

*West Coast District Health Board  
Midwifery Service Review*

**FOR PUBLIC RELEASE**

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## **1.0 Executive Summary**

The New Zealand College of Midwives (NZCOM) was approached, during February 2007, by Jane O'Malley Director of Nursing and Midwifery (DONM) on behalf of the West Coast District Health Board (WCDHB) to conduct a review of midwifery services across the DHB. The review was to pay specific attention to the Kawatiri Maternity Unit in Westport.

Norma Campbell (NZCOM Midwifery Advisor) and Lesley Dixon (NZCOM Midwifery Advisor) agreed to conduct the review on behalf of the DHB. It should be noted at this point that the NZCOM considers that it is independent from the West Coast DHB. NZCOM considered it appropriate to conduct this review when the issues were primarily workforce ones and the maternity workforce on the West Coast consists mainly of midwives. The College emphasises the importance of understanding that it is both the employed and self employed midwifery workforce which provides the integration of midwifery services. Midwifery then has the capacity to work alongside the medical and obstetric services in a supportive and collegial manner that meets women's and babies' needs. The WCDHB has an essential role in providing a facilitative environment and the infrastructural frameworks for this to occur.

The Terms of Reference of the review encompassed two overarching objectives:

- An appraisal of how the District Health Board, and in particular the Kawatiri Unit, provides maternity services in relation to Section 88 of the New Zealand Public Health and Disability Act 2000, the Maternity Service Facility Specifications and the current draft Primary Maternity Service Specifications.
- Evaluation of current processes and practices and how these might need to be developed or adapted to ensure the West Coast District Health Board continues to provide a clinically safe and viable service now and into the future.

And thought these objectives could form the main themes of the press release

Additional advice was also requested as outlined in Appendix 1.

The reviewers made some immediate recommendations to the DHB at the conclusion of the review. These are recorded in Appendix 3. These recommendations were considered interim proactive measures to provide a more strengthened infrastructure for current midwifery and other staff at Buller until the full report was written.

The framework used to report back to the DHB has been to follow where possible the Terms of Reference provided to us prior to the review. Other issues were apparent as the review progressed and they are also addressed.

## **1.1 Workforce**

1.1.1 Currently, despite the lack of midwives at Kawatiri, the two midwives are adequately meeting the Section 88 Maternity Notice requirements by providing antenatal and postnatal care, with the Grey hospital midwives providing the services for labour and birth. However this is only a short term solution as working in this way is not professionally rewarding for the midwives.

The message was clear that it is not acceptable to the women of Buller and does not assist the service to be sustainable in the long term. The staffing situation at Kawatiri must be rectified for long term sustainability of this service and for the women of Buller.

1.1.2 A concern that was highlighted to the reviewers is the ongoing disruption to maternity services for the women of the Westport community due to midwifery staffing shortages and the impact this is also having on the remaining midwives. Workforce stability is required for the Kawatiri Maternity facility so that the community can once again be proud of and have confidence in the services offered to them. This is also essential if a midwifery workforce is to be recruited and retained long term in Westport.

1.1.3 Immediate recruitment is required to fill current vacancies at Kawatiri to return the staff numbers to four FTE midwives. The team of four midwives working at Kawatiri unit has worked well historically and provides a high quality service for the women of the area.

1.1.4 Consider staffing skill mix and expectations of the staff in relation to the secondary service specifications within the McBreaty maternity unit at Greymouth. As an example, within the unit there are enrolled nurses working within an acute secondary environment. It was unclear what support they have been given to ensure they and other staff members clearly understand their role and the limitations of their scope of practice.

1.1.5 The Greymouth unit appears to currently be staffed by a number of casual midwifery staff, some of whom may be happy to move to more permanent shifts with the accompanying benefits. Working with a high level of casual midwives leaves the service vulnerable as they can all decline to work. This needs to be addressed and monitored.

1.1.6 From a workforce recruitment and retention perspective we recommend that the DHB continue to employ LMC midwives at Grey hospital. This is supported by the new Primary Maternity Service Specifications.

Whilst there are self employed midwives working in the Grey District, on the West Coast the stable workforce has historically been the employed LMCs. This is likely to be related to the low (by other Board standards) birth rate and the geographical spread required for service provision. It is important for the DHB to continue offering these roles as a recruitment strategy especially for graduate midwives coming to the area. It is also important for the DHB to support the graduate workforce whether they are employed or self employed.

**1.2 Clarification of roles**

1.2.1 Clarify management roles and professional leadership roles so all staff are informed of the different roles and responsibilities.

[Redacted]

1.2.2 As recommended at the conclusion of the review we suggest that the Buller Hospital Manager manage the day to day operations of the Kawatiri unit to ensure closer management support and integration of the maternity services with the wider health community of the Buller region.

[Redacted]

1.2.3 [Redacted]

[Redacted]

1.2.5 As a further example the consumers in Westport were also surprised that the day to day management has not always been carried out by Buller Health. Again whatever is implemented as a result of the review must be conveyed by the DHB to the community.



1.2.6 The DHB needs the services of a hospital aid at Kawatiri. It is the view of the New Zealand College of Midwives that the current Hospital Aid/Doula title for this role is leading to unrealistic expectations, within the community, about what this role can provide.

### **1.3 Interprofessional issues**

1.3.1 The structure of the midwifery services and professional advice and support is as follows and should work accordingly. The Director of Nursing and Midwifery (DONM) is responsible to the CEO for working with nurses and midwives to develop and maintain an appropriate standard of patient care (position description attached Appendix 4). The DONM takes advice from the Clinical Charge Midwife and as appropriate from NZCOM in relation to standards of care related to midwifery practice, midwifery services and midwifery workforce. The DONM, the Clinical Charge Midwife and the Nurse Manager, Acute and Specialty Services work together to achieve quality patient care outcomes.

1.3.2 Professional advice and support for the midwives of the West Coast should overtly belong to the Clinical Charge Midwife role at Greymouth. This will concern day to day practice and professional decision making and issues and liaison with the other health professionals working/interfaces with maternity eg St Johns, anaesthetists, obstetricians. To ensure seamless professional and operational activities the Clinical Charge Midwife will communicate regularly on relevant matters with the manager of the maternity service, the Nurse Manager, Acute and Specialty Services.

1.3.3 Professional advice and support about maternity issues for the nurses who are either working in or interfacing with maternity on the West Coast should be collaboratively given by the Director of Nursing and Midwifery and the Clinical Charge Midwife at Greymouth. This would include those working at McBrearty at Grey, Foote Ward at Westport, Public Health Nurses, those in South Westland and the Well Child Providers.

### **1.4 Education**

1.4.1 Regular meetings and collaboration between groups would help to develop an understanding of roles and responsibilities and collegial networking. Currently this does not occur.

1.4.2 An introductory workshop needs to be planned for the midwives about the MECA's Quality and Leadership Programme (QLP). Those midwives who wish to participate need to be supported to apply, and assisted to meet the requirements.

- 1.4.3 Maternity emergencies – drills and skills sessions for all health professionals with close links to care provision for maternity need to be regular and current.
- 1.4.4 Education in neonatal care should be strengthened - pre term birth, stabilizing the neonate and follow on care when discharged from the neonatal unit is required.
- 1.4.5 Midwives at Westport do not currently attend the multidisciplinary education meetings held at Buller Health. If the case is not pertinent to maternity, there would still be value in participating in the business part of these meetings as a chance to improve collegial networking. It is recommended that, every quarter, one of the above meetings has maternity as the topic.
- 1.4.6 It is also recommended that there are formal opportunities to debrief following a difficult/complex case for all practitioners involved in maternity on the Coast.
- 1.4.7 Consider the use of telemedicine for education with other centres or with Greymouth.
- 1.4.8 All midwives and health professionals providing maternity services should have the opportunity to be involved in clinical guideline development.

