pathways into the Taranaki Stop Smoking Service and also support professional development for the maternity/child health workforce. This professional development will focus on supporting the workforce to have courageous conversations with pregnant women and their whanau and to promote the uptake of Nicotine Replacement therapies .

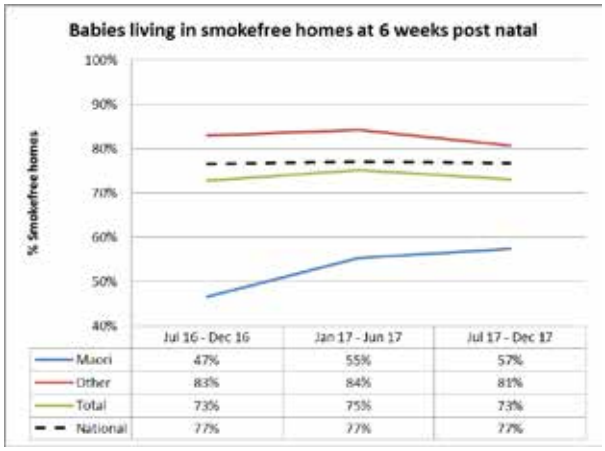
3.

Further plans for 2018/19:

The development of the System Level Measures plan for 2018-19 has been an opportunity to generate a commitment across the sector to supporting pregnant women to engage with the local stop-smoking support service. It is anticipated that an incentives based programme for pregnant women will be developed by the end of year.

Proportion of babies who live in a smoke-free household at six weeks – "A healthy start"

Where are we now? Proportion of babies who live in a smoke-free household at six weeks
This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment and will encourage an integrated approach between maternity, community and primary care.
Measure description
Number of new babies* with no record for household smoker at a WCTO Core Contact before 50 days of age, divided by Number of new babies* with Yes or No recorded for household smoker at a WCTO Core Contact before 50 days of age (i.e. not null)
Baseline Data - Three reporting periods going back to July 2016



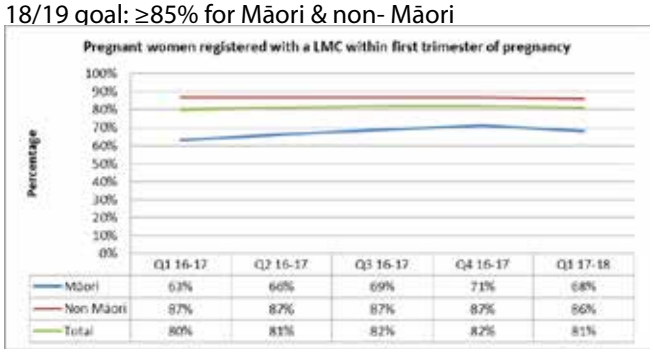
	Jul 16 - Dec 16	Jan 17 - Jun 17	Jul 17 - Dec 17
Māori	47%	55%	57%
Other	83%	84%	81%
Total	73%	75%	73%
National	77%	77%	77%

Where do we want to be?	
Long term goal:	95% of Māori and Non-Māori babies will live in smokefree homes
Target for 2018/19:	Reduce inequity by increasing the number of Māori babies living in smokefree homes to 70% whilst maintaining current non-Māori rates
Rationale:	Taranaki has a significant equity gap between Māori and non-Māori, and our focus will be to reduce and then eliminate this gap.

1. Pregnant women registered with a Lead Maternity Carer within first trimester of pregnancy

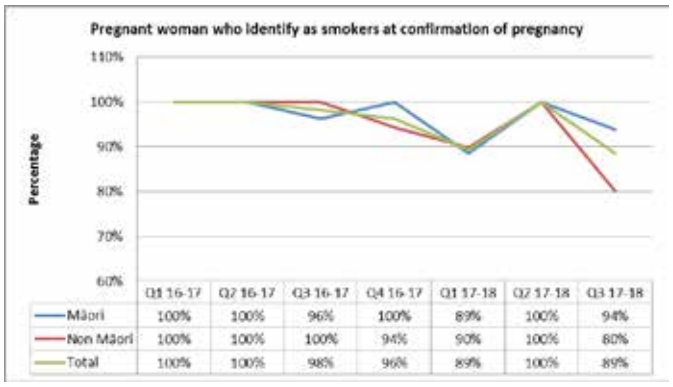
Measure description: Total number of women who register with an LMC in the first trimester of pregnancy

Baseline Data	Activities that will enable us to achieve the goals
18/19 goal: ≥85% for Māori & non- Māori	• Undertake a Health Equity Assessment (HEA) to understand why less Māori women are registering with an LMC in the first trimester of pregnancy compared to non Māori (DHB - Māori Health) • Work with key stakeholders to implement recommendations from HEA (DHB – Māori Health) • Implement Hapū Wānanga, a kaupapa Māori antenatal education programme that will identify the services Māori women and their whanau engaged in the programme need and will make appropriate linkages including referrals to LMCs if required, Māori provider networks, smoking cessation services, home insulation services and other providers of services for mama and pepi (P&F/Māori Health)

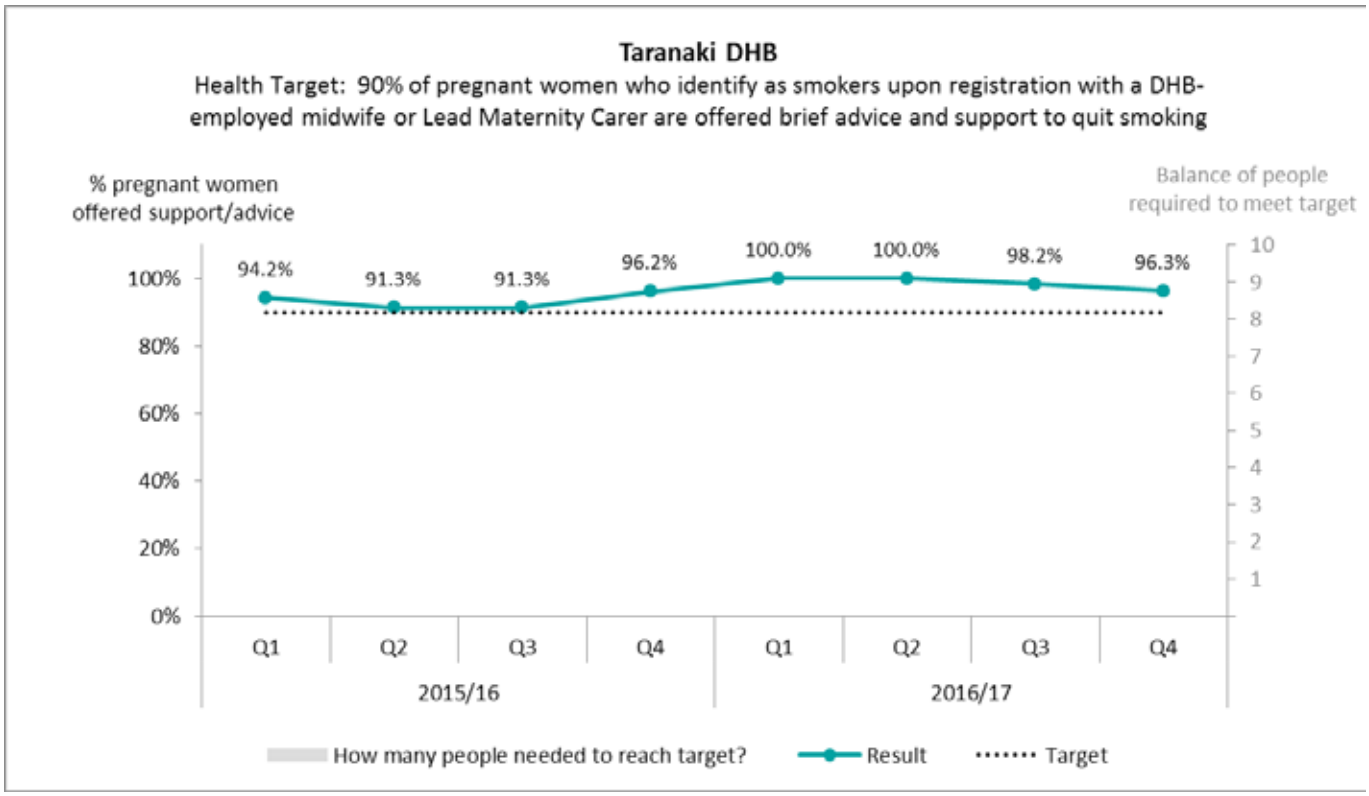


	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	Q1 17-18
Māori	63%	66%	69%	71%	68%
Non Māori	87%	87%	87%	87%	86%
Total	80%	81%	82%	82%	81%

2. Pregnant woman who identify as smokers at confirmation of pregnancy	
Measure description: Number 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	
Baseline Data	Activities that will enable us to achieve the goals
2018/19 goal: 100% of Māori hapū wāhine are offered ABC whilst maintaining current rate for non-Māori	• Develop a tobacco outcomes framework (P&F) • Undertake a co-design process with hapū māmā, PHO, Te Kawau Maro alliance / Māori provider network and other key stakeholders to: » Understand the pathways and barriers for hapu wāhine accessing cessation services and design referral pathways and processes to overcome the barriers ready for pilot implementation in 2019/20 – Q4 » Investigate successful incentives-based programmes for Māori women to quit smoking, develop and implement at least one such intervention as a trial in two locations (North and South Taranaki) by Q4 (Tui Ora TSSS) • Establish a Smokefree Maternity Coordinator (DHB - Maternity)



	Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	Q1 17-18	Q2 17-18	Q3 17-18
Māori	100%	100%	96%	100%	89%	100%	94%
Non Māori	100%	100%	100%	94%	90%	100%	80%
Total	100%	100%	98%	96%	89%	100%	89%



Breastfeeding

Baby Friendly Hospital Initiative

Annual surveys for Taranaki Base Maternity and Hawera Maternity Units have been completed and forwarded to NZ Breastfeeding Alliance.

NZBA collates the national data and forwards to the MOH.

The annual survey requires annual feeding data and progress on recommendations from the previous external BFHI audit which is due again in 2019.

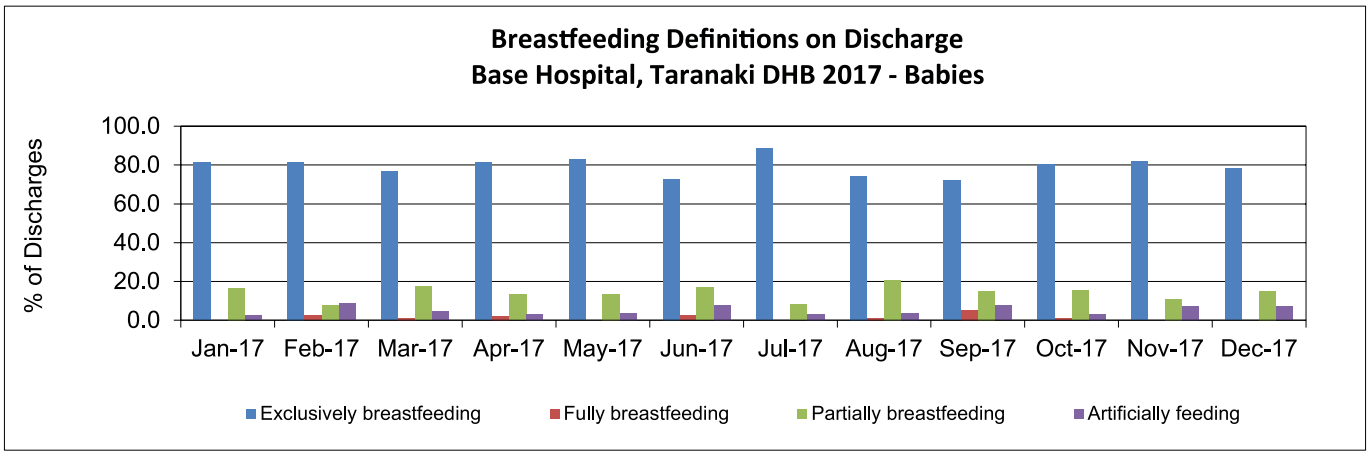
From 2018 the process has altered with data now being collected monthly instead of annual reporting.

Taranaki Base Hospital Maternity Unit

2016: 83% Exclusively breastfeeding on discharge
2017: 79% Exclusive breastfeeding on discharge

The 4% drop in exclusively breastfeeding has been absorbed by 1% increase in artificial feeding, 2.5% increase in partial breastfeeding and 0.5% fully breastfeeding on discharge.

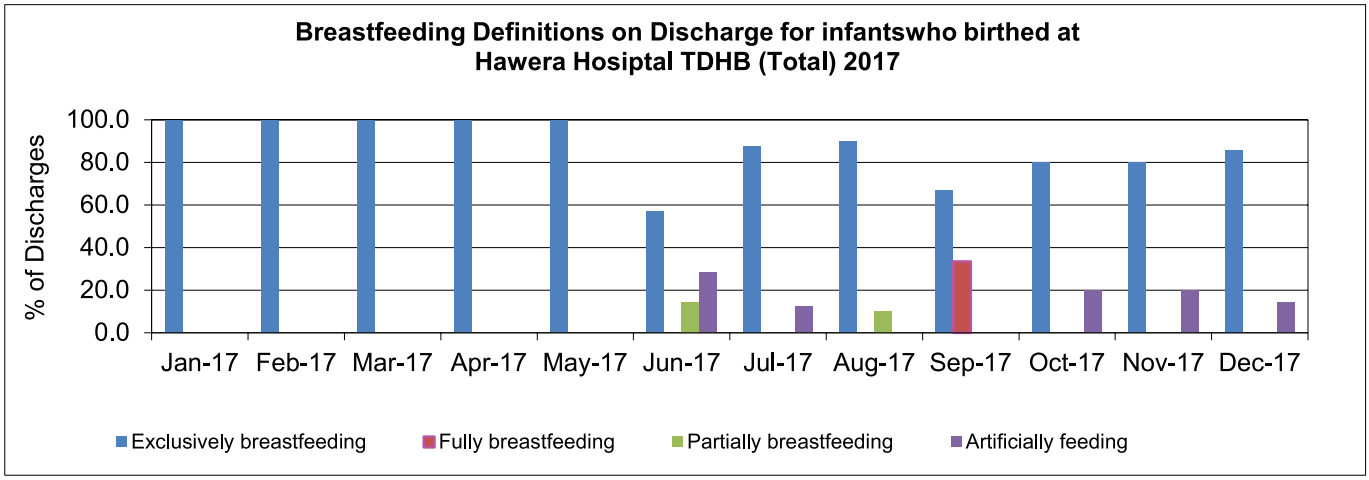
This reflects the increase of late pre term admissions to post natal, management of gestational diabetic mothers and parental choice for formula supplementary feeds.



