

Maternity Quality & Safety Programme

Annual Report
6/30/2013

Michelle Bailey





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Acknowledgements

The people who have contributed to this report

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Michelle Bailey - MQSP facilitator.

Laura Drewet – Maternity Quality facilitator



Northland DHB Vision and Mission

Create opportunities for improving health and wellbeing, and promoting independence of all the people of Northland/Te Tai Tokerau.

Mahi tahi te kaupapa o Te Tiriti o Waitangi he whakarapopoto nga whakaaro o te Whare Tapa Wha me te whakatuturutahi i te tino rangitiratanga te Iwi whanui o Te Tai Tokerau.

Northland DHB Values

The Values are of particular importance as they are the organisation's framework for the way it works. They are:

- **People First** – *Tangata i te tuatahi*: People are central to all that we do
- **Respect** - *Whakaute (tuku mana)*: We treat others as we would like to be treated
- **Caring** – *Manaaki*: We nurture those around us, and treat all with dignity and compassion
- **Communication** – *Whakawhitiwhiti korero*: We communicate safely, openly and with respect to promote clear understanding
- **Excellence** - *Taumata teitei (Hiranga)*: Our attitude of excellence inspires success, competence, confidence and innovation.



Purpose

Maternity Quality and Safety Programme

The purpose of establishing the Maternity Quality and Safety Programme is to find effective ways to strengthen clinical leadership, so that all maternity providers and consumers work together at the local level in a way that builds the workforce and improves safety and quality of maternity services for women and their babies, with a particular emphasis on integration of hospital and community services.

Maternity Annual Report

This Annual Report covers the implementation and outcomes of NDHB's Maternity Quality & Safety Programme in 2012/2013

This Annual Report:

- Demonstrates NDHB's delivery of the expected outcomes as set out in the Strategic plan
- Outlines progress towards NDHB's MQSP Strategic Plan deliverables in 2012/13 which are ongoing
- Highlight NDHB's plan to improve the quality and safety of its Maternity services in 2013/14.

The vision and mission statements of the Northland District Health Board align with the purpose and establishment of the Maternity Quality and Safety programme.



Background

Alignment with New Zealand Maternity Standards

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

Expectations of the New Zealand Maternity Standards	
Standard One: <i>Maternity services provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies</i>	
8.2	Report on implementation of findings and recommendations from multidisciplinary meetings
8.4	Produce an annual maternity report
8.5	Demonstrate that consumer representatives are involved in the audit of maternity services in NDHB
9.1	Plan, provide and report on appropriate and accessible maternity services to meet the needs of the Northland 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
Standard Two: <i>Maternity services ensure a women-centred approach that acknowledges pregnancy and childbirth as a normal life stage.</i>	
17.2	Demonstrate in the annual maternity report how Northland DHB have responded to consumer feedback on whether services are culturally safe and appropriate
19.2	Report on the proportion of women accessing continuity of care from a Lead Maternity Carer for primary maternity care
Standard Three: <i>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.</i>	
24.1	Report on implementation of the Maternity Referral Guidelines processes for transfer of clinical responsibility



Section 1 - 1st year Objectives of Maternity Quality and Safety Programme.

- Establish a Clinical Governance Framework - achieved
- NDHB policies are developed using national guidelines and recommendations- ongoing
- Establishment of processes to identify and actively manage risk.- established and ongoing
- To work collaboratively with the Maternity Sector.-ongoing
- Community Maternity Services Liaison role is established - achieved
- To compare NDHB outcomes against benchmarked Ministry of Health data- achieved
- To develop a dashboard of clinical Indicators for the Maternity service-achieved.

Current projects

Project	Planned outcome
Northland SUDI prevention project	Significant reduction in the 5 year rolling number of SUDI in northland
Breastfeeding Community initiative	Increase in exclusive breastfeeding rates at 6 weeks and 6 months
Clinical Risk Management	Improved maternity care for women of Northland in response to case reviews.
Maternity New Build	Purpose built maternity unit ready to move into in 2014 with new model of care developed.
Smoke free	All women are screened at booking and on each admission to hospital and are offered brief intervention advice. Reduction in number of smoking mothers in Northland
Immunisation	On time immunisations for babies in Northland.
Flu and Pertussis	Pregnant women are vaccinated against flu and pertussis
Timing of Registration with an LMC	Increase in the number of pregnant women booked with a Lead Maternity Carer by 10 weeks gestation.



NDHB Associate Director of Midwifery (ADOM)

Report for the Annual Maternity Quality and Safety Programme for 2013.

Over the past 12 months since the inception of the Maternity Quality and Safety Programme, the ADOM has worked closely with the Maternity Quality and Safety Facilitator to offer support and advice on the number of projects that have been commenced during the year, with the aim to improve understanding of the needs and reality of the Northland community, which will enable NDHB to provide an equitable and safe maternity service for all of the population.

In addition to the projects and quality initiatives outlined in the 2013 annual report, the NDHB maternity services, have also implemented other initiatives to provide an integrated approach to health care within the community, working collaboratively with primary health care, Lead Maternity Carers, the two Primary Health Organisations (PHOs,) and non government organisations (NGO) including Maori health providers.

These initiatives include the introduction of an early notification consent form to assist parents to choose a GP and well child provider for their new baby, and encourage early enrolment, to assist with the baby having its first immunisation on time at 6 weeks old. This has been successful with the percentage of infants receiving the first immunisation on time rising from 47% to 90% over the past 12 months. It has also improved the enrolment of the infant with a well child provider by 6 weeks of age.

A further integrated multidisciplinary project has been the introduction of midwifery led drop in facilities within the maternity units, to enable eligible pregnant women to be immunised free of charge for influenza and pertussis, by midwives who have undergone training to provide this service. It is a part of a larger campaign within the community, to encourage as many pregnant women to be vaccinated as possible, especially whilst the current pertussis epidemic is still prevalent.

The smoke free programme has been well supported, and Northland DHB initiated the change within Midwifery council to enable midwives to provide quit cards to extended family to encourage a smoke free environment which will benefit all the whanau.

Finally good communication and relationships between practitioners is paramount to reduce risk and improve outcomes for the women and babies. Therefore a framework has been developed to ensure a robust and fair system is in place to deal with any complaints or disputes between practitioners, with the emphasis on gaining mutual understanding, and respect, resulting in improved communication and workplace relationships.

Lesley Franklin

NDHB Associate Director of Midwifery

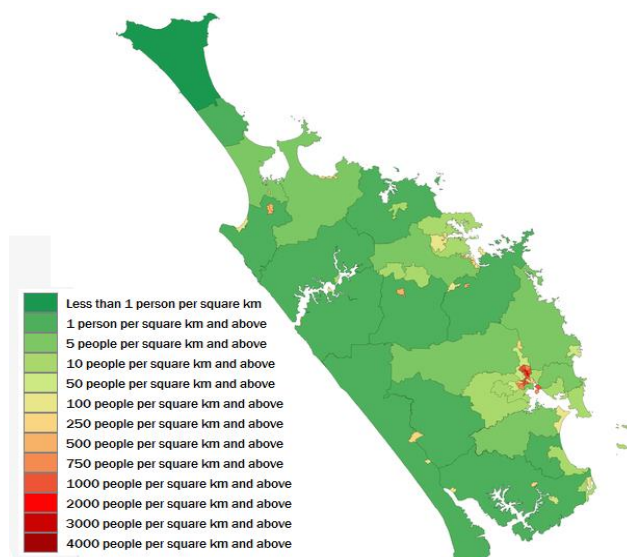


Northland Context

It is recognised that the health status in Northland is poor in comparison to other regions of New Zealand. This is closely linked with deprivation, with the Northland region showing a greater disadvantage for all measures of comparison including income, housing, employment social and occupational class and educational achievement.

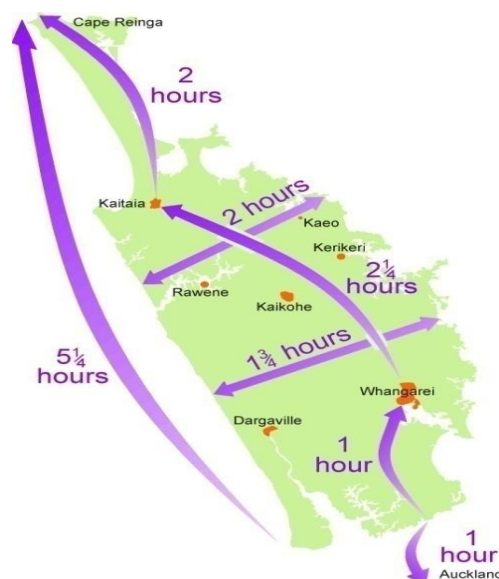
Northland's only significant urban area is Whangarei, which contains about one-third of its population (Figure 1). The remainder live in small towns (the largest of which are Kaitiā, Kerikeri, Kaikohe and Dargaville at about 5,000 each) and rural areas across the district.

Figure 1: Northland population distribution



Northland is a long narrow peninsula and is about 343km long (by road) and only 80 km across at its widest point. Northland has many isolated communities; it takes over five hours to travel from Northland's northern to southern extremities and up to two hours east to west (Figure).

Figure 2: Travel times across Northland and to Auckland





Only a small percentage of the population live more than 60 or 90 minutes away from any hospital but access to care is difficult for many people. Barriers to accessing services result from a combination of factors including long distance, deprived and scattered population, poor road conditions, and minimal public transport services.

Northland's estimated population in 2012 is 159,160, or 3.6% of New Zealand's population. Māori comprise around 30% of Northland's population. (Figure 3) Of the total Maori population about half live in the Far North District, 40% live in Whangarei District and 10% in the Kaipara district.

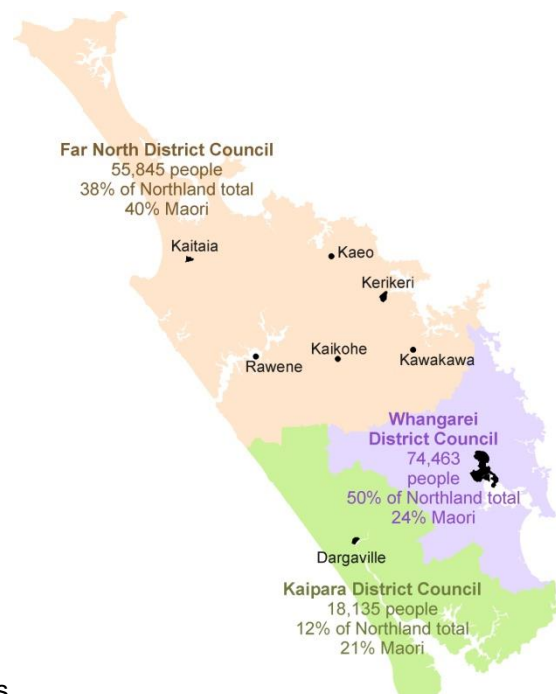
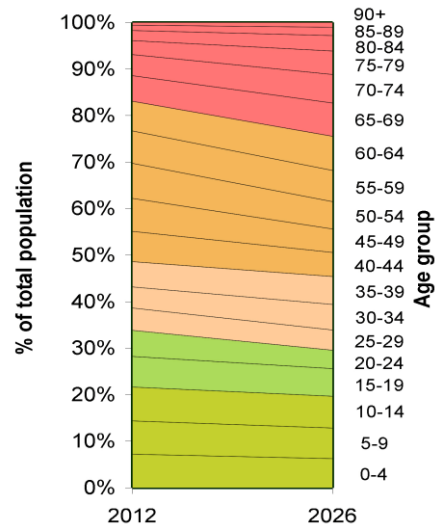


Figure 3: Northland population, 2006 Census

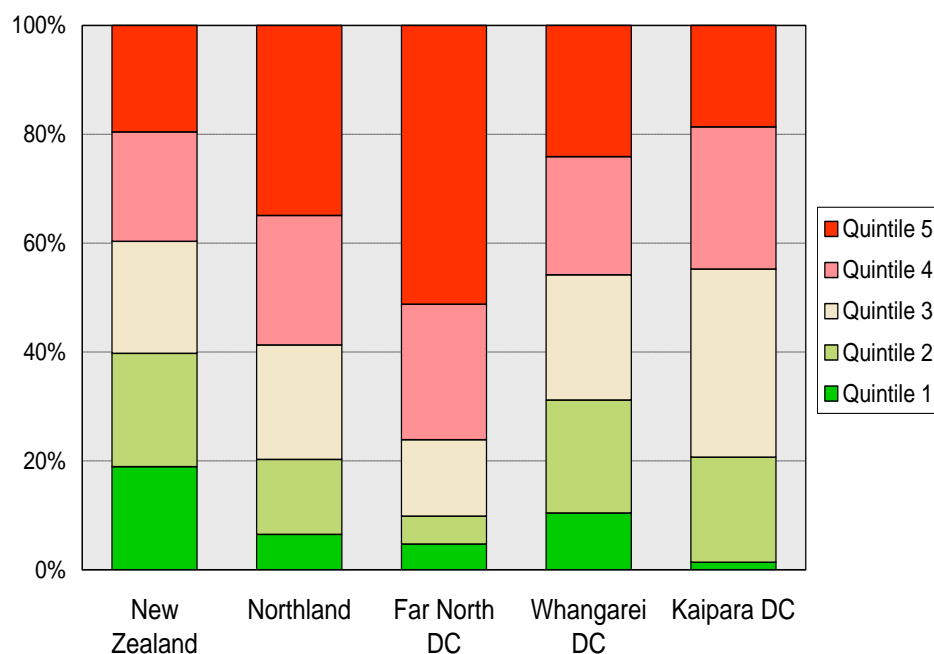
Northland's population is 'ageing' because older age groups are increasing in both number and proportion, while those of children and youth are decreasing (Figure 4). Significant change in the age structure of Northland is projected between 2012 and 2026

Figure 4: Northland population ageing – 2012-2026



Northland has one of the most deprived populations in the country (Figure 5). Deprivation levels vary across Northland.

Figure 5: Northland deprivation by area and compared to New Zealand profile (Quintile 5 most deprived, Quintile 1 least deprived)





Key Northland Demographics and Social Determinants in comparison to the National average

- Birth rates in relation to females of child bearing age are higher in Northland
- Fertility rates for Maori women are higher than non-Maori women in Northland
- Teenage birth rates in Northland for Maori were higher than European although rates for both ethnic groups are higher than the national average.
- Pre term births are significantly higher for Maori babies, males, and those residing in more deprived or urban areas in Northland
- Northland currently has the highest rate of sudden unexpected death in infancy (SUDI) in New Zealand.
- Family violence incidents have risen in past 10 years in Northland
- The incidence of family violence in Northland is still higher when compared to the National average
- The Northland DHB population has a much lower proportion of the population earning over \$30,000 in personal income



Northland Health Services

Northland has one major secondary care hospital, Whangarei Hospital. A further four district hospitals provide urgent care and acute medical, primary maternity, intermediary, and rehabilitative care (Figure 6). Women in need of secondary services e.g. for caesarean section are transferred by road ambulance or in urgent cases by helicopter.

Figure 6: Northland hospitals



Hospitals in Auckland, primarily Auckland City Hospital, provide more specialised (tertiary) services for Northlanders. This includes Maternity services. It takes about two hours to reach Auckland by road from Whangarei. Acute cases are transferred by helicopter

Maternity Services

Northland District Health Board (NDHB) maternity services are provided on 4 hospital sites, Whangarei, Kaitaia, Bay of Islands and Dargaville. Whangarei hospital provides secondary maternity care and is a primary facility for the women of Whangarei and Dargaville. Kaitaia and Bay of Islands hospitals provide primary birthing facilities and Dargaville hospital provides post natal services only. Women requiring tertiary level maternity care are transferred to Auckland City hospital.

Whangarei hospital has 8 rooms in delivery suite which can be used for assessment, induction of labour, birthing and care of women requiring high dependency care. There is 1 room which can be used as an isolation room, 1 birthing pool and 22 ante/post natal beds. Kaitaia has 6 beds. Bay of Islands has 8 beds and Dargaville has 4 beds.

A new purpose built secondary care maternity unit is planned to open in 2014 in Whangarei.

NDHB employs a range of health professionals, providing care as a multidisciplinary team. This includes, Midwives, Specialist Obstetricians, Anaesthetists, Paediatricians, Specialist pain nurses, Registered Nurses, Physicians, Enrolled Nurses, Lactation Consultants, Social Workers, Health care assistants, and a Maori directorate, who provide cultural assistance and advice as needed.



In addition, Rawene hospital, a public health trust in Hokianga, has a primary birthing unit. This provides primary care for approximately 50 women per year. Any woman requiring secondary care will be referred to Whangarei hospital.

Antenatal Care

Secondary maternity antenatal care is delivered from all four hospital sites in via outpatient clinics on a referral and appointment basis.

Whangarei operates 4-5 Obstetrician led clinics per week. A Medicine in Pregnancy clinic provides care for women with diabetes and complex medical issues. This clinic has an Obstetrician, Physician, Midwife and Specialist Diabetic Nurse working collaboratively. Kaitia has one consultant clinic per week, Bay of Islands has one consultant clinic per week and Dargaville has one consultant clinic per month. LMC's refer to these clinics for consultation as per referral guidelines and the clinics provide secondary ante natal care for more complex women. A consultant clinic is also provided every 2 months in Rawene.

Antenatal Education

In the Whangarei city area antenatal classes are held on Tuesday and Wednesday evenings. Each set of classes run for a 6 week period. There is also a 2 - day weekend course which is held once a month.

There is a large demand for these classes and a waiting list is held. An increase in the number of these classes is being discussed.

Antenatal education classes are also held specifically for pregnant teenagers. These classes are run 4 times per year and are based at The Pulse, a one stop shop, which includes the school for teenage mothers. The classes run over 7 weeks. A coffee group is also held at The Pulse. This is an education session with guest speakers and homemade food for the teenage mums. The aim was to get a peer support network running for breastfeeding mums and this has worked well. Angela Yendall (Lactation Consultant) provides breastfeeding support, Jigs Bradley from Parents as First Teachers provides invaluable information and Leanne Going from Plunket provides well child checks. We are pleased to report that 100% of these babies are fully immunised, the breastfeeding rates are increasing and the teenage mums are thriving with motherhood. Some are back at the Teen School, some are attending a course and all are enjoying motherhood.

Antenatal classes in Whangarei specifically for Maori are being explored as the current uptake by Maori women is limited.



Section 2- Data Analysis

Birthing Profile/Data Analysis

Please note that any data recorded for 2013 in this report does not represent a completed fiscal year.

2028 women gave birth in 2012 in Northland. 51% (1034) of these women identified themselves as Maori and 44 % (886) as European. The other 5 % (107) were Asian, Pacific and unknown ethnicity.

Figure 7 - Table of ethnicity 2012

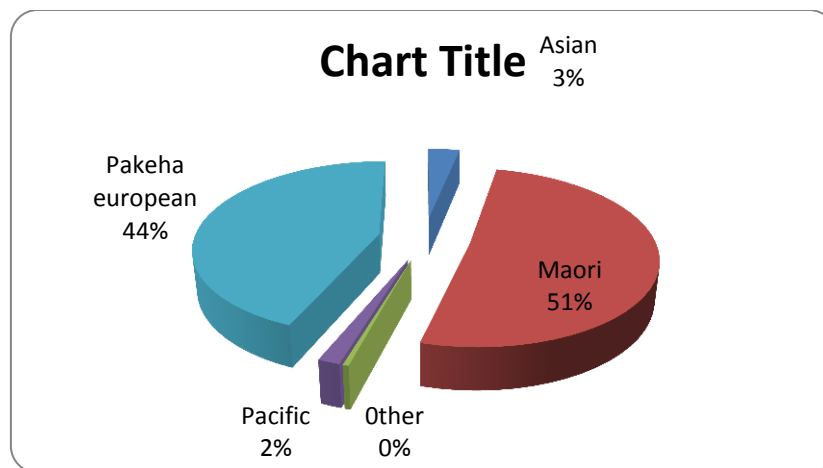


Figure 8 demonstrates that there was a trend of increasing birth numbers in Northland from 2008 until 2011, however, in 2012 there was a 5.4% drop in birth numbers regionally. There were 2028 births in Northland DHB hospitals in 2012

Figure 8 - Table of Northland births 2008 - 2012

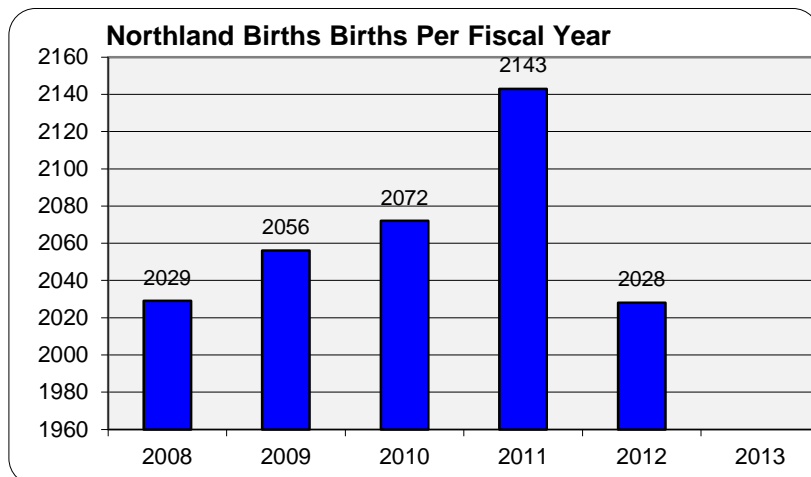


Figure 9 demonstrates the same trend for Whangarei Hospital Maternity unit. In 2012 there was a 6.6% decrease in the number of births in Whangarei Hospital. There were 1641 births in Whangarei hospital in 2012.

Figure 9 Table of births in Whangarei hospital 2008-2012.

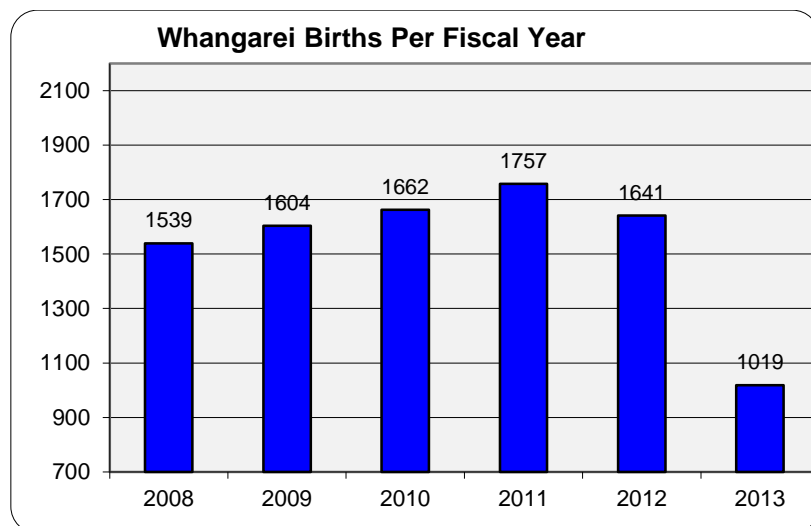


Figure 10 demonstrates the number of births in Kaitia have remained static over the last 3 years. This is the only hospital within NDHB which has not demonstrated a drop in birth numbers. In 2012 there were 168 births in Kaitia hospital.

Figure 10 -Table of births in Kaitia hospital 2008-2012

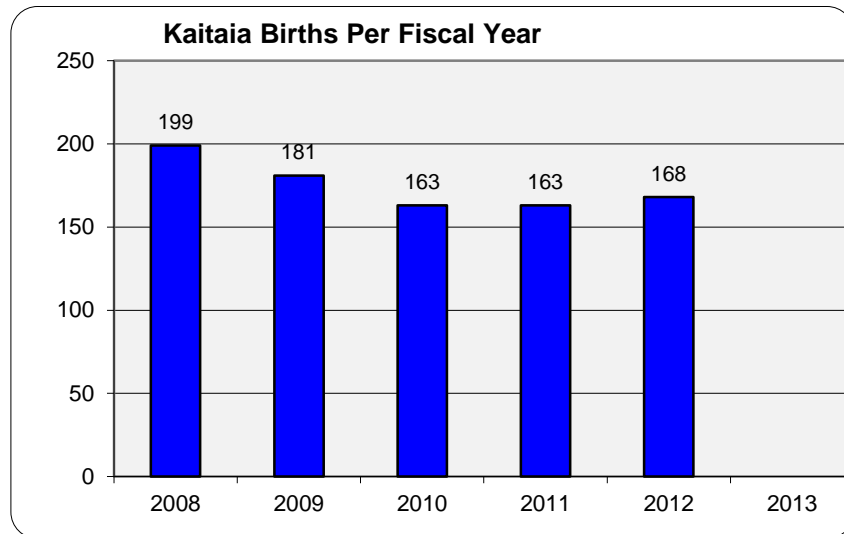
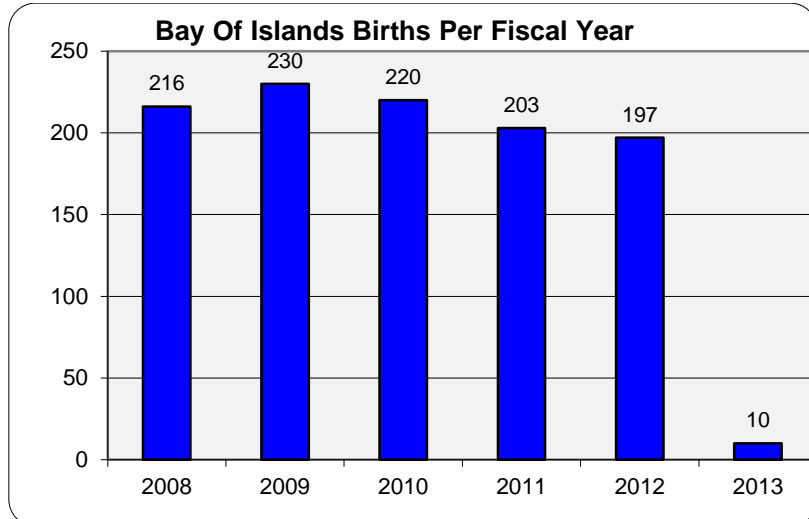


Figure 11 demonstrates a small falling trend in birth numbers from 2009. There was a very small 3% decrease of in the number of births in 2012 in the Bay of Islands hospital. There were 197 births in Bay of Islands hospital in 2012.

Figure 11 - Table of births in Bay of Islands hospital 2008-2012



Although birthing facilities are currently unavailable in Dargaville hospital there were 10 births recorded in 2012.

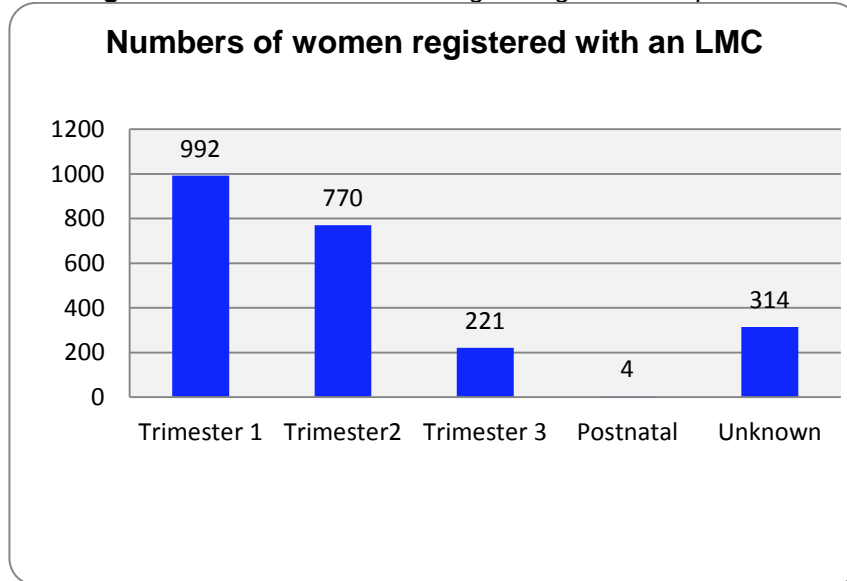
National Maternity Collection Data produced by Ministry of Health in February 2013 states that in 2011 calendar year there were 145 homebirths in Northland. Unfortunately this data is not collected at local level and the 2012 data is not yet available.