### **1.5 Graduate midwives**

- 1.5.1 Continue to offer placements to the Schools of Midwifery for student midwives as this is an acknowledged recruitment strategy.
- 1.5.2 The reviewers understand the DHB currently offers support to people considering education to become a health professional. This needs to be promoted to the community as there were women who spoke to the reviewers who are interested in becoming midwives for the West Coast.
- 1.5.3 Discussions with the School of Midwifery in Christchurch about the possibility of a joint project to recruit undergraduates from the West Coast community would be helpful.
- 1.5.4 Encourage experienced midwives currently employed to consider the role of mentor. Support these midwives to participate in the preparatory education required and offered by the profession.
- 1.5.5 Plan to encourage recruitment of graduates from either Otago or Canterbury commencing 2008.
- 1.5.6 Aim to take one to two new graduates a year and offer them a supportive environment for practice.

- 1.5.7 There is no necessity for the DHB to establish its own midwifery programme as such but there is a need to consider what the DHB can offer midwifery graduates that would support and interface with the aims and requirements of the Clinical Training Agency's Midwifery First Year of Practice Programme.
- 1.5.8 One of the ways the DHB can encourage recruitment of new graduates is to improve orientation processes for employed and self employed new graduates in the area by providing them with approved local mentors and offering preceptorship when working in the DHB.

**1.6 Interface between neonatal nursing and midwifery; inclusive of the multidisciplinary care and transfer of neonates.**

- 1.6.1 Progress with plans for new unit with closer geographic location of maternity and paediatrics.
- 1.6.2 Drills and skills workshops held regularly for all staff (including all medical staff) involved in the resuscitation and/or transfer of neonates. This will assist the development of collegial relationships as well as an appreciation of different skills. These workshops, if planned in advance, could coincide with the Canterbury DHB paediatrician's visit and become regular occurrences for all staff to attend annually.
- 1.6.3 Ensure these workshops are not only offered to the employed midwives but also to South Westland self employed midwives and Buller Health staff.
- 1.6.4 Maintain relationships with neonatal services at Canterbury DHB. Ensure any changes to obstetric policies have an involvement, where applicable, with the neonatal service at Canterbury DHB as it may have an effect on retrievals.
- 1.6.5 Create an environment where cases that have required resuscitation and/or transfer can be discussed as a quality assurance activity by all involved including feedback from the neonatal retrieval service at Canterbury Health if retrieval has occurred. This is not currently happening and provides valuable learning opportunities to improve systems.
- 1.6.6 Maintain close relationships with St Johns. They also run courses and it appears that these have not been tapped into eg flight rescue for one or two of the midwives as elective education.

### **1.7 Orientation to the New Zealand maternity service on the West Coast**

It is important that all new practitioners to the West Coast have a formal orientation not only to their workplace but to the community, the region, colleagues and their roles as well as who they are expected to interface with and their role. For maternity it is also important that there is a chance to become familiar with the New Zealand maternity service as it does differ from anywhere else in the world.

### **1.8 Dissemination of information**

Dissemination of information (*such as service statistics, staff changes, policy changes, educational updates and feedback*) via minutes, newsletters or news updates needs to occur and could be a collaborative project between the West Coast DHB maternity services, maternity providers, the Canterbury West Coast region of the College of Midwives and others who interface with maternity.

### **1.9 Section 88 claiming**

During the review it came to the attention of the reviewers that the Section 88 claiming that is currently done by the DHB may not be accurate or up to date. Concerns were also raised that some claiming may have been missed completely. Whilst not specified in the Terms of Reference, the reviewers would like this to be noted as these inaccuracies may impact on future funding levels when Section 88 funding is devolved from the Ministry of Health, and therefore impact negatively on the future provision of maternity services in the area.

### **1.10 Position descriptions**

The review referred to position descriptions for maternity services. These need to be reviewed in line with the professional requirements of an employed midwife. [REDACTED]

[REDACTED]. The position description at Westport refers to the role of Hospital Aid/doula. For the reasons noted previously this also needs to be reviewed.

## **2.0 Introduction**

The New Zealand College of Midwives was approached during February 2007 by Jane O'Malley Director of Nursing and Midwifery (DONM) on behalf of the West Coast District Health Board (WCDHB) to conduct a review of midwifery services across the DHB, paying specific attention to the Kawatiri Maternity Unit in Westport.

Norma Campbell (NZCOM Midwifery Advisor) and Lesley Dixon (NZCOM Midwifery Advisor) agreed to conduct the review on behalf of the DHB.

The Terms of Reference for the review are attached (Appendix One). It was explained at the beginning of the review by the DHB that there was no underlying agenda in relation to closure of the Kawatiri Maternity Unit. Indeed the DHB gave the College a strong commitment to retain the Kawatiri Maternity Unit and the midwifery service that operates from it as part of its maternity services provision for the region.

### **2.1 Review Process**

Appointments were allocated, on behalf of the reviewers, by the Director of Nursing and Midwifery following discussions between her, the Clinical Charge Midwife, the Nurse Manager Acute and Speciality Services (manager of the maternity service) and NZCOM advisors about who may have an interest in contributing to the review. A public forum was also arranged to ensure the people of Westport were able to contribute directly to the review process.

The review was conducted on 8 and 9 March, 2007. The list of those who contributed is recorded in Appendix two.

The reviewers assured those who participated in the interviews that the discussions were confidential, themes were being looked for, that notes were made as prompts only and not as a record of the conversation. All participants agreed with this. The public forum was also informed that we were looking for themes and a way forward.

The reviewers would like to express their thanks to all those who contributed to this review. Their honesty was appreciated. We recognise it was difficult at times for some of those who were interviewed. We would also like to express our thanks for the warmth and hospitality we received from all those we met both in Greymouth and Westport, even those not directly involved in the review. It was appreciated.

### **3.0 Background**

During the course of the review, it was necessary for us to ascertain the maternity service as it is currently provided in the West Coast DHB. This requires an understanding of the unique geography of this DHB. In practice, this means that providers have at times to work in isolated situations to ensure women do receive maternity care. From discussions, we have developed the following understanding. In 2004, 79% of births to usually resident West Coast women occurred in West Coast Hospitals. This was the most recent data given to us. This means that 14% of women give birth in other DHBs. Some may be because of clinical reasons but we are aware that others are as a result of unavailability of local services. The actual percentage of births that occur elsewhere because of unavailability of services cannot be quantified.

#### **3.1 Services based in Greymouth- McBrearty Ward**

There are approx 260 births a year at Greymouth Hospital - McBrearty Ward. This unit provides primary care for women on the West Coast who do not birth at the Westport unit or at home. It is also the secondary maternity unit for the West Coast. As such it is required to provide services as outlined in the Maternity Primary and Secondary Service Specifications which can be viewed on the Ministry of Health website - [www.moh.govt.nz](http://www.moh.govt.nz) The West Coast DHB owns the facility and employs all of the staff. The West Coast DHB covers a large geographic area equivalent to driving from Wellington to Auckland in distance. Ambulance and helicopter emergency retrieval systems are well established but again at times the isolation can mean significant time delays.

##### Staffing of the unit

There are 2.8 FTE employed midwives providing the Lead Maternity Care (LMC) service. One midwife takes a clinical and a managerial role. The Clinical Charge Midwife also has a 0.8 FTE role as an LMC. The maternity unit operates with an equivalent of 5 FTE midwives, many of whom currently are casual staff. There is a further 3.3 FTE which is made up of two Enrolled Nurses, one Registered Nurse and one Obstetric Nurse.

There are now three permanently employed Obstetricians at Greymouth. The past ten years have seen a series of locums in these roles. Anaesthetic services are provided at Greymouth. Paediatric services are provided by a team of senior medical staff with telephone back-up from speciality services at the Canterbury District Health Board and the services of visiting specialist paediatricians. A close working arrangement has developed as a result of having no local paediatric medical specialists, with clear transfer and transport protocols to Christchurch. Staff at Greymouth feel the paediatric service has been increasingly streamlined for women and their babies. There is an acknowledgement that the ideal would be to have local paediatricians, but this may never be the reality.