Hawera Hospital Maternity Unit

2016: 86.8% Exclusively breastfeeding on discharge
2017: 88.5% Exclusively breastfeeding on discharge

This discharge percentage includes mothers who have transferred into the unit being exclusive on admission.



Breastfeeding Welcome Here Health Equity Assessment

The purpose of the Health Equity Assessment (HEA) undertaken in 2016/17 was to apply an equity lens to the Taranaki District Health Board's (TDHB) Breastfeeding Welcome Here (BFWH) Programme to assess its impact on inequity in breastfeeding rates in Taranaki.

In conducting the Health Equity Assessment Tool (HEAT), it became evident that wider issues that impact on inequalities in breastfeeding rates also needed to be addressed, including the need for more services offering breastfeeding support specifically in South Taranaki, such as lactation consultants and more promotion and development of existing services, such as peer support.

The HEA explicitly found that the BFWH project did not contribute to addressing inequity in breastfeeding in Taranaki. Therefore, in 2017/18, the Public Health Unit discontinued delivery of the BFWH programme and a self-audit toolkit was developed for existing sites. (TDHB sites will continue to be audited as they contribute to the BFHI accreditation for the DHB).

Other recommendations from the HEA included incorporating action around breastfeeding promotion into the Taranaki Childhood Obesity Prevention Action Plan (yet to be implemented); supporting to the implementation of the Hapū Wānanga programme in Taranaki (pilot completed 17/18); and advocacy for Taranaki DHB to strengthen organisational and staff cultural capabilities and increase Māori workforce capacity.

Find the Health Equity report here www.tdhb.org.nz/services/public_health/health_equity_assessments.shtml

Lactation Consultant Scholarships

Taranaki's breastfeeding rates overall are below the Ministry of Health's targets and there is significant inequity between non-Māori and Māori rates. Improving breastfeeding is a Māori Health outcome target. The Health Equity Assessment of the Breastfeeding Welcome Here programme has made some clear recommendations on how the inequity in Taranaki DHB's breastfeeding rates could be reduced. One recommendation from this report was to increase in designated Community Lactation Consultant (LC) hours, particularly in South Taranaki.

The intention of this scholarship programme is about recognising the importance of increasing the capacity and capability of Māori health providers to deliver Lactation Consultant expertise to the people they engage with. A scholarship worth $8,000 for kaimahi Māori who works in the maternal and child health sector to become a certified Lactation Consultant was made available. The rationale for targeting this funding to a Kaimahi Māori is to ensure that the selected Lactation Consultant has strong linkages with kaupapa Māori services and is comfortable operating within a kaupapa Māori framework. It is also hoped that embedding the Lactation Consultant a Kaimahi Māori will improve Māori mother's access to Lactation Consultant support as assisting Māori mothers to access support in relation to smoking cessation and SUDI prevention.

The Lactation Consultant Scholarship was advertised and two equally experienced kaimahi Māori who work in maternal and child health applied. It was decided by the selection panel to split the funding and provide a scholarship to both applicants. The recipients have now enrolled in the International Board Certified Lactation Consultant programme and are undertaking the educational and clinical components to become certified.

Mother Maree Vesseur and daughter Remi (born 13 May 2018)

Base Hospital's new PARENT ZONE for whānau and staff

"We have achieved a fabulous new and private space for families to enjoy, where they can offer their babies and children the support they need."

Creating a comfortable family-friendly space for breastfeeding and bottle feeding parents and staff with young children was the mandate for a recent renovation project at Taranaki DHB.

A true team effort was required to design the new Parent Zone space for whānau and staff at Taranaki Base Hospital, including style advice from Cat Glass and Jeremy Hill, who featured on TV3's The Block, in 2015.

With a touch of fame and great collaboration between the Taranaki Health Foundation (THF) and a Taranaki DHB project team the new space easily came together. Led by Taranaki DHB's service improvement advisor, Mary Bird, the project was also supported by Debbie Wright, Philip Olckers and whānau representative Christine Strydom.

Mary Bird says, "We are delighted with the revamp of the old existing parenting room. We have achieved a fabulous new and private space for families to enjoy. It's a place where they can care for their babies and children in comfort and style too."

THF was fortunate to secure sponsorship through a local partnership with RJ Eagar, a well-known Taranaki-owned furniture and home design store. Securing this business sponsorship allowed many of the large ticket items to be achieved, including new carpet, new furniture and window treatments.

THF general manager Bry Kopu says, "We were thrilled to be able to connect Taranaki businesses to this worthy cause; it is a win-win situation for everyone. RJ Eagar's generous sponsorship has made this project a reality and we are very grateful for their enthusiasm. It is wonderful that whānau and visitors will have a calm, family friendly space to take their children when visiting the hospital and waiting for appointments."

Mary Bird reveals, "We listened to the feedback from parents who frequent the hospital and they wanted the new parent room to feel warm and welcoming, not like a waiting room. It is breastfeeding and express-friendly with a functioning curtain and lock, it offers comfy seating with a power socket nearby and a table at arms reach. And let's not forget the lovely play corner for toddlers while mothers are feeding."

Since opening in December 2017 the new Parent Zone has been a hive of activity, providing the comfort for parents, staff and whānau that it set out to. Maree Vesseur and daughter Remi were grateful for the Parent Zone at their recent hearing screening appointment. Maree says, "The room was a great bright and welcoming space to escape to with a little one. I also really like that there are toys that can help entertain toddlers."

New visitors will find the Parent Zone located off the main corridor on Level 2, between the Outpatients and Maternity departments.

From left to right: Mary Bird (Operations manager and project lead), Christine Strydom (Taranaki DHB family advocate), Bry Kopu (Taranaki Health Foundation general manager), Siobahn (Sponsor: The Decorator Centre) and Toni Lewis (Sponsor: Kidszone Preschool and Nursery)

Breastfeeding Welcome Here resources

Breastfeeding Welcome Here

FAQ

1. What is Breastfeeding Welcome Here?

Breastfeeding Welcome Here aims to increase support and advocacy for breastfeeding in the community by providing a tool for sites to assess if they are breastfeeding-friendly.

There are a variety of community settings including cafes, libraries, medical centres and other public places that undertake self-audits to assess whether their environments are breastfeeding friendly.

2. But can't women just breastfeed anywhere?

Yes, a breastfeeding woman is entitled to breastfeed anywhere she is legally allowed to be.

If you are treated unfairly because you are breastfeeding or expressing breast milk, it is a form of sex discrimination under the Human Rights Act. The Human Rights Act says it is illegal for someone to stop you breastfeeding at work, where you are studying, on public transport, in government departments, in public places and in restaurants and shops. The Human Rights Act lists all the areas of public life where your right to breastfeed and express milk is protected.

3. What are the criteria?

- ✓ Staff are supportive and welcoming to breastfeeding mothers.
- ✓ The site is committed to providing a smokefree environment, including outdoors.
- ✓ The site provides a safe environment for toddlers, e.g. electricity sockets covered, play area etc.
- ✓ The environment enables the woman to breastfeed discreetly.
- ✓ Comfortable and appropriate seating is provided, preferably with low arms.
- ✓ Clean
- ✓ Comfortable temperature year round.
- ✓ There is sufficient room for pushchairs. A twin pushchair is able to fit through the front door.
- ✓ Off-floor baby change area provided with hand washing facilities nearby.

4. How can I tell if somewhere is breastfeeding friendly?

Sites which have assessed themselves as being breastfeeding-friendly will display this sign:

breastfeed
me hoki ki te ūkaipō
BREASTFEEDING WELCOME HERE

5. I have further questions. Who do I contact?

Please contact the Taranaki DHB Public Health Unit on 06 753 7799.

TARANAKI
District Health Board

BREASTFEEDING WELCOME HERE

breastfeed
me hoki ki te ūkaipō
BREASTFEEDING WELCOME HERE

Breastfeeding for mum helps with...

- Losing pregnancy weight
- Getting a better quality sleep
- Reducing stress and improving mood
- Increasing confidence in mothering ability
- Bonding and attachment to baby
- Reducing the risk of anaemia, osteoporosis and heart disease
- Reducing the risk of cervical, breast and ovarian cancers.

Breastfeeding can help baby by...

- Protecting against infections
- Decreasing the risk of allergies, obesity, diabetes, childhood cancers and SUDI
- Promoting optimal brain development
- Promoting a sense of trust, security and pleasure.

FEED ANYTIME, ANYWHERE
HEALTHY MUM + HEALTHY BABY = HEALTHY FAMILY OVERALL

06-2018

BREASTFEEDING WELCOME HERE

breastfeed
me hoki ki te ūkaipō
BREASTFEEDING WELCOME HERE

SELF-AUDIT CHECKLIST

- ☐ **Staff**
  Staff are supportive and welcoming to breastfeeding mothers.
- ☐ **Smokefree**
  The site is committed to providing a smokefree environment, including outdoors.
- ☐ **Safe & secure environment**
  The site provides a safe environment for toddlers, eg. electric sockets covered, play area.
- ☐ **Some privacy**
  The environment enables the woman to breastfeed discreetly.
- ☐ **Comfortable seating**
  Provision of appropriate seating, preferably with low arms.
- ☐ **Clean**
- ☐ **Comfortable temperature**
- ☐ **Pushchair access**
  Is there sufficient room for pushchairs? Is a twin pushchair able to fit through the front door?
- ☐ **Off floor baby change & hand washing area nearby**

06-2018

Change Table

When changing your child on a high surface keep one hand on them the whole time.
Tiaki tō pēpi i te wā kia tīni kope

breastfeed
WELCOME HERE
me hoki ki te ūkaipō
TARANAKI
District Health Board

Please take used nappies away with you

Haria ōu kope ki tō kainga

breastfeed
WELCOME HERE
me hoki ki te ūkaipō
TARANAKI
District Health Board

Tongue Tie resource

What are the risks and benefits of frenotomy?

Current evidence suggests that there are no major safety concerns about cutting of tongue-tie by trained health professionals using a surgical cutting (scissors) technique.
Complications are rare but can include:

- bleeding
- damage to tissues around the cut
- ulceration
- infection
- recurrence (re-joining) of the tongue-tie
- sometimes feeding problems continue.

There is no evidence to predict which babies will benefit 100% from tongue-tie release and which ones will still have some feeding or other problems.

Nipple pain may continue until latching is corrected and nipple damage heals. Ask about breastfeeding support options available.

www.tdhb.org.nz

Patient Code of Rights

YOUR CODE OF RIGHTS

- Respect and privacy
- Fair treatment
- Dignity and independence
- Proper standards
- Effective Communication
- Information
- Your choice and decisions
- Support
- Rights during teaching and research
- Your complaints taken seriously

Contact

For more information please contact your lead practitioner, for example your GP, midwife, Wellchild/Tamariki Ora nurse or lactation consultant.

Published: Communications Team
Responsibility: Maternity
Date Published: October 2017
Last Reviewed: October 2017
Version: 1

TDHB 10-2017

TARANAKI DISTRICT HEALTH BOARD

Tongue-tie & breastfeeding

What you need to know

Taranaki Together, a Healthy Community
Taranaki Whanui He Rohe Oranga

What is tongue-tie?

Tongue-tie or Ankyloglossia occurs in about 4 – 10 percent of babies. It often runs in families and is more common in boys. It is a condition where the tongue can't move freely because the frenulum (the membrane that connects the tongue to the floor of the mouth) is too tight or too short.

Will having a tongue-tie be a problem for my baby?

All of us have a membrane (frenulum) under our tongue. Just because you can see a frenulum, doesn't mean that your baby has a tongue-tie or that there'll be a problem.

If the tongue can't move freely, feeding may be affected. To breastfeed effectively, the baby's tongue needs to latch well on to the mother's breast (not just on the nipple) and it needs to cover baby's lower gum so the breast tissue is protected.

Breastfeeding babies with tongue-tie can't extend their tongue over the lower lip at the same time as opening their mouth so it's hard to get what we call a deep latch.

These babies tend to slide back on to the nipple. The nipples can become sore and the baby may feed poorly. Some babies may lose weight and some mothers may find their milk supply is low.

Will my baby need treatment?

For most babies there is no reason to treat the tongue-tie urgently. Keep things simple while you and your baby are getting to know each other. Sometimes it takes a few days to get over the birth, especially if you had medications in labour or birth, surgery or a difficult birth.

If your baby has a tongue-tie you may need extra support with breastfeeding to help baby latch effectively. The most important thing is to make sure that the baby is positioned and latched well at the breast. This may take a few days/weeks to learn and you may need to hand and pump express breast milk to maintain your supply.

There is still a lot we don't know about tongue-tie, which means there is a lot of information and stories which are not always correct or helpful. It is important to speak to someone trained in assessing tongue-tie and its effect on breastfeeding for example your midwife, GP or lactation consultant.

What options are available?

Some babies will benefit solely from skilled assistance with latching and positioning from a lactation consultant or other support.

You and your baby may need to be referred to a specialist to consider frenotomy (tongue-tie release). In Taranaki this is usually an Ear, Nose, Throat (ENT) consultant, either within the DHB or privately.

What is a frenotomy?

This is a procedure involving cutting the frenulum. In babies that are only a few weeks or months old anaesthetic is not usually needed.