The National Maternity Collection Data also informs us of trimester of registration with LMC.

In 2011 calendar year the following registrations with LMCs were recorded in Northland



Figure12- Numbers of women registering with LMC per trimester



Interestingly when registrations with LMC between Maori and non Maori are compared there is a noticeable difference.

Trimester of booking	Maori	Non Maori
1 st Trimester	39%	61%
2 nd Trimester	69%	31%
3rd Trimester	76%	24%
Postnatal	75%	25%
Unknown	67%	33%

Although it is difficult to draw conclusions as to why a marked difference exists further investigation is warranted as women who book late, do not access timely screening and early antenatal care.

Early Registration with an LMC aligns with the National recommendations and the National Monitoring Group Objectives.

The Clinical Governance Group identified the need to review local data and establish how many women were not accessing Maternity care early in their pregnancy. The consensus was to review women booking after 36 weeks in the first instance. (Appendix 1)

A retrospective review of local data in 2012 demonstrated that in Whangarei hospital, 73 of the women who birthed were booked with a care provider after 36 weeks gestation or unbooked at the time of delivery. 12 of these women were from out of area and had care with an LMC elsewhere so were excluded from this study. 61 women remained. This represented 3.74% of our birthing population.

Audit Project (appendix 2)

Reviewing the local data for numbers of births in each DHB facility it was identified that the number of births in the Bay of Islands hospital are decreasing. The trend was demonstrated in Figure11.



Following discussion with the Clinical Governance Group it was decided that this required further investigation. The Bay of Islands hospital is a small regional hospital which has a primary birthing unit and is situated 45 minutes north of Whangarei hospital and averages around 200 births per fiscal year. There were 235 women booked in the Bay of Islands from January until June 2012

Local data demonstrated that in the first 6 months of 2012 there were 146 women residing in the Bay of Islands who birthed in Whangarei hospital. 54 of these women transferred to Whangarei during pregnancy and 27 of these women were transferred in labour.

A retrospective audit was done to ascertain the reasons for so many women birthing in Whangarei rather than in their local primary unit. The audit hoped to identify whether patient choice was the reason women were birthing in Whangarei secondary care facility or if there were medical/obstetric reasons for this. There were 129 completed audits. 13 women were excluded as they did not live in Bay of Islands' area and we were unable to get data for 4 others.

Conclusion

The audit clearly demonstrated that patient choice is not the main reason for women residing in the Bay of Islands birthing in Whangarei. It is clear that there are a number of obstetric and medical reasons for transfer to Whangarei. Previous LSCS is the most common obstetric reason to book in Whangarei and IOL is the most common cause of transfer in pregnancy.

The regional demographic data indicates that diabetes is increasing in Northland and it was interesting to note that 5 of the 14 women booking in Whangarei because of medical problems did so because of Diabetes and 3 women were transferred during pregnancy due to Gestational Diabetes.

Diabetes is identified as a key action plan in both the Northland health Services Plan and the NDHB Maori Health Plan, and there are a number of initiatives within Northland aiming to improve healthy lifestyle choices, screening in primary care and improved glycaemic control.

This audit also demonstrates women are choosing to birth in their local primary birthing units and the Maternity services provided in Northland are ensuring the women of Northland an approach to birth being a normal physiological process.

This audit was repeated in Kaitia as part of an ongoing review of services (Appendix 3)

The numbers of women birthing in Kaitia have remained constant over the last three years. The purpose of this audit was to identify the reasons why women who live in the Kaitia area are birthing in Whangarei hospital. It was expected the outcome of this audit would be similar to the one completed in the Bay of Islands. Local data demonstrates from July to December 2012 there were 49 women residing in Kaitia who birthed in Whangarei hospital. 16 women booked in Whangarei and 25 women booked in Kaitia 15 women transferred to Whangarei during pregnancy and 10 of the women were transferred in labour.

A retrospective audit was completed to identify the reasons women were birthing in Whangarei rather than in their local primary unit. The audit particularly attempted to identify whether it was patients choice or medical/obstetric complications that influenced the place of booking.

The audit tool developed for the Bay of Islands audit was used. A nurse in Kaitia hospital reviewed the notes and completed the audit forms. The completed forms were returned to the Maternity Quality and Safety Programme facilitator for interpretation.

There were 41 completed audits for women residing in Kaitia who birthed in Whangarei. There were 7 women who were recorded as living outside Kaitia so they were excluded from the final results. We do not have the data for 1 woman

The audit demonstrated that patient choice is not the main reason for women residing in the Kaitia birthing in Whangarei. It is clear that there are obstetric and medical reasons for transfer to Whangarei. Previous LSCS is the most common obstetric reason to book in Whangarei and IOL is the most common cause of transfer in pregnancy. Comparing this audit to the one completed in the Bay of Islands it demonstrates similar outcomes. Previous LSCS was also the most common reason for women booking in Whangarei and IOL was the most common reason for transfer in pregnancy. Failure to progress was the most common reason for transfer in labour in both audits. The main



difference between the audits is that in Bay of Islands only 12.5% of the women who booked in Whangarei chose to do this where as in Kaitaia 25% of the women booked in Whangarei chose this. There were also more medical complications sited in the reason for booking in Whangarei in the Bay of Islands audit.

Transfer in labour from a primary unit or home became trigger in the clinical risk management process in response to this audit. This allows the review of every transfer to Whangarei, looking at processes and ensuring all women who were transferred needed to be.



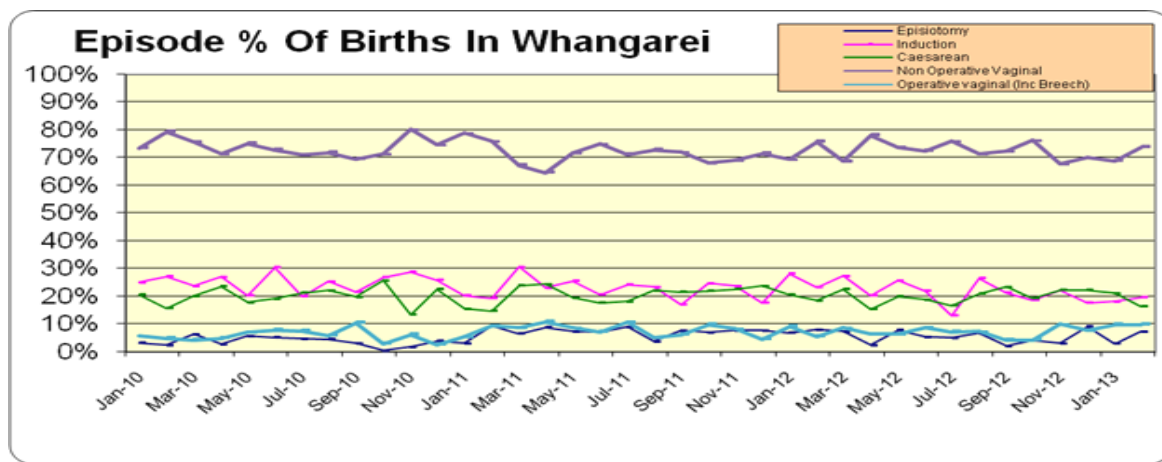
Figure 13 demonstrates the type of births and interventions as a percentage in Whangarei hospital. Spontaneous vaginal delivery rate averages around 72% of total births in 2012 (range 68-78% per calendar month).

Caesarean birth rate averages 20% of total births in Whangarei hospital (range 15-24% per month)

Ventouse, forceps and vaginal breech births average 8% of births in Whangarei hospital (range 5 - 11%)

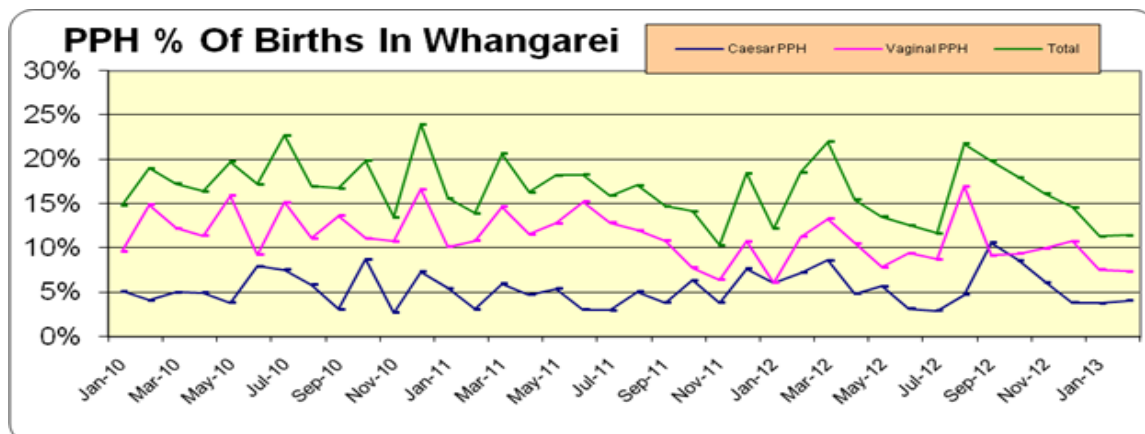
23% of births at Whangarei hospital followed Induction of labour

Figure 13 – % of births in Whangarei



The episode of Post Partum Haemorrhage (PPH) varies from 13% to 22%. Please note PPH following a vaginal birth is classified as a blood loss of more than 500mls and a PPH following a LSCS is classified as a blood loss of more than 750mls.

Figure 14 - % of PPH of Births in Whangarei





Baby Friendly Community Initiative

All Maternity units within Northland DHB are Baby Friendly Hospital Initiative (BFHI) accredited and will be going for their fourth reaccreditation in 2014. The exclusive breastfeeding rates have continued to rise and Northland leads with exclusive breastfeeding rates upon discharge. The secondary unit in Whangarei has the highest exclusive breastfeeding rate on discharge for all secondary units in New Zealand at 94.3%.

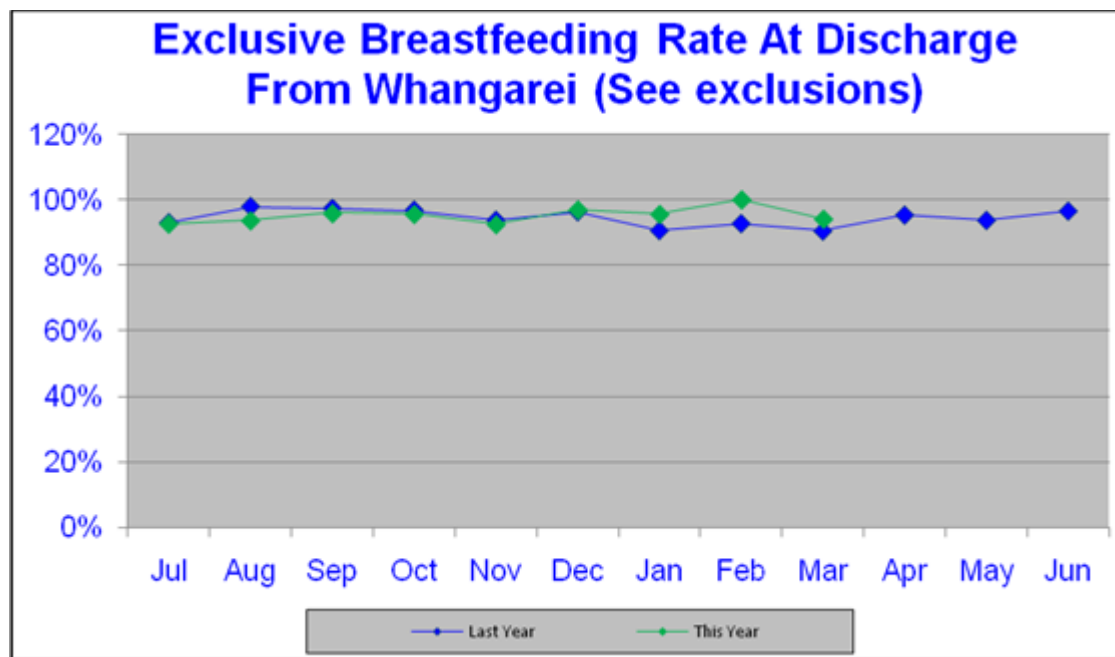
On-going breastfeeding support is offered through the provision of antenatal and postnatal care which includes free lactation consultant assessment as required. Additionally, all women on our maternity ward are seen by a Lactation Consultant each day. We provide free on-going community Breastfeeding clinics Tuesday/Thursday 10.00 -14.00hrs. These are well attended with an average of 10-15 women/partners/Whanau attending. The breastfeeding policies and protocols are currently under review and due to go out for consultation.

As part of this we are also developing Baby Friendly Community Initiative (BFCI), which aims to increase the exclusive breastfeeding rates and duration of breastfeeding rates in Northland. We have a steering committee, and have developed a policy which is currently under review.

We are also providing education for health workers employed by NDHB to gain BFCI accreditation for both the Whangarei Hospital Children's ward and Child Health Centre for 2014. We are currently developing an innovative on-line (Moodle) education service for NDHB employees which we anticipate can be used by PHOs in the future.

We are currently using HEHA funding provided by the Ministry of Health to develop and educate breastfeeding champions in the community who will share their knowledge and support women, partners and Whanau targeting Maori communities to breastfeed exclusively for six months and for up to two years. This programme involves training peer supporters in the community to provide consistent, evidence-based support alongside embodied knowledge and will run until June 2014.

Figure 15 – Exclusive breastfeeding rates on discharge



Exclusions: Babies who go to SCBU, Stillbirths & deaths, B.F status not recorded

Northland SUDI (Sudden Unexpected Death of an Infant) Prevention Project

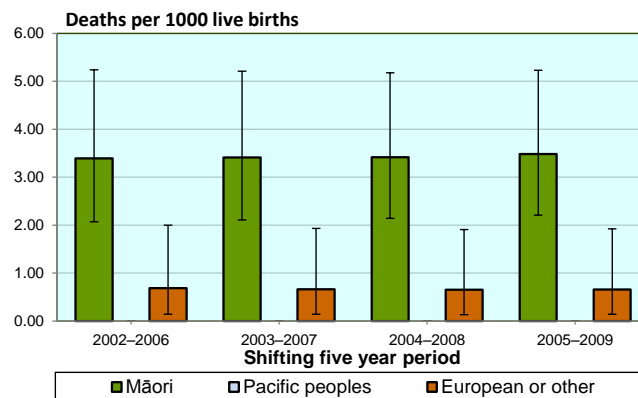
Project Vision: To make every sleep a safe sleep for all infants

Project Outcome : A significant reduction in the 5 year rolling average of SUDI related deaths per 1000 live births for Maori (3.48:1000) toward that of non Maori (<0.5:1000) by December 30 2017.

Context

Northland has one of the highest rates for SUDI in New Zealand with 68.3% of the deaths occurring in infants aged 28 days to less than one year being coded as SUDI during 2004–2009. Currently the five-year rolling average mortality rate for Maori due to SUDI is 3.48 per 1000 live births (2005–2009) Rates of SUDI in Maori are significantly higher than Non- Maori as demonstrated in the data in figure 26.

Figure 16 - SUDI mortality (rate per 1000 live births and 95% confidence interval) by five-year rolling average rate, Northland 2002 – 2009 (n=41 deaths)



Source: *Numerator:* Mortality Review Database; *Denominator:* NZHIS Live Births 2002–2009

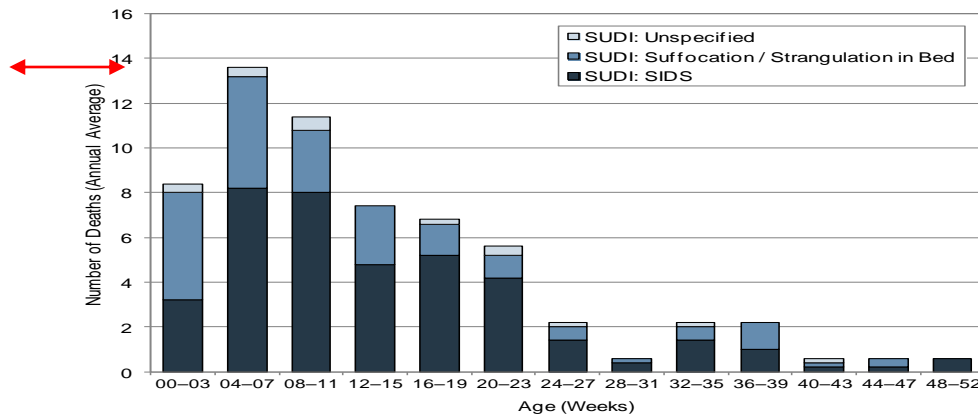
Figure 17 - Sudden Unexpected Death in Infancy, Northern region vs. NZ 2004 - 2008

DHB	Number: Total 2004- 2008	Number: Annual Average	Rate per 100,000	Rate Ratio	95% CI
SUDI in Infants <1 Year					
Northland	25	5.0	222.0	2.20	1.46–3.30
Waitemata	27	5.4	72.6	0.72	0.49–1.07
Auckland DHB	22	4.4	68.4	0.68	0.44–1.04
Counties Manukau	59	11.8	139.4	1.38	1.05–1.82
New Zealand	311	62.2	100.9	1.00	

Source: *The Health Status of Children and Young People in the Northern District Health Boards November 2011*



Figure 18 - Sudden Unexpected Death in Infancy by Type and Age in Weeks, New Zealand 2004–2008



Source: The Health Status of Children and Young People in the Northern District Health Boards November 2011

The Risk Profile for a SUDI includes Mothers who are

- Living in a High Deprivation community
- Are Maori
- <25 years of age
- Smoking during and after pregnancy (significant risk for SUDI particularly when combined with bed sharing)
- Premature infant <37/40
- Bed sharing with their baby on the same sleeping surface.
- Have experienced a previous SUDI

The SUDI project is a quality improvement project. The purpose is to undertake a multi pronged approach to reducing the risk of SUDI occurring by addressing some of the factors that potentially impact on the vulnerable infant. Some of the focus of this work is achieved through strengthening alignment and collaboration of existing projects and programmes and some through the development of new initiatives.

A SUDI Prevention Plan has been developed for Northland with key actions in the following areas:

1. Alignment with the regional SUDI strategy, including agreed principles and the development of a shared Safe Sleep Policy across the DHBs.
2. Partnership with Whakawhetu (Maori SIDS) for health professional training with evidenced and consistent messages regarding safe sleep utilising the PEPE acronym.
3. Explicit Maori leadership in direction of SUDI prevention actions in Northland
4. Alignment with Northland programmes that address issues impacting on infant vulnerability; smoking cessation, support for breastfeeding, maternal mental health, A&D issues
5. Pilot and evaluation of a SUDI prevention initiative in SCBU and Whangarei maternity Services. This includes a SUDI risk alert, targeted additional safe sleep discussion, particularly the increase risk associated with smoking and bedsharing, offer of a wahakura or pepepod, post discharge home visits, improved information sharing at points of transition of care, linkage of whanau to LMC/WCTOP and other support services.
6. Community awareness campaign; Marae based discussion forum and social media.

New Zealand Distribution by Age

In New Zealand during 2004–2008, SUDI mortality was highest in infants 4–7 weeks of age, followed by those aged 8–11 weeks and those 0–3 weeks. Of note, SUDI: Suffocation/Strangulation in Bed accounted for 57.1% of all SUDI deaths in those aged 0–3 weeks and 36.8% of SUDI deaths in those aged 4–7 weeks



Section 3- Governance

The Maternity Quality and Safety Programme was introduced by the Ministry of Health to be implemented at DHB level. In response to this NDHB have set up a Maternity Clinical Governance Group (CGG) to oversee the implementation of this plan and a Maternity Quality and Safety Programme Facilitator was employed to work 0.8 FTE. This role was developed to establish systems and infrastructure to support the following:

- Case review
- Audit process
- Strategic planning
- Annual reporting
- Review of clinical indicators
- Data monitoring
- Consumer engagement
- Stakeholder engagement
- Coordinate the implementation of MQSP.

The Maternity Clinical Governance Group is a multidisciplinary group and its key focus was the setting and communication of priorities and direction of the Quality and Safety framework. Terms of reference were established and position descriptions for the Consumer and LMC representatives were developed. Meetings were held on a 2 monthly basis until the group became established and now meetings are held every 3 months. Members of CGG include the following:

- Clinical Director of Child and Maternal Health. (Paediatrician)
- 1 Obstetrician
- 1 G.P
- Associate Director of Midwifery
- Clinical Midwife Manager
- Maternity Quality and Safety Programme Facilitator
- Midwife Educator
- Core Midwife
- NZCOM Co Chair – who is also a rural Lead Maternity Carer (LMC)
- 3 LMC's (1 from each Region)
- 2 Maori representatives from Maori Directorate
- 2 Consumers (1 Pacific representative)

The CGG reports directly to the DHB Clinical Governance Board who are sent the agenda and minutes of the CGG meetings. The Associate Director of Midwifery is a member of both groups and has responsibility for reporting on key issues to the Clinical Governance Board. The representative from each area and discipline has the responsibility to feedback to the wider stakeholder groups.

A Community maternity services liaison role was established as part of the Associate Clinical Midwife Manager Position in the community. The aim of this position is to establish and improve communication networks between DHB, Primary Health Organisations (PHO) and Non Government Organisations (NGO) stakeholders.

Consumer representatives, GP's and LMC's are paid for their time and travel to attend this group. For those members in the regional areas teleconferencing facilities are available.

In addition to the consumer representation on the CCG consumer feedback is gathered as a routine.



Section 4 – Quality improvement

Consumer feedback

There are three types of consumer feedback forms/surveys used in the Maternity unit in Northland DHB.

- Complaints/compliment form- readily available in all clinical areas.
- Patient satisfaction survey- completed for 1 month of every 3 months (appendix 4)
- Breastfeeding support surveys- offered to all women to complete at discharge (appendix 7)

All women who fill in a complaint form receive a response and follow up from the Quality and Safety department within a specified period of time and all complaints are investigated.

The consumer feedback is collated and e mailed to all stakeholders and is displayed by way of posters in the staff/office areas (Appendix 5, 6 and 9) Breastfeeding surveys are collated on a monthly basis by Maternity Quality Facilitator (Appendix 8)

A patient newsletter has been developed to close the feedback loop. Comments made by women are written into the patient information newsletter to allow women to see we take their feedback seriously. (Appendix 11)

Information gained from consumer surveys is included in the direction of service delivery.

Maternity staff have been informed by the surveys and are now more aware of the issues.

During the post natal stay we encourage staff to:

- Offer women analgesia more regularly
- Review and visit the women at least hourly during the day and 2 hourly during the night.
- Offer more frequent bed linen changes.

Consumer Survey

Standard 3-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.

It was recognised that 3.74% of women were not accessing maternity services until late in their pregnancy and there was concern that these women may not be aware of the availability of Lead Maternity carers. This data was taken from the retrospective audit completed in July 2012 in Whangarei. The data from the National Maternity collection supports this as over 50% of the women in 2011 did not book with an LMC until the 2nd and 3rd trimesters. We needed to attempt to find out if the information was not readily available to women or whether there is a possibility they chose not to book for care.

A maternity consumer survey was undertaken to find out how women were accessing information to enable them to find a Lead Maternity Carer. This demonstrated that 25% of woman in the survey did not have internet access and 50% of women found a midwife by recommendation. Only 18 of the 216 women found information on the internet.

In response to this information NDHB Maternity services have drafted a poster (appendix 12) "Finding a midwife in Northland" with free phone contact numbers for women to ring to help them find a local LMC. This will be displayed in local pharmacies, supermarkets and GP surgeries. For those women who have internet access websites are also included. This enables us to reach the wider community and also incorporates national initiatives such as the "find a midwife site" launched by NZCOM earlier this year. The plan is to repeat the survey with some modifications to see if there is a decrease in the number of women accessing care in the third trimester.



Frameworks for case review and Audit

In accordance with Standard 1, the Maternity Quality and Safety programme requires DHBs to establish systems and frameworks to support case review and clinical audit.

One of the tools used for this purpose is the Mortality and Morbidity Meeting (M&M). These meetings are intended to provide a multidisciplinary, supportive and open forum of discussion on topics of interest and perinatal loss and neonatal and maternal deaths. These are usually cases that have presented in the previous month

To ensure NDHB is maximising the potential of the meetings to meet the intended objectives and Standard, a review of the format, objectives and outcomes from these meetings should be evaluated. The following is a review of the meeting objectives and performance in meeting those objectives; identification of any issues and benefits; and a planned strategy to improve issues identified.

Overview

From a comprehensive review of the previous year's minutes and discussion with various staff members, the following key elements were identified.

- The meetings occurred on a monthly basis and were well attended.
- Cases of interest and perinatal mortality were presented. The presentations were without dedicated format and varied in content and direction.
- Meetings were a forum to discuss policy and guideline changes and the discussion would include information that would be given to the woman regarding the care recommendations for her next pregnancy
- Changes to service provision were discussed on occasions
- The meetings minuted excellent discussion points though points and actions had not been clearly identified.
- Each meeting appeared to be a stand-alone occurrence and follow up information was not disseminated or carried over to the next meeting.

Actions from Review

A small group of stakeholders drafted a new format for the meetings. This highlighted

- Changing the format to consist of 2 case reviews followed by items of interest. This allowed the variable focus and objectives to be clearly separated
- Making all records visible to all participants by storing documents and templates on the NDHB M drive. Documents include previous minutes, presentations and case. Templates include agendas, minutes, presentations and a calendar of events.
- Sending out the Agenda the week before to all stakeholders for an opportunity to consider any other business to be raised by participants.
- Identifying learning outcomes and recommendations clearly and planning action for inclusion into service provision.
- E mailing the minutes of the meeting to all stakeholders within 48 hours to allow timely verification.



- The presentations from the meetings embedded into the minutes.

New Format

All stakeholders received a draft copy of the proposed format and were invited to provide feedback. All respondents agreed to the new format and the first trial was planned for the July 2012 meeting. A few stakeholders were asked for immediate feedback following the trial and no changes were recommended at that time.

The draft format was reviewed by means of a feedback form in October 2012. Stakeholder feedback was positive and the meetings are achieving high multidisciplinary attendance.

Learning outcomes and recommendations to change in practice have seen some processes streamlined improving patient safety. Video conferencing facilities are available for midwives from regional units to participate.

Meetings to be held in Regional units are planned for this year.



Clinical Risk Management

In accordance with Strategic plan submitted to the Ministry of Health, the Maternity Quality and Safety programme requires DHBs to establish systems and frameworks to support case review and clinical audit. A process to identify and actively manage risk is also a requirement.

One of the tools currently used worldwide in Healthcare is Trigger Tool Reporting and Clinical Risk Management. This is a systematic approach used to reduce the risk of harm to patients. Risk Management is a tool for improving quality of care and is a more proactive way to manage risk rather than a reactive response following an incident. Within the wider service Clinical Risk Management links to audit, teaching, development of guidelines and facilitates service planning.

Overview

Northland DHB currently had the following risk management processes in use.

- IHI Global Trigger tool
- Quantate – computer programme for logging risk.
- Emergency planning and activation (CIMS)
- Incident reporting
- Root cause analysis
- Risk register
- Mortality and morbidity meetings
- Skills and drills training.

Benefits of Trigger Tool reporting

- Unbiased way of case selection
- Improved communication and working relationships
- Identification of quality initiatives
- Identification of trends
- Improved patient safety
- Promotion of awareness and understanding of patient safety
- Involves service providers in enhancing safety of women's health care
- Nurtures an environment that facilitates learning from patient safety incidents.
- Provides an efficient system for the collection and analysing of data
- Reinforces best practice/increases awareness of guidelines.

A computer based trigger alert form was developed and a process for case review developed. A clinical risk management project was commenced on the 4th February 2013. It is a voluntary reporting system relying on staff reporting clinical events.