Primary maternity service

There is a midwife LMC antenatal clinic held in Greymouth plus one at Reefton and Hokitika each week. These are run by the employed LMCs for the women booked to birth at Greymouth. The women from Hokitika who are booked with the employed LMCs receive postnatal care from them. The women of Reefton booked with the employed LMCs receive a combined service with the employed LMC and the local Public Health Nurse. Midwives employed as LMCs at Greymouth currently only travel as far south as Hokitika.

There are three self employed Lead Maternity Carer (LMC) midwives who are access holders to Greymouth Maternity facility. The West Coast has one of the highest homebirth rates nationally with 7%. Any homebirths in the area are provided by the self employed LMCs with the majority of these women residing at the Gloriavale Christian Community. Other homebirths north of Westport are attended by a midwife from outside the DHB.

Secondary maternity service

The obstetricians in Greymouth run antenatal clinics for women and there is a plan to have more satellite obstetric clinics for women who live in other parts of the DHB. The unit provides secondary maternity care which is now provided by three permanent obstetricians in collaboration with midwives, anaesthetists and the neonatal service at Canterbury DHB.

The Primary and Secondary Service is managed currently by the Nurse Manager, Acute and Specialty Service, who reports to the general managers secondary Services.

**3.2 Kawatiri Maternity**

This is a four bed primary maternity facility situated in Westport, Buller District which is approx 1½ to 2 hours from Greymouth. There were 92 confirmed pregnancies in the Buller last year but only 18 women birthed at Kawatiri.. Kawatiri also covers the area further north and is required to provide services as outlined in the Primary Service Specifications which can be viewed on the Ministry of health website- [www.moh.govt.nz](http://www.moh.govt.nz). The West Coast DHB currently employs two midwives (staffing should be four midwives but there has only been three midwives for the past 18 months) and a hospital aid in this facility. It is attached to a rural hospital which provides acute and medical services (Foote Ward). There are currently six employed general practitioners also working in the Buller community as well as Plunket Nurses, Public Health Nurses and the nurses employed by the Foote Ward.

At the time of the review the Kawatiri Maternity Unit was closed for births due to the shortage of midwifery staff. The women are currently advised to travel to Greymouth or if labour is established to be assessed by the midwife on call at Kawatiri. A decision is then made in relation to whether it is best to remain at Kawatiri or transfer to Greymouth.

In the event of the need to remain at Kawatiri, staff who work in Foote Ward can be called on as emergency support. They are not available for backup under normal circumstances. If labour is well established, but transfer is deemed safe, the ambulance service transports the woman with the midwife to Greymouth. The midwife then returns with the ambulance to ensure the Buller area still has midwifery cover.

There was considerable community concern at the current shortage of midwives and whether a recruitment process had begun. The Kawatiri Action Group has been reformed. This group was formed some ten years ago when the unit was under threat of closure and has acted as a watchdog for the community in relation to retention of maternity services in the area. There continues to be confusion about the current situation.

### **3.3 Westland**

There is no maternity facility in Westland. There are approximately 68 confirmed pregnancies in the Westland District each year. These women have their antenatal care provided by a general practitioner who is an LMC based in Westland, or one of the three self employed midwives who have access agreements with Greymouth. The self employed midwives used to travel as far south as the glaciers but now only go as far as Hari Hari. The women in South Westland are cared for/supported postnatally by the local Rural Nurse Specialists. Midwives, both the employed and self employed, liaise with these providers. The women generally travel out of the district to birth going to Greymouth or leaving the West Coast to birth in Christchurch or Dunedin.

### **3.4 Tertiary services**

These are provided by Canterbury DHB at Christchurch Women's Hospital. Ambulance and helicopter emergency retrieval systems are well established and the reviewers received positive feedback from all those who are involved.

## **4.0 Themes identified during the Review**

The reviewers made it clear to all of those interviewed that the intention of the review was to look to the future. Whilst it is of course necessary to consider the past, it is best not to dwell there particularly if things have not been working well. However it was also not the intention of the reviewers to make recommendations to change systems if they have been working well. We were also aware of the constraints under which organisations such as District Health Boards operate - financial, industrial, etc. We have remained cognisant of these and also recognise that whilst some of the recommendations may be able to be implemented easily and quickly, some may take more time.

At the conclusion of the review, the reviewers made some immediate recommendations to the DHB that we considered too important to wait until this report had been written. These are recorded in Appendix 3 (attached). Whilst they were discussed at the debrief on the last day of the review they were not formalised until the Monday following and it was recognised that they still would take some time to implement.

The framework used to report back to the DHB has been to follow where possible the Terms of Reference provided to us prior to the review. Other issues which became apparent as the review progressed are also addressed.

### **4.1 An appraisal of how the District Health Board maternity services, and in particular at Kawatiri Unit, are provided in relation to Section 88 of the New Zealand Public Health and Disability Act 2000, the Maternity Service Facility Specifications and the current draft Primary Maternity Service Specifications.**

#### **4.1.1 Kawatiri Maternity, Westport**

At the time of this review being conducted there was some discrepancy in understanding between the wider health professional network at Buller and the employed midwives in relation to the roles and responsibilities at Kawatiri.

The position descriptions for employed midwives outline their roles and responsibilities and describe both the role of a midwife providing LMC services as described by Section 88 Maternity Notice and for core midwives the role required to participate in the provision of core facility midwifery services. Within the core facility midwife role position description are the expectations for running the maternity facility as outlined within the Maternity Facility Services Specifications ([www.moh.govt.nz](http://www.moh.govt.nz)). This includes that a midwifery service is to be provided 24 hour a day, seven day a week. These specifications also outline access expectations, service components that must be provided and services that must be offered.

These facility specifications are the minimum that the Ministry of Health expects when they contract with District Health Boards.

The current caseload of the midwives at Kawatiri at the time of the review was 50 women antenatally and approx 13 women still receiving postnatal care. The service at Kawatiri usually provides antenatal care including miscarriage support, labour and birth as well as postnatal care. Even whilst there are no births occurring at Kawatiri the midwife on call is still required to attend to all antenatal care, including miscarriages and postnatal care.

The birth volumes at Kawatiri over the past year looked low to the reviewers. With 92 confirmed pregnancies in the Buller area, only 18 women birthed at Kawatiri. The reasons given to the reviewers were varied with some suggestion that it was due to midwifery staffing shortages and the subsequent disruption of maternity services. Feedback was clearly provided to the reviewers from the public forum held in Westport about the value of the maternity service to the community when it was fully staffed with four midwives who provided both the LMC role for women as well as cover the facility. The reviewers consider that within the position descriptions, the West Coast DHB has some clear expectations of the midwives they employ at both Kawatiri and Greymouth. Minimum responsibilities both as LMCs and core midwives are outlined and reflect what is required to meet the Maternity Facility Service Specifications and the Section 88 Maternity Notice. These requirements are not unusual for employees of a rural maternity facility in New Zealand. The workload when the staffing is at four midwives was reported as being manageable by all midwives interviewed who are either current or past employees of Kawatiri.

Currently, despite the lack of midwives at Kawatiri, the two midwives are adequately meeting the Section 88 Maternity Notice requirements by providing antenatal and postnatal care, with the Grey hospital midwives as the providers for labour and birth. However this is only a short-term solution, as working in this way for the midwives is not professionally rewarding. The message was clear that it is not acceptable to the women of Buller and does not assist the service to be sustainable in the long term. The staffing situation at Kawatiri must be rectified for long-term sustainability of this service and for the women of Buller.

A concern that was highlighted to the reviewers is the ongoing disruption to maternity services for the women of the Westport community and the impact this is also having on the remaining midwives. Stability is required for the Kawatiri Maternity facility so that the community can once again be proud of and have confidence in the services offered to them. This is also essential if a midwifery workforce is to be recruited and retained long term in Westport.

#### **4.1.2 McBreaty Ward, Greymouth**

McBreaty is licensed as a Secondary Maternity service. There are also a number of women having primary births who access the service.