- Before any procedure you should be given enough information and time to make a decision. Ask questions if you need more information.
- If you decide to have this procedure (frenotomy), you will be asked to give your consent.
- At Taranaki DHB you will be encouraged to feed baby before the procedure so baby will be settled in your car seat. If awake, baby may be wrapped and lay supported on the bed. It is a quick procedure.
- It's likely that the cut will bleed a little.
- You will be encouraged to breastfeed immediately following the procedure.
- You may see a small discoloured area under the tongue for a few days during healing.

Lingual frenulum

Surgical cut releases frenulum

www.tdhb.org.nz

Taranaki Together, a Healthy Community
Taranaki Whanui He Rohe Oranga

Breastfednz Smartphone App Update

The popularity of a free smartphone app designed to provide new mothers, especially those in remote areas, with practical advice and support on breastfeeding has exceeded expectations since its launch in August 2015 with now more than 20,000 downloads across BreastFedNZ is a free app available on iTunes and Google Play Stores. It provides simple, consumer focused information alongside illustrations, photos, video clips, web links and personal stories.

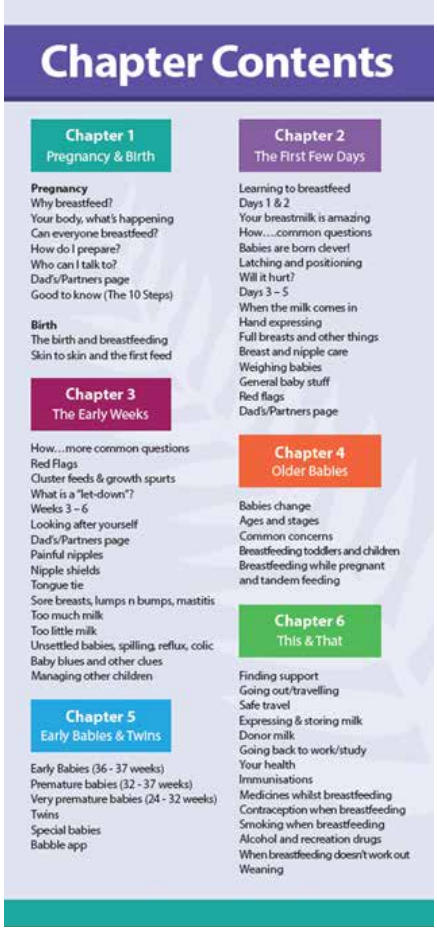
The app was developed by the Midland Maternity Action Group, a clinical network of the five Midland District Health Boards, in response to feedback from a 2013 study which identified a need to harness smartphone technology to provide new mothers with instant user-friendly advice and support about breastfeeding. It continues to be downloaded by health professionals and consumers and updated at regular intervals.

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

20,000 downloads

iTunes App Store

GooglePlay app store



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"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

SUPPORTING NZ PARENTS since 1996 bounty® a reassuring world for parents

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

Summary of the Taranaki DHB Universal Newborn Hearing Screening and Early Intervention Programme 2017/18

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 (NBHS) programme is managed by the UNHSEIP Coordinator and is part of the Allied Health, Scientific and Technical Service.

Staffing

The service was without a coordinator since February, when Mary Bird handed in her resignation. There were no major issues during this time and a new coordinator Carol Wells was in post in May. Carol will be undertaking her screening training in July in Christchurch. The service is fully-staffed. All staff, including newly appointed coordinator, have attended the 'Engaging with Māori' Workshop, which was a requirement following the last National audit.

Quarter Report 3 (Jan – March 2018)

Staff were unable to attend the annual screener training workshop as priorities were elsewhere at the time, (absence of coordinator, working towards appointment of one) Implementation of the new service model has occurred with a change to the NBHS services reporting line to the newly established Women, Children & Youth Services Directorate.

Newborn Hearing Screening Base and Hawera Hospital

Babies offered screening	395
Completed Screening	364 (92%)
Did Not Attend (DNA)	4 (1.1%)
Loss of contact	0
Missed babies	0
Referrals	3 (0.8%)

Attendance / Did Not Attend (DNA) rate for audiology

Total Attendance	90%
DNA	10%

Babies in Neonataul Unit

Screened	47
Passed	46
Referred	1 unilateral
Surveillance	4

Finances are within budget.

Future Plans

- Implementation of NHIMS (Newborn Hearing Information Management System) is planned, following the implementation of MCIS.

Safe transport for Taranaki's youngest patients

In the last 12 months Taranaki Patriotic Trust has donated $30 000, which has paid for not one, but two specially-designed, high-tech baby pods to transport ill babies by air to hospitals around the country for treatment.

One pod is based in New Plymouth and the other in Hawera, where it will safely transport babies from South Taranaki to New Plymouth's Taranaki Base Hospital by road, as well as being used by Taranaki Air Ambulance for transport.

New ambulances are arriving in the region in the next few months but it is understood that existing (older) incubators cannot fit in these vehicles. Having done more than 220 flights in the last seven years as a neonatal flight nurse, Evelyn Kelly said the demand for the new pods was certainly there.

"This generous donation makes transporting infants by air ambulance so much easier. The new pods can be securely strapped on top of a stretcher and don't rely on power to keep babies warm and in a stable condition during transport," she added.

Taranaki Health Foundation general manager Bry Kopu, told the trusts it was "a true Taranaki community collaboration".

"We acknowledge these wonderful trusts for their commitment to improving patient safety in Taranaki. This new equipment will make it so much easier for staff to care for patients in transit.

In 2015 the Patriotic Trust also donated $200,000 to St John for a new ambulance in Taranaki, and in 2017 donated $100,000 towards the new angiography machine at Taranaki Base Hospital, $25,000 to Taranaki Hospice and the Taranaki Rescue Helicopter Trust.

Evelyn Kelly, a registered neonatal nurse at Taranaki DHB, demonstrates the features of the baby pods to Taranaki Patriotic Trust and Taranaki Air Ambulance Trust (TAAT) trustees.

Taranaki AIR AMBULANCE TRUST

TARANAKI PATRIOTIC TRUST

SUMMARY OF AUDITS 2017/2018

Are Prophylactic Antibiotics Being Given During Delivery for GBS Positive Women at TDHB

Students: James Kennedy and Amy Xiao

Standard:

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists have a detailed guideline published in 2016, surrounding the investigation and management of women with Group B streptococcus (GBS) in pregnancy. They highlight 3 major recommendations relevant to this audit:

1. All maternity services should have an established plan for prevention of neonatal transmission of GBS
2. Universal culture based screening using a combined low vaginal +/- anorectal swab at 35-37 weeks gestation or a clinical risk factor approach to determine those women with GBS carriage
    a. Risk factors
        i. Spontaneous onset of labour at ≤ 37 weeks gestation.
        ii. Rupture of membrane ≥ 18 hours.
        iii. Maternal fever 38C.
        iv. A previous infant with early onset of GBS.
        v. GBS bacteriuria during the current pregnancy.
        vi. Known carriage of GBS in current pregnancy.
        vii. Clinical diagnosis of chorioamnionitis
        viii. Other twin with current EOGBS.
3. Intrapartum antibiotic prophylaxis with IV penicillin G (Benzylpenicillin) or ampicillin should be offered to all women at increased risk of GBS
    a. In women who are penicillin allergic; suitable alternatives include cefazolin, clindamycin or vancomycin, depending on sensitivity profiles

Summary of Findings:

There were a total of 57 women who had at least one GBS positive swab during pregnancy between the 01/01/2017 – 30/09/2017. Eleven of these women had not delivered at the time of analysis, and one further woman was excluded as she had a termination of pregnancy. This left a remaining 45 women available for analysis.

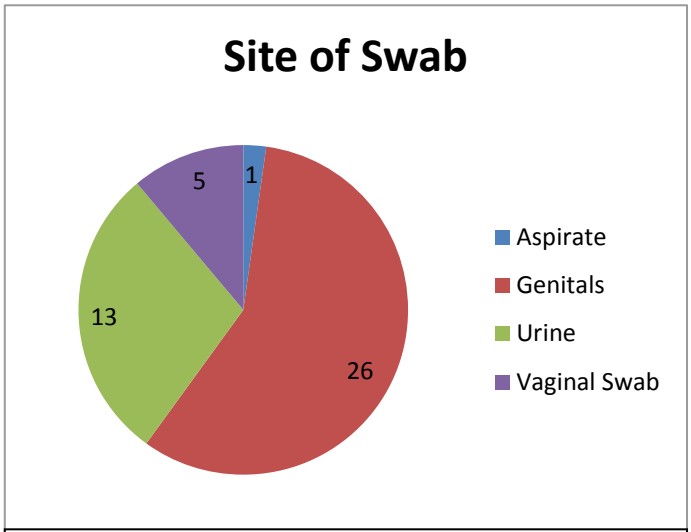


Figure 2: Source of GBS Isolate

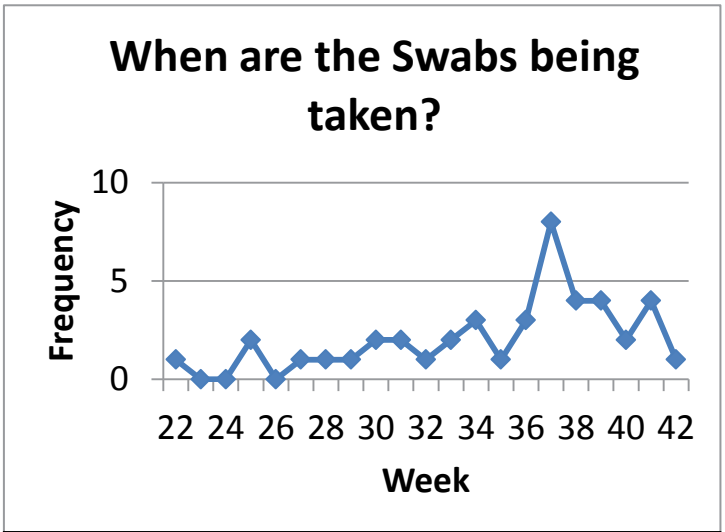


Figure 1: Gestational Age of Baby at time of Swab

Where and when is GBS Carriage being confirmed?

A total of 31 swabs (68%) showed GBS carriage in the genital region of which 5 (11%) were specifically designated as vaginal swabs and a further 26 (57%) were generically noted as genital swabs. In 13 (28%) patients GBS was isolated from a urinary culture. (Figure 1) One patient had GBS isolated from a breast milk aspirate.

Figure 2 illustrates the gestational age of the baby at the time that the carriage was isolated. The most common gestational week was the 37th with a total of 9 isolates. 16 of the 45 swabs were taken during the recommended 35-37 week of gestation period with swabs being taken on average 7.5 days prior to delivery.

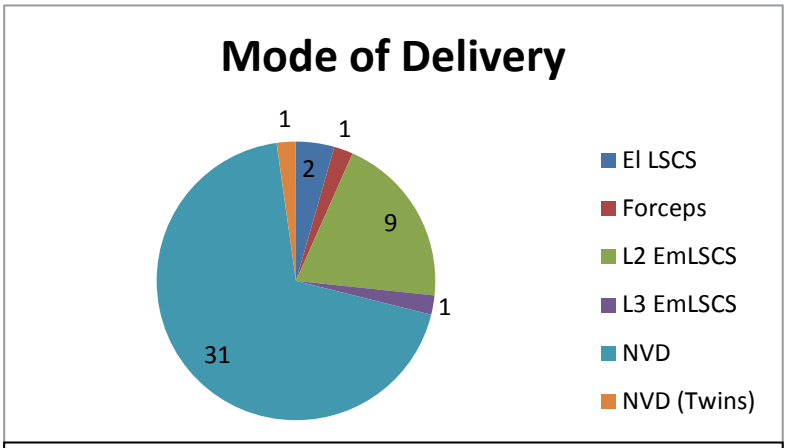


Figure 3: Mode of Delivery

Antibiotics given during delivery:

A total of 32 (71%) women received an antibiotic during the labour and delivery phase of their care however; 22 (48%) of these administrations could be considered appropriate according to the standard. Subgroup analyses of this data indicated that those administrations considered "appropriate" two were the administration of antibiotics in theatre prior to elective section and 20 were the administration of an appropriate antibiotic during labour. This meant that 13 (28%) women underwent labour without any prophylactic antibiotic administration, six (13%) with antibiotics only immediately prior to emergency section and two received antibiotics that are not on the recommended list (2x erythromycin) but do appear on the recommendation of other colleges (CDC and RCOG, UK) and a final two received amoxicillin and Augmentin which may have been appropriate.

The most significant finding of this audit is that while antibiotic prophylaxis is recommended during labour for the prevention of GBS infection in the neonate it is not being given in all cases. In terms of the other compliance to the RANZCOG guideline which is illustrated above , 16 of the 45 swabs that were taken in this analysis were taken within the 35-37 week interval which is recommended. On average swabs were taken within 7 days of delivery which illustrates that they were being taken appropriately to determine whether GBS prophylaxis was required.

Recommendation:

The data presented in this audit suggests that intrapartum antibiotic prophylaxis is not being given as often as recommended for those women with known GBS infection. It would therefore be useful to introduce an intervention such as staff education, the use of bright labels, or a checklist based approach and performs this audit again in the future to determine whether this develops greater compliance with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists standard.

Admission to Taranaki Base Hospital Base Maternity Unit Audit

Auditor: Sharon Howe **Date:** 02/10/2017

Standard:

Taranaki Base Hospital Maternity Unit adheres to the New Zealand Maternity Service Specifications-2015. Taranaki DHB Maternity Unit provides and promotes a supportive learning environment and culture

This tier one service specification provides the overarching service specification for all Maternity Services funded by District Health Boards (DHBs).