Multidisciplinary case review meetings are held twice weekly to discuss trigger events. Identifying information is removed to ensure anonymity. Some process gaps have been identified and are currently under review. In response to identified trends and PMMRC recommended review we have 2 projects planned for 2013/2014

- Fetal surveillance workshops
- Transfer of clinical responsibility working group.



Guidelines and policies

The strategic plan and standard 1 of the Maternity Quality and Safety programme requires NDHB policies to be developed in accordance with National standards.

Policies and guidelines need to be developed using an organisational template and referenced to legislation and current evidence.

It was agreed at CGG to set processes to review and develop guidelines. A guidelines committee was set up in January 2013.

The purpose of this committee was to develop and review primary care guidelines and process obstetric guidelines to ensure a consistent format and to ensure all guidelines are current and placed on the DHB Clinical Knowledge Centre (CKC)

The members of this committee are:

- Associate Director of Midwifery
- 2x Associate Clinical Midwife Managers (1 is community based)
- Midwife Educator
- Quality Facilitator
- Maternity Quality and Safety Programme Facilitator
- 2x Lead Maternity Carer
- Core Midwife.
- 1 Obstetrician

Anaesthetists and Lactation consultants are opted on and off this committee when required.

Terms of reference were agreed at the first meeting with monthly meetings to be held.

Obstetric guidelines are being reviewed and updated by an Obstetrician with an interest in drafting guidelines. These are then reviewed by the Obstetric team, and once consensus is reached, the guideline is sent to the Guidelines Committee for review. Once reviewed, they are forwarded to Head of Department and Clinical Midwife Manager for final approval. Once approved it is the role of MQSP facilitator to update on CKC.

Midwives are encouraged to review and draft guidelines as part of the QLP. Midwives from the guidelines committee review all primary care guidelines and ensure they are formatted correctly. They will be agreed at committee level and sent to stakeholders for feedback with a specified time frame. Once feedback has been received and reviewed, and required alterations made, the final draft will be resent to stakeholder's. Final feedback will be incorporated and the draft sent to Clinical Midwife Manager for final approval. Once approved it is the role of MSQP facilitator to update this on CKC.

The Maternity guidelines committee is currently designing a more user friendly Maternity webpage for the CKC which will be uploaded to the system by December 2013.

It is planned that all guidelines will be reviewed, updated and current on CKC by December 2013.



Clinical Indicators

The Ministry of Health issued the 2010 clinical indicators report in 2012. The data and comparisons in this report were reviewed and a local report was drafted for the Clinical Governance Group and key stakeholders of Northland. This report advised that for those DHB'S with clinical indicators sitting outside the average parameters that and in depth review of systems and processes should be undertaken.

It was agreed at the Clinical Governance meeting that Northland DHB and Whangarei hospital were demonstrating similar outcomes to other regions and facilities in New Zealand. The small changes that were noted nationally were also apparent in Northland.

It was noted that the premature birth rate had remained static. A reduction in babies being born before 37 weeks gestation is a performance measure in the Northland health Service Plan 2012-2017.

In the 2010 Clinical Indicators report none of the measures for Northland and Whangarei were significantly different when benchmarked against other DHB's and also when benchmarked against the 2009 report.

No quality Initiatives derived specifically from this report.

The 2011 Clinical Indicators have subsequently been published and some areas for investigation were highlighted:

- Although the SVB rate in the standard primipara is still above average it has reduced by 7.5%
- The instrumental delivery rate increased by 5.2%
- The Caesarean Section rate increased by 2.3%
- Episiotomy rate increased by 9.4%

Having had some general discussion about the reasons for the changes from 2010 to 2011 it appears it could be attributed to having a number of locum obstetricians at this time. Whangarei currently has a full complement of permanent obstetricians therefore it is anticipated this is not a trend. This will be monitored and reviewed when the 2012 Clinical Indicators are released.

Maternity Dashboard- local clinical data

In accordance with the strategic plan the CGG agreed a dashboard of clinical indicators for Maternity services was to be developed. NDHB had a dashboard of clinical indicators for Maternity Services; however, this could only be accessed at management level and was not able to be reviewed at a clinical level to identify trends and identify quality initiatives.

A second maternity dashboard has been developed. This dashboard is situated on hospital intranet page. This dashboard has the following information incorporated in a number of graphs:

- Northland Birthing numbers
- Whangarei birthing numbers
- Kaitaia birthing numbers
- Bay of islands birthing numbers
- Number of woman booking after 36 weeks
- Vaginal birth rates
- Instrumental delivery rates
- Caesarean section rates (elective and emergency)
- Intervention rates (Epidural, Artificial rupture of Membranes)
- Perineal trauma rates
- Post Partum haemorrhage rates.
- Breastfeeding rates.

It is expected that stakeholders will review the data and maternity quality initiatives will be developed.

Future developments will include some of this data to be reviewed at consumer level



Referral guidelines

In response to the referral guidelines we do not have a referral policy as such but Lead Maternity Carers are expected to use the 2012 guidelines to make decisions about referral as this is mandatory. The woman needs to know this and may choose not to be referred but that discussion needs to be documented.

The protocol for regional maternity transfer of pregnant, labouring or post natal women from the regional maternity units to Whangarei secondary unit or to a tertiary unit was reviewed and revised. This policy has now undergone an update from the previous transfer and retrieval process issued in 2007 and is situated on CKC.

Documentation of Referral

The referral guidelines also require appropriate documentation surrounding transfer of clinical responsibility. This process was highlighted as an issue in NDHB from the clinical risk management process. A document was drafted for the transfer of care of woman/baby from primary to secondary care and the plan was to trial this form for 3 months, and request feedback from stakeholders. The form is based on the communication tool SBAR. (Situation, Background, Assessment and Recommendations), and is used to aid effective communication and documentation on transfer.

No-one completed this form on transfer of responsibility.

A transfer of clinical responsibility working party is to be established looking at the referral guidelines and establishing a robust process for documentation. This working party will consist of LMC representatives, obstetrician, core midwives, midwifery management and MQSP facilitator.

SBAR has recently been introduced to NDHB Midwifery Services as an aid to verbal handover.

Communication tool cards have been developed and given to all Maternity Staff. Education workshops have been held to encourage stakeholders to use this tool.



Review of post dates induction process

Research supports Induction of Labour for uncomplicated post date pregnancies, after 41 weeks gestation and before 42 weeks gestation to reduce the risk of perinatal mortality.

The current system in northland DHB is to book women into the antenatal clinic nearest to where they live prior to 41 weeks gestation to have the discussion with the obstetric team and arrange a date to present to the maternity unit in Whangarei for IOL.

A short snap shot audit was undertaken to review the number of women who attended clinic for a post dates consultation and then subsequently delivered prior to the agreed induction date. The numbers are demonstrated in figure 29

Figure 19 - Short snap shot audit of IOL from Jan-June 2012

Number of post date IOL booked through Whangarei ANC	161 women	
Number of women delivered prior to their IOL date	53 women	33%
Number of women booked for IOL between 41weeks and 41+4weeks gestation	118 women	73%
Number of women booked at 42 weeks gestation for IOL	8 women	4%
Number of women birthed before 41+4 weeks gestation	33 women	20%

The aim of NDHB is to achieve standard 2 of the MQSP ensuring that a woman centred approach acknowledges pregnancy and childbirth as a normal life stage. It was recognised that women often have an IOL consultation and then birth their babies prior to the IOL occurring. Suggestions were put forward by staff to see if our current services were women focused or if NDHB should move to a virtual clinic system for booking uncomplicated post dates IOL. Surveys were completed and the results collated (appendix 8).

Conclusion

Although the idea of a virtual clinic for booking an IOL is favoured by LMCs, neither the Obstetricians nor the women in this study support this view. This was not the expected outcome of the audits. As a consequence the current system of visits to the Antenatal Clinic is to continue at this time. This will need to be explored further to ensure it offers consistency to the women and facilitates the attendance of LMC's at appointments to allow the three way discussions to occur as per the referral guidelines

In addition, the use of GROW charts in Northland needs to be encouraged, as per PMMRC and NZCOM recommendations, to ensure consistent care for women.



Section 5 : Deliverables for 2013/2014

Objective	Strategy	Outcome	Review date
Review of Maternal mental Health Services in Northland	<p>Multidisciplinary focus group will be identified.</p> <p>Key stakeholders will map the women's journey</p> <p>Review of current systems and processes</p>	<p>will inform areas to be addressed</p> <p>Women will have access to appropriate services to address their needs.</p>	July 2014
Evidence based guidelines will be updated and easily accessible on Clinical Knowledge Centre	<p>Multidisciplinary Guidelines Committee has been established.</p> <p>Maternity guidelines will be reviewed and updated in alignment with National guidelines.</p> <p>Clinical Knowledge Centre will be more user friendly</p> <p>Web pages will be designed to improve access to guidelines.</p>	<p>Regional guidelines will be current.</p> <p>Regional guidelines will be aligned with national guidelines</p> <p>Regional guidelines will be easily accessible.</p>	December 2013
Clinical Risk Management Project process will be evaluated	<p>Stakeholders will be surveyed</p> <p>Attendance at review meetings will be reviewed</p> <p>Triggers will be reviewed</p> <p>Review of current process</p>	<p>Clinical Risk management will become a part of business as usual</p> <p>Trends will be identified and investigated</p> <p>Quality improvement initiatives will be identified</p>	August 2013
Breastfeeding community initiative (BFCI) will be progressed	<p>BFCI Co-ordinator has been employed.</p> <p>Policies and guidelines will be developed</p> <p>Education packages</p>	<p>NDHB will work towards achieving BFCI status in Whangarei</p>	July 2014



	are being developed Breastfeeding education champions for the community are being developed		
Objective	Strategy	Outcome	Review date
Health point will be updated	Associate Community Midwife Manager has been employed Review of current information on Health Point for consumers Information and guidelines for GP's regarding early pregnancy care to be updated Link to find your midwife website to be developed	Consumers will have up to date information about Maternity services in Northland GP's will have access to current evidence based guidelines regarding early pregnancy care Women will have access to information to aid then to find a midwife	July 2014
Decrease in the number of babies born before 37 weeks gestation	Identify causes of premature birth in Northland Work across the sector to increase health messages	There will be an increase number of babies born between 37 and 42 weeks gestation.	July 2014



Updated Strategic Plan



Key Result Area: Governance

Strategic Intent

A clinical Governance Framework is developed and implemented to support a quality focused Maternity service.

Date	Objective	Strategy	Outcome	Date of review/completion
March 2012	Establish Clinical Governance frameworks for Maternity Services.	TOR were developed and agreed. Position profiles for consumer and stakeholder representatives were developed. Maori representation was achieved. Stakeholder membership was achieved. Consumer representation was achieved. Clinical leaders were identified.	Clinical governance frameworks are consistent and reflect current service provision Consumer and Stakeholder representation is reflective of the community	completed 30/06/2012 Completed 30/06/2012
March 2013		Setting and communicating of priorities is ongoing	Priority settings and decision making frameworks are explicit and include input from consumers and key stakeholders	Ongoing
March 2013	NDHB policies are developed using national guidelines and recommendations.	Guidelines committee has been established. January 2013 Stakeholder involvement is achieved TOR have been agreed Approval process has been established. Authors of guidelines identified	Guidelines are developed utilising national guidelines and recommendations. All DHB maternity guidelines will be: Referenced and linked to legislation Use organisational template and in line with organisational process. System maintained to identify review date.	Ongoing For review December 2013



Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	Establishment of processes to identify and actively manage risk.	A trigger tool has been developed to identify clinical risk and to alert the service to developing trends.	Proactively monitor information to identify trends for Quality and Safety improvement	Ongoing
		Twice weekly case review meetings have been established.	A review of outcomes from case reviews will be conducted producing local data.	Review and evaluate August 2013
		Mortality and Morbidity meetings are used to identify learning outcomes, recommendations for practice and planning actions for inclusion into service provision	Promotion of multidisciplinary discussion.	Ongoing
			Team building	Ongoing
		Overview of Incidents and complaints undertaken by Clinical Midwife Manager	Education	
			Identifying areas for improvement	Ongoing
		Patient Satisfaction surveys have been completed	Incidents will be used to indicate areas for quality improvement.	Ongoing
			Data from surveys used to identify areas for quality improvement by highlighting gaps in processes.	Ongoing
			Staffing levels are appropriate to provide high quality safe maternity Care	Ongoing
		Trend Care is used to assess workforce capacity		Ongoing



Key Result Area: co ordination and administration

Strategic Intent;

The Maternity Service is Quality and Safety focused and committed to improving women's care

Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	To implement the Maternity Quality and Safety frameworks.	<p>A Maternity Quality and Safety programme facilitator was appointed June 2012</p> <p>Systems and infrastructure are being established to support:</p> <p>Case review</p> <p>Audit process</p> <p>Strategic quality planning</p> <p>Oversight of annual report</p> <p>Clinical Indicators</p> <p>Data monitoring</p> <p>Consumer and Sector Engagement</p>	<p>Coordination and Administration of the Maternity quality and Safety plan is being implemented at NDHB maternity services</p>	<p>June 2012</p> <p>Ongoing.</p>
March 2013	Community Maternity Services Liaison role is established	The role of the Community Associate Clinical Midwife Manager includes the responsibility to establish and improve communication networks between DHB, Primary health Organisations and Non Government Organisations.	Improved interface between community and hospital services.	<p>New community Midwife manager appointed To start March 2013</p> <p>Ongoing.</p>



Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	Clinical Leaders are informed and engaged in the implementation of the Quality and Safety Framework for Maternity Services	<p>Key leaders are identified.</p> <p>Specific areas of focus have been developed.</p> <p>Maternity unit is working towards establishing quality and safety as business as usual.</p> <p>Key performance indicators are being achieved.</p>	<p>Priorities are communicated.</p> <p>Stakeholders are informed</p> <p>Stakeholders are given opportunity to contribute to discussion and decision making</p>	Ongoing.

Key Result Area: Stakeholder engagement

Strategic Intent:

To improve engagement of the Health Sector in the Maternity Quality and Safety Programme.

Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	Develop and enhance communication and information networks.	<p>Required networks are to be identified.</p> <p>Infrastructure needs to be available to support identified networks.</p> <p>Health Point website is developed in collaboration with Key Stakeholders.</p>	Maternity service networks are improved to support the interface between hospital and community services.	Ongoing



Date	Objective	Strategy	Outcome	Date of review/completion
March 013	To work collaboratively with the Maternity Sector.	<p>Key stakeholders are involved in monitoring and improving accessibility to current Maternity information,</p> <p>Emergency response plans are audited and findings are fed back to relevant services.</p> <p>Education provided/organised by the Midwifery Educator is collaborative and accessible</p> <p>Services provided for access agreement holders are monitored.</p> <p>Opportunities are given to access agreement holders to feedback to service provider.</p>	<p>Collaboration occurs across the sector to ensure That Maternity services are inclusive of all providers and users.</p> <p>Quality and Safety improvements occur in response to review of emergency response plans.</p> <p>Education opportunities reflect current need e.g. SUDI workshops.</p> <p>Skills and Drills training and in service training</p> <p>Organising compulsory education</p> <p>Improved relationships and collaboration with access agreement holders</p>	<p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>
March 2013	Improve access for Maternity Stakeholders to Health Point.	<p>Health Point to be used to engage stakeholder networks.</p> <p>Health Point site includes NDHB Maternity Services.</p> <p>Obtain feedback from users.</p> <p>Information for GP's to be updated</p> <p>Report to Maternity Clinical Governance</p>	<p><i>Health Point to be current.</i></p> <p><i>Health Point page to be updated</i></p> <p><i>Feedback from e forums is utilised to direct Quality and Safety Programme</i></p>	<p>Ongoing</p> <p>December 2013</p> <p>December 2013</p>



Strategic intent:

Data collection is accurate and used in to identify Quality Initiatives

Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	To compare NDHB outcomes against benchmarked MoH data	<p>Audits have been undertaken and results reported and discussed at clinical Governance Group.</p> <p>Areas of focus were identified:</p> <p>Late booking</p> <p>Primary unit birthing numbers</p> <p>IOL processes</p> <p>How do women access information</p> <p>Trends are monitored for quality improvement</p>	<p>NDHB outcomes for maternity service are comparable to national data.</p> <p>Audit complete</p> <p>Audit complete</p> <p>Audit in progress</p> <p>Survey completed</p> <p>Poster for information on how to find a midwife currently being developed</p>	<p>Ongoing</p> <p>July 2012</p> <p>September 2102</p> <p>May 2013</p> <p>October 2012</p> <p>July 2013</p> <p>Ongoing.</p>
March 2013	<p>To Develop a dashboard of clinical Indicators for the Maternity service</p> <p>Information will be available to consumers and the wider sector</p>	<p>Dashboard for management review already in place</p> <p>Dashboard of Maternity data available on hospital intranet for clinician review</p> <p>Trends will be reported to the Clinical Governance Group</p>	<p>NDHB has 2 dashboards of up to date Maternity data that are relevant to maternity care</p>	<p>June 2012</p> <p>April 2013</p> <p>March 2014</p>



Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	An audit Schedule is developed to monitor NDHB adherence to MoH NZ Maternity Standards	<p>Priorities are identified.</p> <p>Implementation plan is developed.</p> <p>Incidents are monitored.</p> <p>Outcomes are monitored.</p> <p>Compliance is monitored.</p> <p>Will advise on system and process changes.</p> <p>Evaluate effectiveness</p>	NDHB adherence to MOH NZ Maternity Standards	Ongoing
March 2013	Evaluation will be an integral component of all changes within the service	<p>Planned projects/change management identify evaluation pathways.</p> <p>Evaluation is undertaken utilising SMART principles</p>	Reports completed and evaluations identify effectiveness of the changes and areas for improvement	Ongoing

KEY RESULT AREA: information and communication systems

Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	Information and communication systems are developed to improve access to local information and communication systems for all hospital and community based clinicians	<p>Health point is further developed to provide a web based public information system for maternity services</p> <p>Facilitate the development of web page for stakeholder and community discussions</p>	Key Stakeholders are informed on DHB progression towards meeting the Maternity Quality and Safety programme	Review July 2013



KEY RESULT AREA: Consumer Engagement

Strategic Intent:

To support the participation of consumers in the Maternity Quality and Safety Programme

Date	Objective	Strategy	Outcome	Date of review/completion
March 2012	To engage Consumer involvement into the implementation of the Maternity Quality and Safety framework	Processes were instigated to enable Consumer participation in Clinical Governance Group. Position descriptions meeting frameworks and communication networks for consumer representatives have been developed.	There is consumer representation on Clinical Governance Group	Completed 30 th June 2012
March 2013	Be consumer focused in the development of the Quality and Safety framework	Build on and improve communication with consumer and consumer groups. Engage primary maternity service users Further develop consumer feedback processes	Improved interface between women and child health providers, and consumer/ consumer groups	Ongoing
March 2013	To provide culturally appropriate services to Maori and other ethnic Groups to honour Treaty of Waitangi	Te Poutukomanawa acts as an advisor to the Clinical Governance Group. Guidance is sought with Maori Consumers and representatives.	Maternity Services provide culturally appropriate services to meet the needs of Maori and Other Ethnic groups.	Ongoing



Date	Objective	Strategy	Outcome	Date of review/completion
March 2013	Consumer satisfaction surveys inform service delivery	<p>Consumer satisfaction surveys are completed every 3 months over a 1 month period</p> <p>Breastfeeding surveys are offered to all women on discharge</p> <p>Complaint/compliment forms are available in each clinical area.</p> <p>Data is collated from these surveys and informs future direction of service delivery</p> <p>Feedback to consumers and community agencies.</p>	<p>Information gained from consumer surveys is included in the direction of service delivery.</p> <p>All staff are e mailed a copy of the reports and posters are displayed in staff/clinical areas.</p> <p>Areas for improvement are highlighted.</p> <p>Patient information newsletter has been developed and feedback from surveys is included in this newsletter to close the feedback loop</p>	<p>Ongoing</p> <p>3 monthly</p> <p>3 monthly</p> <p>Bi monthly</p>



APPENDIX

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Appendix 1

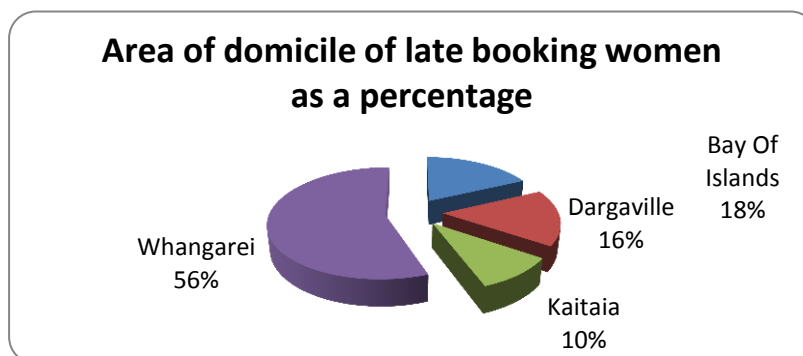
Women who book for care after 36 weeks gestation birthing in Whangarei

A retrospective review of local data in 2012 demonstrated that in Whangarei hospital, 73 of the women who birthed were booked with a care provider after 36 weeks gestation or unbooked at the time of delivery. 12 of these women were from out of area and had care with an LMC elsewhere so were excluded from this study. 61 women remained. This represented 3.74% of our birthing population.

Area of domicile was examined and the results demonstrated

- 55.7% (34) of the women lived in Whangarei
- 9.8% (6) of the women lived in Kaitaia
- 16.3% (10) of women lived in Dargaville
- 18.03% (11) lived in Bay of Islands.

Figure 1-area of domicile of late booking women

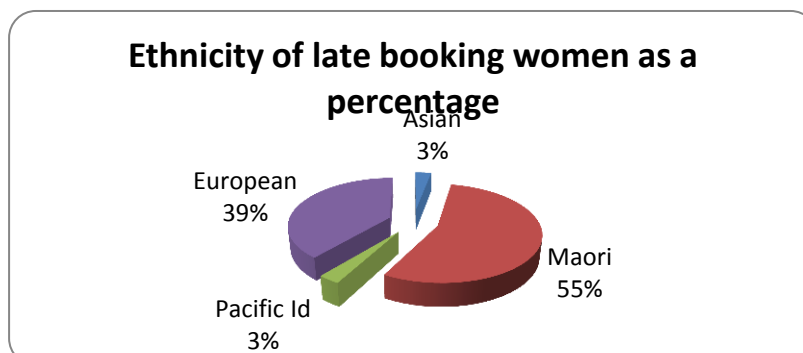


Ethnicity of women booked after 36 weeks was reviewed:

- 55% (33) women identified themselves as Maori
- 39% (24) women identified themselves as European
- 3% (2) women identified themselves as Asian
- 3% (2) women identified themselves as Pacific Island.

This data corresponds directly to our birthing population numbers for ethnicity

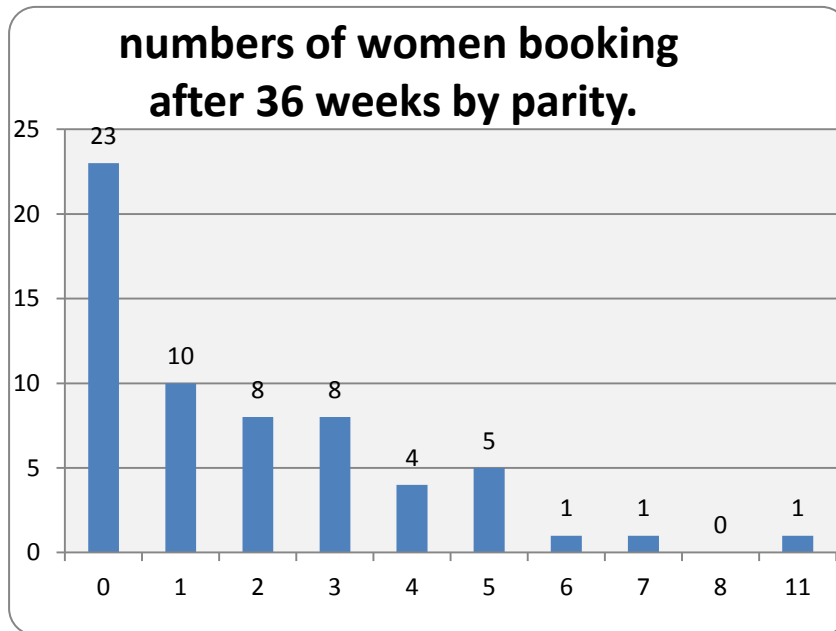
Figure 2 –Ethnicity of women booked after 36 weeks





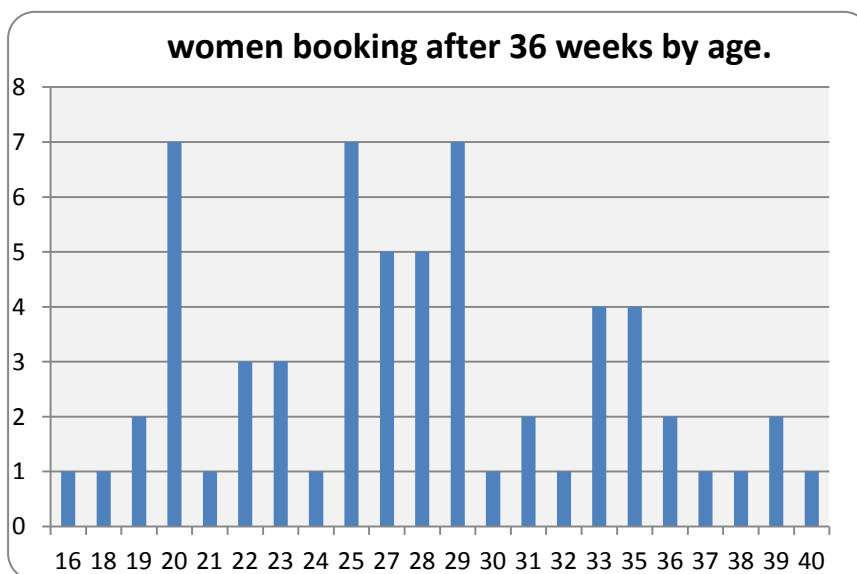
Parity of the late booking women was reviewed. 39% (23) of the women were primigravida and the other 61 % were multigravid. Number of births is on the vertical axis and parity along the horizontal axis

Figure 3 - women booking after 36 weeks by parity



The age range of women booking late for care i.e. for care after 36 weeks was also reviewed. 64% (39) of the women were 20-29 years old. This is demonstrated in Figure 15 number of women is demonstrated on the vertical axis and age along the horizontal axis.

Figure 4 - women booking over 36 weeks by age





27 women who booked after 36 weeks had care provided by a LMC in labour

34 women who booked after 36 weeks had labour care provided by core midwives



Appendix 2

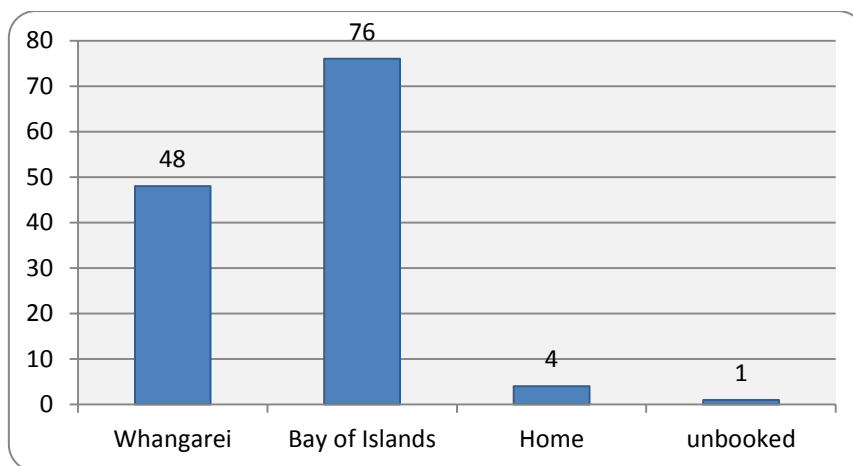
Why women living in the Bay of Islands are birthing in Whangarei Hospital

Results

55 women were having their 1st baby and 74 women were multiparous. This is consistent with the regional demographic data.