Whilst reviewers have no issues with the way in which the primary service has been arranged there are clearly some gaps in service delivery that are present. The feedback from the women is the need to have antenatal clinics further south at Hari Hari. Currently the employed LMCs only go as far south as Hokitika. There also needs to be better liaison between the self employed midwives and the facility employed midwives - LMC and Core. A regular meeting in relation to workloads for all to attend is recommended. Other DHBs have models which work well and some professional leadership is required in this area.

From what we could ascertain, the unit operates as a secondary service with good relationships overall. There was some confusion noted in relation to roles and responsibilities due in part to the employment of enrolled nurses in an acute secondary environment but generally the midwives have worked to ensure they are suitably supervised and work within the scope of practice. The reviewers did note that the newly employed obstetricians were still trying to orientate themselves to how the service operates and who is responsible for what. Others who access the unit are similarly confused about the roles within the service and associated accountability.

##### Entry into and out of the secondary service

The issue of referrals and handover to secondary care, whilst not unique to the West Coast, did form a topic for discussion and with such a small workforce this could easily be resolved especially as there is now a stable Obstetrician and Gynaecologist (O&G) workforce. Attention to the Maternity Facility Service Specifications for this would also assist to clarify roles and responsibilities. It was unclear whether all parties had seen these specifications, the Referral Guidelines and the Section 88 Maternity Notice and how they intersect. This was especially true of the O&Gs who had not received this formally as part of their orientation and effectively 'came upon' what was expected of them.

There have clearly been some gaps in the service provision over the past few years as a result of the serial nature of the locum obstetric workforce. This has been difficult at times for the midwifery staff in particular. There was general acknowledgement and excitement that this would now be changing with the permanent obstetric appointments. This in itself will cause some challenges to the midwifery workforce who, as it was noted, “have been completely in charge of the secondary as well as the primary services because they were the stable staff”. There will need to be some work done to facilitate how this transition occurs not only for the midwives but also the women and the new obstetricians. There will also need to be recognition of the work needed to assist this relationship as it changes and develops with the tertiary referral centre at Christchurch Women’s Hospital also.

#### **4.1.3 Consumer Feedback**

Both reviewers were overwhelmed by the amazing support the women of the West Coast have for the midwifery model of care and the midwives working on the West Coast who provide it, often in difficult circumstances. This was a highlight for us and it is important for this to be noted. District Health Boards are charged with delivering a service to the community which meets their needs. The women and their partners who met with us in Greymouth, at the public forum in Westport and at Kawatiri Maternity Unit were clear they wanted continuity of care to continue to be provided by midwives who had a strong, clear midwifery philosophy.

There was also awareness, by those consumers we spoke with, that the midwives need ongoing professional support and clear policies to assist them to provide such care especially at Kawatiri. Concern was expressed at the lack of clear organisational processes around performance management and other quality initiatives that have existed in Westport with some attributing this lack of clarity as adding extra stress to a unit already functioning with one midwife short.

There was also community awareness in Westport of differences that exist between the midwives. This is having some repercussions as women are being ‘caught’ in the middle of this. This needs to be managed and professional guidance provided to the midwives.

A mechanism for the women who may be feeling confused by conflicting advice also needs to be developed both at Kawatiri and Greymouth for them to take their concerns. Currently these women are instead moving out of the district for a consultation. This is both financially and professionally problematic for the DHB.

#### **4.1.4 Actions recommended**

1. Recruit immediately to fill current vacancies at Kawatiri back to four FTE midwives. The team of four midwives working at Kawatiri unit has worked well historically and provides a high quality service for the women of the area.
2. The staffing for Kawatiri of four midwives working in two teams of two, one week on and one week off, is an attractive option and is supported by the reviewers to cover the caseload in Buller District. It also meets the requirements of the Section 88 Maternity Notice.
3. Involve the Westport community in the recruitment and orientation of new midwives to the area. The Kawatiri Action group signalled their support for being involved in this.
4. In order to promote retention of staff and reduce the professional isolation that is inherent in rural communities, new staff (including medical staff) should be orientated to both the units and overall midwifery services on the West Coast.
5. The need at Kawatiri to foster a team approach should be highlighted and supported by management with input from the profession following recruitment of midwives to this unit.
6. When a woman is an inpatient in a primary maternity facility a midwife is required to be *available* 24 hours a day, seven days a week. This availability may mean that the midwife is on call but not continuously present. The Foote Ward staff covering overnight is not an unusual arrangement in rural primary units in New Zealand as long as a midwife is close by if needed by the woman.
7. The policies in relation to accessing the Foote Ward staff and/or the on call general practitioner seem to be clearly understood by the Foote Ward staff but not as clearly by the midwives.

We recommend that the midwives, nurses and general practitioners sit together and review the current arrangements taking cognisance of the expertise of the current staff.

8. Foote Ward staff and Buller general practitioners need to have annual updates on neonatal resuscitation, and drills and skills workshops for obstetric emergencies that may unexpectedly occur at Kawatiri.

9. A low level complaints/inquiries process needs to be developed between Greymouth and Kawatiri and advertised to the consumers who use the unit if they have any concerns. This is especially so in relation to conflicting clinical advice between midwives. When such situations occur, mechanisms need to be put in place to discuss this with the midwifery team based on the clinical records and evidence informed practice. This can be facilitated by the midwifery leader at Greymouth. If necessary she can also seek support from the professional body - NZCOM.
10. Consider staffing skill mix and the expectations of the staff in relation to the secondary service specifications within the McBreaty maternity unit at Greymouth. As an example within the unit there are enrolled nurses working within an acute secondary environment. This is not usual within a secondary maternity unit but it was unclear what support they have been given to ensure they and other staff clearly understand their supervisory role and the limitations of the enrolled nurse's scope of practice.
11. The unit appears to currently be staffed by a number of casual midwifery staff, some of whom may be happy to move to more permanent shifts with the accompanying benefits. Working with a high level of casual midwives leaves the service vulnerable as they can all decline to work. This needs to be addressed and monitored.
12. From a workforce recruitment and retention perspective we recommend that the DHB continue to employ LMC midwives at Grey hospital. This is supported by the new Primary Maternity Service Specifications. Whilst there are self employed midwives working in the Grey District historically for the West Coast the stable LMC workforce is that provided by employed midwives. For the DHB to continue offering these roles works as a recruitment strategy especially for graduate midwives coming to the area. It is also important for the DHB to support this graduate workforce whether they are employed or self employed.
13. Provide antenatal clinics further south than Hokitika for those women who live in South Westland. Included in this is the possibility of looking at obstetric/midwifery outreach clinics rather than the women having to travel to Greymouth. Obviously this would need to be costed but we consider it is worth exploring.

14. We recommend that strategic planning occur in relation to the decisions about the number of LMC midwives with this being done in consultation with the self employed midwives who are working in the community. Whilst it was stated that there are three employed LMC midwives it was clear that one had a very small caseload, one had a very large one and one had none at all currently. Again this needs to be regularly reviewed and monitored. The employed LMC service is valued by the women but the DHB needs assurance that the midwives employed to do this role have a full caseload each month.
15. Currently the self employed midwives have to pay to use an empty antenatal clinic room at Grey facility. These midwives require nothing other than the space to see the women as they supply all their own equipment. We recommend that the DHB enable these midwives to use this space free of charge as a gesture of support which will assist with the retention of the self employed workforce in the community.

#### **4.2 Evaluation of current processes and practices and how these might need to be developed or adapted to ensure the West Coast District Health Board continues to provide a clinically safe and viable service now and into the future.**

It was difficult to get a clear picture on how the service currently operates. There is a lot of anecdote on how some see that it is operating, a historical view on how it is meant to be operating and then a desire to see what the potential is. The themes that we have identified have been as a result of information presented to the reviewers from a variety of parties.

##### **4.2.1 Professional**

Reviewers noted a number of comments that the midwives at both McBrearty and Kawatiri units are becoming professionally isolated with little interdisciplinary or multi disciplinary communication occurring.

Stronger professional links need to be developed. Workshops that the professional body offers elsewhere could be run at the DHB. This is especially in relation to the Service Specifications and the Section 88 Maternity Notice.