Methods:

Inclusion criteria: All women who were admitted to TDHB BMU antenatally or in labour who presented before their LMC.
Exclusion criteria: Women who arrived with or after their LMC to TDHB BMU
Sampling method: All women who were admitted to TDHB BMU between 21/9/17-27/9/17
Criteria:

Results:

There were 16 confirmed admissions to TDHB BMU where the woman arrived prior to the LMC in the stated time frame and the results are tabulated below:

Criteria	Results
Was the LMC notified if the woman had not informed the LMC of intended admission to BMU? (5.4a)	**N/A=15** **1 =woman arrived from out of town as was visiting**
Did the LMC telephone to advise woman was coming to ward? Document time LMC telephoned?	**1=LMC based in Auckland-woman visiting Taranaki** **10=Yes LMC phoned ahead** **5 unsure as not documented LMC phoned ahead**
Were maternal baseline recordings and abdominal palpation attended and documented by the core midwife in the clinical notes, if LMC not present on woman's arrival? (5.3.1c)(5.4b)	**Baseline Obs +abdominal Palp=9** **Baseline Obs only=2** **Abdominal palp only=1** **None=3** **1=not enough time as LMC arrived simultaneously**
Was the FHR recorded and/or CTG attended if required as per IEFM guidelines?(5.4b)	**13=Yes** **1=not enough time** **2=No**
Were the clinical notes stamped with admission time and date, primary or secondary? **	**9=Yes** **6=No**

Was it documented that the woman and whanau were orientated to the room and call bell in the clinical notes?	**2=Core did not leave room until LMC arrived-not documented that shown either by LMC after 3=both bell and room 6=bell only 5=No**
Was there documentation of time LMC arrived and took over care?	**14=yes 2=N/A**
If the woman was under secondary care with the LMC providing midwifery component of care, did the core inform O&G team of admission?	**2=Yes 14=N/A**
Was appropriate midwifery care as per service specifications given to woman as per her needs until LMC arrived on ward?(5.4.1)	**9=Yes 1=Not enough time-prioritised and looked at pad as ?APH 5=No**

Y/N/NA Yes/No/Not applicable/Not available
BMU-Base Maternity Unit
FHR-Fetal Heart Recording
EFM-electronic fetal monitoring (CTG)
LMC-lead maternity carer
APH-antepartum haemorrhage

Recommendations:

- Larger sample group as small numbers audited
- Core staff who did not provide appropriate admission care be advised of findings and asked to submit reflection on Maternity Unit Specifications and admission to labour ward/antenatal protocol
- Core staff that did not provide appropriate admission care regarding CTG/FHR for admission as per RANZCOG IEFM guidelines, be advised and asked to provide a reflection on these guidelines and how they are appropriate to admission at TDHB BMU and provide evidence of completion of online RANZCOG IEFM learning and attend the next face to face workshop.
- Discuss with staff who did not show bell or room to woman the importance of this and the implication as per previous recommendations

High Dependency Unit (HDU) Audit 2017-2108

Admission period:
Antenatal 5
Labour 2
Postnatal 16
Total = 23
Summary:
Majority of HDU admissions that are maternity related are admitted in the postnatal period reasons are following complications of delivery such as sepsis, Post Partum Haemorrhage, severe Preeclampsia/HELLP and sepsis. The cases related to labour were both elective admissions as the medical condition indicated telemetry monitoring was required. The LMC midwife provided midwifery care while under the secondary service for labour and delivery. The HDU is a considerable distance from the maternity unit which has an impact on midwifery staffing. 12 babies were separated from the mother, five were clinically indicated due to Neonatal Unit admission
Were the mother and baby separated?
Yes in 12 cases, 9 due to Neonatal indication for NNU admission, one as parental request and stayed with father in the postnatal area, the remainder were fit to stay with the mother but the mothers condition either did not allow this or the staffing did not allow this.
Was the woman visited by a midwife /nurse (if PN) each shift?
Yes 2 (antenatal)
Yes 5
No 8
Social Work Referral
N/A 4 (two women prior to this being added to audit)
Yes 8
Unable to confirm 8
Offered and declined 3

Edinburgh Postnatal Depression Scale Offered
N/A 4 (prior to this being added to audit)
Unable to confirm 12
Yes 5
Declined 2
Length of Stay on HDU
< 12 hours 1
< 24 hours 8
< 36 hours 8
< 48 hours 5
3 weeks 1

Was the baby admitted to NNU
Yes 10

If baby admitted to NNU – was it for a clinical reason?
Yes 9
No 1

Recommendation:
Continue to campaign for better telemetry cover in ward 14 so that women can labour and birth in ward 14 rather than in the HDU.
Ensure women in the HDU are visited at least daily by a midwife/maternity or NNU nurse and at every breast feed if indicated.
Continue to monitor HDU admissions. (See HDU flowchart page 48).

Vaginal Birth After Caesarean (VBAC) Audit - Debbie Lee & Freya Forstner

People-powered

Standard

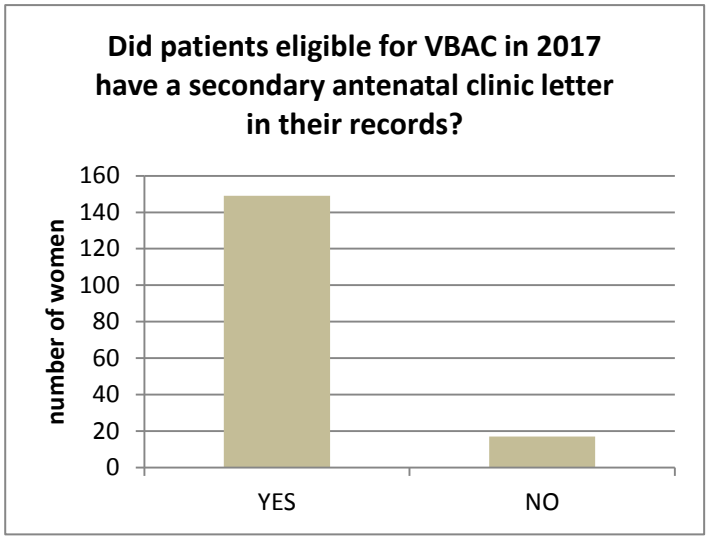
100% of women with a history of a previous caesarean birth will have an antenatal consult with an obstetrician to discuss mode of delivery of their current pregnancy. The clinic letter should have documentation that counselling and written information was provided on vaginal birth after caesarean (VBAC). 100% of women who opt for VBAC should have an IV cannula inserted during the first stage of labour, vaginal exams four hourly or as directed by an obstetrician and fetal heart assessment with continuous electronic monitoring once labour is established.

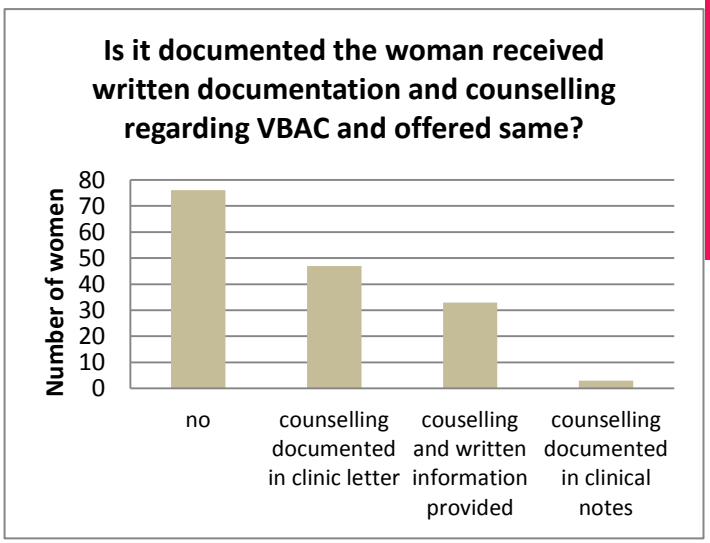
– 166 patients met our inclusion and exclusion criteria

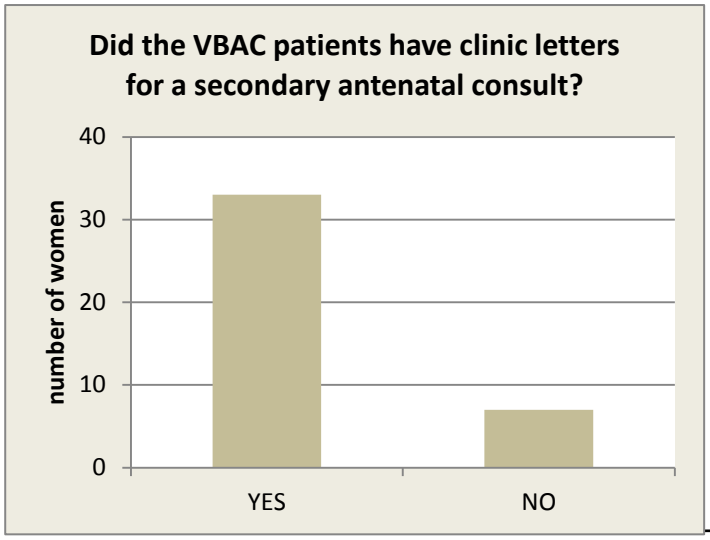
Mode of Delivery in 2017	
VBAC	40
Emergency LSCS	44
Elective LSCS	82
	166 total

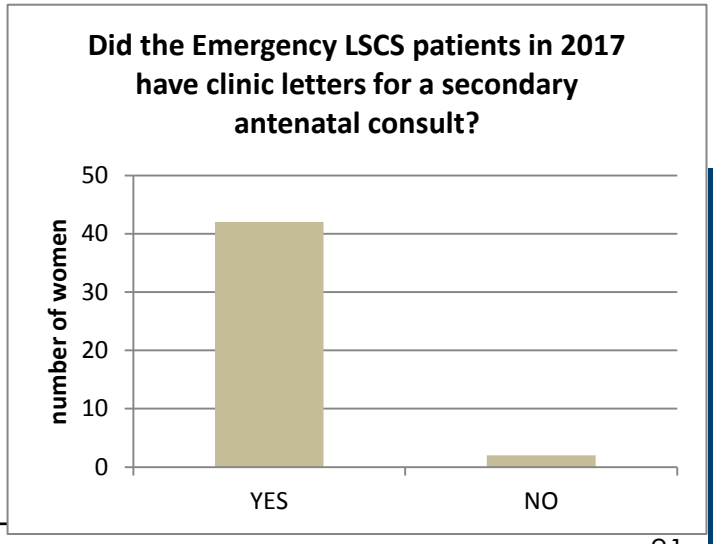
Value and high performance

Findings:

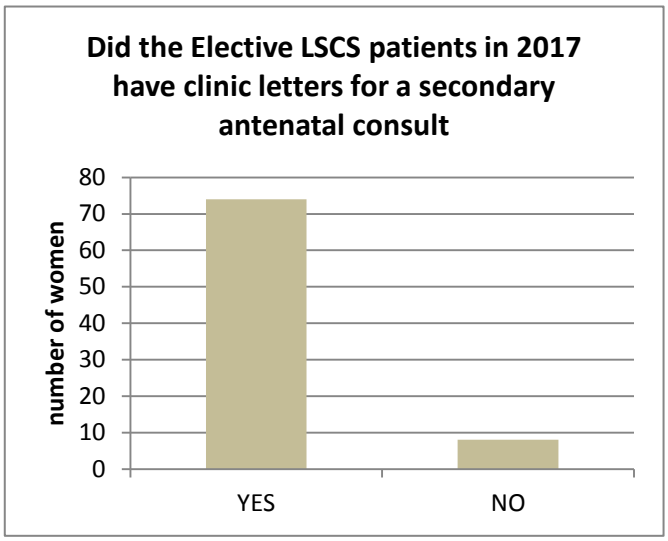


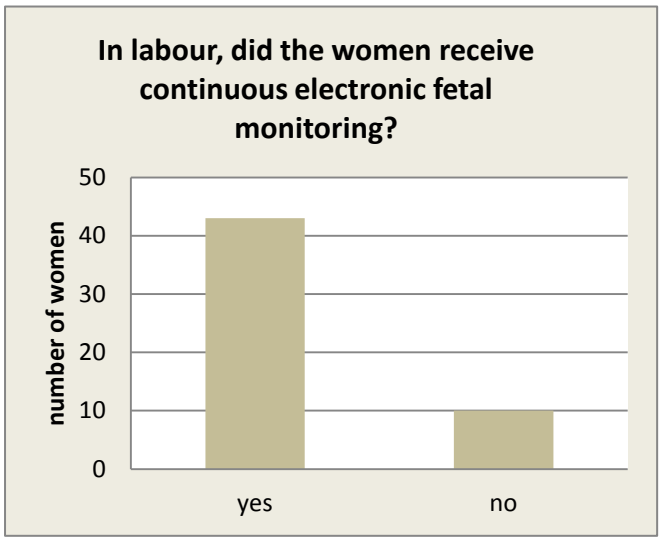


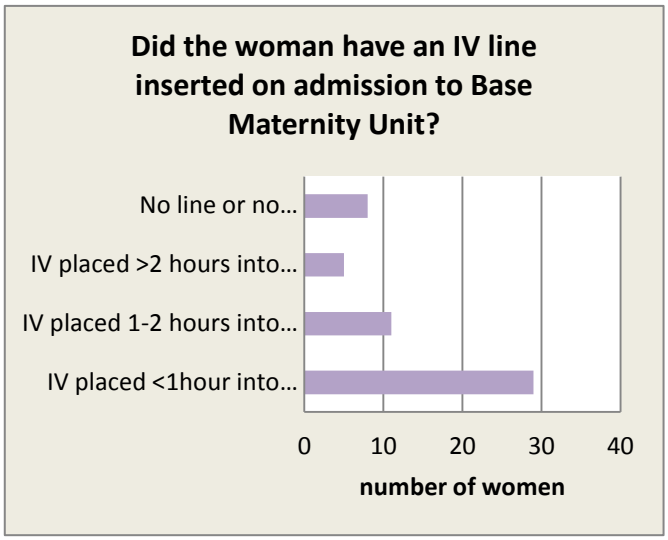


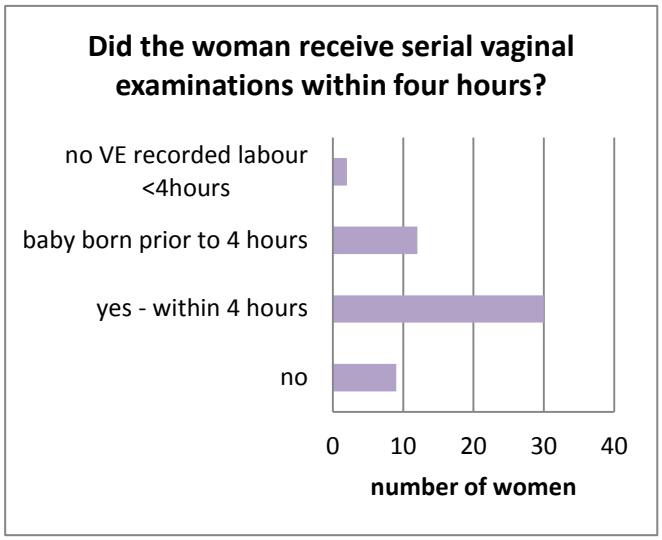


Smart systems









Limitations:

- Small sample size over a 1 year period
- A small number of women did not have documented clinic letters
- Documentation of clinic consults outside of the TDHB catchment area or from private obstetricians were not on Concerto records
- Time when patient is in established labour often not documented. Thus, this required our judgment.
- Dependence on clinical notes and staff records of when events occurred.