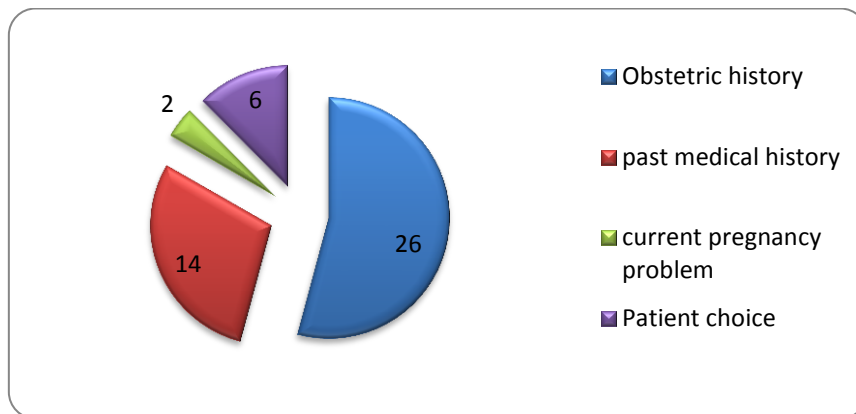
Figure 1 demonstrates in which facility the women were originally booked to birth. 48 of the 129 women were booked to birth in Whangarei and 76 women were booked to birth in Bay of Islands and were either transferred in pregnancy or in labour. 1 woman was unbooked.

Figure 1 – original place of booking



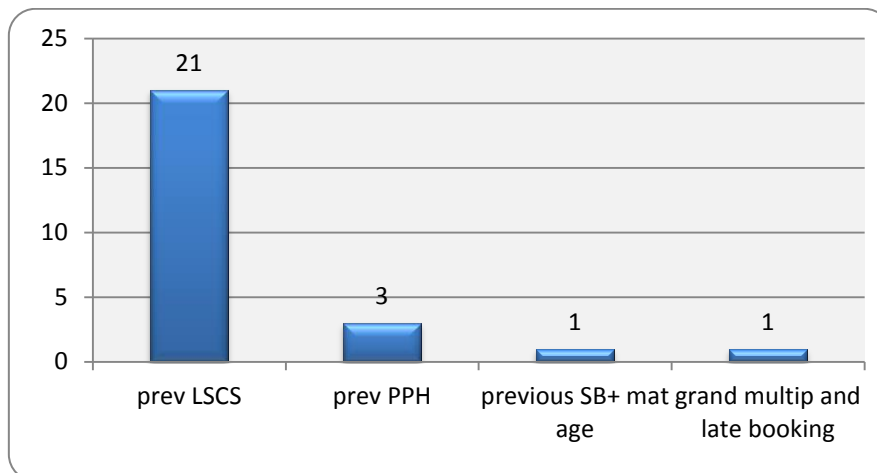
The next part of the audit looked at why the women were booked in Whangarei hospital to birth rather than in booking to birth in the Bay of Islands. The reasons were divided into 4 categories. These were obstetric history, medical history, current pregnancy problem or patient choice. The most common reason for women booking in Whangarei was obstetric history. This accounted for 54% (26) of the women who booked in Whangarei. 29% (14) of the women had medical complication and only women 12.5 % (6 women) chose to book in Whangarei and 4% (2) others had twin pregnancies. This is demonstrated in Figure 2

Figure 2-Reasons for booking in Whangarei



The next series of graphs explores each category in more depth. They look at the different obstetric reasons for booking in Whangarei, followed by the medical reasons for booking in Whangarei. The final of these 3 graphs gives a breakdown of the reasons women have chosen to book in Whangarei. On occasions where a woman had both an obstetric and medical reason for booking in Whangarei the obstetric reason took prevalence. e.g. 1 woman had a previous LSCS and a BMI over 35. If a woman had 2 obstetric reasons for booking in Whangarei the one with the highest priority took precedence e.g. 1 woman had a previous LSCS and previous PPH. The most common obstetric cause for booking in Whangarei was previous caesarean section (LSCS). This accounted for 81% of the 26 women who had obstetric reasons for booking in Whangarei. This is clearly demonstrated in Figure3

Figure 3 - Obstetric reasons for booking in Whangarei (numbers)



14 women booked in Whangarei to birth because of medical history. The most common reason was Diabetes which accounted for 35.7% of the 14 women. Hypertension was the next most common reason but this accounted for only 3 women. The graph below details the variety of medical reasons that booking in a secondary care facility was required

Figure 4 – Medical reasons for women booking in Whangarei

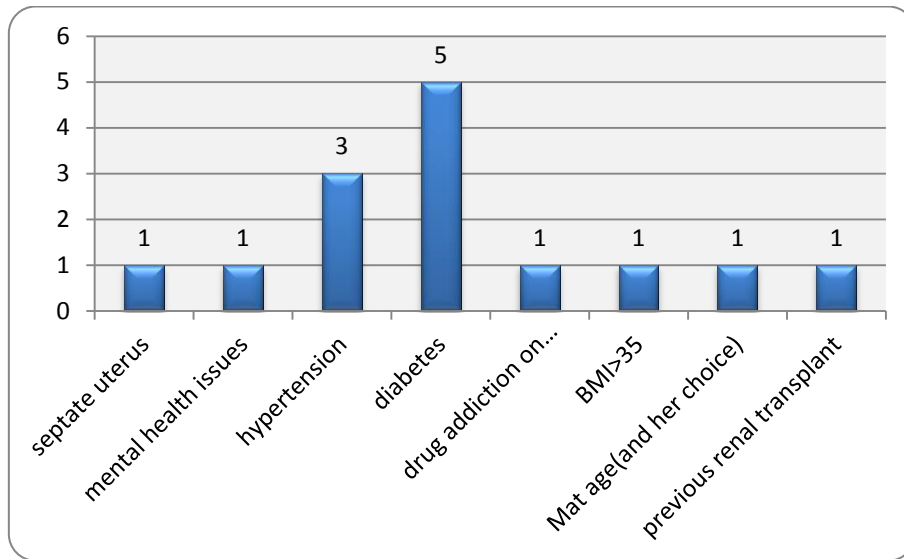
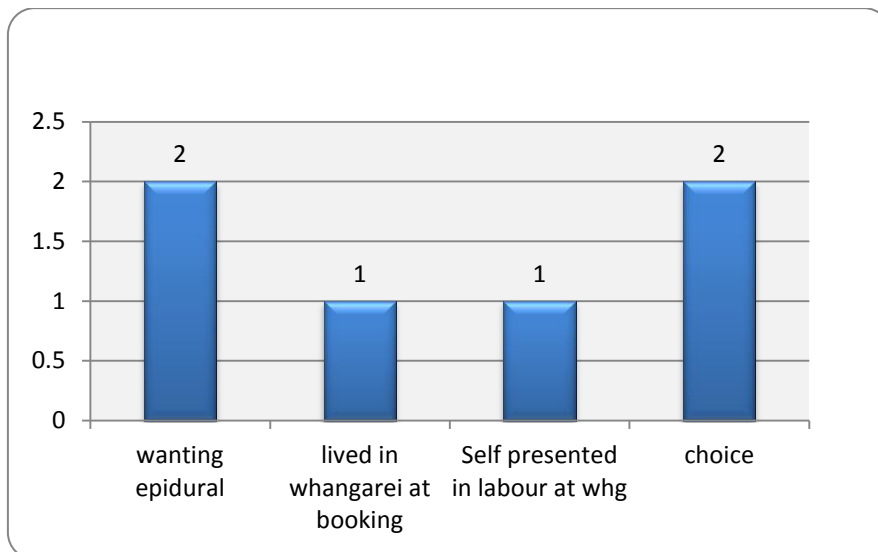


Figure 5 demonstrates that only 6 women actually chose Whangarei as their facility for birth. 2 of these women identified themselves as wanting an epidural. 1 woman had lived in Whangarei at booking and had moved in pregnancy but chose to remain in partnership with her LMC in Whangarei. One of the ladies self presented in labour and the other 2 it was their facility of choice but the reason for this was not documented.

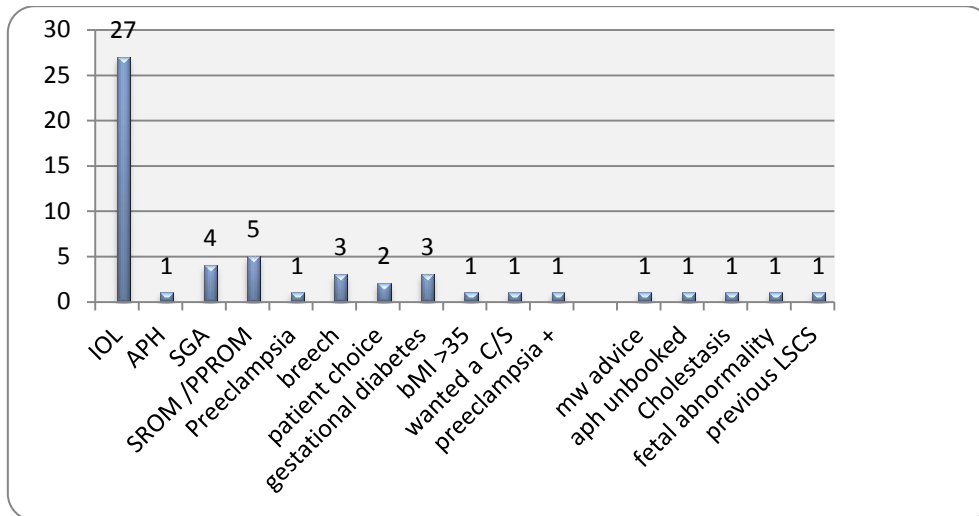
Figure 5 - reasons why women chose to birth in Whangarei



54 of the 129 women had their booking facility changed during their pregnancy. This is nearly 67.5% of the 76 women who booked originally to birth in Bay of Islands. 50% of these women had care facility changed due to requiring a post dates induction of labour. The second most common reason was SROM/PROM which accounted for 5 of the women transferred in pregnancy. Again, there was a variety of reasons for the transfer of women from Bay of Islands to Whangarei to birth. It was interesting to note that 2 women changed facility because of choice. One of these women moved so she could request a LSCS but had the request declined. (had a number of previous uncomplicated deliveries) the other moved from Bay to Whangarei and changed facility of booking. The reasons for transferring facility in pregnancy are shown in Figure6

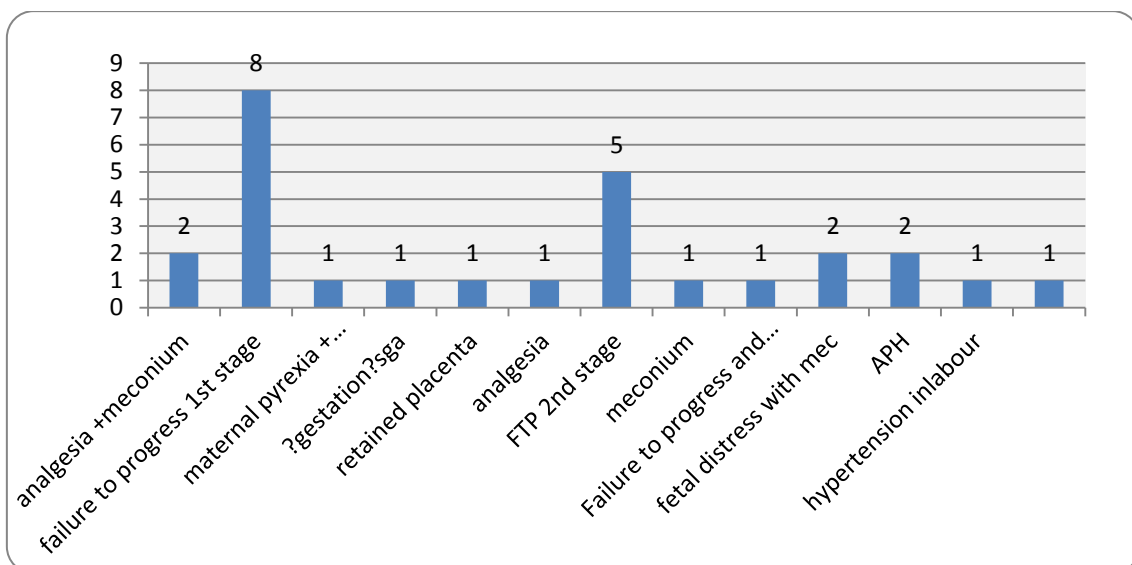


Figure 6 - reasons for women transferring facility during pregnancy.



There were 27 women who transferred from Bay of Islands to Whangarei in labour. 29.6% of the transfers in labour were due to failure to progress in the 1st stage of labour and 18.5% were due to failure to progress in 2nd stage of labour. Some women had more than one indication to transfer to a secondary care facility. This is demonstrated below.

Figure 7 - Transfers of women in labour



Also highlighted in the audit were 6 women who had booked in Bay of Islands and their place of booking was changed in pregnancy to Whangarei. These women were included in the figures for change of booking facility in pregnancy. They presented to Bay of Islands hospital in labour and were then also transferred in labour but have not been included in the graph above as place of transfer had already been documented.



Appendix 3

Why women living in Kaitaia birth in Whangarei hospital

In 2009 the Government agreed to the development of the Maternity Quality Initiative which included the establishment of a Maternity Quality and Safety Programme.

Northland DHB is committed to ensuring services are delivered with Quality and Safety as a focus and have therefore adopted the Maternity Quality and Safety Programme as framework for ongoing systematic review by multidisciplinary teams working together to identify potential improvements for delivery of maternity services. The Maternity Standards state that services should be consistent with national and regional plans and be accessible and appropriate for the local population.

The numbers of women birthing in Kaitaia have remained constant over the last three years. The purpose of this audit is to identify the reasons why women who live in the Kaitaia area are birthing in Whangarei hospital. A recent audit in the Bay of Islands hospital suggested that most of the women birthing in Whangarei had an obstetric or medical reason for doing so. It is expected the outcome of this audit will be similar. Local data demonstrates from July to December 2012 there were 49 women residing in Kaitaia who birthed in Whangarei hospital. 16 women booked in Whangarei and 25 women booked in Kaitaia 15 women transferred to Whangarei during pregnancy and 10 of the women were transferred in labour.

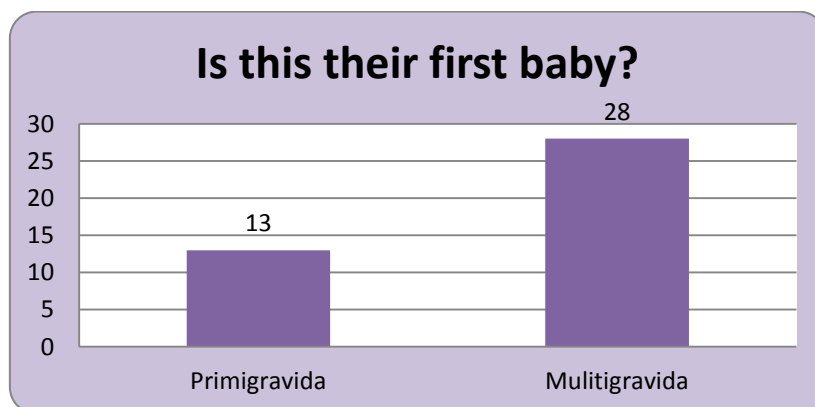
A retrospective audit was completed to identify the reasons women were birthing in Whangarei rather than in their local primary unit. The audit particularly attempted to identify whether it was patients choice or medical/obstetric complications that influenced the place of booking.

The audit tool developed for the Bay of Islands audit was used. A nurse in Kaitaia hospital reviewed the notes and completed the audit forms. The completed forms were returned to the Maternity Quality and Safety Programme facilitator for interpretation.

There were 41 completed audits for women residing in Kaitaia who birthed in Whangarei. There were 7 women who were recorded as living outside Kaitaia so they were excluded from the final results. We do not have the data for 1 woman.

Results.

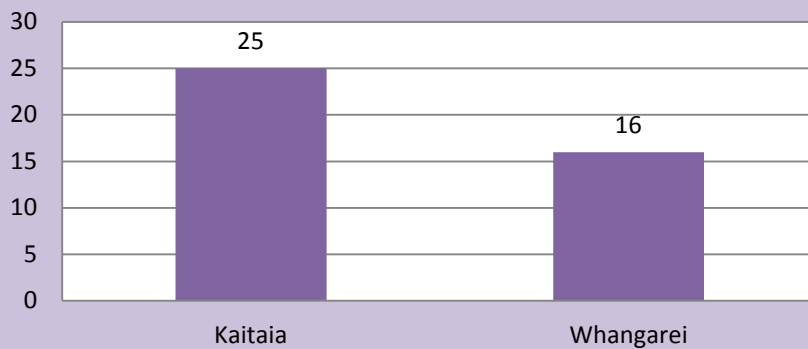
13 of the women were primigravida and 28 of the women were multigravida. This is consistent with regional data.



16 (39%) of the 41 women were booked to birth in Whangarei and 25 (61%) women were booked to birth in Kaitaia and were either transferred in pregnancy or in labour. There were no unbooked women and no women booked for a homebirth who transferred.

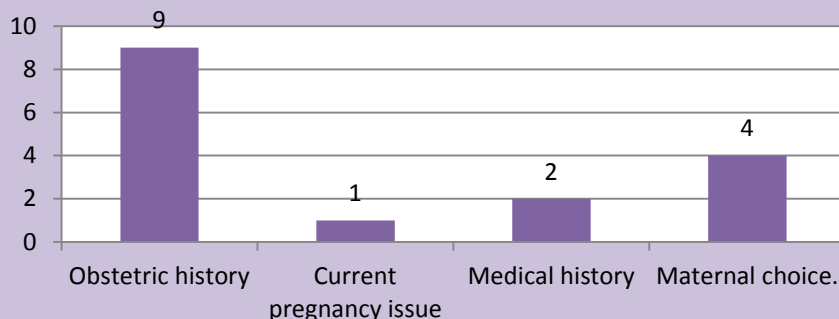


Original place of booking



The audit reviewed the reasons women were booking in Whangarei hospital rather than the local primary Unit in Kaitaia was broken down into 4 Categories. These were obstetric history, medical history, current pregnancy issues or patient choice. Obstetric history was the most common reason for women booking in Whangarei .9 (56%) of the 16 women booked in Whangarei because of Obstetric history. 4 (25%) chose to book in Whangarei, 1(6%) women had a twin pregnancy and 2 (12%) women had medical problems.

Reasons for booking in Whangarei.

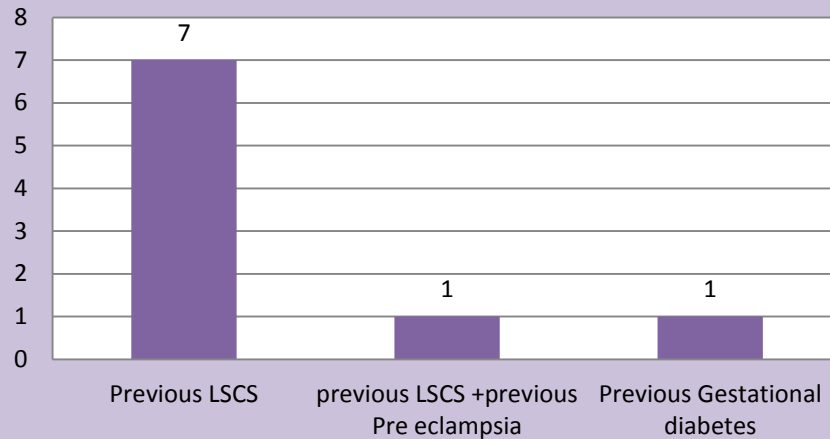


Whangarei was the facility of choice for 4 (25%) of the 16 women.1 of these booked with a LMC from Whangarei, 1 had a previous epidural and Ventouse delivery and was not confident to birth in Kaitaia,1 women had experienced 2 previous growth restricted babies and 1 gave no reason for her choice.

The most common obstetric reason for women booking to birth in Whangarei hospital is previous caesarean section. 8 (88%) of the 9 women who booked in Whangarei had undergone a previous caesarean section. One woman had the added complication of previous Pre eclampsia. The only other obstetric reason was previous gestational diabetes.



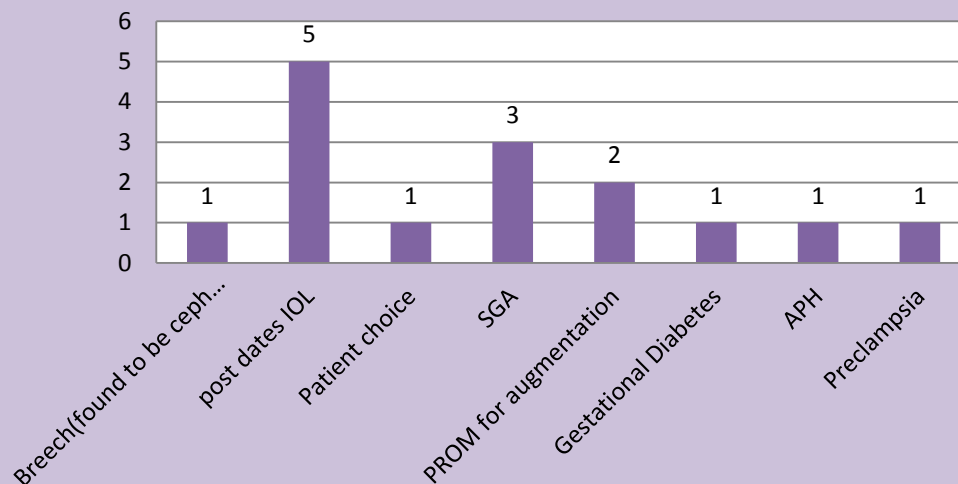
Obstetric reasons for booking in Whangarei



There were only 2 women who booked in Whangarei because of medical reasons. 1 woman was Diabetic and had Graves Disease and the other had severe Vulvodynia. 1 woman booked in Whangarei as she was having twins.

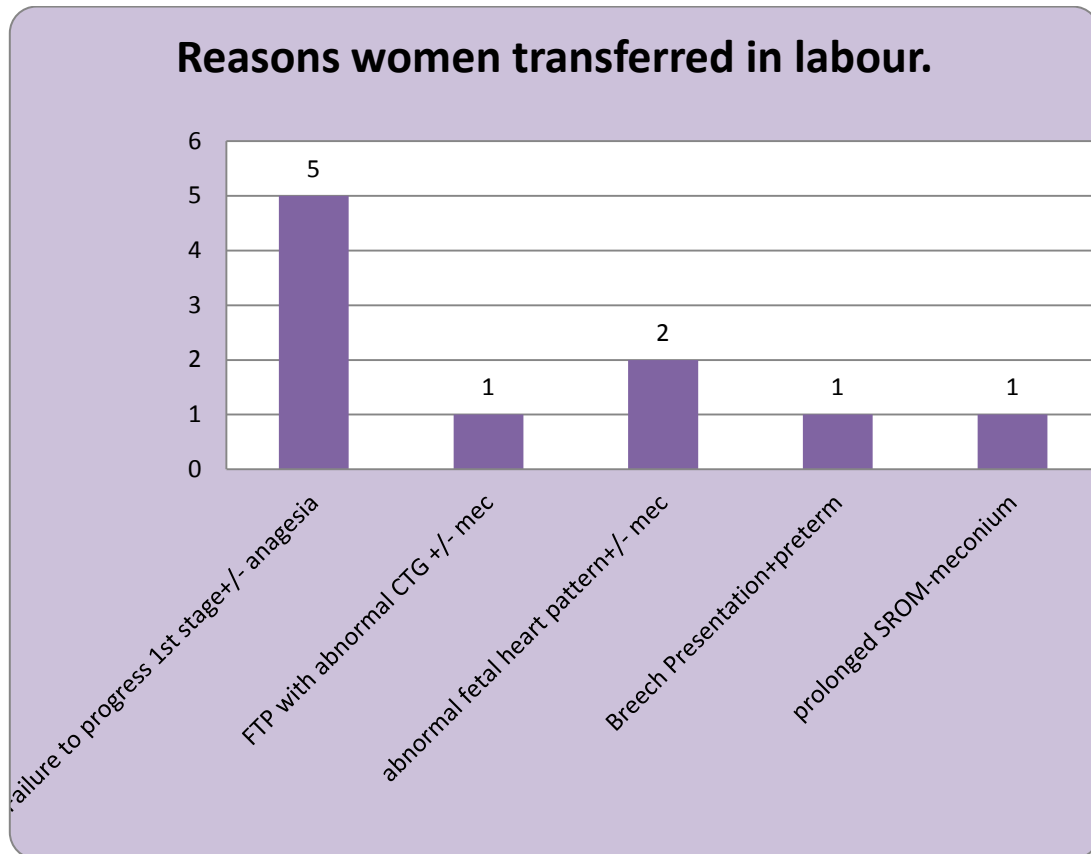
15 women transferred their place of booking during or towards the end of pregnancy. The most common reason for this was post dates induction of labour. This accounted for 5 (33%) of the 15 women. 3 (20%) of women were transferred because they had a growth restricted baby. Only one woman chose to transfer her care during pregnancy. 2 (12%) women had pre labour spontaneous rupture of membranes and were transferred to Whangarei for augmentation of labour. One woman was transferred to Whangarei as she was thought to have a Breech presentation on palpation. (There was no scanner available to confirm) On arrival in Whangarei this was a cephalic presentation but she remained in Whangarei until after the birth of her baby.

Reasons for women transferring booking in pregnancy





10 women were transferred from Kaitaia to Whangarei in labour. Failure to Progress (FTP) in the first stage of labour was the most common reason for this. This accounted for 5 (50%) of the transfers. 3 (30%) were transferred because of an abnormal fetal heart rate pattern. 1 of these women also experienced failure to progress. Most women who were transferred had multiple reasons for the transfer.



In Conclusion

The audit demonstrates that patient choice is not the main reason for women residing in the Kaitaia birthing in Whangarei. It is clear that there are obstetric and medical reasons for transfer to Whangarei. Previous LSCS is the most common obstetric reason to book in Whangarei and IOL is the most common cause of transfer in pregnancy. Comparing this audit to the one completed last year in the Bay of Islands it demonstrates similar outcomes. Previous LSCS was also the most common reason for women booking in Whangarei and IOL was the most common reason for transfer in pregnancy. Failure to progress was the most common reason for transfer in labour in both audits. The main difference between the audits is that in Bay of Islands only 12.5% of the women who booked in Whangarei chose to do this where as in Kaitaia 25% of the women booked in Whangarei chose this. There were also more medical complications cited in the reason for booking in Whangarei in the Bay of Islands audit.



Appendix 4

Maternity Patient Satisfaction Survey 2013

We appreciate you taking time to complete this form. You cannot be identified from the information gathered by this form.

Please circle your answer and feel free to add comments below.

1. During your stay in the post natal ward how often did a nurse/midwife check on you?

Hourly 2 hourly 3 hourly 4 hourly only to answer bell not at all

.....
.....

2. How often were you offered pain relief during your stay?

Less than 4 hourly 4 hourly 6 hourly Occasionally Not offered/had to ask.

.....
.....

3. Were you comfortable and happy to ring your call bell at any time?

Very comfortable Mostly comfortable Slightly uncomfortable Very uncomfortable

.....
.....

4. Were your needs met to your satisfaction and in a timely manner?

Always Mostly Usually Occasionally Not at all

.....
.....

5. How often was your bed linen changed?

Daily Every 2 days Only when you asked Was not changed at all.

.....
.....

6. How did you rate our overall service?

Excellent Good Satisfactory Poor Unsatisfactory

.....
.....



Appendix 5

Consumer Satisfaction survey 2013 (February 2013)

Every 3 months we ask post natal women who have been discharged to complete a patient satisfaction (rounding) survey. This is to give the women an opportunity to provide feedback on their satisfaction levels with the service we provide. The survey is based on a set of 6 questions with each question having 4-6 options from which the woman can choose. We had 57 completed forms in February. This survey asks similar questions to the ones asked in the 2012 survey so results can be compared.