The self employed midwives provide a maternity service for women of the area but do not appear to have formal professional links with their employed colleagues.

Orientation to Maternity services offered by the DHB and how this is conveyed to the public is not integrated across the DHB.

The LMC midwives both employed and self-employed need to work in a more coordinated way. Whilst the DHB does not have any responsibility for the self-employed workforce it is essential that they ensure that this workforce is sustained or there will be a flow on effect to the staffing and workloads within the DHB.

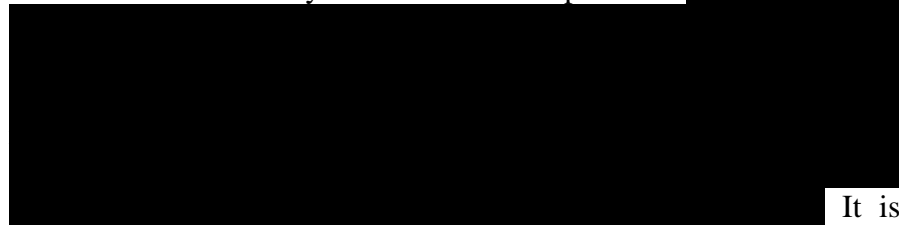
Professional relationships, whilst satisfactory at an individual level, need to be developed at an organisational level.

The issues facing the employed and self-employed midwives are not identified or recognised by each other. As a result there is demonstrable lack of understanding in relation to the way in which services can be maintained. An example is that one of the self employed midwives is due to leave the Coast soon and the employed midwives were unaware of this. Having this practitioner leaving will have a direct flow on effect into the facility workloads.

Transferring birthing women out of Kawatiri impacts on both the viability of Kawatiri and the workload at Greymouth hospital.

#### **4.2.2 Service development and Policy development**

It was difficult to determine who leads developments in the DHB in relation to maternity service development.



It is important for the future development of maternity services that this knowledge is shared and some succession planning starts to occur. For any organisation it is problematic if only one person holds all historical and current knowledge. It is timely to involve a wider stakeholder group including consumers for the strategic planning for maternity into the future as well as addressing some of the current issues identified in this review.

In relation to policy development, in the past there has been an adoption of Canterbury Health clinical policies. Clearly with the employment of three obstetricians there will now be some changes. In fact this was signalled when we spoke with them. Again a stakeholder group should be developed which includes input from Canterbury Health as the accepting tertiary centre to progress the development of these and to review the current policies as to their applicability now the obstetric coverage is stable. The coordination of this will need to be managed and led by both midwives and obstetricians.

Maternity policies which will directly affect the women and practitioners of Westland and Buller need to have input as well from their respective communities, the retrieval services provided by St Johns and those services that interface with maternity - well child, social services, general practice, etc.

Comments

1. For such a rural/provincial DHB which covers a large area but with a scattered population an emphasis has to be placed on ensuring that health professionals working in an area such as maternity are supported to have close professional links. There did not appear to be any professional oversight of the midwives occurring at the time of the review.
2. Maternity care crosses the boundaries between primary and secondary services and the health professionals who provide care on the West Coast need to foster a multi disciplinary approach to care provision. To do this there needs to be an understanding of networking, skill mix and professional development.
3. Midwifery has its own scope of practice and standards of practice. There is a clear need for other colleagues both internally and externally to understand what these are and how the role they provide intersects. This lack of understanding was apparent in some sectors we interviewed particularly in relation to the credentialing of midwives by the DHB.
4. In March 2005 the Canterbury/West Coast region of the New Zealand College of Midwives met with the DHB, along with the NZCOM Midwifery Advisor, to discuss credentialing and the midwifery profession's view of this. At the conclusion of the meeting and subsequently it was clear that the issues that had been raised in relation to credentialing had been resolved. The Midwifery Council of New Zealand has undertaken the responsibility to credential midwives in New Zealand and has not deferred this to the DHBs as the Nursing Council has for nursing. As a result midwives who hold an Annual Practising Certificate sign a statutory declaration each year to state they are working across their scope of practice as a midwife and participating in the Midwifery Council of New Zealand Recertification Programme: ([www.midwiferycouncil.org.nz/main/Recertification](http://www.midwiferycouncil.org.nz/main/Recertification)). Employee requirements to undertake other organisational roles are a different subject and in this instance seem to be confused with credentialing within the WCDHB. The DHB can require its employees to undertake specific education when they are employed in certain roles.

As an example when a midwife is employed to work in secondary care she will be required to provide care in a delegated manner for women who have an epidural. This is not a recertification/credentialing requirement for a midwife but may well be an employee requirement.

5. The midwives of the West Coast do not appear to have any facilitated forums to discuss clinical/professional issues relevant to their practice.

**4.2.3 Clarity of roles within maternity**

1. [Redacted]

2. [Redacted]

[Redacted]



To quote the Royal College of Midwives statement which New Zealand is considering adapting “The RCM believes that in the interest of safety and quality of care for mothers and babies, a registered practising midwife should provide care and support for women and their babies at all times. Doulas should not be used as substitutes for midwives to cover for midwifery staffing shortages” Position statement 6, May 2004, Royal College of Midwives.



#### **4.2.4 South Westland**

It was clear that the practitioners in South Westland are doing a remarkable job despite the geographic isolation. It was also clear that they would like a more coordinated approach in relation to having input into policies and protocols and planning input for the service delivery for the women of South Westland. Currently they provide the service as they see fit but would like more input from management and colleagues. At this stage they are unclear who best to approach in relation to developing the service in South Westland or contributing to education/policy development and this also needs to be addressed.

#### **4.2.5 Actions recommended**

1. Regular meetings and collaboration between groups would help to develop an understanding of roles and responsibilities and collegial networking. Currently this does not occur.
2. Clarify management roles and professional leadership roles so all staff are informed of the different roles and responsibilities. There continues to be confusion expressed by maternity staff about who is managing the service, the Nurse Manager, Acute and Specialty services or the Clinical Charge Midwife. The fact that the Nurse Manager’s role encompasses maternity is one of necessity based on the relatively small size of the service. The clarity required is that this role is a management role and from the understanding of the reviewers the Clinical Charge Midwife role then provides clinical/professional advice to that manager with the support of the Director of Nursing and Midwifery position (Appendix 4). That is not the current understanding of the staff. Clarifying these roles would improve the working environment for the Clinical Charge Midwife, the Managers of the services and other staff members.
3. As recommended at the conclusion of the review we suggest that the Buller Hospital Manager manage the day to day operations of the Kawatiri unit to ensure closer management

support and integration of the maternity services with the wider health community of the Buller region.

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4. The Director of Nursing and Midwifery is responsible to the CEO for working with nurses and midwives to develop and maintain an appropriate standard of patient care (position description attached Appendix 4). The DONM takes advice from the Clinical Charge Midwife and as appropriate from NZCOM in relation to standards of care related to midwifery practice, midwifery services and midwifery workforce. The DONM the clinical Charge Midwife and the Nurse Manager, Acute and Specialty Services work together to achieve quality patient care outcomes.
  5. Professional advice and support for the midwives of the West Coast should overtly belong to the Clinical Charge Midwife role at Greymouth. This will concern day to day practice and professional decision making and issues and liaison with the other health professionals working/interfacing with maternity eg St Johns, anaesthetists, obstetricians. To ensure seamless professional and operational activities the Clinical Charge Midwife will communicate regularly on relevant matters with the manager of the maternity service, the Nurse Manager, Acute and Specialty Services.
  6. Professional advice and support about maternity issues for the nurses who are either working in or interfacing with maternity on the West Coast should be collaboratively given by the Director of Nursing and Midwifery and the Clinical Charge Midwife at Greymouth. This would include those working at McBreaty at Grey, Foote Ward at Westport, Public Health Nurses, those in South Westland and the Well Child Providers.
  7. 
  8. Succession planning with more of the midwives taking the lead on committees such as infection control etc needs to occur with the Clinical Charge Midwife overseeing this but not having to do it all as occurs at present. Currently the Clinical Charge Midwife role is the only point of contact for everyone in the DHB as well as the community point of contact for all things to do with maternity. Whilst this is reflective of the current structure within the DHB, it is important that this knowledge is shared more widely.