Recommendations:

- RANZCOG guidelines: Women who are eligible for VBAC should receive written information in addition to counselling on VBAC.
- This should be clearly documented in the notes or the reason this was not done should be documented.
- Focus attention on ensuring women firstly receive this information and secondly that this is documented in the clinical letter
- "I have discussed the risks and benefits of VBAC and given the handout."
- Look at past and future years to assess for trends in compliance with the protocol over time
- Compliance with other aspects of the Taranaki DH VBAC protocol or RANZCOG guidelines that was unable to be assessed due to time limitations.
- Analysis of CTG traces to assess continuous electronic fetal monitoring in labour

Pre-term Labour and Birth Management

Moerangi Tamati and Tamsyn Newell

Aim

The aim of this audit was a follow up of an earlier review of the management of patients presenting with Preterm labour who met the requirements for the guidelines as set by Taranaki DHB, over the year of 2016.
The data provided for this audit was from the time period 1st of January 2017 to the 7th of September 2017.
In keeping with the 2016 audit, it mainly focussed on the correct administration of antenatal steroids, including repeat steroid doses, and if applicable, tocolysis and Magnesium Sulphate administration.

RESULTS

Steroids

Of the 50 patients analysed 12 delivered before 34+6 weeks. Of these 12 most were well documented if the patient was given steroids or not, and why. In total 21 patients received steroids of any number doses. 4 of these only had one dose. For 2 of these 4 patients, they delivered too soon for the second dose. For the other 2 patients there is no clear reason why the second was not given.
3 patients who were eligible for steroids had none at all however this is explained by a 1) precipitous delivery, 2) born before arrival and 3) a stillbirth.
A total of 12 patients who had any dosage of steroids delivered more than 7 days after administration. However only one of these 1 delivered at less than 34+6 weeks with the other 11 delivering at late-preterm gestation. Regarding rescue doses of steroids the same 1 patient who delivered before 34+6, they had a gap of more than 7 days since the steroid administration. The patient was given steroid doses at 30+0 weeks, and delivered 12 days later with no rescue dose. However it was documented that the patient arrived in labour and went on to deliver quickly.
Of note, there were 7 patients that received antenatal steroids that were late-preterm gestation on presentation which is not in keeping with protocol.

Tocolysis

Of the 50 patients who were analysed, 12 received tocolysis, all of which had documented preterm labour. There were a further 6 that received steroids at <34+6 weeks but did no receive tocolysis – all of which had documented reasons – APH, IUGR, PET, PTL but precipitous delivery.

Magnesium Sulphate

None of the 50 births reviewed received Magnesium Sulphate for fetal neuroprotection as time did not allow or it was not indicated. While 2 births qualified for magnesium sulphate administration being <30 weeks at delivery) they didn't not receive it as one was born before arrival and the other was an intrauterine death.
It should be noted that there were 6 patients that required steroids at <30 weeks gestation, 4 of which were for TPTL (the other 2 were early IUGR and cervical shortening/incompetency). These 4 all received tocolysis but no Magnesium sulphate as they all went on to deliver at >30 weeks gestation: 36+6, 35+4, 36+6, and 31+5.

Interpretation of Findings

It is clear from this audit that in pre-term births occurring before 35 weeks, that there is both the consideration and the administration of two doses of antenatal corticosteroids. This finding supports the previous audit conducted in 2016.
In cases where two doses have not been able to be given, it appears 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. There were two cases where only one dose was given in which it was unclear in the documentation why the other was not given and potentially could have been given. Again this finding is similar to 2016.
A further area of investigation was use of repeat corticosteroids. It is noted that the TDHB recommendations differ from ADHB and from WHO 2015 recommendations - as noted above. There has been uncertainty in previous years about the safety of repeat steroid use antenatally but this has largely been clarified in more recent studies.
This audit found that 21 people were given steroids of any dose, with 5 having a rescue dose. Of those who ended up delivering before 34+6 (n=12), there was one case where a rescue dose was given when greater than 7 days has passed since the previous steroid administration and TPTL was still a clinical impression. This would follow WHO and ADHB guidelines. There was also one patient who had greater than 7 days since the previous steroid administration and went on to deliver prior to 34+5 weeks duration. They did not have a rescue dose and further investigation may be needed to ascertain why. These results suggest that there is a need for clarification around guidelines for repeat antenatal steroid doses – mirrored by the discrepancy between TDHB's guidelines vs WHO/ADHB guidelines.
A greater sample size with further follow up will be needed to properly asses TDHB's protocol for repeat antenatal steroid doses. Collaboration with Consultants would also be useful.

MEWS Spot Audit OCTOBER 2017

Midwife: Sharon Howe Midwife Educator

Dates: October 2017

Objectives:

To determine if the Policy/Protocol Pertaining to Midwifery Early Warning Score (MEWS) was followed for Women who were admitted to Base or Hawera Maternity Unit 6 months post education sessions

Standards:

10 sets of clinical notes that were for discharge in the last week October 2017 from Base Maternity Unit in Labour were audited against the Taranaki DHB Policy/Protocol pertaining to MEWS.

MEWS Standard from Protocol

The Maternity Early Warning System Observation Chart (MEWS) will be correctly completed in a timely manner to recognise the deteriorating or at risk of deteriorating woman and provide early intervention, reducing mortality

Criteria from MEWS Protocol

- This procedure is to be followed by Registered Midwives and Registered Nurses throughout the Taranaki DHB
- In the event of rapid patient deterioration an urgent obstetric review is to be requested and/or the 777 system activated
- All secondary maternity admissions will have their observations completed on the MEWS chart
- All observations will be taken and recorded on the MEWS, and allocated a correct MEWS score
- Algorithms will be activated in response to a MEWS score (Algorithm Guidelines) unless overridden by skilled assessment and clinical reasoning as outlined in Overriding Algorithms
- The MEWS does not negate the need for skilled assessment and clinical reasoning however the decision to override an algorithm must follow the process as outlined in Overriding Algorithms
- All staff will be responsible for the orientation/familiarisation of self to the MEWS chart system
- If the patient concerned is on intravenous fluid or has a indwelling catheter insitu, the fluid balance must be completed and included in the overall assessment
- Patients with a MEWS score requiring interdepartmental transfer, must be escorted with either a
- Registered Midwife, Registered Nurse or doctor in attendance
- Patients in recovery with a MEWS of 3 or greater should not be returned to maternity wards

Results:

A total of 10 sets of clinical notes were reviewed –maternal notes only. 10 sets of notes

AUDIT CRITERIA	Yes (Y) No (No) Not applicable (N/A) Any comments
Are all relevant observations complete?	Y=7 N=3
Are all relevant observations totalled correctly?	Y=8 N=2
Was the MEWS algorithm activated if MEWs scored above 1?	Y=3 N= N/A=7
Was there midwifery evidence of MEWS 1-3 in clinical notes if MEWS score 1-3?	Y=3 N= N/A=7
Was there midwifery evidence of MEWS 4-5 documented in clinical notes if MEWS score 4-5?	Y=1 N= N/A=9
Was there midwifery evidence of MEWS 6-7 documented in clinical notes?	Y=0 N=0 N/A=10
Was there medical evidence of MEWS 4-5 documented if MEWS score 4-5?	Y=1 N= N/A=9
Was there medical evidence of MEWS 6-7 documented if MEWS score 6-7?	Y= N=10 N/A
Was there a change in Parameters clearly documented and on front of mews?	Y= N= N/A=10
Was the MEWS over ride documented?	Y=2 N= N/A=8
MEWS chart not commenced when required?	Y=2 N/A=8

Limitations: Only ten sets of notes audited as follow up spot audit

Interpretation of Results:

- 80% of notes had MEWS scores totalled
- 70% notes had relevant observations completed
- All notes had MEWS algorithm activated for score above 1
- All notes who had MEWS 1-3 had midwifery evidence documented in notes
- The one set of notes had midwifery documentation to say MEWS 4-5 activated in clinical notes
- No notes required a change in parameters
- All of notes had the MEWS override documented on front of MEWS chart that required an over ride
- 2 Charts did not have a MEWS chart commenced when required.

Recommendations from previous Audit:

To follow up:

1 All staff in HMU and BMU received education for MEWS-with emphasis on the interpretation of results findings and also ICUNS on back page
2 Findings and recommendations from audit into weekly newsletter and feedback to MQS, ADOM, QR, DON, ward staff LMC and O&G
3 Further MEWS inaccurate documentation noted will be forward to CMM for follow up discussion and then ME to do Education support plans-this has continued to be done

Positive Findings from this Audit

- Increase in MEWS totalled correctly from 65% to 80%
- Decrease from 75% to 70% had relevant observations completed
- All notes had MEWS algorithm activated for score above 1-increased from 75%
- All notes who had MEWS 1-3 had midwifery evidence documented in notes-remained same
- The one set of notes had midwifery documentation to say MEWS 4-5 activated in clinical notes-remained the same
- All of notes had the MEWS override documented on front of MEWS chart that required an over ride

Recommendations from this Audit

- Education Support plans required for Core Staff who have been identified as not commencing MEWS when required a MEWS
- Education Support plans for Core staff who has not totalled the MEWS chart
- Education Support plans for core staff who did not continue or identify the need to continue the MEWS charts

Retained Placenta /retained products Audit

Objective: To audit the 16 women who were coded as having had manual removal of placenta/retained products post birth at TDHB

Auditor/s: Sharon Howe Date:7/8/17

AUDIT CRITERIA	FINDINGS
What was the Estimated Blood Loss (EBL) for the woman?	1x<500mls 3x500-999mls 7x1000-1999mls 5x 2000-3.8l NB 1 woman did not have a PPH
What was the time from birth to O&G SMO notification?	Ranged from: 3 x woman with SMO present at birth 7 x women 30 mins or less 4 x women between 30-60 minutes 1 woman =9 hrs 20mins-delayed realisation of ongoing PPH/trickling (retained products) Comment: 1 x set of notes could not be located
What was the time from birth to the Manual removal of placenta (MROP)?	Ranged from: 4 women were under 1 hour 8 women were 1-2 hours 3 women were 3 -3 and half hours 1 woman 14 hours (delayed diagnosis) Comment: Would expect that women be in Theatre and MROP by 1 hour to decrease risk of bleeding-need to look further as to why/reason for delay or escalation
What was the reason for MROP given?	Ranged from MROP, cervical tears, EUA
Were blood products or Ferinject given	7 women received nothing 1 woman received 1 RBC 3 women received 3 RBC and a Ferinject 4 women received Ferinject only 1 woman received 6 units of blood products Discrepancies between O&G and anaesthetics as to management. Why some offered Ferinject and others not (further audit question)
Was the woman admitted to HDU/ICU?	Only 1 woman was admitted to HDU due to DKA (not PPH)
Mode of delivery-F/V/N/CS	16=normal Vertex births
Was the management of the third stage of labour active or physiological?	All active management
Was the even in/out of hours?	In hours=5 Out = 11 ¾ out of hours
Was the Dx Summary completed?	3=no 13=yes Good improvement in these-those not completed were; where small amount of EBL and placentas removed on ward not OT-? No transfer to secondary
What was the place of removal?	OT=14 2=Ward 14

Documentation audit:

AUDITOR Carol Wells PN Coordinator

Oct 2017

Objectives:

Following a case review from a maternity admission that revealed gaps in documentation and care planning this audit was initiated to determine if this was an isolated incident or a maternity unit wide issue.

Standards:

To examine the records (mother and baby) of 20 PN admissions to ward 15 maternity (randomly selected x 5 per week) in relation to documentation, care planning and prescribing.

Results:

A total of 20 clinical notes reviewed and the results as per table 1 below.