Women were asked “During your stay in the post natal ward how often did a midwife/nurse check on you?”

Figure 1 demonstrates that 49 % of women stated that they had been checked upon hourly during their stay with us, 28% were checked upon 2 hourly and 14% of women were checked 3 hourly. 5.5% claim to be seen only when they rang their bell. Unfortunately this shows that women's perception is that checks were less frequent than in November 2012.

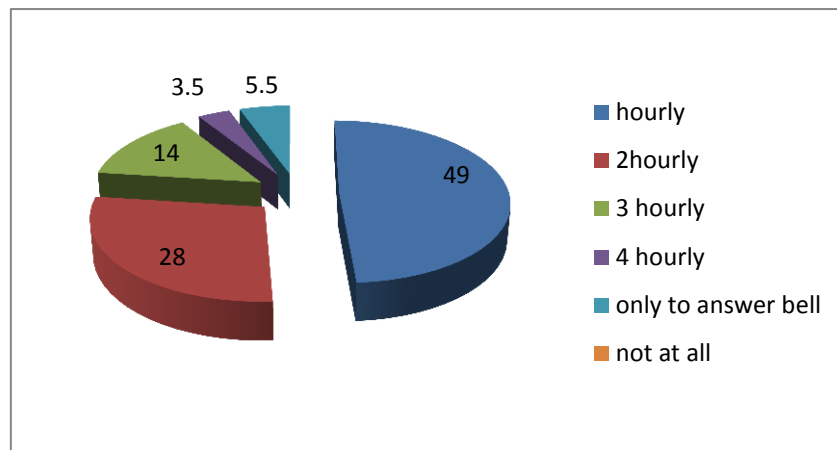


Figure 1

Some women's comments were:

“I only stayed from 01.30 until 09.00 not 100% sure about how often I was checked but it was definitely satisfactory”

“Sometimes they stopped to check but usually just if we rang the bell and needed help. Thank you.”

“Varied on the staff but mostly 2-4 hourly”

“Very friendly and it was made clear they were here to help

Women were asked “How often were you offered pain relief during your stay”

Figure 2 demonstrates that 68.5% of women were offered pain relief 4 hourly or more regularly. Sadly 17.5% of women were only offered pain relief occasionally and 7% were not offered and needed to ask. In comparison, in November 2012, 89 % of women categorized the offer of pain relief as good or excellent. It appears we are not as good as we were in November in offering pain relief to our post natal women.

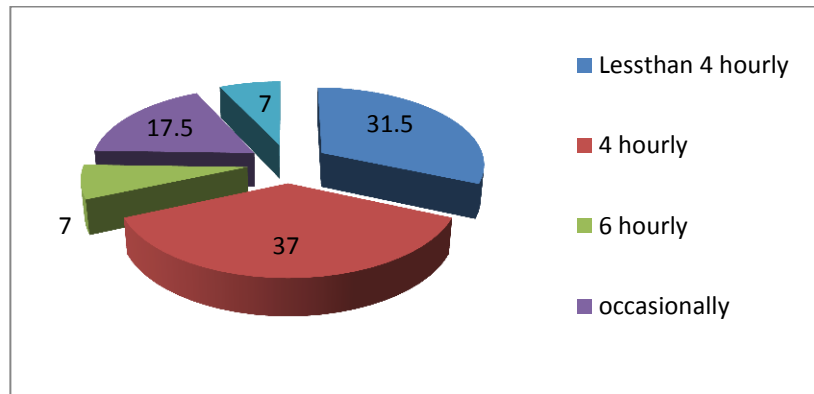


Figure 2

Some women's comments were:

"When they came they asked but I had to ring the bell for it during the night"

"Asked often"

"Needed more"

"I was offered Panadol once on the ward but only stayed for a few hours and had some in delivery"

Women were asked "Were you comfortable and happy to ring your bell?"

Great news! 81% of women responded that they were very comfortable to ring their bell for assistance. This demonstrates excellent communication skills. There was only 1, (2%), woman who reported that she felt uncomfortable to ring her bell. This is demonstrated in figure 3

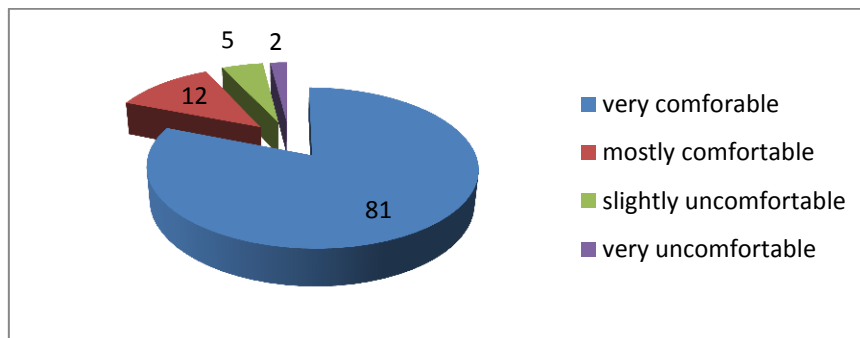


Figure 3

Some women's comments were:

"There were staff always ensuring you and baby were ok"

"And the ladies came super fast every time"

"I didn't need to but would have been happy to ring if I did"

"When it got busy I didn't want to ring it too much."

The one lady who circled uncomfortable wrote "only because it is in my nature to be self sufficient"



Women were asked “Were your needs met to your satisfaction and in a timely manner?”

93% of women responded that their needs were always or mostly met in a timely manner. This demonstrates that the timeliness of our responses continues to show improvement. No one commented that their needs were not met at all.

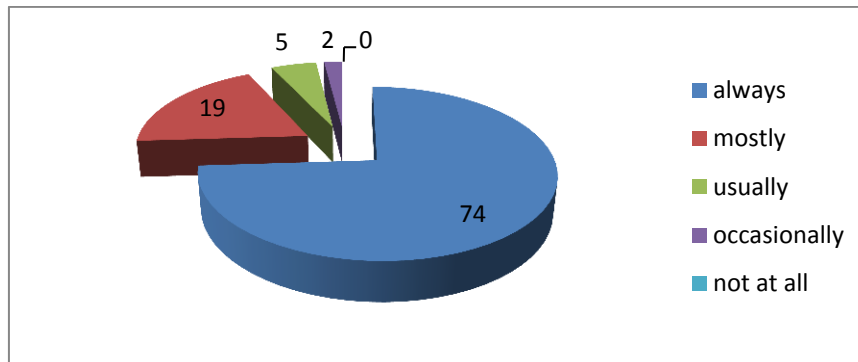


Figure 4

Some women’s comments were:

“Would loved to have stayed if needed to”

It was mostly because “it got very busy but everyone was very helpful”

Always “even on a very busy night”

Women were asked “How often was your bed linen changed”

Only 54% of women responded that their bed linen was changed daily. 12% of women responded that their beds were changed every 2 days. 5 women commented that their beds had not been changed but were only on the ward for a few hours. In a previous survey 88% of the women commented the bed changing service was good or excellent. If we used these categories now the corresponding number would be 66% a drop of 22%. We need to offer more bed changing.

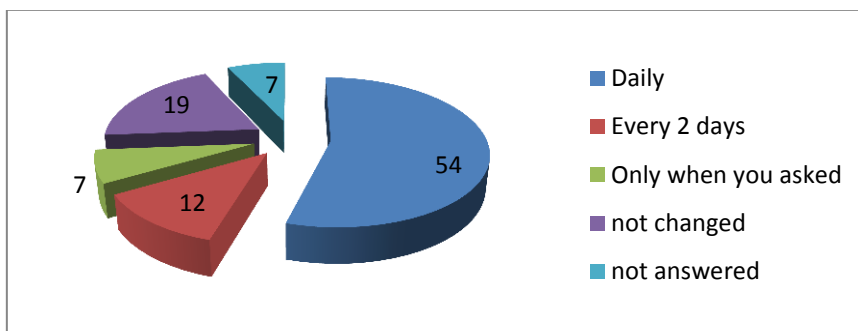


Figure 5

Some women’s comments were:

“Was only in for 2 nights” after circling bed linen not changed at all

“Excellent service”

“Clean sheets were not offered at all in my 3 day stay”

“I didn’t stay long enough for clean sheets.



Women were asked “How did you rate our overall service?”

72% of the women rated our overall service as excellent, a fall of 5 % from last survey. 25% rated our service as good which is a 4 % improvement on last survey. No women rated our service as less than satisfactory. Overall 97% of our women rated our service as good to excellent. Well Done.

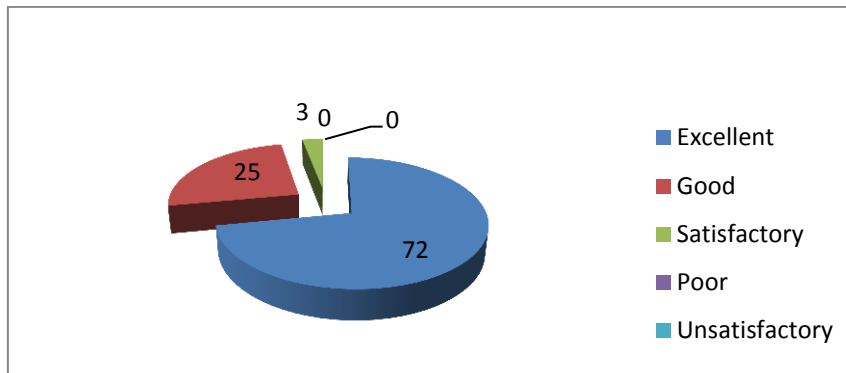


Figure 6

Some women’s comments were:

“Very happy with the care I received and the help and information given”

I cannot speak highly enough of the night staff. They were supportive, knowledgeable and helpful”

“The level of care at the Whangarei hospital maternity Ward is outstanding! Northlanders are very lucky!”

“Lovely Staff”

“Fantastic staff – made you feel safe and secure at a time when you need that most. Thank you.”

“I enjoyed my stay in the Post Natal ward. Thank you very much.”

“The service and people here are helpful and yes very excellent service. Thank you.”

“Very helpful, pleasant staff- good instructions about breastfeeding”.

Conclusion

97% of the woman who responded to our survey felt the overall service was good to excellent.

Throughout this report there is an indication that the women feel very comfortable asking staff for help and that communication is very good on the ward. Comments demonstrate that the women found staff to be pleasant, helpful and knowledgeable. Most women responded that their needs were met to their satisfaction in a timely manner demonstrating we respond to the women’s individualised needs.

Some of the feedback received suggests there are a few areas that need a little improvement. 23% of the women responded saying they were checked upon less than 3 hourly. The hospital guideline for rounding is that women are checked hourly during the day and at least 2 hourly during the night. This is to ensure their needs are met. Evidence suggests that women who are checked regularly recover better and have no need to ring their bells as often.

Over 20% of our women were only offered pain relief occasionally or they needed to ask for it. This is something for us to improve upon.

Bed linen changing needs to be reviewed as only 54 % of the women stated the linen was changed on a daily basis and a number of women noted the linen had not been changed at all.

Overall the service provided is good and a few adjustments will help make it excellent. Well Done!



Appendix 6

Maternity Consumer Satisfaction survey 2013 (May 2013)

Every 3 months we ask post natal women who have been discharged to complete a patient satisfaction (rounding) survey. This is to give the women an opportunity to provide feedback on their satisfaction levels with the service we provide. The survey is based on a set of 6 questions with each question having 4-6 options from which the woman can chose. We had 81 completed forms in May.

Women were asked “During your stay in the post natal ward how often did a midwife/nurse check on you?”

Figure 1 demonstrates that 38% (30) of women stated that they had been checked upon hourly during their stay with us, 31% (25) were checked upon 2 hourly and 13% (11) of women were checked 3 hourly. 4% (3) claim to be seen only when they rang their bell. 2 women left this question unanswered.

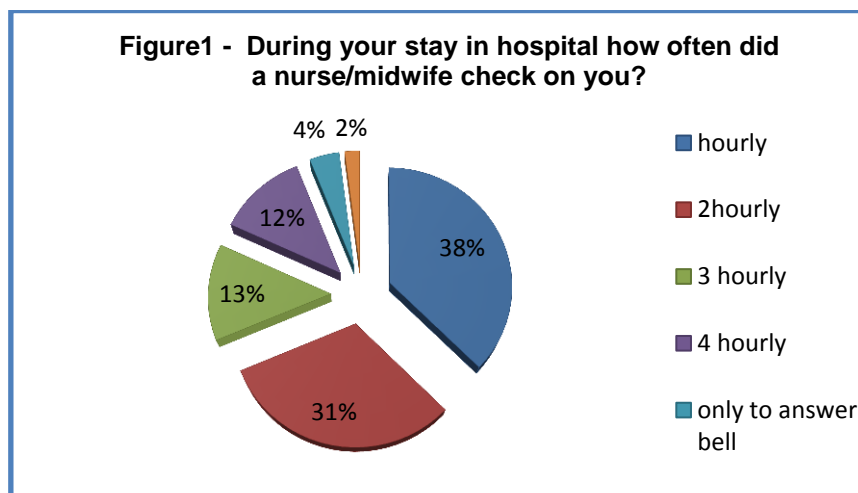
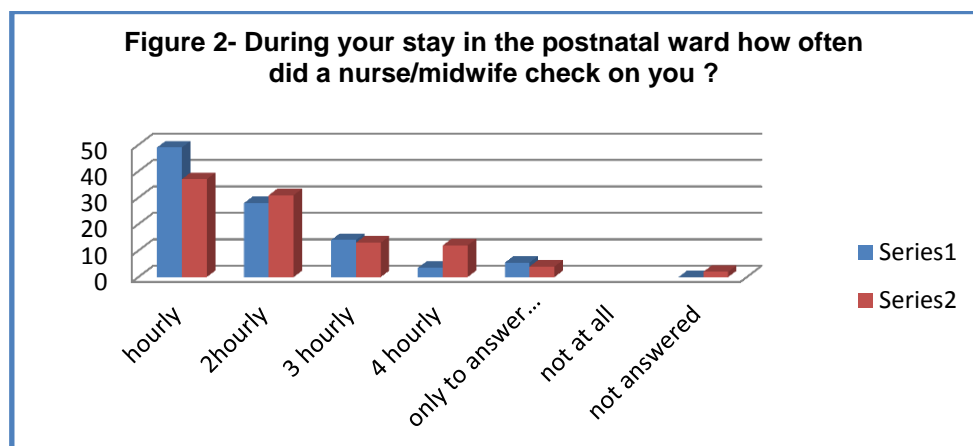


Figure 2 displays a direct comparison between the survey done in February (blue on graph) and the survey done in May (red on graph). Unfortunately it seems the women’s perception seems to be that they were checked on less frequently in May than in February. The DHB standard is that patients are checked hourly during the day and 2 hourly at night. This is an area for a little improvement.



Women’s comments included:



- “In the beginning was regularly then as I settled didn’t need them to keep checking”
- “Depended upon time of day. Between 8am and 3pm it was 2hourly, 3pm-11pm was 3 hourly then 11pm-8am only to answer bell.”
- “2 hourly initially then less as I stayed longer-care was excellent”
- “It varied depending upon the midwife but approximately every few hours I think .Some only checked when I needed.”

Women were asked “How often were you offered pain relief during your stay”

Figure 3 demonstrates that 65% (49) of women were offered pain relief 4 hourly or more regularly. Sadly 23% (18) of women were only offered pain relief occasionally and 5% (4) were not offered and needed to ask.

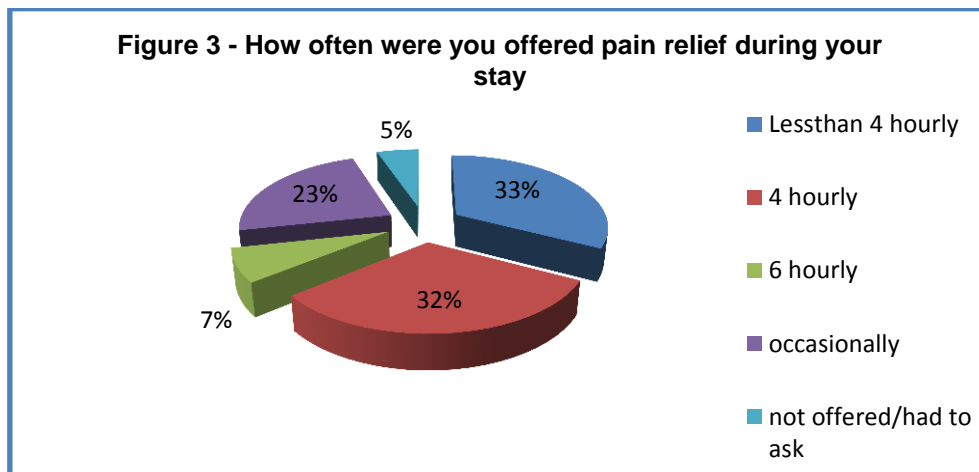
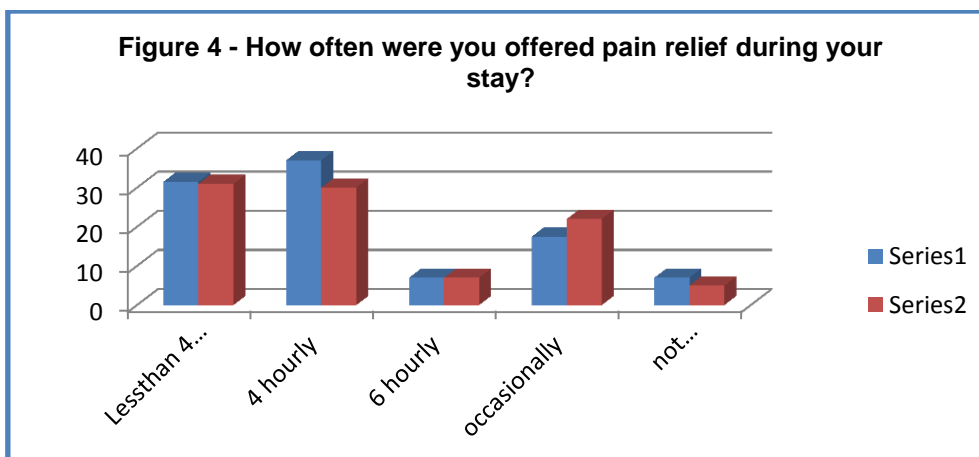


Figure 4 demonstrates the comparison between the survey completed in February (blue) and the survey completed in May (red). The same percentage of women were offered pain relief less than 4 hourly but in February more women were offered pain relief 4 hourly than in May. More women reported been offered pain relief occasionally in May. This is something that can be improved.



Women’s comments included:

- “Every time someone came to check up on me I was asked about my pain and offered pain relief”
- “Usually offered once or twice a shift”
- “May have been 4 hourly-depending upon the medications I was given and how often I should have them”



- “I don’t know but it always seemed to arrive on time .Staff seemed to know exactly what is going on”
- “Every time I saw a new nurse I was offered pain relief”
- “They were really helpful with my pain relief”

Women were asked “Were you comfortable and happy to ring your bell?”

Great news! 78% (63) of women responded that they were very comfortable to ring their bell for assistance and 19% (16) responded they were mostly comfortable to ring their bell for assistance. This demonstrates excellent communication skills. There was only 1, (2%), woman who reported that she felt slightly uncomfortable to ring her bell. This is demonstrated in figure 5

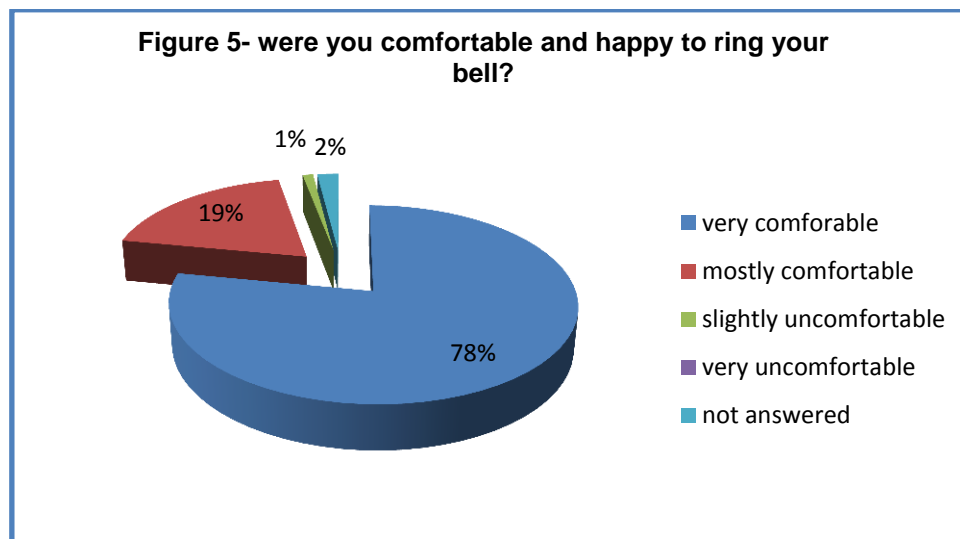
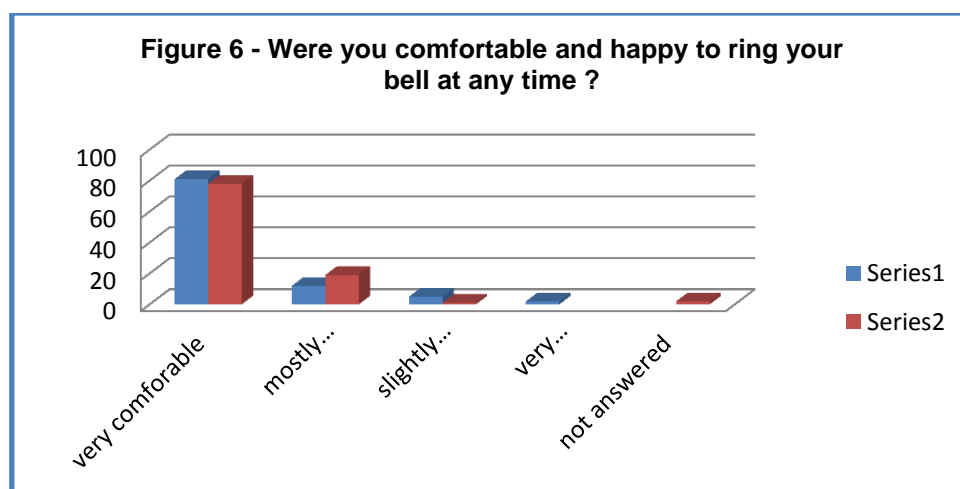


Figure 6 displays a direct comparison between the survey done in February (blue on graph) and the survey done in May (red on graph). Awesome news, 97% of women reported being comfortable to ring their bells in comparison to 93% in February. Fewer women reported feeling uncomfortable.



Women’s comments included:

- “Staff were quick and helpful”



- “Mostly comfortable-This is how I felt rather than them-nothing was a problem for the midwives”
- “On the first night the ward was busy and it took a long time for the bell to be answered.”
-

Women were asked “Were your needs met to your satisfaction and in a timely manner?”

97% (78) of women responded that their needs were always or mostly met in a timely manner. This demonstrates that the timeliness of our responses continues to show improvement. No one commented that their needs were not met at all.

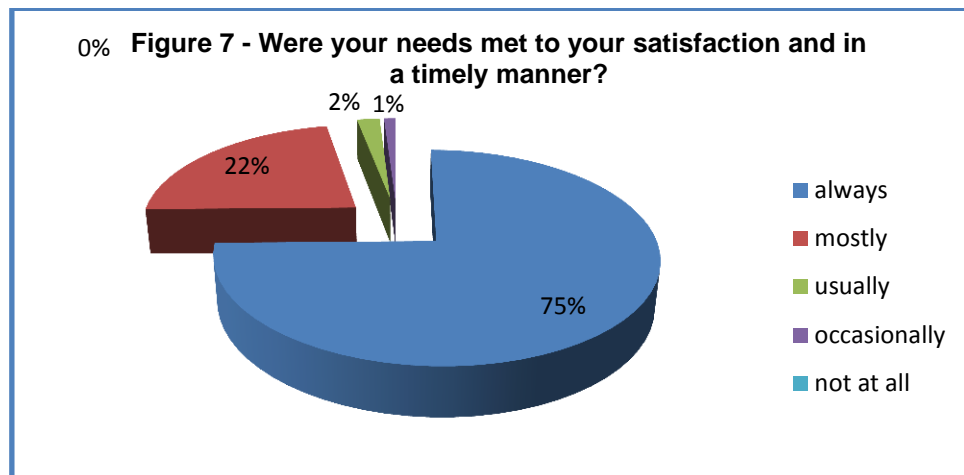
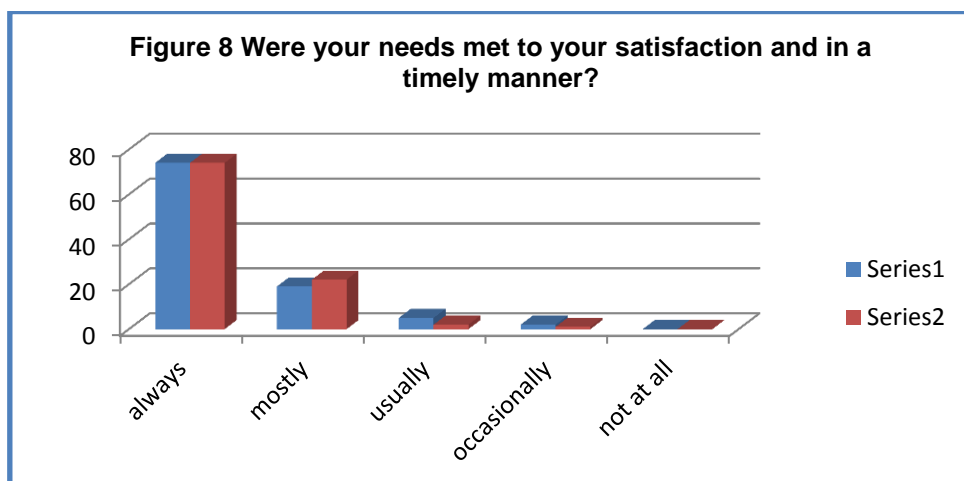


Figure 8 displays a direct comparison between the survey done in February (blue on graph) and the survey done in May (red on graph). This graph demonstrates that we have maintained a very high standard of always meeting our women's needs in a satisfactory and timely manner and have shown improvement in the mostly meet the needs of our women.



Women's comments Included:

- “all except the 1st night , but I think it is only because the ward seemed so busy”
- “Staff were so helpful and made me feel comfortable”
- “on a few occasions where I had to ring 2 or sometimes 3 times before I was seen but this was not often enough to complain”
- “I didn't want to be a pain but if I totally needed to ring I would”



Women were asked “How often was your bed linen changed”

66% (52) of women responded that their bed linen was changed daily. 6% of women responded that their beds were changed every 2 days. 12% (10) women did not circle an answer but commented that their beds had not been changed but they were only on the ward for a few hours.