It is still important that the role is a central point of contact but that the role is clearly required to delegate where possible and practicable to distribute some of the tasks. Others must be given the opportunity to have a role and this is especially relevant to the Quality and Leadership Programme within the DHB.

9. There is currently a lack of clarity around management processes and lines of management within the DHB. This was demonstrated a number of times when we asked who reported to who and we were met with the answer “who would know?” This is problematic within the secondary unit and for employees. Some education about the structures both within the DHB and to the community would assist.
10. As a further example the consumers in Westport were also surprised that the day to day management has not always been carried out by Buller Health. Again whatever is implemented as a result of the review must be conveyed by the DHB to the community.
11. The DHB need the services of a hospital aid at Kawatiri. It is the New Zealand College of Midwives view that calling this role Hospital Aid/ Doula is currently leading to unrealistic expectations within the community on what the role can deliver. This role confusion needs to be clarified with the individual, the midwives, other staff at Buller and the community.

#### **4.3 The processes the West Coast District Health Board uses to provide support for midwifery students and potentially for the provision of a Midwifery New Graduate Programme in the future.**

Currently the West Coast DHB supports up to six midwifery students a year in placements within the area. These students are from the Otago Midwifery School and the Canterbury (CPIT) Midwifery School. This level of activity is to be applauded and should continue because it is from this pool that new graduates will be encouraged to work in the DHB. There is currently one new graduate who has joined the self employed midwifery practice working mainly in Greymouth or homebirths.

There was also a lengthy discussion at the public forum about developing a workforce of midwives from local women and how this could be done. There were plenty of suggestions and much enthusiasm for distance learning options with clinical practice achieved on the West Coast.

The national Midwifery First Year of Practice Programme (MFYPP) commenced on 1 February 2007. Midwives currently employed within the DHB need to be encouraged to put themselves forward to be mentors.

One of the requirements of the MFYPP is for the graduate to have a mentor. If this mentor is an employee, the DHB is funded to release her for the time required by the graduate. The DHB is also funded if it employs graduates to release them for the required education component of the MFYPP. This education is funded and is available at no cost to the DHB employed graduate. This way the DHB gains graduates who are supported through their first year of practice at no cost to the DHB for this support. The current self employed graduate is on this programme and is being mentored by a midwife from Christchurch.

#### **4.3.1 Actions recommended**

1. Continue to offer placements to the Midwifery Schools for student midwives.
2. We understand the DHB currently offers support to consumers in the community considering education to become a health professional. This needs to be promoted to the community as there were women who spoke to the reviewers who are interested in becoming midwives for the West Coast.
3. Discussions with the School of Midwifery in Christchurch about the possibility of a joint project to recruit undergraduates from the west coast community.
4. Encourage experienced midwives currently employed to consider the role of mentor. Support these midwives to participate in the preparatory education required and offered by the profession.
5. Plan to encourage recruitment of graduates from either Otago or Canterbury commencing 2008. Aim to take 1-2 new graduates a year and offer them a supportive environment for practice.
6. There is no necessity for the DHB to establish its own midwifery programme as such but there is a need for it to consider how what it can offer midwifery graduates interfaces with the aims and requirements of the MFYPP.
7. One of the ways the DHB can achieve the integration and encourage recruitment of new graduates would be to improve orientation processes for new graduates in the area whether employed or self employed, provide them with approved local mentors and offer preceptorship when working in the DHB.

#### **4.4 The current practices involving the interface between neonatal nursing and midwifery; inclusive of the multidisciplinary care and transfer of neonates.**

##### **Midwifery and neonatal service configuration in a potential Grey hospital rebuild.**

The above two Terms of Reference were combined for the purpose of this report.

The reviewers received positive reports from all of those questioned about the interface with neonatal nursing and midwifery on the West Coast. It appears that over the past few years, referral processes and transfer mechanisms have been increasingly refined to ensure that the health of the women and their babies who need this additional support is provided in the most seamless manner possible.

Obviously there were the comments that it would be good for all of the community if the women could remain at Greymouth to have their premature babies rather than having to transfer to Christchurch. The reality is that in a rural provincial DHB the services that can be provided to a standard that is professionally acceptable for these babies are those offered by a tertiary centre. Again it is an understanding of the community, through good communication by the DHB, that makes this more acceptable and it was clear that this has been done. As current technologies progress and research into the area of the causes of premature labours and what can be done to prevent them develops more options may be able to be offered on the West Coast. The current staff are aware of these and are looking at what is feasible in conjunction with Canterbury DHB. Some of this is also now more possible as a result of having a fully staffed obstetric roster.

In discussions with Canterbury DHB Neonatal Unit there is a need for a more formalised education programme for neonatal resuscitation for all staff that are in attendance at births. There was also recognition of the permanent recruitment of the obstetric staff and the implications this may have in relation to obstetric decisions that may have an impact on neonatal retrieval. To date there have been no formal mechanisms to have the discussion between the obstetricians at Greymouth and the neonatologists at Christchurch Women's Hospital in relation to any policy changes and the potential neonatal retrieval implications.

Overall there also appears to be good relationships with St Johns, the organisation that provides the transport of women and neonates from Greymouth to Christchurch. The same cannot be completely said for the relationships at Kawatiri. This is a real issue currently with the staffing shortages there and there is clearly a need for some factual appreciation of the experience of some of the crews and what they are funded to provide by both the community and the DHB staff there.

It was clear to the reviewers that the plans for the new facility at Greymouth will support the working relationship between the two services to be developed more than currently occurs. The new facility will assist in this by having a closer geographic location for maternity and paediatric service provision. This is also a sensible use of limited staffing resource. The reviewers appreciated that the paediatric nurses currently assist with resuscitation and stabilisation of neonates when possible but that this is not always able to occur because of their workload in paediatrics.

Again there does need to be some development of the working relationships as tensions were detected between the midwives as they spoke of the involvement of additional staff when a baby is unwell. These episodes are uncommon but never the less, need forward planning in relation to the responsiveness of the service. It also highlighted to reviewers the need for all of those involved to have the opportunity to formally debrief following them. This would give valuable learning opportunities to all concerned as well as assist in the development of working relationships. Drills and skills workshops both at Kawatiri and Grey for neonatal emergencies would also assist and when suggested by reviewers were received positively by all parties.

#### **4.4.1 Actions recommended**

1. Progress with plans for new unit with closer geographic location of maternity and paediatrics.
2. Drills and skills workshops held regularly for all staff (including all medical staff) involved in the resuscitation and /or transfer of neonates. This will assist the development collegial relationships as well as an appreciation of different skills. These workshops, if planned in advance, could coincide with the visit of the paediatrician from Canterbury DHB and become regular occurrences for all staff to attend annually.
3. Ensure these workshops are not only offered to the employed midwives but also to South Westland, self employed midwives and Buller Health staff.
4. Maintain relationships with neonatal services at Canterbury DHB. Ensure any changes to obstetric policies have an involvement where applicable with the neonatal service at Canterbury DHB as it may have an effect on retrievals.
5. Create an environment where cases that have required resuscitation and/ or transfer can be discussed as a quality assurance activity by all involved including feedback from the neonatal retrieval service at Canterbury Health if a retrieval has occurred. This is not currently happening and provides valuable learning opportunities to improve systems.

6. Maintain close relationships with St Johns. They also run courses and it appears that these have not been tapped into eg flight rescue for one or two of the midwives as elective education.

#### **4.5 Strengthening the implementation of the Quality and Leadership programme (QLP).**

The QLP is the agreed national framework by the midwifery profession, MERAS and NZNO. The requirement is on the DHB to ensure it is offered to all midwife employees and that a mechanism exists within the DHB to do this. This is a requirement of the MECA.