Audit criteria	**COMMENTS**
NHI	Present on all sets records
Is the patient label attached to **EACH** PAGE?	Yes 20/20
Has the parent's ethnicity been documented?	Yes 20/20
Is EVERY section of the booking sheet complete?	Yes 14/20 No 4/20 Missing - mothers maiden name x 1. Blood Gp/results x1. Feeding Plan x 1. Date/signature x 3.
Is the Smokefree form completed/ VTE form?	Yes 20/20 Smoking. Yes 17/20 VTE No 3/20
Has the **ISBARR** tool been used**?**	Applicable in 3 sets notes Yes 1/3
Do the clinical notes contain an admission assessment	Yes 20/20 Although sometimes not a full assessment. This would only be necessary for a secondary admission.
Are all entries legibly signed including designation?	A few signatures difficult to read.
Are all entries sequential?	Yes 17/20. 3 sets notes no date/time when entry continued over the page 2our 3 by Dr, 1 midwife.
Are blue clinical pages numbered?	Occasional page not numbered, majority 90% were
For entries after the event are they marked 'in retrospect' with date, time and signature?	Yes where applicable
Is allergy status clearly indicated on the Booking sheet?	Yes 20/20
Is allergy status clearly indicated on the medication chart?	Yes 20/20

Has a midwifery care plan been commenced and updated?	Mum: Yes 17/20 No 2/20 Baby: 13/20
Has the mother daily check and education care plan been completed?	Mum: Yes 8/20 No 12/20 Big gaps in education on care plan, not always the same things, often written in body notes instead. Baby: Yes 8/20 No 12/20 Guthrie, Hip check, Red reflex not signed off often written in body notes instead.
Has the breast feeding and safe sleep plans been completed?	Safe Sleep: Yes 19/20 No 1/20 Breast Feeding: Yes 16/20 No 4/20
Is there evidence of preparation for discharge?	Yes 19/20 No 1/20
Are all treatment orders clearly documented?	Yes 18/20 No 2/20
Is informed consent for Vitamin K documented?	Yes 20/20
Was Vitamin K checked by 2 people and signed for	Yes 13/20 No 7/20
Is frequency of documentation appropriate for status of patient?	Yes 18/20 No 2/20
Are only TDHB/unit approved abbreviations and symbols used? Or Abbreviations written in full and then used afterwards.	Yes 20/20
Are the Mews charts filled out correctly including rationale for decisions to override an elevated score	Yes 16/20 if decision to override elevated score not signed by 2 people. Occasional score not documented 4 NA
Are the notes stamped for transfer of care and discharges	Yes 16/20 No 4/20
Is there an initial feeding plan documented	Yes 16/20 No 4/20
Was any IV infusions instigated and if so was there a Fluid Balance chart?	Yes 13/20 of these 13 none of them were totalled. IVF time and signature missing on drug chart when completed.
Was LMC contacted re: change in care if applicable and on discharge	Yes 20/20
Are corrections made so that original entry remains legible?	Yes 19/20 No 1/20
Are lines drawn through empty spaces?	No set of notes had lines drawn through all empty spaces. Drs documentation had many gaps/ spaces in particular one Dr. Midwives were good on the whole approx 90%

Further comments:

On the initial booking sheet there was something missing on each one absent information varied and included, smear date, initial bloods, feeding plan, smoking cessation, date of booking and signature.

X2 sets of notes showed poor documentation and these were taken to CMM to be followed up.

Labour Summary page only partially filled out if women delivered by C/S

Recommendations:

1. Present findings to Base maternity unit staff	PN Coordinator within two weeks
2. Feedback via Leadership midwives re requirement to complete the hospital booking from	ADOM next leadership meeting
3. Discuss with Core staff importance of filling out all the details on booking form	CMM within two weeks
4. Education of the correct filling out of Fluid Balance Chart (FBC) Sample of correct FBC completion on wards 14 & 15 to get some uniform with filling them out	Midwife Educator/PN Coordinator ongoing
5. Care reviews on ward 14 and 15 will include documentation check on a daily basis	CMM /Midwife Educator/ PN Coordinator Approx 1 month
6. Discuss with Drs re: lines through spaces 7. Further maternity clinical records audit in six months	CMM to discuss with HOD to bring up with Drs

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
- 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)
- Monthly Taranaki Immunisation strategic group
- Monthly Planning and Funding /Maori Health and Maternity meetings

Changes in clinical practice and quality improvements driven by MQSP

- Post Partum Haemorrhage (PPH) Review and recommendation
- Analytics for Late Preterm babies, PPH and Induction of labour
- Maternity obstetric outcome newsletter
- Maternity Roadshow Stratford

New maternity Initiatives

- Blood tube bottles – now can have NHI label for all except group and hold
- On call midwife contact by Taranaki DHB operator in times of emergency
- Pre eclampsia pharmaceutical flowchart
- Reduce, reuse, recycle-all plastic milk bottles and non blood contaminated products are taken for recycling by staff member-collected in a bin
- Breastfeeding equipment now kept in bowls in mothers room when postnatal ward is closed and postnatal women combined with antenatal and labour
- Maternity antenatal care plan
- Maternity thermal blanket fro transfer suitcases
- OT postnatal maternity transfer checklist
- Pharmaceutical Treatment of Acute Severe Hypertension/Pre eclampsia Flowchart for maternity
- Operator changes for 777 call in maternity for houseoficers cell phone
- RANZCOG terminology laminated for good practice ideas
- Baby bottle brushes initiative for each mother
- New resuscitairs for maternity
- Neopuffs for maternity
- Epidural chart added to back of partogram, so less paperwork and ease of documenting blood pressures
- Extra 777 call added to maternity (777 paediatric arrest – baby)
- Newborn life support trolleys for delivery, postnatal, theatre and Hawera maternity
- PPH bloods laboratory form – PPH can now be written instead of individual bloods named
- Change of phone tone for maternity call through into neonatal ward
- Secondary antenatal clinic women all notes stamped with Active Third Stage
- Choking infant u-tube clip to maternity staff desktops

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

SUMMARY OF WORK CARRIED OUT, DELIVERABLES AND 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	Progress	Responsibility
1	*Carried forward from 2016/17* *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.	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.	**Work is in development on stage 2 of project Maunga, the clinical services plan and progress is being made on the exploration of the options for what our maternity services may look like in the future**	**Project Maunga**

2	*Maternity workforce development carried forward 2016/17:* *A Investigate current funded core midwifery model of care and ensure it meets the needs of the service in times of high acuity.* *B. Continue to review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres* *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* *D. Lactation services are accessible and equitable*	A. Midwifery staffing meets the safe staffing standards and the needs of the service. Providing a model that focuses on providing continuity of care, integrated, efficient and effective use of staff. This includes seamless transfer of responsibility between midwives and services 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. 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 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 breastfeeding.	**Midwifery and nursing staff engagement with the acuity tool Trendcare has been a focus which is providing information for safe staffing, acuity and rostering.** **Maternity staffing forum meetings have been initiated along with a flexible 8 and 12 hour shift roster. The roster is progressing to one roster for the unit opposed to two wards so that staffing and skill mix will be appropriate to the level of need for each area, with a focus on continuity.** **Roster guidelines have been formulated to assist with safe staffing** **A neonatal Unit (NNU) nurse attends caesarean section and where maternity unit staffing allows a core midwife may attend instead of a NNU nurse. This will be carried forward to the 2018/19 work plan.** **No progress has been made with C.** **There have been two Māori Practitioner Lactation Consultant scholarships for training awarded.**	**Service Director, Operations manager, CMM, ADOM, DON , Human Resources, and maternity representatives**
3	*Recruit a second maternity consumer*	Consumers in TDHB have a forum/space to share ideas and connect with other maternity consumers to ensure all ethnicities and needs are met	**This has not been achieved however consultation is sought via Maori Health services and Maori representatives**	**ADOM and consumer**
4	*Carried forward 2016/17* *The maternity unit has a risk register.*	Corrective actions and identified risks are documented in the register	**Work has begun on this in 2017/18**	
5	*Nuchal Translucency*	There is equity of access to NT scans in Taranaki for 100% of	**There have been on going issues in accessing**	**Service director,**

	scanning service	pregnant women who meet the criteria/ who make the informed choice for combined maternal screening, or have a reliable alternative screening available.	**pregnancy ultrasound scanning services due to long term leave of a sonographer and a national and local shortage of sonographers, despite efforts to recruit. AS well as an increase in demand for ultrasound scans.** **Taranaki DHB assisted a local Obstetrician to complete accredited training so it is hoped that NT scan access may improve in the near future**	**Operations manager, Obstetrician**
6.	*HDU*	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 no en suite bathroom facility)**.**	**Progress has not been able to be made due to the current building not being compatible with a fully reliable Wi-Fi system** **HDU audit of admissions has been completed**	**QR, CNM, HDU,CMM, service manager**
	AUDITS			
1	*Syntocinon Augmentation in labour*	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	**Due to increased workloads this will be carried forward to 2018/19**	**O and G**
2	*Intrapartum Fetal surveillance audit*	To audit practitioners pre and post RANZCOG fetal surveillance training as per RANZCOG	**There has been progress in the number of Midwives gaining level 2 and 3 of the RANZCOG fetal surveillance training.**	**HOD O and G**
3	*PPH*	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 %.	**Please see external review findings in the report and analytics** **Analytics provides on going information on PPH, reasons for and rates. Current rate has reduced to 14.43%, with more out of hours than in hours.**	**ADOM, educator, O and G**

4	*SGA*	**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.	**Growth Assessment Protocol (GAP) training completed and Taranaki DHB adopted the GAP education programme in November 2017, offered to all maternity practitioners**	**ADOM, Educator, O and G**
5	*High Dependency Unit*	-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)	**Please see HDU audit section** **Completed please see Quality Initiatives**	**Educator, CMM and PN coordinator, NNU CNM.**
6	*Length Of Stay*	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.	**Work in progress**	**QR/CMM/PN coordinator/Hawera core midwife**
7	*Group B Streptococcus (GBS)*	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.	**Completed. See page 76.**	**O and G audit team/QR**
8	*Preterm Birth (recommended further audit from 2017 audit recommendations)*	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	**Audit not completed due to staffing and time constraints will be carried forward to 2018/19.** **Taranaki DHB advises early consultation, consideration of progesterone treatment, cervical length measurement.** **Taranaki DHD have a protocol and facility to carry out Fetal fibronectin testing, use of anten**atal **steroids, tocolysis, magnesium sulphate for neuroprotection and in utero transfer**	O and G team
9	*Third degree tear audit*	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	**All 3/4th degree tears are reviewed as part of the case review process (Indicator for review) in relation to identifying if any improvements in**	O and G/QR/MQS

		prevention (See UK and Southland initiatives).	**practices/initiatives for prevention could be actioned. Any recommendations and fed back to individual practitioners.**	
10	*VBAC*	results of this audit should be reviewed in the future in accordance with RANZCOG guidelines.	**Completed. See page 81.**	O and G MQC
11	*Instrumental birth*	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 delivery.	**Audit not completed due to staffing and time constraints will be carried forward to 2018/19.**	O and G/MQC
	EDUCATION			
	PPH	To maintain continuing PPH education for TDHB staff	**Completed**	**ADOM, Educator, O and G**
	Signs of the deteriorating maternity patient	To further educate maternity staff on the signs of the deteriorating maternity patient by gearing all relevant education eg PROMPT, Midwives Annual Emergency Refresher, Recognition of deteriorating patient etc towards this item.	**Midwives Emergency day and PROMPT courses (see Education planner)**	**Educator/PROMPT instructors**
	RANZCOG FSEP	To provide continuing FSEP education for TDHB as part of HDC recommendations for TDHB staff. Booked for 20 April- will be the 3rd year with this programme for TDHB	**Completed April 2018**	**O and G/Educator**
	NZCOM	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 held a perineal suturing workshop**	**NZCOM**
	Breech	Midland co-operative venture for 2018	**On going planning**	**Educators**

MQSP STRATEGIC PLAN DELIVERABLES FOR TARANAKI DHB

List of Priorities, Deliverables and Planned Actions for 2018-2020

Maternity Quality Committee (MQC) Two Year Programme 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 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	Time Frames	Responsibility
1	*Continue with planning for the future maternity services; a new secondary maternity unit, what the services will look like in Taranaki with a focus on strengthening primary birth and including, exploring the feasibility and options for the a further primary maternity unit as part of the planning process for stages two and three of Project Maunga, the three-step redevelopment of Taranaki Base Hospital. Ensure Hawera primary maternity unit is utilised to its full potential and the workforce/staffing model supports this*	Taranaki DHB 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 equipment, staff and sustainable workforce. **People-powered** **One team** **Closer to home** **Value and high performance** **Smart systems**	**July 2019**	**Project Maunga, Operations Manager, ADOM, HOD O&G Service Director**
2	*Workforce Development carried forward from 2017/18:* *A Investigate current funded core maternity model of care and ensure it meets the needs of the service in times of high acuity including the secondary antenatal clinic services in Taranaki Base Hospital and Hawera* *B. Continue to review the responsibility and care for mothers and babies during transfer, delivery and return from the operating*	A. Midwifery staffing meets the safe staffing standards and the needs of the service, consumer and workforce satisfaction. Provides a model that focusses on providing continuity of care, integrated, efficient and effective use of staff. This includes seamless transfer of responsibility between core and community midwives and obstetric service. Trendcare is embedded with reliable data with a fully Implemented 8 and 12 hour maternity shift roster. Variance Response Management is embedded	**March 2019** **December 2018** **February 2019**	**Operations Manager, ADOM, DON, Service Director**

	theatres *C. Explore how Gestational diabetes services can be improved.* *D. Lactation Consultant services are accessible and equitable*	Care Capacity Demand Management is embedded Recruitment schemes attracts medical and midwifery workforce to North, Central and South Taranaki. MQSP governance group write to request that Midwifery is reinstated on the Voluntary Bonding Scheme (VBS) in Taranaki B. All cases 24/7 have a core midwife/nurse/NNU 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. The core funded FTE and services support this. 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. D. Māori Lactation scholarship training is supported; increasing capacity and capability to provide LC services with a focus on improving Breast feeding support and rates in Māori babies. People-powered · Value and high performance · Smart systems	**January 2019** **June 2019** **September 2019** **May 2020**	**Māori Health, Planning and Funding, ADOM**
3	*Explore consumer models/options to increase consumer consultations from all ethnicities/demographics*	Consumers in TDHB have a forum/space to share ideas and connect with other maternity consumers to ensure all ethnicities and needs are met People-powered	**May 2019**	**OPs Manager, ADOM and consumer/quality rep**
4	*PPH*	Fully implement the PPH review recommendations and monitor analytics data and work toward a reduction in PPH at TDHB by June 2019 to 10 %. People-powered · Value and high performance · Smart systems	**June 2019**	**ADOM, Educator, CMM, HOD O and G, Operations Manager**
5	*Health Equity for access and outcomes in maternity care:* 1. **Engaging with an LMC** Undertake a Health Equity Assessment (HEA) to understand why less Māori	1. **18/19 goal:** ≥85% for Māori & non-Māori engage with an LMC in the first trimester who have access to culturally appropriate advice, services, treatment and maternity education programmes and early referral to support services where indicated.	**June 2019**	**DHB Māori Health, Planning and Funding, ADOM, Ops Manager**

	women are registering with an LMC in the first trimester of pregnancy compared to non-Māori • Work with key stakeholders to implement recommendations from HEA • Implement Hapū Wānanga, a kaupapa Māori antenatal education programme that will identify the services Māori women and their whanau engaged in the programme need and will make appropriate linkages including referrals to LMCs if required, Māori provider networks, smoking 2. **Smoking in Pregnancy** • Develop a tobacco outcomes framework **(P&F)** • Undertake a co-design process with hapū māmā, PHO, Te Kawau Maro alliance / Māori provider network and other key stakeholders to: • Understand the pathways and barriers for hapū wāhine accessing cessation services and design referral pathways and processes to overcome the barriers ready for pilot implementation in 2019/20 – Q4 • Investigate successful incentives-based programmes for Māori women to quit smoking, develop and implement at least one such intervention as a trial in two locations (North and South Taranaki) by Q4 **(Tui Ora TSSS)** • Establish a Smokefree Maternity and SUDI Coordinator **(DHB - Maternity)** 3. Pregnancy support directory for maternity practitioners and stakeholders is available and up to date	2. **18/19 goal:** 100% of Māori hapū wāhine are offered ABC whilst maintaining current rate for non-Māori. • Increased rate of referrals to the Taranaki Stop Smoking Service (TSSS) • Reduction in the number of pregnant women smoking in pregnancy. • Equity for Māori People-powered / Closer to home Value and high performance / Smart systems 3. **The pregnancy support directory** is updated annually and circulated to maternity practitioners and stakeholders to ensure knowledge of available services and contacts/referral information within the region	**June 2019** **December 2018**	