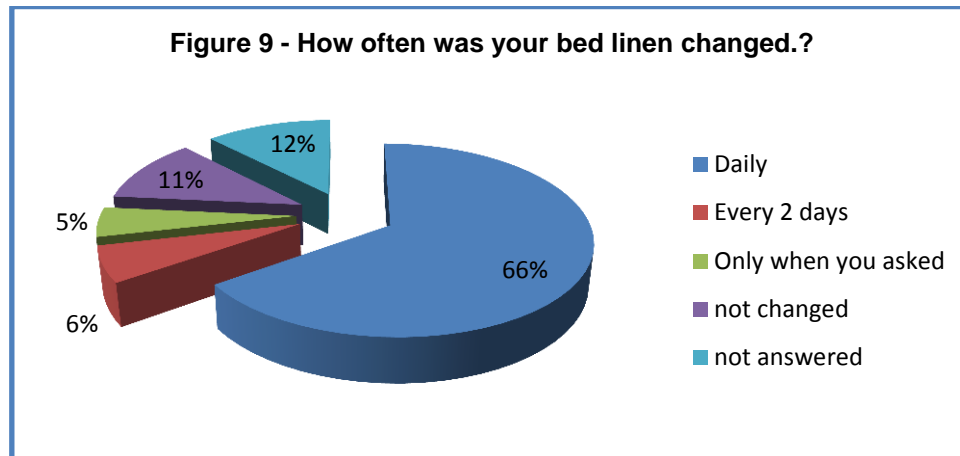
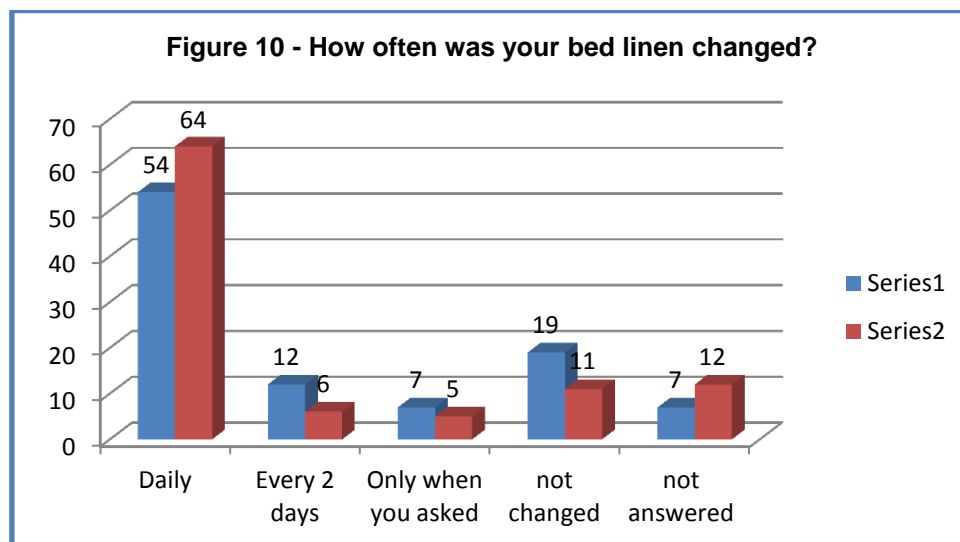


Figure 10 displays a direct comparison between the survey done in February (blue on graph) and the survey done in May (red on graph). The graph demonstrates a 10% improvement in the number of women who responded that their bed linen was changed daily. Fewer women responded they did not have their bed linen at all. 10 women did not answer but they made comments indicating their ward stay was of a short duration. The women's comments also indicate an improvement to February's survey. Keep up the good work as there are still a small number of women commenting their linen was not changed at all. For the next survey it may be pertinent to add a question about how long the women stayed on the ward.



Women's comments included:

- “In the first day it was changed a few times then daily”
- “I was only in overnight but had the linen changed very quickly when baby soiled on the bed”



- “Linen was changed when required”
- “Have been here for 1 night so hasn’t been changed”
- “Only stayed 1 night”
- “I had my bed linen changed 3 times in the 12 hours I was there”

Women were asked “How did you rate our overall service?”

64 % of the women rated our overall service as excellent, a fall of 8 % from last survey. 31% rated our service as good which is a 6 % improvement on last survey. No women rated our service as less than satisfactory. Overall 95% of our women rated our service as good to excellent. Well Done.

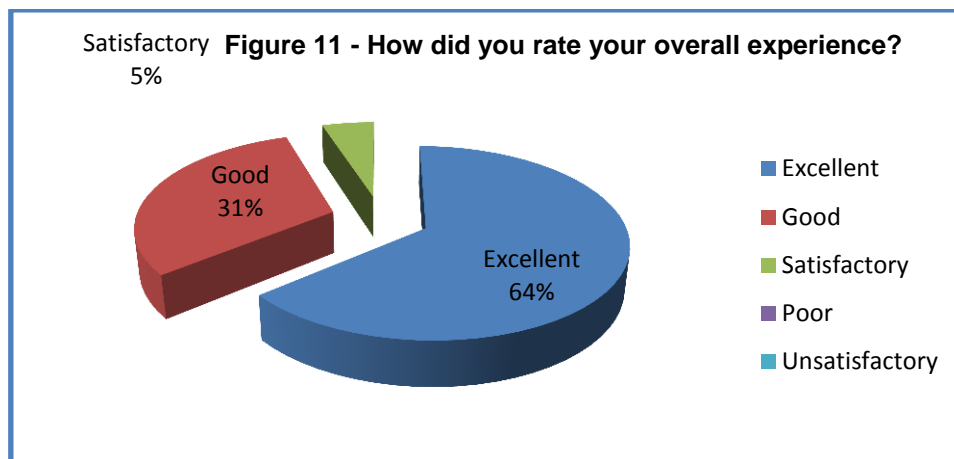
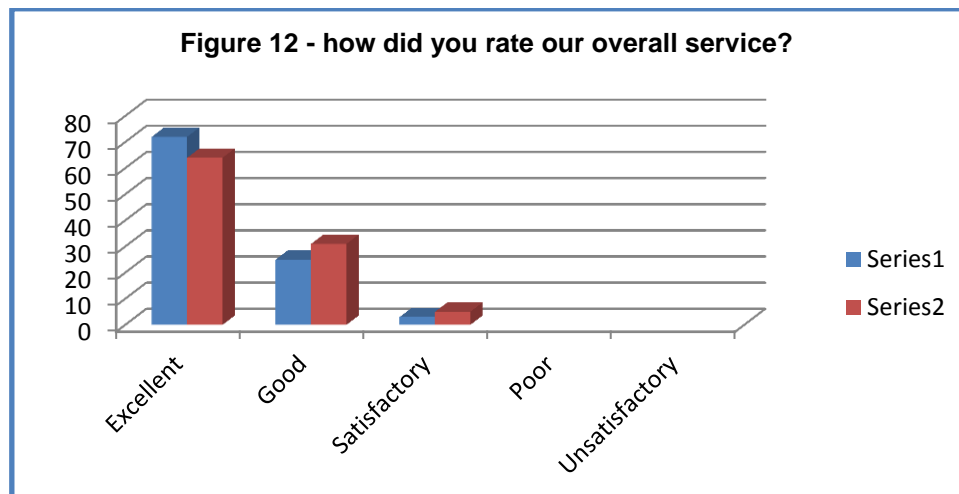


Figure 12 displays a direct comparison between the survey done in February (blue on graph) and the survey done in May (red on graph). The graph demonstrates the fall in the number of women who rated our service as excellent and the increase in the number of women who rated our service as good. Neither survey had a woman rate the service as poor or unsatisfactory.



Women's comments included:

- “I felt safe and supported. If I needed help with anything it was there!! Thank you.”
- “Have had some good care but also some very poor care”
- “From the time we arrived the staff have been faultless. Very impressed with the level of care given by every staff member.
- “Wonderful supportive team”
- “Very well looked after, enjoyed having the professional help when needed.”



- “Could have done with a few more midwives on at night to help out. They seemed to be run off their feet. Services were a bit slow.”
- “Nurses, Midwives and Lactation Consultants were all pretty good. Usual issues with the room.”
- “Thank you so much.”
- “Thank you!! Better than NSH.”
- “Absolutely loved Tracey (Midwife)”
- “Thanks to Elizabeth for all your great advice and help”
- “midwives are very informative and supportive”
- “Thank you for all the help and support provided from all the Midwives. Very helpful and much appreciated. Thanks again!
- “Very Kind and helpful- a pleasure to stay here- thank you.”

Conclusion

95% of the woman who responded to our survey felt the overall service was good to excellent. Throughout this report there is an indication that the women feel very comfortable asking staff for help and that communication is very good on the ward. Comments demonstrate that the women found staff to be pleasant, helpful and knowledgeable. Most women responded that their needs were met to their satisfaction in a timely manner demonstrating we respond to the women's individualised needs.

Some of the feedback received suggests there are a few areas that need a little improvement. 29% of the women responded saying they were checked upon less than 3 hourly. The hospital guideline for rounding is that women are checked hourly during the day and at least 2 hourly during the night. This is to ensure the individual needs of the women are met. Evidence suggests that women who are checked regularly recover better and have no need to ring their bells as often.

28 % of the surveyed women were only offered pain relief occasionally or they needed to ask for it. This is something for us to continue improve upon.

Bed linen changing is improving. 64% of women responded they had the bed linen changed daily as per infection control recommendations..

Overall the service provided is good and a few adjustments will help make it excellent. Well Done!

Appendix 7**WHANGAI U SURVEY****Breastfeeding survey 2013.**

Thank you very much for taking part in our survey. This survey will assist us to improve our service given to women.

Please circle below where appropriate.

1. What is your ethnicity?

Maori European Tongan Samoan Chinese Indian Other

.....

2. Is this your first baby?

Yes (Go to Question 4)

No (please answer question 3)

3. If this is not your 1st baby, have you breastfed before and for how long?

.....

.....

4. Where did you get your information about breastfeeding?

Whanau/Family Antenatal classes Midwife Internet Others

.....

.....

5. Did you feel well prepared for breastfeeding based on your antenatal education?

Yes

No

Comments.....

.....

6. Did you receive the booklet "Breastfeeding Simply the Best"

Yes

No

7. Was this booklet helpful?

Yes

No

8. Did a midwife discuss this booklet with you?

Yes

No

Comments

.....



9. When your baby was born did you have skin to skin contact?

Yes

No

10. How long was your baby left skin to skin with you at birth?

11. Were you given assistance with positioning and attaching baby to the breast?

Yes

No

Comments.....

.....

12. Were you shown how to hand express?

Yes

No

13. Was the information, help and support given to you regarding breastfeeding, the same from all staff members?

Yes

No

Comments

.....

14. Do you have any suggestions to help us improve the way we support breastfeeding?

.....

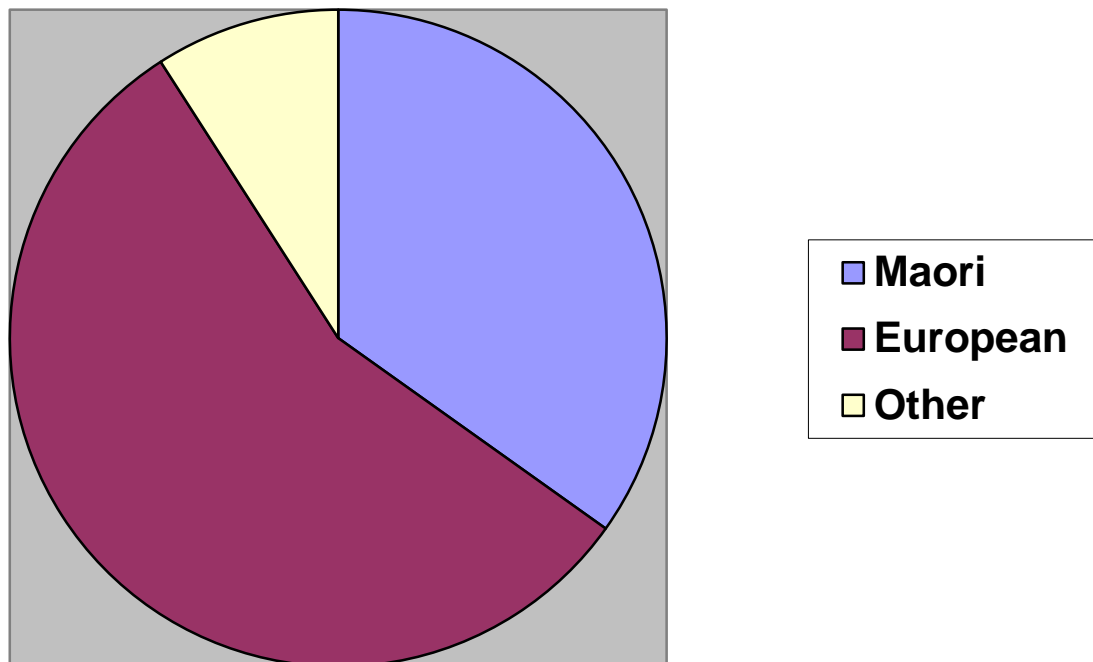
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Appendix 8

APRIL 2013 EVALUATION OF WHANGAI U / BREASTFEEDING SURVEYS

Total of 66 forms received back over April and summarised here

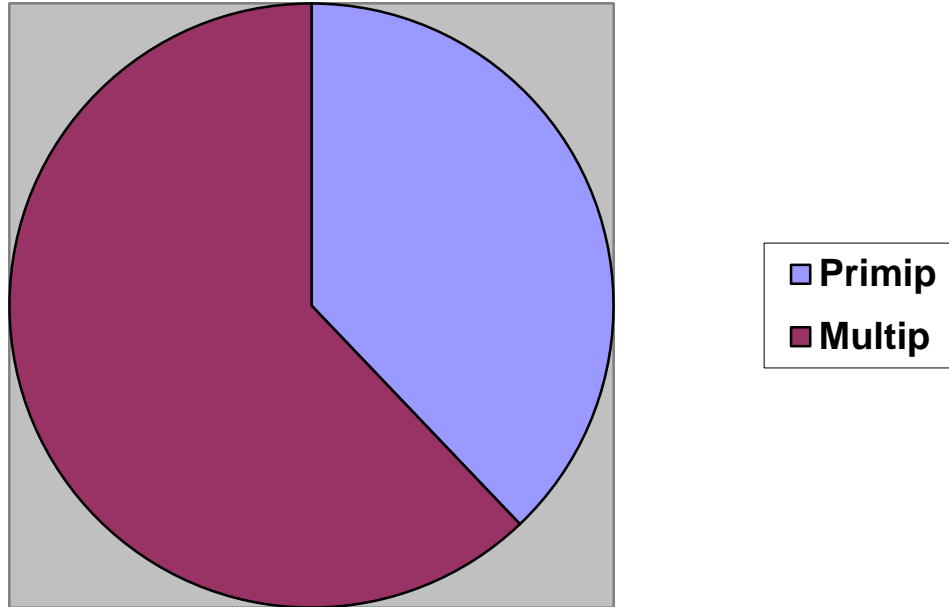
Ethnic Groups of those returning Surveys



- 23 (35%)of women responding to the surveys identified as Maori
- 37 (56%) of respondents identified as European
- 6 (9%) identified as Other Ethnic Groups



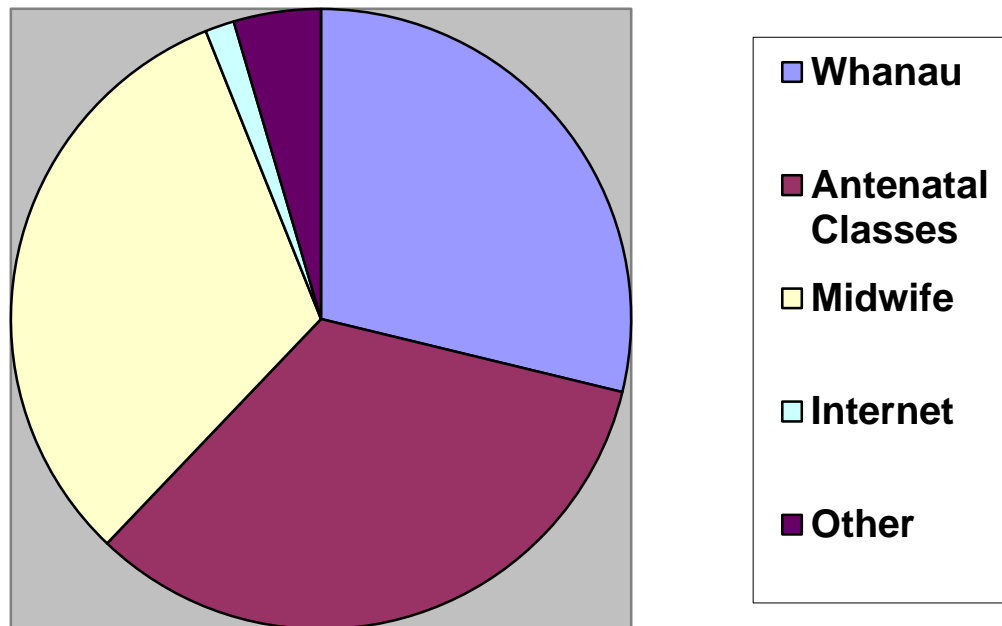
First or Subsequent Baby



- 25 (38%) of survey respondents identified as having their first baby
- 41 (62%) identified as having a subsequent baby



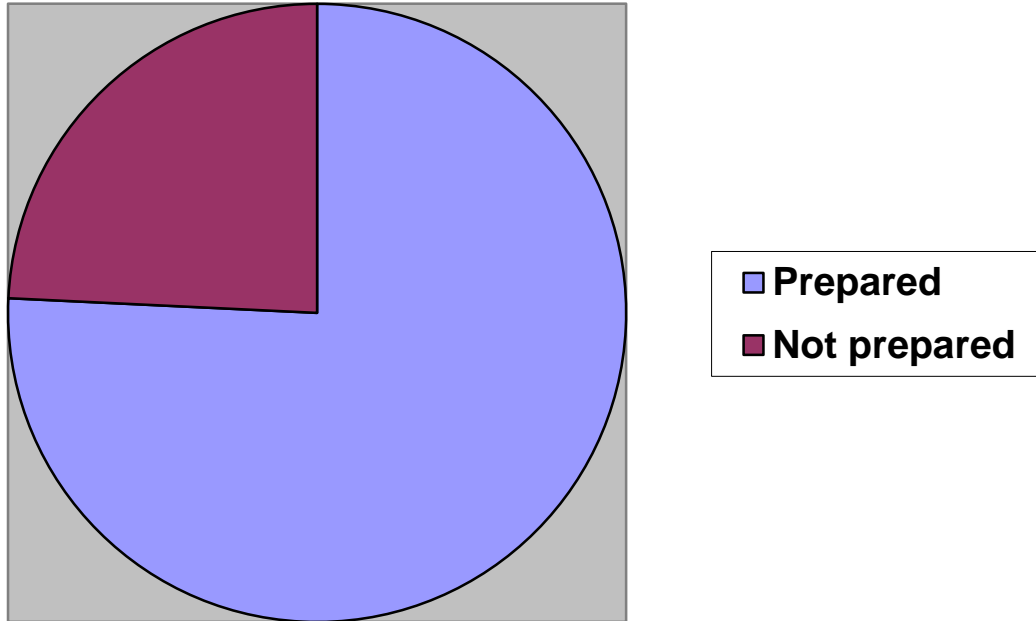
Source of Information about Breastfeeding



- 19 (29%) of women identified their Whanau / Family as a source of Breastfeeding information
- 22 (32%) of respondents said that they sourced Breastfeeding information from Antenatal classes
- 21 (32%) of women named their Midwife as their source of Breastfeeding information
- 1 (2%) identified the Internet as a source of Breastfeeding information
- 3 (5%) identified Other



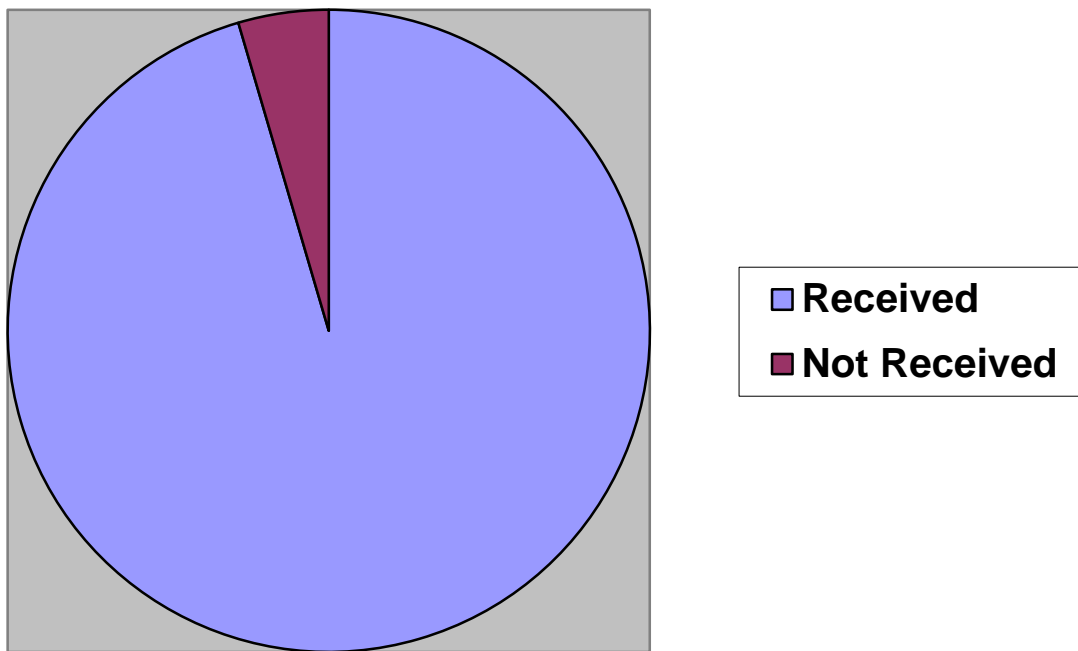
Preparation for Breastfeeding based on Antenatal Education



- 50 (76%) of respondents said they did feel well prepared for Breastfeeding based on their Antenatal Education
- 16 (24%) said they did not feel well prepared



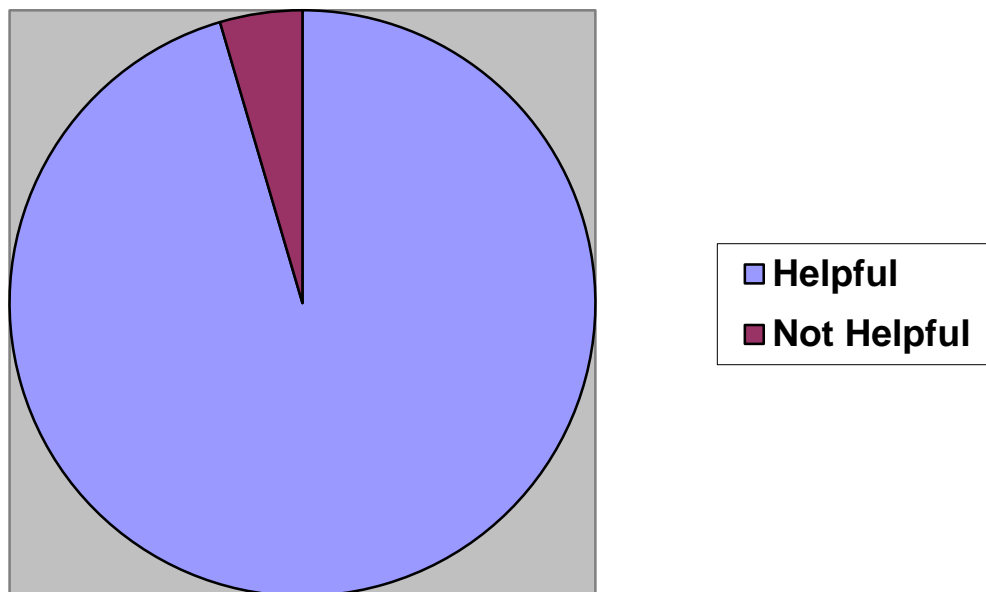
Received the booklet – Breastfeeding ‘Simply the Best’



- 63 (95%) of respondents said they had received the breastfeeding ‘Simply the Best’ book
- 3 (5%) did not receive the booklet



Helpfulness of the Breastfeeding Booklet



- 63 (95%) did find the booklet helpful
- 3 (5%) did not find the booklet helpful

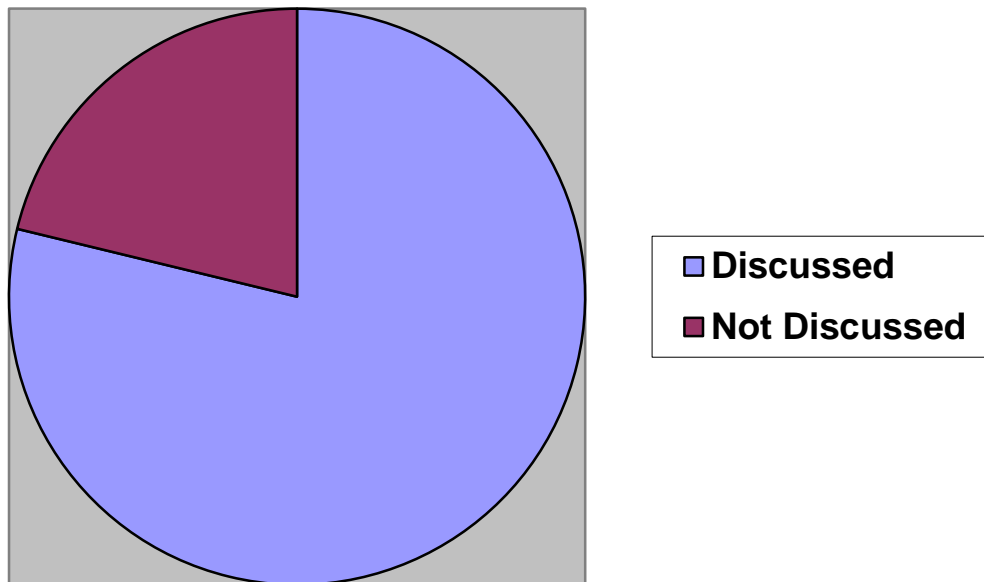
Comments included ...