The reviewers noted that despite the best efforts of the PDRP/QLP coordinator midwives professed very little understanding of the QLP for midwives within the WCDHB. Whilst it is recognised that two midwives had attended an education day the week of the review in Christchurch it was clear that others have no understanding of what they have to do to achieve the different Domains within the QLP. While a structures and process for the QLP has been in place in the DHB since July 2005 it appears that the programme has not been widely promoted within the midwifery profession internally. We do understand that there has been a focus on the Recertification required by the Midwifery Council. If the QLP was well understood then those midwives who have worked hard to complete those requirements should have been made aware of the fact that as a result they are already on Domain one of the QLP. Whilst this does not attract any payment it does recognise the Recertification requirements.

Strengthening the reporting structure between the Clinical Charge Midwife, the QLP coordinator and the DONM will strengthen the support for the programme and develop a midwifery workforce that recognizes the importance of clinical experience and fosters leadership within the workforce. Involvement with clinical policies and multi disciplinary decision making should be encouraged for all staff members. Involvement in professional activities such as policy development or audit is an existing requirement of the Recertification process for midwives and the QLP.

A formal study day would improve understanding and for many of the midwives assist them to consider applying as the QLP is an enabling process. To do this there is a need to foster an environment in which midwives are recognised for their knowledge and experience. This would strengthen the implementation of the programme. It would recognise the existing leadership within the current workforce as well as assist with succession planning.

#### **4.5.1 Actions recommended**

1. Introductory workshop needs to be planned for the midwives about the QLP.
2. Those midwives who wish to participate need to have their application supported and be assisted to meet the requirements.
3. The DHB are aware that the QLP is a contractual requirement of the current MECA. As such there is a requirement for the implementation of it in each DHB to be reviewed in a joint MERAS/ NZNO review. Although this is now being addressed little has been done so far on the West Coast The DHB will need to be clear about the reasons QLP has taken so long to become part of the organisational structure for midwives.
4. The QLP requirements need to also be understood by management. As an example before midwives can apply for QLP Domains there needs to be a successful performance appraisal included within the portfolio. If there are any issues it is reliant on managers having the Human Resource processes in place for these to be addressed and recorded. It is important for the integrity of the process that it is those midwives who meet all the Domain requirements are the ones who are recognised and rewarded

#### **4.6 Best practice guidelines for General Practice support and participation in maternity services especially in Buller and South Westland.**

Buller and South Westland have varying needs regarding the support they currently provide in relation to maternity care.

##### **4.6.1 South Westland**

The general practitioner is expected to provide maternity care for the majority of the women antenatally and postnatally in partnership with the local Rural Nurse Specialists. He is the LMC for these women with the labour and birth care provided by midwives either in Greymouth or sometimes outside the Coast if the woman's family lives elsewhere. The self employed midwives based at Greymouth occasionally also provide care for women of Westland. Contractually it is important that these women have the care required by Section 88.

The DHB needs to work with this general practitioner and the Rural Nurse Specialists to determine what ongoing education in relation to maternity he may require. It is important that general practitioner LMCs be provided with the opportunity to participate in any discussions about change in policies that the obstetricians or maternity service may make or be informed about latest evidence/ changes to service which may affect care he provides.

There was also a desire expressed to have better links with all providers in Greymouth- midwives and obstetricians. Now there is full recruitment of obstetricians guidelines will undoubtedly be reviewed and redeveloped in a formalised manner with all disciplines involved including the general practitioners.

The manner by which these are then finalised and distributed to inform practice needs to be transparent. The College of General Practitioners will also have standards that the general practitioner will be expected to work to and it is important that these are understood by those who then link with the women being cared for in Westland.

#### **4.6.2 Buller**

Buller Health has a robust multidisciplinary meeting which is held regularly. They have been inviting the midwives to participate but this has not happened to date. The general practitioners here have a role when there is an unexpected outcome at Kawatiri and they are on call for emergencies. They are dependent on the midwife giving a complete, concise history and articulating what she requires. This necessitates a collegial working relationship. It was clear that the general practitioners here are often locums with varying degrees of experience in maternity. It is therefore very important that the orientation and clinical expectations are made clear about their role in any maternity emergency and that they have the opportunity to meet the midwives who work at Kawatiri before this occurs. The DHB could facilitate this in the interests of building collegial relationships.

#### **4.6.3 Actions recommended**

1. Maternity emergencies – drills and skills for all health professionals with close links to care provision for maternity.
2. Education in neonatal care- pre term birth, stabilizing the neonate and follow on care when discharged from the neonatal unit is required.
3. Midwives at Westport attending the multidisciplinary education meetings. If the case is not pertinent to maternity there would still be value in participating in the business part of these meetings as a chance for collegial networking.
4. Ensuring that every quarter, one of the above meetings has maternity as the topic.
5. Formal opportunities to debrief following a difficult/ complex case.
6. Use of telemedicine for education with other centres or with Greymouth.

7. Involvement in clinical guideline development.
8. Creating a network around the general practitioners in the DHB for distributing current maternity evidence. This might be done through the College of General Practitioners, journal club, etc.

#### **4.7 Other themes noted during the review**

##### **4.7.1 Orientation to the New Zealand maternity service on the West Coast**

It is important that all new practitioners to the West Coast have a formal orientation not only to their workplace but to the community, the region, colleagues and their roles as well as who they are expected to interface with and their role. For maternity it is also important that there is a chance to become familiar with the New Zealand maternity service as it does differ from anywhere else in the world. The reviewers were also questioned by the obstetricians about how to uncover the evidence for common practices both in New Zealand and on the West Coast as there are different clinical thresholds in different areas/ parts of New Zealand/the world as a result of population differences e.g. management of Group B Strep guidelines differ in New Zealand to Australia or America.

Whilst orientation does occur it appears to be an ad hoc process. This was the view of almost all interviewed. Clearly there are DHB wide aspects to the orientation that need to be completed but the orientation to how maternity operates on the Coast- distances, transfer times, emergency services available, facilitated discussions for new staff with Christchurch Women's Hospital, does not reliably occur and needs to be reviewed.

An example that was spoken of highly is occurring in Westport at Buller Health. When there is an applicant to a position the whole package that prospective employees need to understand before accepting a role is discussed with them not just the job itself. This expertise should be drawn on for maternity position appointments. Whilst the professional needs of the area are addressed the need to retain employees may be better addressed by listening to those who clearly have some experience in this area. Working collaboratively when employing may assist with the initial settling into the community period.

The Kawatiri Action Group was very enthusiastic about being involved in the orientation of new midwives to the area. This needs to be recognised and utilised in the future.

Having regular practitioner meetings of all the health professionals involved in and interfacing with maternity will also foster communication and networking as well as understanding of the roles, responsibilities and experience levels of other team members. This is especially true for those practitioners new to the West Coast to assist them to work out how the service meshes together including differences in clinical practices and the evidence that informs those differences.

#### **4.7.2 Education**

In rural areas there are often difficulties in attending or accessing education because of the rural isolation, distances to travel and a lack of cover to leave the area to attend study days or courses. We were assured that education requirements for all the employed midwives were up to date. We were given a printout of education undertaken by those employed in maternity. Whilst there has certainly been considerable education undertaken by some, much of it is what is annually required of DHB employees. There were some clear gaps in relation to Recertification in the record we were given on the day of the review.

Concerns were raised by the anaesthetists that not all employed midwives had undertaken the DHB epidural update. Again we note that three midwives have attended the pain management course (we have assumed this is the epidural update for midwives but would need to look at the content specifics) but not all the currently employed midwives, who may be asked to provide this care as part of the secondary midwifery service, have this recorded.

#### **Suggestions:**

1. Portfolio workshop held as soon as possible for all midwifery employees to review what they have done to date. It may be that all is achieved as we were told but the records do not support this. The DHB employs the midwives and needs to ensure that they have all met the necessary requirements by March 31 2008. Some may require some assistance to achieve this.
2. Update current education register to reflect Midwifery Council requirements and distinguish these from the DHB employees' requirements.
3. Identify locum cover that can be provided for education and annual leave. A number of midwives are casual employees who may be able to fill this gap if well planned.
4. Telemedicine and the use of videoconferencing could be extended to include isolated health professionals.