	AUDITS	People-powered / Value and high performance / Smart systems		
1	*Syntocinon Augmentation in labour*	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		**HOD O and G/QR**
2	*Induction of Labour*	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).		**HOD O and G**
2	*Intrapartum Fetal surveillance audit*	To audit practitioners pre and post RANZCOG fetal surveillance training as per RANZCOG		**HOD O and G**
4	*SGA*	Investigate whether the mothers of the SGA infants in the audit conducted in 2013 and 2014 were appropriately managed in subsequent pregnancies for prevention/early detection and treatment of SGA.		**HOD O and G**
5	*High Dependency Unit*	Replicate audit in 2018-2019 to investigate if there has been any reduction in admission rate and improvement in processes and outcomes		**Core midwife/QR and ADOM**
6	*Length Of Stay*	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 /O and G/coordinator/Hawera midwife**
7	*Preterm Birth (recommended further audit from 2017 audit recommendations)*	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 (investigate quantitative), use of antenatal steroids, tocolysis, magnesium sulphate for neuroprotection and in utero transfer		**HOD O and G team**
8	*Instrumental birth*	To investigate the incidence and indication for assisted birth (Ventouse and forceps) compare rates to previous years and identify if evidence based/best practice was followed in relation to care in labour and birth.		**HOD O and G/MQC**

	EDUCATION	People-powered / One team / Value and high performance / Smart systems	See education Calemdar	
	PPH	To maintain continuing PPH education for TDHB staff in relation to investigative outcomes (see audit and PPH review recommendations section)		**Midwife educator and ADOM/ HOD O and G**
	Signs of the deteriorating maternity patient	To further educate maternity staff on the signs of the deteriorating maternity patient and escalation of care by providing all relevant education eg PROMPT, Midwives Annual Emergency Refresher, Clinical scenarios, recognition of deteriorating patient, MEWS.		**Midwife educator/ PROMPT educators**
	RANZCOG Fetal Surveillance Education Program (FSEP)	To provide continuing FSEP education for TDHB as part of HDC recommendations for TDHB staff. Booked for 20 April-will be the 3rd year with this programme for TDHB. Requires an O and G to lead this audit.		**HOD O and G**

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

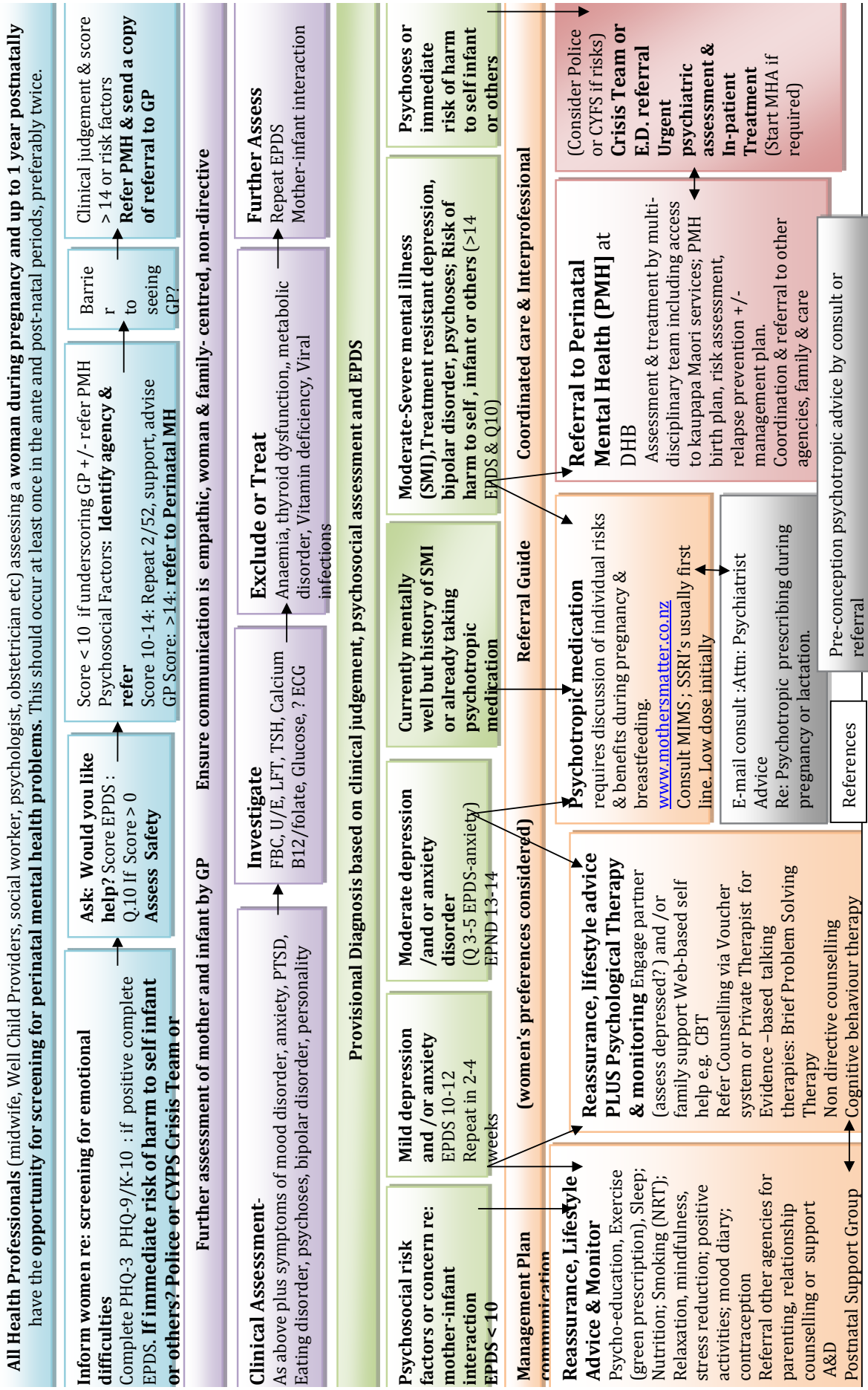
	Project	Expected outcome	Planned activities	Measure	Work progress/ Completed
1	**Inclusion of consumers in the Maternity Quality & Safety Programme (MQSP) governance at Taranaki DHB to enable consumer informed decision-making** • Consumer engagement survey • Consumer representative for the Maori, Indian and Pacific ethnicities identified and utilised to assist MOC.	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 See advice from Maori Health services and representatives Health Equity assessments on initiatives	100 consumer surveys completed 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 2nd consumer not achieved for 2017/18 however Maori Health services and representatives are utilised for advice

	Project	Expected outcome	Planned activities	Measure	Work progress/ Completed
2	**Promotion of primary birth campaign (use of primary facility and homebirth)** **Strengthen the model of care at Hawera Maternity unit-aligning with past Stratford unit.** • Upgrade of Hawera primary maternity unit	Increase in consumer knowledge of primary birthing. Safe, low tech homely environment that is whanau/family friendly and meets the needs of the local population for low risk birthing Timely emergency response and skills from St John and base hospital for neonatal retrieval Increase in bookings for primary birthing Upgrade of Hawera Maternity facility is completed	An information leaflet on Hawera Primary maternity unit is to be developed and published 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. Upgrade facility and market the changes and facility Upgrade the TDHB Internet site on maternity services and local information on primary and homebirth Neonatal Emergency Response Team (NERT) process to be implemented in consultation with rural midwives, St John and Taranaki base hospital PROMPT training to be held twice yearly in Hawera primary maternity unit to promote relationships within rural emergency response services Rural midwives and St John encouraged to share orientation of layout of emergency resuscitation equipment and communication	Information leaflet developed by September 2016 Proposal development Upgrade of facility commenced by June 2016 TDHB Maternity Internet site has up to date information on availability of maternity services in Taranaki and information on homebirth Increase in bookings at Hawera Maternity unit to 120 by June 2018 NERT response is implemented PROMPT training is implemented and held twice yearly	Staff member identified to lead this project-completed in 2016 Visit to other primary units has been completed and proposal drawn up in Oct 2015. Awaiting facilities management-completed 2017 Work commenced in Maternity Internet information update in Oct 2015-completed in 2016 and on going updated in 2018 This has not been achieved NERT response flow chart implemented in July 2015and reviewed in 2018 PROMPT training presented annually CURT completed in 2016/17/18 Hawera upgrade has been completed in 2017

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	Key stakeholders and community groups identified Draft project plan by June 2015 Agreed governance structure and participation By beginning of July 2015 Establish a governance group structure and participation Assess feasibility for hub by : Engaging the Bishops action foundation trust to run the scoping project for a hub Develop Project Scope Including • 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 enragements with mothers and families about services for the area Complete a report on findings	Scoping project for hub completed by June 2016 Report completed by Sept 2016	Draft project plan and governance structure completed in June 2015 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
4	**Review the responsibility and care for mothers and babies during transfer, delivery and return from the operating theatres**	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. Reduction in number of babies admitted to NNU for <24hrs	Project group to be formed with representation from quality and risk, operating theatre, NNU, maternity, service manager and consumer 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	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. Reduction in babies admitted to NNU <24hours by 20%	Sept 2015 project group initiated October 2015 admission to NNU < 24hrs old examined and costed Staffing options explored Oct 2015 This is on going in 2017/18 Workforce and model of care is continuing to be examined 2018/19

5	**Stop smoking support and NRT therapy for pregnant women, partners and whanau is available and executed in a timely manner**	All pregnant women are screened for smoking in pregnancy and are given brief advice and offered referral to smoking cessation support and NRT therapy Posters initiated, distributed and displayed around Taranaki promoting pregnant women and families to quit smoking Purchase of 3 CO monitors in use in primary community to support LMC's in smoking cessation promotion Increase in number of pregnant women who have received NRT, referral and or quit smoking who are hospitalised 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 Reduction in number of small for gestational age babies (SGA) born in Taranaki at term Reduction in rates of SUDI in Taranaki	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 Monitor the number of pregnant smokers to specialist stop smoking services Develop and establish a referral process and pathway for hospitalised pregnant smokers to specialist stop smoking cessation services by April 2016 enable training around best practice to support attainment of quit smoking support indicator for all pregnant women within Taranaki Provide training to maternity practitioners in use of CO monitors to use as a tool to encourage pregnant women to stop smoking	95% or > pregnant women who identify as smokers are screened for smoking, given brief advice 100% of women who consent to referral to smoking cessation support services are referred 100% of women who are referred are contacted and seen within 7 days of referral 2 training sessions per year are presented in Taranaki to engage all maternity related practitioners in smoking cessation training including use of CO monitors	CO monitors received end Oct 2015 2017 Data shows 100% women screened in TDHB maternity 2017 Training on CO monitors completed New provider and planning and Funding investigating education provider for 2017/18 Maternity smoking cessation coordinator position to be in place 2018/19 (see stop smoking services section)

Appendix 1 - Perinatal mental health local referral pathway



Appendix 2 - Newsletter

VOLUME 2 ISSUE 16

Maternity Weekly Education Newsletter

15 June 2018

Inside This Issue

1 Kia ora & updates, smart 5

2 PPH corner & Updates

3 Updates

4 Upcoming education /work shops

SMART 5

Smart 5 is an initiative where a topic is broken down into 5 short sharp messages-really good for education purposes. This weeks **SMART 5** is:

Pepi Pod

- Screen all women in early pregnancy
- Refer in early pregnancy for a Pep Pod if meet the criteria
- Revisit the screening before birth or if circumstances change
- Complete maternal care plan section for referral if you have referred and screened
- Pepi Pod forms available on TDHB Wilson under Forms

http://chirp.hiq.net.nz/site/TDHBintranet/Forms/Pepi%20Pod%20Referral%20Form.pdf

Kia ora

Hi everyone

This week marks the 30th anniversary of Merry Sorensen, commencing work at TDHB. What a wonderful achievement Merry! Merry commenced work at the old Barrett St hospital and then moved here to Maternity 29 years ago where she has stayed ever since. Merry was our Safe sleep/SUDI and Pepi Pod champion for many years and secured a $10,000 donation from Todd Energy, single handedly for more Pepi Pod's. Merry is a dedicated, hard working nurse and is our Danish Pocket Rocket whom we all love. Thank you for all you do and for all your years of service. Afternoon tea date will be sent out when Merry has agreed to a date that suits her ☺

Updates

Ultrasound Scans Updates

The sonographers have asked if all LMC attach/send previous obstetric reports if a USS has not been performed at TDHB. The sonographers require the previous report to ensure they have all relevant information available when performing the scan and will greatly assist.