- Excellent
- Information on sore nipples and how to avoid it
- Good summary of how to breastfeed and information
- Great help
- Good booklet, has storage information good as going back to work in 3 months



- Good positioning and latching info

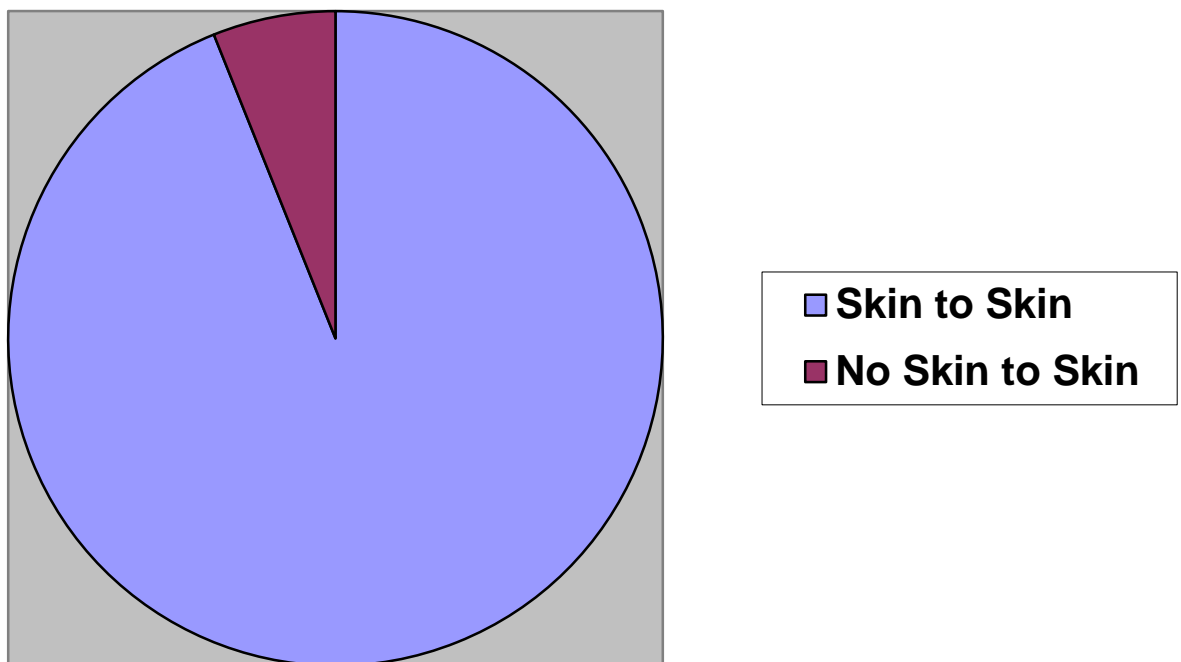
Booklet Discussed with Woman by Midwife



- 52 (79%) of respondents said that the Breastfeeding Booklet had been discussed with them by their Midwife
- 14 (21%) said the Midwife had not discussed it with them



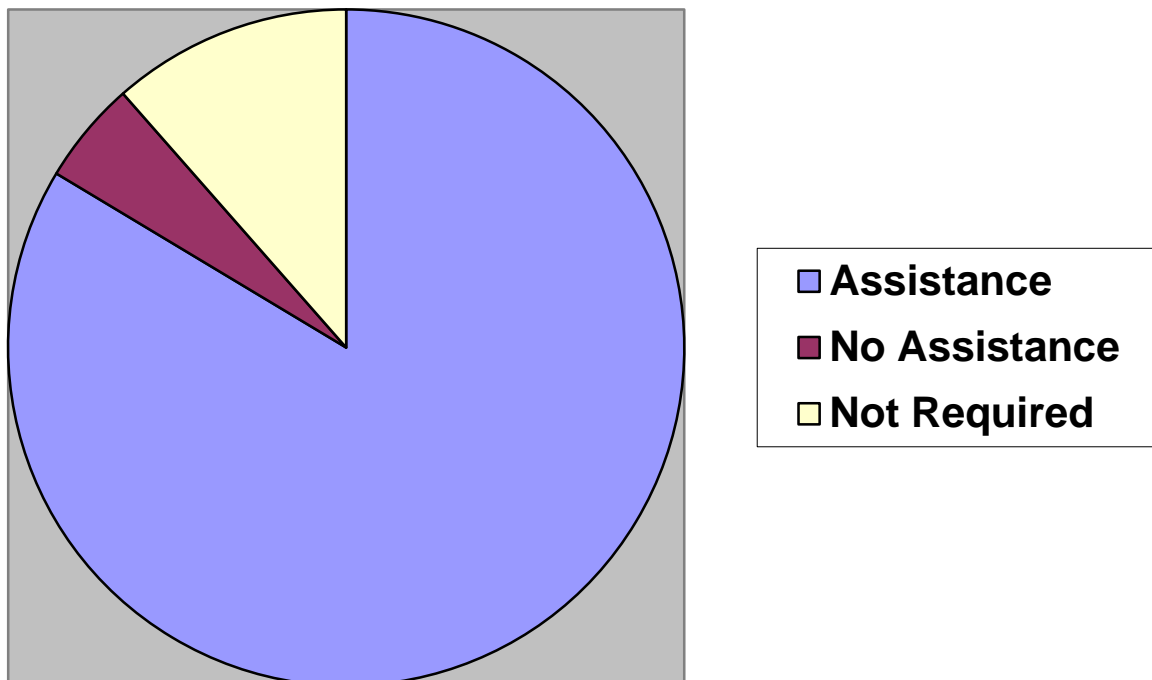
Skin to Skin contact with Baby after birth



- 62 (94%) said they were offered Skin to Skin contact with their Baby following Birth
- 4 (6%) said they were not



Assistance given with Positioning and Attaching Baby to the Breast



- 56 (82%) of Women were given support to assist their Babies to the Breast

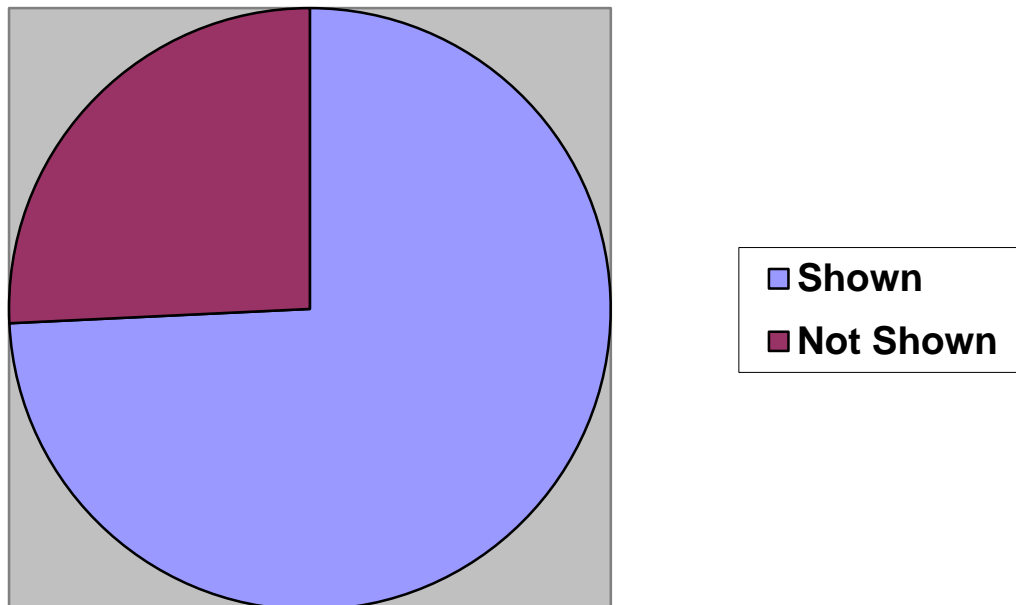


- 3 (4%) of Women were not given Breastfeeding assistance
- 10 (14%) of Women did not require Assistance

Comments included ...

- Great support
- Being showing correct latching technique
- Felt much more supported, other children in Auckland -
- Didn't breastfeed my two other children - really enjoying this one - thank you all

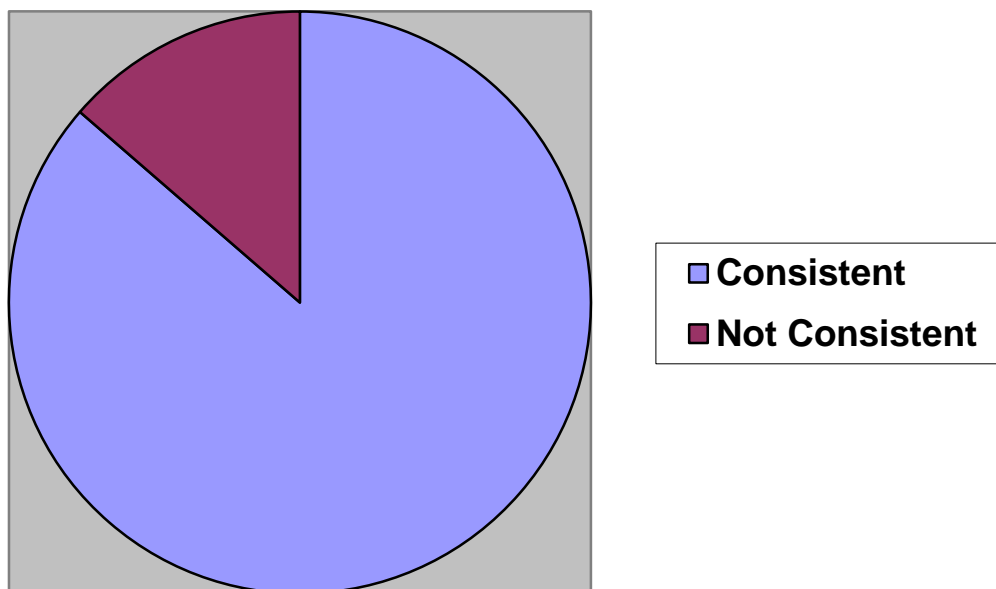
Shown how to Hand Express



- 49 (74%) Women stated they had been shown how to hand express
- 17 (26%) Women stated they had not been shown



Consistent Information Help and Support regarding Breastfeeding from all Staff



- 57 (86%) Respondents identified the breastfeeding information as being the same from all staff



- 9 (14%) Respondents noted it to be different

Comments included ...

- Different ideas I got confused
- Some were different but information was good
- Got confused on positions - got there in the end

Suggestions to help us Improve the way we Support Breastfeeding

Comments included ...

- Nothing at all just want to say thank you
- Keep up the great job
- No comment you are all awesome
- Was good to see Lactation Consultant every morning
- Good support, great communication
- Everyone was wonderful



Appendix 9

COMPLIMENTS AND COMPLAINTS FOR MATERNITY VIA PURPLE FEEDBACK FORMS (FEB - JUNE 2013)

Total of 10 forms received with 12 comments about our service

All 10 women wrote copious comments about how well they were treated by staff, leading to great satisfaction of our service.

Environmental issues were not even mentioned.

I have included these comments below for all to read:

It confirms what we already know, how simple things go a long way e.g. a warm welcome, making the bed, enquiring about a baby in SCBU. Generally, the staff showed empathy in all of these cases. However, a special thank you needs to be mentioned to the following staff mentioned in these comments:

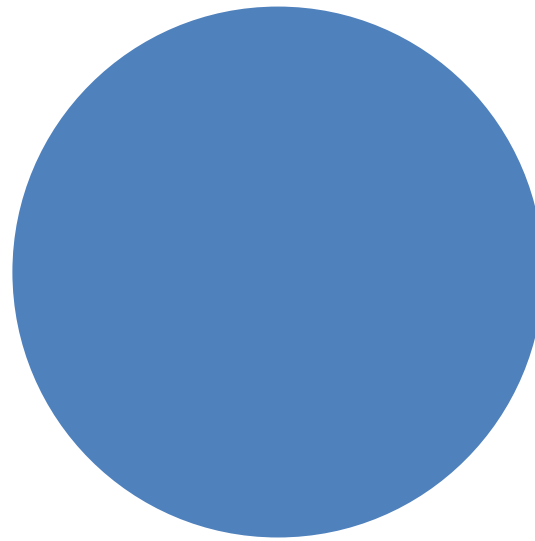
- MaryAnne Kaye
- Charli
- Aileen
- Hasina
- Joy,
- Annemeike
- Linda Clancy
- Barb
- Helena
- Jo Cotterill
- Beau, Gwen
- Sarah (from SCBU)
- Helen

Note, that not all staff could be named due to memory

The complaints were around the food including menus going amiss, reminding us that meals are a huge part of a woman's experience here in hospital. We also need to remember that partners not being able to stay accentuates the need for support and reassurance overnight.



Compliments



- Staff
- Food
- Whanau
- Privacy
- Building

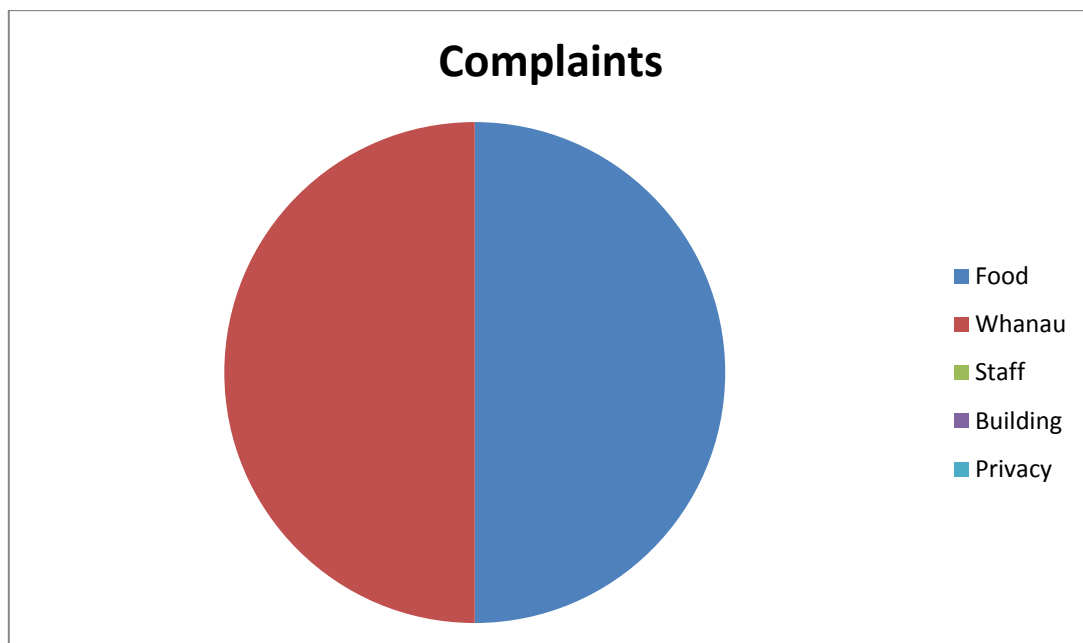
COMPLIMENTS

Staff

- Lovely Midwives! Very helpful, friendly and respectful. Especially MaryAnne and Charli – they were amazing! All staff were good remembering me and my daughter, always asking how she was going in SCBU
- Aileen and Hasina have been really good to me since I've been here with my baby. They are very caring and lovely ladies. Aileen has made me feel very comfortable and has always attended to me even when I least expect it. Thank you to all staff that have helped me and my baby
- I would like to acknowledge the treatment that the staff on Ward 11 has given. The many staff are generally pleasant but Hasina is very helpful and made my stay here very enjoyable and comfortable. I was very upset and in pain. She showed compassion and kindness
- I am really pleased with the way I was treated. Everyone encouraged me with every decision I made and everyone were very friendly too, especially Annemeike
- Hasina was very helpful to me, very considerate to my needs. Joy looked after me. She was very helpful with info and in doing my cares
- I would like to thank the Midwives, Nurses and Surgeons of Whangarei Hospital. On my arrival into Whangarei Hospital, I was greeted with a nice warm welcome from staff. I arrived late on a Sunday night. From that time right until now, the nurses, midwives and doctors have been so patient, welcoming, helpful, caring and sharing advice. I would like to thank Linda, Barb and Aileen for all their help and kindness throughout this hard but joyful time



- This is an appraisal for Annemeike Becks. She is by far the best Midwife that I came across during my stay at Whangarei Hospital. She is supportive, caring, clear, committed, organised. She listens to my feelings and fear. She involved my partner too. This ward could benefit from more Midwives like her. She is the reason my daughter managed to get her blood sugars back up and stay safe. Together we were a team. She was also clean. She changed my bed while I showered (the only one that did). Also, the only other one that I found good was Aileen. Thankyou both!
- I'd like to thank all the staff that helped with the delivery and aftercare that myself and our newborn received. Unfortunately, due to a serious case of baby brain and a lot of stress, I can't remember names of all the people that cared for us. On the first night on the ward, there was a lovely nurse that looked after us till 1pm. She was so nice and caring as I was pretty scared with my partner leaving. Helena was extremely supportive during delivery, aftercare. Jo Cotterill helped set my mind at ease, actually get some sleep when bubs was under lights. There are other Nurses/Midwives that cared for me and I'd be grateful if they could be thanked for my care. Helen (LC) was primo
- I had the privilege of having Beau as a carer. Excellent service from Beau
- While in hospital having our son via CS, we had a few issues mainly with feeding but also with a skin reaction as
- well as needing IV antibiotics. The whole situation was really stressful for us but we had a few staff that really shone out and made our stay bearable. These staff helped to get me sorted for feeding which was amazing and they let me go out on leave once I lost the plot (when hearing that I needed to stay for longer than 5 days). I honestly could not have coped as well as I did especially in the middle of the night once my partner went home. I can't remember everyone's last names, but these staff are Linda Clancy, Gwen, Sarah (SCBU nurse), Mary Anne Kaye and Iris





COMPLAINTS

Food

- Not getting Food I ordered. Hospital food is average at the best of times but when your forgotten (after being there over two weeks) or your menu disappears. It's a bit annoying

Partners not staying

- One complaint is that the hospital and antenatal classes we took were big on supporting postnatal depression and stuff like this. As a first time Mum, it is very traumatic and stressful to give birth and of course I wanted my partner or a family member to be with me on the first night, and then especially when we found out bubs needed to be put under lights. I believe it caused unnecessary stress that I couldn't have someone there with me and I also heard a man being questioned as to why he was on the ward after hours. When he said his wife was seriously distressed, he was told to leave and come back at 11am (which was another 3 hours away). I know that it is probably due to security and safety why this is in place, but the birth of a child is a very special (and can be scary) time for a family, and it seems unfair that your policy seems to push fathers away from this and causes distress to all involved and I think it could lead to postnatal depression and needs to be addressed. Especially if your baby is sick and you need that family aroha around you more than ever



Appendix 10

Should the process for booking an uncomplicated post - dates induction of labour be changed to incorporate a non contact referral for the women of Northland?

Evidence supports Induction of Labour (IOL) for uncomplicated post-date pregnancies, after 41 weeks gestation and before 42 weeks gestation to reduce the risk of perinatal mortality.

The current system in Northland DHB (NDHB) is to book women into the antenatal clinic (ANC) prior to 41 weeks gestation to have the discussion with the obstetric team and arrange a date to present to the maternity unit in Whangarei for IOL.

Perceived problems with this policy of management were:

- From a brief audit of figures (Table One) approximately 33% women had delivered before the date they are booked for their IOL.
- Increased pressure on already busy obstetric clinics in Whangarei and regional hospitals.
- A significant use of Lead maternity Carer (LMC) time is used to refer women to an Obstetrician and clerical staff take time to prepare clinic appointments for women who birthed prior to date for IOL.
- Women occasionally have the appointment to discuss IOL with the obstetric team prior to prolonged pregnancy dates due to an inability to have an appointment at an appropriate time.
- Difficult for women to opt for IOL when pregnancy is prolonged, after planning a normal birth and declining initial option of IOL.

Table one: Snap shot view of numbers of women birthing before IOL date.

Number of post-date IOL booked through Whangarei ANC	161 women	
Number of women delivered prior to their IOL date	53 women	33%
Number of women booked for IOL between 41weeks and 41+4 weeks gestation	118 women	73%
Number of women booked at 42 weeks gestation for IOL	8 women	4%
Number of women birthed before 41+4 weeks gestation	33 women	20%

It was decided that NDHB should review the current system for the booking of uncomplicated post-dates IOL with an option of referral to a virtual clinic or a consultant ANC. This was completed as part of the Maternity Quality and Safety Programme established in 2009 by the Ministry of Health. Standard 2 states "Maternity services ensure a woman-centred approach that acknowledges pregnancy and childbirth as a normal life stage."

Other regional DHB's already undertake a non-contact referral process for women with an uncomplicated post-dates pregnancy, therefore making the proposed change of offering an option of referral to a virtual clinic, would bring NDHB into alignment with the Northern Region DHB's.

Suggested process for booking women for uncomplicated post-dates IOL into a virtual clinic were:



- Ensure an accurate date of expected delivery is clearly recorded and understood by the woman. Plan a dating ultrasound scan (USS) early in the pregnancy to confirm dates if possible.
- The Lead Maternity Carer (LMC) to have a preliminary discussion with women of the management of prolonged pregnancy in the antenatal period, with further discussion around 39 weeks gestation and begin the plan for IOL if required and consented by the woman.
- Offer stretch and sweep at 41 weeks.
- At 40+4 weeks send in a referral to the virtual clinic.

Include in referral:

- A full antenatal history,
- Copies of all USS reports,
- GROW chart,
- A documented discussion with the woman to confirm she agrees to have a notes only referral with the obstetric team should also be included,
- Completed referral form, with all criteria met.

It was assumed that the women of Northland would prefer referrals to a virtual clinic, taking into account some of the barriers to attending a hospital Antenatal Clinic. Following discussion at the Consultants meeting it was agreed that a survey should be completed prior to changes being made, taking into account the women's, the midwives and the Obstetrician's perspectives. Three surveys were undertaken (appendix 1, 2, and 3).

Reviewing the suggested process, as well as looking to see if women wanted to change the method of referral, we reviewed current practice to see how many midwives and Obstetricians would need to alter their current practice to comply with the amended guideline.

Method

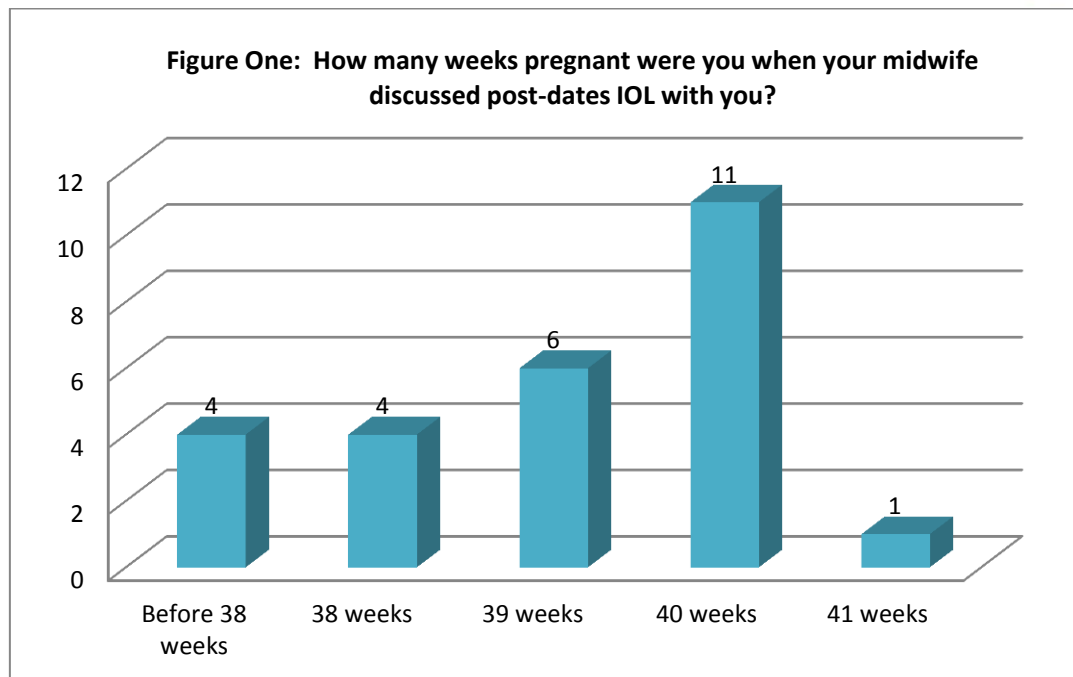
Paper surveys were placed in the Delivery Suite of Whangarei hospital and were offered to all women being induced for post-dates from the 1st of November 2012 until the 31st January 2013. The survey was then offered to all women attending Whangarei hospital Antenatal Clinic for post-dates referral from 1st February until 30th April 2013.

Concurrently all Lead Maternity Carers in Whangarei, Bay of Islands, Kaitaia and Rawene were given midwifery questionnaires to complete, to be returned by 30th April 2013.

The 6 Obstetricians in Whangarei were given questionnaires to complete in May 2013.

Results

26 women, 19 midwives and 6 Obstetrician's completed questionnaires



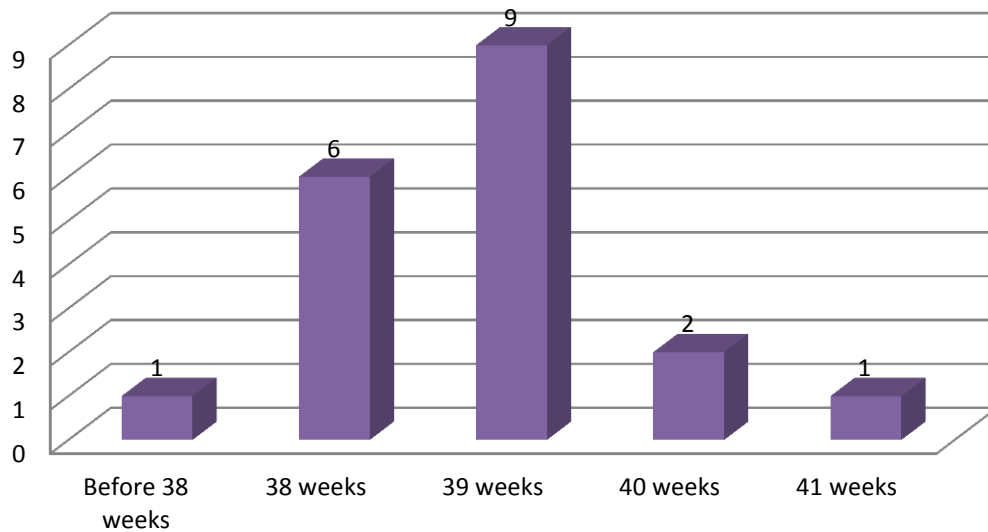
42% (11) of the women indicated that post-dates IOL was first discussed with them around 40 weeks and 14 (%) women stated that post-dates IOL was discussed at or before 39 weeks gestation. Only one woman answered that her midwife waited until 41 weeks gestation to discuss IOL. Thus very few women would have had a discussion with their midwife by the required time for participating in a virtual clinic.

Midwives' responses to the same question are below (Figure Two). 84% (16) of the midwives responded that they discussed IOL at or before 39 weeks. This practice would support the use of a virtual clinic referral. Only one of the midwives who responded waited until 41 weeks before having this discussion with her women.

Two of the midwives commented that they give this information as individually indicated by the women's needs. One midwife commented that it is often discussed prior to 38 weeks as this is something she finds her women are very interested in.



Figure Two: How many weeks pregnant are women when you first discuss post dates IOL ?



The Obstetricians were asked for their views on how many weeks gestation a woman should be when referred for a consultation regarding post-dates IOL.

One Obstetrician stated at 38 weeks, one Obstetrician stated 39 weeks, one Obstetrician stated 41 weeks and three felt IOL could be discussed at any convenient time for the woman. There appears to be no consensus amongst the NDHB Obstetricians regarding the timing of the referral.

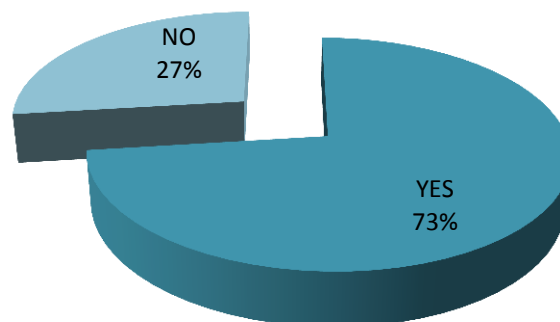
Women were asked if they had the IOL process explained to them by their midwife. 73% (19) of the 26 women reported they had the procedure explained to them (Figure Three). The quality of the information given has not been captured by this survey. Women commented:

“Very briefly, she just said when to meet her and that I’d have to stay overnight”

“Very clearly and I felt quite comfortable about the process”

“We had an appointment with the Obstetrician who explained it”.

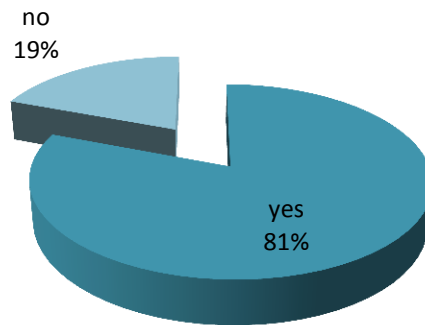
Figure Three: Was the IOL process explained to you by your midwife





81% (21) women reported receiving written information from their midwife about IOL (Figure Four).

Figure Four: Were you given any written information about Induction of labour?



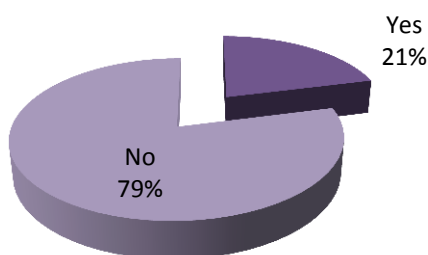
All 21 women who had been given written information regarding post-dates IOL from their midwives responded that they found this useful. One woman commented:

“Not from the midwife but from the doctor in the Antenatal Clinic”

Midwives were asked if they gave written information to women regarding post-dates IOL and have they had feedback or comments from the women about this?

79% (15) of the 19 midwives responded they did not give written information to the women regarding post-dates IOL (Figure Five), however the four that did responded that the women they gave information to commented upon its usefulness. Again this survey has not sought to comment on the quality of written information.

Figure Five: Do you give women written information regarding IOL?



All six of the Obstetricians give women written information when they attend clinic for a post-dates induction consultation. One Obstetrician commented

“We have a standard IOL booklet we give to all women who attend for IOL discussion”.

Women were asked, “Did you have a better understanding of the IOL process and the reasons for induction after the consultation?” 88% (23) women felt they had a better understanding following the consultation (Figure Six). Of the three women that said no they commented:

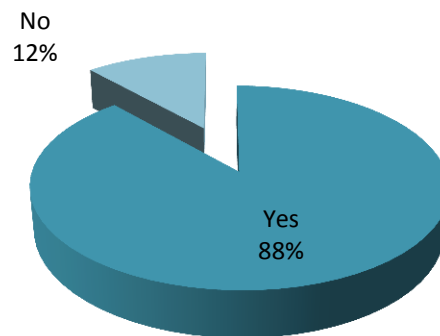


“My understanding remained the same”

“My midwife explained it to me”

“No change in my understanding”.

Figure Six: Did you have a better understanding of the IOL process and the reason for IOL after the consultation?



Women were asked if the appointment to see the doctor was convenient for them. 25 of the 26 women said the appointment it was. One woman commented that the timing of the consultation was convenient but:

“I had to travel from Dargaville”.

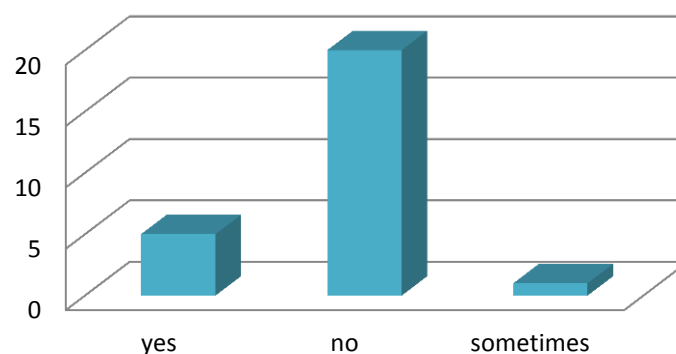
Women were asked if their midwives attended the ANC appointment with them (Figure Seven). 19% (five) of the 26 women stated the midwife attended the appointment with them. 20 women attended the appointment without the midwife. One of the women who responded her midwife did not attend with her commented:

“She was not required I didn’t need her to”.

One of the women who attended with her midwife commented:

“My LMC offered to attend the meeting with me and my husband. Really appreciate it”

Figure Seven: Did your midwife attend this appointment with you?

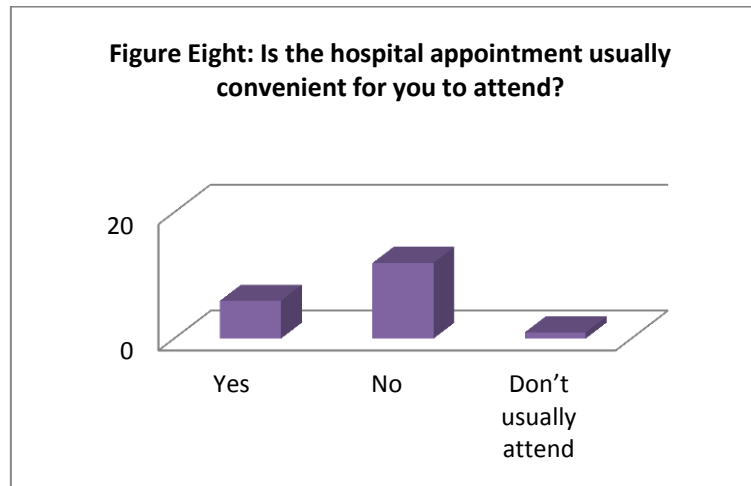




Midwives were asked if the ANC appointments were convenient for them to attend? (Figure Eight). 63% (12) of the midwives stated the appointment was not convenient for them to attend. One midwife stated she doesn't usually attend. One midwife commented

"Why do they need us to attend with them?"

"There is only one clinic per week (at best). Very short appointment time and some women have to travel long distances."



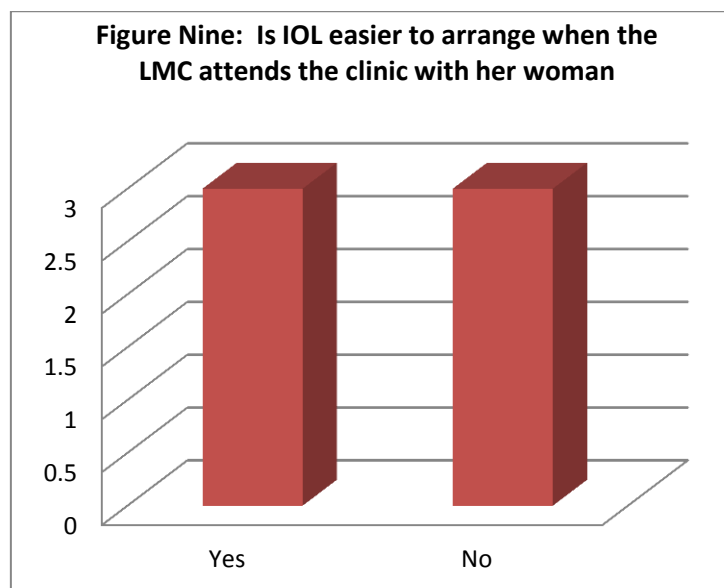
Obstetricians were asked, "Do LMC's attend ANC appointments with the women?" One Obstetrician stated yes and five stated sometimes. One Obstetrician commented

"Not always. It is very helpful to me to have the LMC there as that gives the woman and the LMC the "three way" consultation and the ability to ask questions together. I know and understand it may be difficult to arrange this but I am ALWAYS happy when I have the LMC present for these discussions."

When asked if they found IOL easier to arrange when the LMC is with the woman, three responded yes and 3 responded no (Figure Nine). Obstetricians commented:

"The date needs to be booked in consultation with the LMC – best if they book"

"Being able to discuss the rationale of IOL with the LMC and woman together is useful to me."





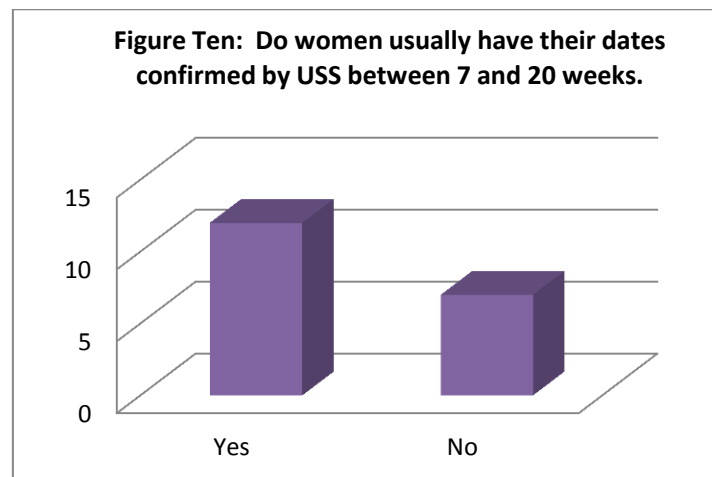
Midwives were asked, “Do the women you care for have dates confirmed by USS between 7 and 20 weeks gestation?” (Figure Ten). 63% (12) midwives stated yes and the other 37% stated no. Midwives commented:

“Not dating scans more nuchal scans and or anatomy. Reasonable number of late scans for dating with late presentation”

“Not confident in using late scans for dates, the earlier the better. Dating scan only organised if unsure dates”

“Not if they have a reliable last menstrual period (LMP). Not enough resources in Kaitiaia”

“Very occasionally have a woman who chooses no scans”.



Obstetricians were asked, “Should all women have dates confirmed by USS between 7 – 20 weeks?” All six Obstetricians agreed that dates should be confirmed by USS. Comments made by Obstetricians were:

“YES at the 1st visit to LMC”

“Good practice for managing all the pregnancy”.

There is a difference in the views of the midwives and Obstetricians regarding early confirmation of dates through the use of USS which would need to be addressed before a virtual clinic could run successfully.

Midwives were asked if they complete customised GROW charts for all women. Over half of the midwives (ten) currently do not use routine customised GROW charts for the women they are providing care for. (Figure 11) Three of the Midwives commented:

“I use a growth chart only if there is a concern with fetal growth” another commented “I feel this is abnormalising the normal. I will use if concerned or if risk factors”

“Used them as required/indicated – but have commenced now using them for all women”

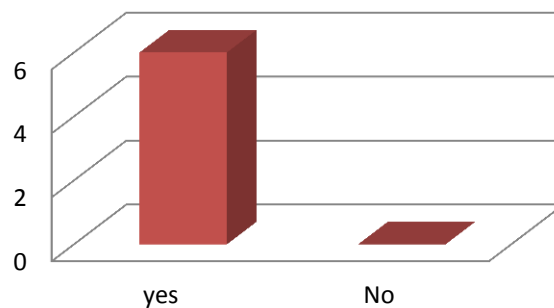
“Use them on most women, and if feels small or large or has a history of Small for dates”.



Figure 11: Do you currently use GROWcharts for all women?



Figure 12: Should all women have a GROW chart completed during pregnancy?



Obstetricians were asked if they agreed all women should have GROW charts completed during pregnancy (Figure 12). All six Obstetricians agreed this would be their recommendation. Comments made by the Obstetricians were:

“This is a very important tool to diagnose fetal growth problems; each woman, including primagravidas, should have one created at her booking visit to be used when measuring fundal heights later in the pregnancy”

“Good practice for managing all the pregnancy”

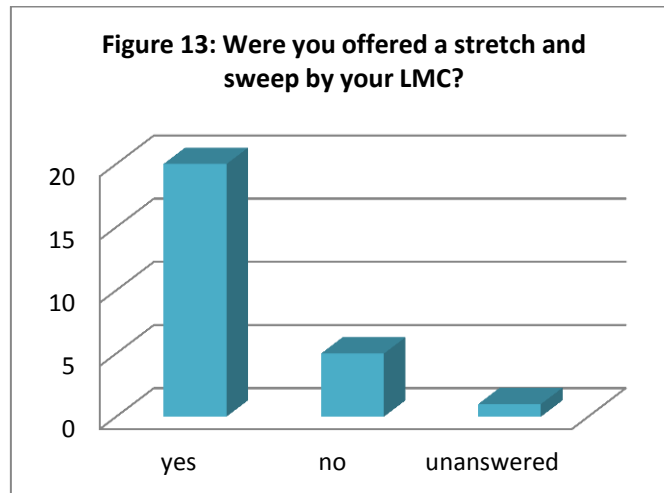
This also highlights a difference in the opinions of midwives and Obstetricians around the use of GROW charts, which is one of the criteria to be met before being referred to the virtual clinic.

The women were asked if they were offered a stretch and sweep by their midwives (Figure 13). 77% (20) women were offered stretch and sweep by their midwives, one woman left this question unanswered. One woman commented:

“I don’t think so but I’m not sure, but she did explain to me what it was”.



Figure 13: Were you offered a stretch and sweep by your LMC?

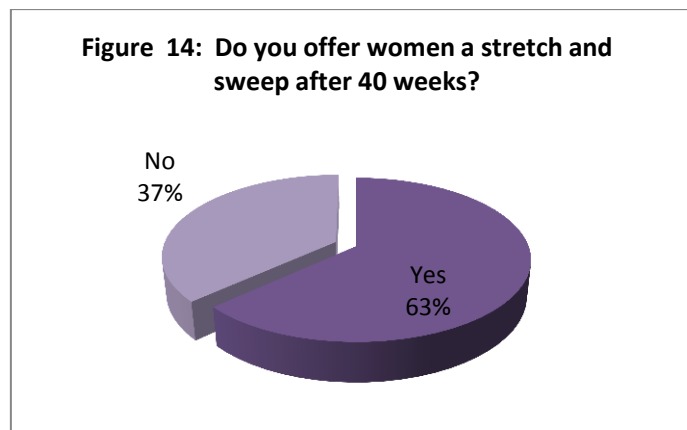


The midwives were asked if they offered stretch and sweep to their women. 37% (seven) of the respondents did not offer stretch and sweep after 40 weeks (Figure 14). Of the seven midwives who replied “no” four of them commented that they discuss stretch and sweep with the women after 40 weeks

“I discuss it with the women and they decide if they want it or not”

“I usually discuss it at 41 weeks”.

Figure 14: Do you offer women a stretch and sweep after 40 weeks?



The Consultants were asked if they recommended a stretch and sweep for all women with post-dates pregnancies. Four of the six consultants stated yes and two stated no (Figure 15). Obstetricians commented:

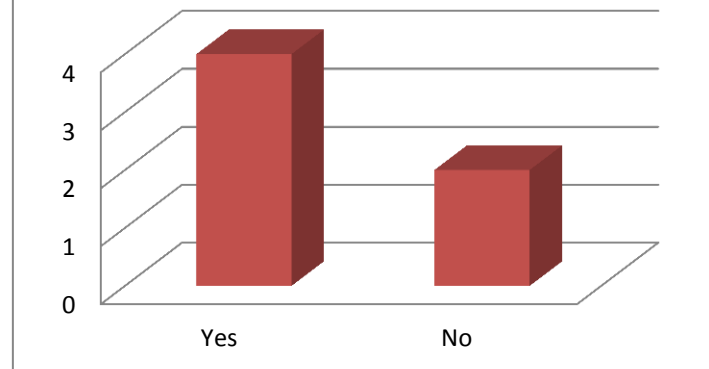
“I would recommend offering all women a stretch and sweep at 40 weeks and repeat if necessary at 41 weeks”

“It may be appropriate, but we should still remember that it is induction – a process designed to initiate labour. That it takes a few days to work is neither here nor there. It should not be offered prior to 40 weeks, as sometimes happens.”

“I would say any time after 39 weeks!”



Figure 15: Do you recommend a stretch and sweep for all post dates women after 41 weeks



Women were asked if they had a choice, how they would like their IOL arranged? The options offered to women were:

- A consultation between your midwife and the doctor with no hospital visit
- A consultation with the doctor at the hospital antenatal clinic.

81% (21) women would choose to have an appointment with the doctor in the ANC (Figure 15).
Comments Included:

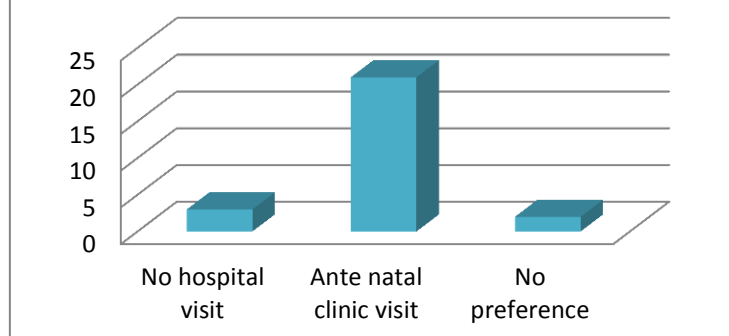
"I am happy with my arrangement and wouldn't expect a different approach"

"It's nice to be involved, have questions answered"

"No preferences"

"I am comfortable with the ways things are going".

Figure 15: If you had a choice how would you have preferred your IOL to be arranged?



Midwives were asked would they prefer IOL to be arranged by:

- Consultant visit in the ANC
- Referral to a virtual Clinic
- To have an option of choosing a clinic visit or a virtual referral.



79% (15) midwives would prefer to have an option of being able to refer a woman to a virtual clinic or to a hospital antenatal clinic (Figure 16). Only one midwife responded that she would like to continue with the current practice and three would have opted for a virtual clinic only. Comments documented by midwives were as follows:

"I often provide more information than a visiting SHO and find the process frustrating. All primips are offered an Obstetrician consult as a means of offering choice. It works in the rural setting and facilitates good communication between practitioners"

"I would like to be able to book via a telephone conversation when women are overdue. It seems like a waste of time and resources to do a virtual or real clinic consult on the small chance of a woman not going into spontaneous labour"

"Individualised care"

"Women from Rawene have a two hour trip each way to discuss IOL. An option of a virtual clinic would be very good"

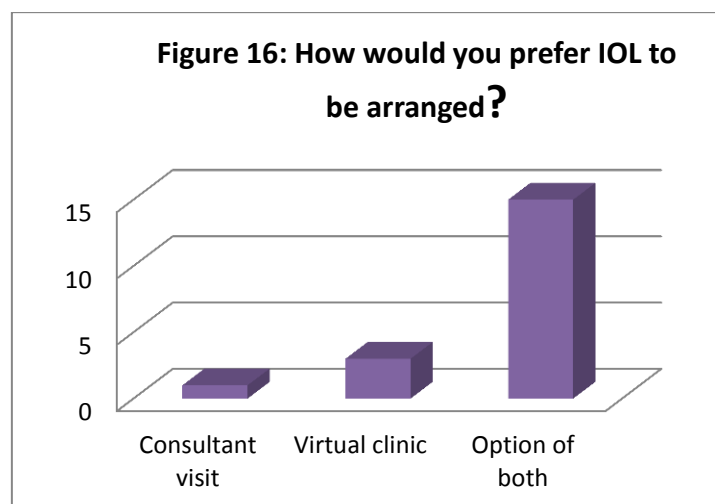
"Some women refuse to have a consult re IOL as they don't want to be induced for post-dates. If an obstetric reason occurs (e.g. PROM), they need to be induced which is then difficult if they haven't had the appointment and staffs attitude can be unhelpful".

One midwife would like to have the option of both but commented:

"More appointment times if current system remains".

One of the midwives stated she would prefer to refer to a virtual clinic but have the option of referring to a "Consultant (not SHO) if there are concerns. The information is always more appropriate from a consultant. More all rounded and targeted to the individual needs of the woman. The SHO gives a standard view and is not generally able to back the view or any other view with credible research".

Another Midwife suggested "Women should always see the same consultant each visit, that once the consultant has made a decision regarding a woman's care then another should not come along and change the plan. The LMC should be informed when an appointment is, so we can attend. Induction should be arranged at a time which is convenient for the woman and her midwife not at a set time according to the consultant".



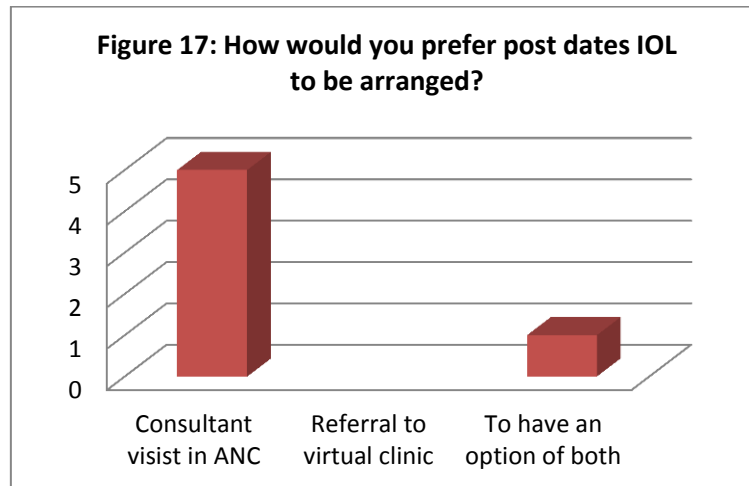
The Obstetricians were asked the same question. Five of the six Consultants preferred to keep the current system with all post-dates IOL having an ANC visit to see a doctor (Figure 17). Comments from the Obstetricians were:

"I think the only value of a clinic visit is for women who don't want IOL. Otherwise this can all be arranged via standing orders and policies."



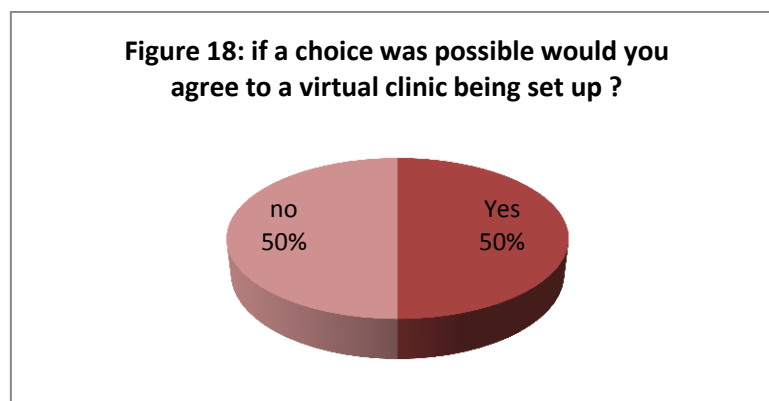
“This allows the woman the opportunity to ask questions directly to the person best able to answer them, and maintains the seamless, collaborative service that the Ministry requires from us all.”

“I think there are certain situations where a virtual clinic is appropriate in particular for women who live remotely. I also find these IOL discussions provide valuable teaching opportunities for the students so selfishly would like to keep them but I do realise that is a totally non patient-focused answer!!!”



The Obstetricians were also asked, “If it was possible to offer a woman a choice, would you agree to a virtual clinic being set up?” Three of the Obstetricians would not agree to a virtual clinic and three would agree to it being set up (Figure 18). Comment included was:

“I think there are certain situations where it is appropriate – but I would probably reserve it for women who have a long way to travel and it may end up being a delay in the long run if they do not meet the criteria set up for eligibility for the virtual clinic. I think that if everyone were to agree with this I do not have strong objections, but I would expect spotless records, a GROW chart and a dating scan.”



Discussion

This survey was completed as part of the Maternity Quality and Safety Programme to ensure that NDHB provides services that are women centred. We were reviewing the process of LMC’s booking post-dates IOL via a virtual clinic rather than a visit by the woman to the hospital ANC. It was assumed that women would find a non contact referral more convenient.

The survey also reviewed current practices of Obstetricians and Midwives to ascertain how much change would be needed by practitioners to comply with a robust guideline for referral.

It was noted that, although there is a current guideline for referral for uncomplicated post-dates IOL, practice varies in both the Midwife and Obstetrician groups



Most women had the process of Induction explained to them by their LMC and were also given written information, however most women stated that they had a better understanding of the process following their hospital visit. All women who were given written information responded that they found this information useful. The majority of midwives and all the Obstetricians give women written information regarding IOL

Only one woman felt her hospital appointment was not convenient for her but only five women had her LMC accompany her to her appointment. Twelve of the midwives felt the hospital appointments were not convenient for them to attend and one stated she did not usually attend. Obstetricians noted that midwives sometimes attend appointments with the women and half of the Obstetricians stated it was easier to arrange an IOL with the LMC present and half felt it was not.

Obstetricians stated that all women should have their dates confirmed by USS between 7 and 20 weeks but 37% of midwives responded that not all of their women have dates confirmed. The comments made by midwives indicated a few reasons for this discrepancy. Patient choice, late booking and not enough resources available in rural areas were three of the reasons listed.

Obstetricians responded that all women should have a GROW chart completed but just over half of the midwives do not complete GROW charts for their women. Both the PMMRC and NZCOM recommend the use of GROW charts as best practice as a tool to aid the identification of intra uterine growth restricted babies. Further discussion and education needs to take place in Northland to ensure women are getting a consistent approach to antenatal care from practitioners. GROW charts would be need to be completed to meet criteria if virtual clinic offered

Most women indicated they were offered a stretch and sweep. Midwifery replies suggested that most midwives discuss it with the women. Obstetrician's opinions differed as to when a stretch and sweep should be offered to a woman.

81% of women would choose to keep the current system of booking and referral for IOL and five of the six Obstetricians would also prefer to keep the system as it is. However 79% of the midwives would like to have the option of offering the women a referral to virtual clinic or a hospital visit. Half of the Obstetricians would not agree to a virtual clinic being set up if they had the choice The only support for a virtual clinic is from the midwives. Perhaps this could be because the midwives, Obstetricians and women's perceptions are different. Midwives see the outcomes from many consultations but the women only experiences one consultation. Obstetricians do not experience each other's consultations. Midwives may have formed the impression that there are inconsistencies in the service and advice which the women would have not experienced.

Conclusion

Although the idea of a virtual clinic for booking an IOL is favoured by LMCs, neither the Obstetricians nor the women in this study support this view. This was not the expected outcome of the audits. As a consequence the current system of visits to the Antenatal Clinic is to continue at this time. This will need to be explored further to ensure it offers consistency to the women and facilitates the attendance of LMC's at appointments to allow the three way discussions to occur as per the referral guidelines

In addition, the use of GROW charts in Northland needs to be encouraged, as per PMMRC and NZCOM recommendations, to ensure consistent care for women.

Whānau Whāre Pēpe Pānuī

Kia Ora,
Congratulations to all our Mums and Whanau on the birth of their babies.
We had 122 babies born in February and 145 babies born in March in Whangarei Maternity Unit.

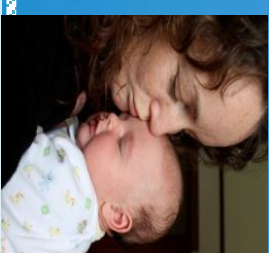
Post Natal classes especially for our teen mums:

Ange Yendell (lactation consultant) runs a Yummy Mummies coffee group which is held at The Pulse. This an education session with guest speakers and homemade food. The aim was to get a peer support network running for breastfeeding Mums and this has worked well. Ange provides breastfeeding support, Jigs Bradley from Parents as First Teachers provides invaluable information and Leanne Going from Plunket provides well child checks. We are pleased to report that 100% of these babies are fully immunised, the breastfeeding rates are increasing and the Yummy Mummies are thriving with motherhood. Some are back at the Teen School, some are attending a course and some are enjoying motherhood.

Your Opinion Counts!

Patient satisfaction surveys were collected during the month of February from women who had birthed and stayed in our post natal ward.
Thank you to the 57 women for the feedback. ☺

97% of the woman who responded to our survey felt the overall service was good to excellent. Throughout this report there is an indication that the women feel very comfortable asking staff for help and that communication is very good on the ward. Comments demonstrate that the women found staff to be pleasant, helpful and knowledgeable. Most women responded that their needs were met to their satisfaction in a timely manner.
Some of the feedback received suggests there are a few areas that need a little improvement. 23% of the women responded saying they were checked upon less than 3 hourly. We expect women staying on the ward to be checked hourly during the day and at least 2 hourly during the night. This is to ensure that your needs are met. Evidence suggests that women who are checked regularly recover better. We will not wake you up to tell you we are checking on you. Over 20% of our women were only offered pain relief occasionally or they needed to ask for it. This is something for us to improve upon.



If you know someone who is pregnant encourage them to book early in their pregnancy with a midwife so that they access good antenatal care and advice.

Protect yourself and your baby-

Immunise-Current advice is all pregnant women are vaccinated against flu and whooping cough. Flu vaccinations are free to all pregnant women and you can get them from your GP or from drop in clinics in the Antenatal Clinic in Whangarei hospital. Whooping cough is also free for women in the third trimester of their pregnancy. **Drop in clinics Monday – Friday afternoons until 4pm Antenatal Clinic Whangarei Hospital**

If you have any comments or want to contribute to this newsletter please contact

Michelle.bailey@northlandhb.org.nz

April 2013

FINDING A MIDWIFE IN NORTHLAND

Professional Midwifery Care

Midwives are specialists in pregnancy and birth. They provide care from early pregnancy right up to six weeks after your baby is born. Midwives provide information to enable you to make the right decisions and choices that are right for you, your baby and your family.

WHANGAREI AREA

Antenatal Clinic
Whangarei Hospital
Hospital Road
Whangarei
Tel (09) 430 4101
extension 8605
0800 696 439

BAY OF ISLANDS AREA

Bay of Islands Maternity Unit
Hospital Road
Kawakawa
Tel (09) 404 0280
0800 264 222

DARGAVILLE AREA

Dargaville Maternity Unit
Awakino Road
Dargaville
Tel (09) 439 3330

HOKIANGA AREA

Hokianga Health
Enterprise Trust
63 Parnell Street
Rawene
Tel (09) 405 7709

KAITAIA AREA

Kaitaia Maternity Unit
29 Redan Road, Kaitaia
Tel (09) 408 9180
0800 582 643



Useful Websites

Find a Midwife

www.findyourmidwife.co.nz

New Zealand College of Midwives

www.midwives.org.nz

Northland District Health Board

www.northlanddhb.org.nz