Also please send GROW chart's as these are especially helpful if the LMC is concerned about SGA

Remember to include if the woman has an increased BMI on the referral form as this will ensure the woman has her scan between 22-24 weeks which is recommended for women with inc BMI and will hopefully decrease the need for a further USS due to inability to visualise features-thank you

PPH Corner

Analytics info for PPH

TDHB births from 1/1/18 too 14/6/18= 619

PPH's from 1/1/18 too 14/6/18=86

TDHB PPH rate from1/1/18 to 14/6/18=13.89%

Thanks everyone for your hard work-we have dropped half a percent in a week ☺

Huge Congratulations to the Hapu Wananga Team

Congratulations and well done to the team after their inaugural workshop yesterday. It looked like a fabulous day with lots of fun, kai and great learning. Please don't forget to refer any women for the South Taranaki Hapu Wananga next month. Referral form attached again below ☺

Referrals.docx

Birth Equipment

The disposable equipment can be purchased through stores here at base. Any outstanding non disposable equipment, can it please be returned to our ward as we are very low on equipment-thank you.

Breastfeeding Updates

Changes to Breastfeeding Welcome Here

Breastfeeding Welcome Here to be self-auditing

Taranaki DHB is grateful to the approximately 150 Taranaki businesses and service providers which have worked with us to normalise breastfeeding in public places and encourage women to breastfeed anywhere, anytime through the 'Breastfeeding Welcome Here' health promotion programme. The programme was launched about 15 years ago and run by Taranaki Public Health.
Following the completion of a Health Equity Assessment last year, the majority of sites accredited for Breastfeeding Welcome Here are changing to self-auditing. Taranaki DHB sites will continue to be audited by Deb Wright and a Public Health rep.

Sites will receive a self-audit toolkit which contains information to help them to continue to operate as a 'Breastfeeding Welcome Here' environment, with suitable conditions for mothers and young children. The toolkit information is also available on the Taranaki DHB website for future reference:
http://www.tdhb.org.nz/services/maternity/bfwh.shtml

Early Life Nutrition Symposium Spring 2018

A one-day symposium for all involved in the care of mothers and babies

Save the date! Our forthcoming nutrition symposium is an ideal professional development opportunity for midwives, Plunket nurses, GPs, nutritionists, dietitians, nurses, pharmacists and healthcare workers. Your chance to get up to date with the latest research in nutrition during pregnancy, lactation and early childhood, along with some practical, take-home learning that you can apply to your practice.

More information coming soon on the exciting range of topics and speakers we have for you this year.

Date: **Tuesday 4th September 2018**
Venue: **The Atrium, Massey University, Auckland (Free Parking)**
Scheduled times: **08:45 – 16:30** (registration opens from 8:00am)

Registration (includes lunch and refreshments) – coming soon:
- Earlybird:$100
- Standard (from 21st August): $150
- Student (any institution): $75

More information here soon:
www.massey.ac.nz/nutritionsymposia

View web version
Join us for the 2nd Annual
GOLD Neonatal Online Conference
June 4 - August 3, 2018

The 2nd Annual GOLD Neonatal Conference is now underway with many of the presentation recordings online, and ready for your viewing pleasure! We've heard from 10 amazing Speakers and have received such wonderful comments from attendees. If you're looking to access the latest neonatology research & clinical skills, there's still plenty of time to join in on the fun! Please see attached document for further details below.

FW Explore the Power of Touch w Ma

Babies and Mothers with Unknown GP or Struggle to Engage with GP

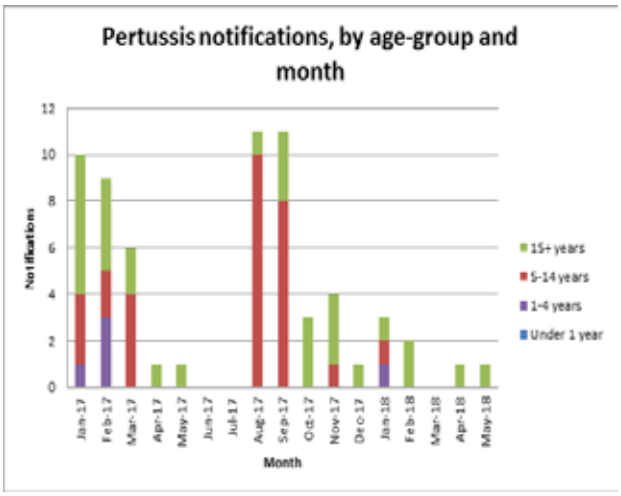
As per Belinda's email earlier in the week, it is great that Awhina has agreed to be the contact for women and or babies that have unknown GP and are struggling to get engaged with a practice.
Please see her letter attached for her contact should you have anyone with this issue that you can refer women/babies to for assistance.

2017-08-06 LMC Babies enrolment with

Taranaki Pertussis Update from Jonathan Jarman TDHB Chief Medical Officer for Health

Below are our pertussis statistics for Taranaki up until last month. There were only two cases notified between March and May. The lack of under-ones is a reflection of our immunisation coverage in Taranaki.
A national pertussis outbreak is ongoing although weekly notifications have been declining recently.

Jonathan



2 New Workshops from NZCOM- in New Plymouth 28 June

1. Grounding practise within Te Tiriti/The Treaty relationship
NZCOM have placed this full day interactive workshop in New Plymouth, free of charge, which unpacks the history of our place, Aotearoa, in order to understand the present, in the context of health and midwifery. Whilst the workshop is open to all midwives, Sharon, as a Pākehā educator, has a passion in supporting people to understand how we can be honourable partners in the Treaty relationship.

It will help midwives come to a place of valuing our bi-cultural heritage, in order to be real and authentic in implementing the Treaty and its principles as a framework for practise.

Workshop costs: This workshop is provided free of charge. *Full catering and resources are included.*

To enable professional discussion places are limited, book early to avoid disappointment. The College has allocated this workshop 8 hours of continuing midwifery education.
Click on the workshop date to book **http://portal.midwife.org.nz/member/workshop/268**

2 Birthing Across Cultures in Aotearoa-not in NP

This interactive work shop, will enable midwives across NZ to consider the importance of culture on birth. Further details on both below

NZCOM New Workshops.pdf

Reflection on the Practicalities of being a Mentor Midwife Workshop in Auckland 22/2/17 by Carol Wells

Thank you Carol, for your insightful reflection on this workshop. Huge thank you to all who mentor and precept our nurses and midwives. Please remember that to mentor in the MFYP programme, you do need to be a member of NZCOM and to have participated in the MFYP programme.

To precept a RN here in maternity you need to have completed the TDHB Preceptor Course within the last 3 years

To precept a RM here in maternity, you need to have completed a midwifery preceptor course either the Otago Junction or the NZCOM preceptor workshop within the last 3 years.

Reflection on the practicalities of being

JUNE 2018						
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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

JULY 2018						
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

Upcoming Education and Events & Dates

PROMPT	June 22
Maternity Quality Committee	June 26
Grounding Practise within Te Tiriti/The Treaty Relationship	June28
Engaging Effectively With Maori	July 17
Flight Training In Service	TBA
Electronic Allergy Updating	TBA
Cervidil In Service	TBA
Wound Care	TBA
AUT Presentation	TBA

TDHB Professional Development Calendar 2018

2018 PD planner.docx

PCA PUMPS

A further plea from the Acute Pain team-please for goodness sake, wrap up the PCA cords properly before sending back with the orderlies and ensure they are well cared for and actually have a cord attached when sending back!!!!!
Please take care of our DHB Equipment

Appendix 3 - Midwifery professional development

TDHB MIDWIFERY PROFESSIONAL DEVELOPMENT 2018

REGISTRATION: **Bookings only accepted once course has been advertised.**
VIDEOCONFERENCING: *** indicates if available**

COURSE NAME	HOSPITAL RN, MW	PRIMARY SECTOR	DATE(S)	FACILITATOR	APPROX. TIME
Epidural Ko-Awatea on line plus 1hr session practical	**RM only**	✓	23 February + 30 November	Sharon Howe Tom Lupton, Emma Patrick, Duncan Brown	0900-1300 Corp 1
New born life support NZRC – full day	**RN RM & Paed & O&G Dr's ONLY**	✓	May 18 Nov 16	Richard Smiley, John Doran, Raimond Jacquemard, Abigail Webber, Belinda Chapman & Sharon Howe	0900-1630 Clinical Skills Lab/Corp 1/Ward 14
New born life support NZRC-full day Hawera	**RN RM ED Doctors & Staff**	✓	23 November	Richard Smiley, Abigail Webber, Sharon Howe	0830-1630 Hawera Board Rm and HMU
Breastfeeding Workshop	**RN RM Paeds, LMC's, Maternity, Well Child Providers**	✓	31 October	Sharon Howe Debbie Wright	Lecture theatre
Perineal Suturing; Ko-Awatea on line plus 2 hr practical	**RM only**	✓	21 Feb 7 Nov	Sharon Howe, Edward Williams	1230-1630 Education Centre Rm 2
Perinatal Mortality Meeting	**O&G, NNU, Paeds, LMC's, Maternity**	✓	20 Feb and Sept 18th*	Belinda Chapman, Jeremy Smith	7-9pm Lecture Theatre TDHB
PROMPT BASE	**RM, Obst, Anaesthetists**	✓	22 June	PROMPT Faculty- Tom Lupton, Rosemary Darby, Sharon Howe, Belinda Chapman/Finola Mooney/Sandra Luxton	0800-1630 Corporate Meeting Rm 1
PROMPT HAWERA	**RM,RN, ED Dr's, ST John Ambulance**	✓	X 1 (October)	Rosemary Darby, Sharon Howe, Belinda Chapman, Finola Mooney	0830-1630 Hawera Board Room & HMU

Midwives Emergency Refresher Day	**RM, Maternity RN's am only**	✓	9 Feb, 16 March, 9 October 9 Nov -max 16	Sharon Howe	Clinical Skills Lab 0800-1630
Safe sleep, Smoking Cessation	**RM, RN, Child health**	✓	TBA	Planning and Funding to sort this	
RANZCOG FSEP	**RM, Obstetricians**	✓	6 April	RANZCOG	Lecture Theatre Education Centre 0900-1600
Midwives Primary Secondary Interface	**RM**	✓	May 9	Belinda chapman	Ed Centre room 4
NZCOM Treaty of Waitangi Wrokshop	**RM**	✓	June 29	NZCOM	NP

NZMC Midwives compulsory education requires:

- Annual Midwifery emergency skills day which includes adult CPR intermediate response, Newborn life support 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 3yearly (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
- CPR Intermediate response; annually (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)
- Suturing refresher (once every 3 years)
- Epidural refresher (once every 3 years)

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

Appendix 4 - Quality audit and reporting grids

Taranaki DHB Maternity Quality Audit Grid 2018/19

	2018							2019				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
MEWS *CORE REP*				☺						☺		
Customer Satisfaction Survey *CONSUMER*												☺
Documentation Audit *ME*						☺					☺	
ISBARR *Postnatal Coordinator*					☺				☺			☺
Electronic Fetal Monitoring **Audit** *ME*	☺							☺				
Safe Sleep Audit *Safe sleep champion*		☺										
C-sections *O&G*			☺								☺	
Birth rate Data and Trends for Base Hospital and Hawera Primary maternity unit *MQC*			☺								☺	

Taranaki DHB Maternity Quality Committee Reporting Grid 2018/19

	2018							2019				
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
PMMR and case review/trends/great saves *ME/ADOM*				☺						☺		
Maternal mental health *Numbers/Trends – MMH Team Leader*		☺										
Complaints/ consumer feedback trends *Maternal Child Health Manager/CMM*		☺						☺				
Wound infections/ general anaesthesia and blood transfusions (caesarean section) *CNS – Infection Control*				☺					☺			
HDU admissions audit *ME*						☺						☺
Consumer report *Consumer Representative*		☺										
Clinical Indicators *ADOM/HOD*											☺	
Newborn Hearing Screening *Allied Health Manager*								☺				

Acknowledgments

Belinda Chapman - MQSP Coordinator & ADOM
Bernadette Winks - Core Midwife Hawera
Bob Stephens - Taranaki DHB Analyst
Carol Wells - Newborn Hearing Screening Coordinator
Christine Strydom - Consumer Representative, Maternity Quality Committee
Deb Wright - Lactation Consultant
Finola Mooney - FAU Midwife
Glenda Martin - Core Midwife
Helen Burley - Customer Services
Honor Lymburn - Data Analyst, Midland Maternity Action Group
Dr Jeremy Smith - Obstetrician HOD O&G
Judith Moorhead and SANDS members of New Plymouth
Karen Janes - Antenatal Coordinator
Laura Scholey - PMMR Midwife champion
Maria McInerney - Information Analyst
Marianne Pike - Violence Intervention Coordinator
Marnie Reinfeld - Planning and Funding
Mary Lawn - Child & Maternal Health Clinical Services Manager
Maternity Quality Committee Governance Group Members
Melanie Clark - Web Admin and Graphic Designer
Ngawai Henare - Chief Advisor Māori Health
Patrick Morris and Karen Meads - Perinatal Mental Health
Rebecca Madden - Safe Sleep Champion
Rebekah Langton - Admin Hawera
Sadie Walker - Baby Loss Midwife Champion
Sharon Howe - Midwife Educator
Sharron Wipiti - Hapu Wananga Facilitator
Stephanie Cowan - Change For Our Children
Tamara Ruakere - Tui Ora
Tawera Trinder - Hapu Wananga Facilitator
Trainee Inters: James Kennedy, Amy Xiao, Debbie Lee,
Freya Forstner, Moerangi Tamati, Tamsin Newell

Report compiled by:
Belinda Chapman - ADOM/MQSP Coordinator
Melanie Clark – Design and compilation
Sharon Howe - Midwife Educator and Quality Rep