5. Links with other DHBs in similar situations should be improved so that collaborative arrangements for education can be made.

Area specific education

All staff members that have a management element within their role require education around management processes such as HR, budget management, performance management, performance review and quality processes. There is an expectation that when a role has been held for some time this is offered or has already been achieved. Regular updates with other managers/ clinical leaders in the DHB assist with this professional development for those in these roles.

Maternity emergencies – drills and skills for all health professionals with close links to care provision for maternity. This includes the nurses and general practitioners at Buller.

Keeping birth normal workshop.

Waterbirth workshop: Reviewers were surprised that whilst women labour in water, no education in relation to women birthing in water has been provided, even if not planned, because a woman is labouring in water, a birth may still happen in water.

Neonatal care - pre term birth, stabilizing the neonate and follow on care when discharged from the neonatal unit.

Westland and the Public health nurses would value the opportunity to participate in education sessions especially in relation to antenatal care and care of the woman and her baby postnatally.

**4.7.3 Dissemination of information**

It came to the attention of the reviewers that whilst meetings may be attended, the decisions made and any changes occurring in service models, the method of communication by which these are conveyed to the wider staff in maternity was sporadic or even non existent. This was especially true when it came to the interface with external providers and the messages that they wanted to ensure the maternity units received. It was commented by external providers e.g Well Child that it is easier to network these messages to the self employed LMCs than it was to the employed LMC's

It also became clear that whilst there may be correspondence internally the DHB maternity service has to look externally at who they interface with. There are some issues in relation to the interface with Well Child services.

Regular participation in meetings with external agencies such as Plunket, ambulance, other Well Child providers, general practitioners and other providers is necessary for maternity providers. They do not have to be frequent but we understand there is a Well Child network already established, and midwifery is rarely if ever represented at it. In a small community when referrals to Well Child are not occurring this needs to be addressed.

Dissemination of information via minutes, newsletters or news updates needs to occur and could be a collaborative project between all the West Coast regions and maternity providers and those who interface with maternity.

#### **4.7.4 Section 88 claiming**

During the review it came to the attention of the reviewers that the claiming currently done by the DHB may not be up to date. Concerns were also raised that some claiming may have been missed completely. The reviewers would like this to be noted whilst not specific in the Terms of Reference as if these are not correct there may be an impact on funding levels for the 2007/2008 funding from the Ministry of Health.

#### **4.7.5 Position descriptions**

As part of the review the position descriptions were referred to. These need to be reviewed in line with the professional requirements of an employed midwife. The Clinical Charge Midwife position description is called a Charge Nurse and does not reflect the professional midwifery leadership role this position requires within the DHB. The position description at Westport refers to the role as Hospital Aid/doula. For the reasons noted in 4.2.3(3) this also needs to be reviewed.

## **Appendix 1**

### **Midwifery Services, West Coast District Health Board**

#### **Terms of Reference**

The Terms of Reference of the review encompass two overarching objectives:

- An appraisal of how the District Health Board maternity services, and in particular Kawatiri Unit, are provided in relation to Section 88 of the New Zealand Public Health and Disability Act 2000, the Maternity Service Facility Specifications and the current draft Primary Maternity Service Specifications.
- Evaluation of current processes and practices and how these might need to be developed or adapted to ensure the West Coast District Health Board continues to provide a clinically safe and viable service now and into the future.

In addition we would like advice on:

- The processes the West Coast District Health Board uses to provide support for Midwifery students and potentially for the provision of a Midwifery New Graduate Programme in the future.
- The current practices involving the interface between neonatal nursing and midwifery; inclusive of the multidisciplinary care and transfer of neonates.
- Midwifery and neonatal service configuration in a potential Grey hospital rebuild.
- Strengthening the implementation of the Quality and Leadership programme (QLP).
- Best practice guidelines for general practice support and participation in maternity services especially in Buller and South Westland.

## **Appendix 2**

### **Participants in the Review**

Kevin Hague, CEO West Coast DHB

Jane O'Malley, Director of Nursing and Midwifery, West Coast DHB

Jude Bruce, Clinical Charge Midwife, WCDHB

Dot O'Connor Clinical Charge Nurse, paediatrics (neonatal nurse representative).

Lisa Mullen, Dina Robinson, Mary McGrain, Paddy O'Connell - Grey LMC midwives, employed and self employed

Emma Morgan, Lorraine Menzies, Linda Monk, Anna McEnroe, Mary McGrain - core midwives

Lorraine Savage, Barbara Roberts, Bev Siinott - Enrolled Nurses

Patsy Sara, Margaret Jamieson - Registered Nurses

Michele Barber, Nurse Consultant West Coast DHB (PDRP/QLP Coordinator. New Graduate Programme's Coordinator.)

Consumer Group from Greymouth

Chris le Prou, General Manager Secondary Health Services

Jenny Hanson, Nurse Manager Acute and Speciality Services

Wayne Ah-Sa and Malcolm Stuart, St John Ambulance Services

Vicki Robertson; Nadir Hanna; Erika Hunter - Obstetricians

Malcolm Stuart and Suzy Newton - Anaesthetists

Shar Ransom, Plunket

Martin London, General Practitioner, South Westland

Anne Fitzwater, Rural Nurse Specialist, South Westland

Public Forum in Westport

Jenny Robertson, Manager, Buller Health

Caroline Goulding, Mary Mc Grain, NZNO rep Core midwives - Buller Hospital

Justine Hancock, Buller LMC midwife

Helen Sayers, Registered Nurse, Foote ward

Lesley Burke, Buller LMC midwife

Dr Stu Malone, General Practitioner Buller Health,

Joc Wallace, Clinical Charge Nurse, Buller ED (Foote Ward)

Consumer Group from Westport, Kawatiri Action Group

Nicola Austin, Clinical Director, Neonatal Unit- Canterbury DHB

Linda Brace, Staff Nurse Foote Ward (NZNO representative)

### Appendix 3

#### **Recommendations made by Lesley Dixon and Norma Campbell to Chris le Prou, Jane O'Malley and Jude Bruce at the conclusion of the Review of Midwifery Services in the West Coast DHB at 4.00pm on Friday, 9 March 2007**

Before presenting the Report to the West Coast DHB we wish to recommend, that in the interim:

- **Kawatiri Maternity Unit be managed operationally by Jenny Robertson**

##### Rationale

There have been some ongoing operational management issues. Feedback has indicated that it has been difficult to manage these, on a day to day basis, from Greymouth. We consider it important that both of the current midwifery staff members could be supported more at this time by implementing this management arrangement until the review report has been considered by the DHB.

- **Midwifery staff members at Kawatiri Maternity Unit have close professional support provided by Jude Bruce**

##### Rationale

In order to professionally support midwives and keep the unit open during this time of staff shortages, weekly review of cases and professional support for decision making be overtly provided by midwifery advice provided by Jude Bruce.



The above are our immediate recommendations as a result of the interviews during 8 and 9 March 2007. We acknowledge that management may choose not to follow these recommendations and choose to wait for the full report. The draft report will be available within a month but we consider it important, in the interim, to provide a more strengthened infrastructure for current midwifery and other staff at Buller. We also acknowledge that the above recommendations will require changes to role/discussions which may take some time to implement

We recommend a recruitment process commence for Kawatiri as feedback was very strong that when DHB midwifery staffing is at four midwives, the service works well for both the midwives and the women of Buller. We are aware that this may have commenced within the DHB but certainly this is not widely known amongst the wider professional community. The full draft report will be available within a month. Please do not hesitate to contact either Norma Campbell or Lesley Dixon if you require any further assistance in the interim.

## Appendix 4

### POSITION DESCRIPTION

Location: Greymouth  
 Employment: Individual Employment Agreement  
 Reporting to: Chief Executive Officer

### PRIMARY FUNCTION

The primary function of the role is to provide strategic advice on nursing and midwifery services and effective leadership and direction, for nurses and midwives employed by the West Coast District Health Board (WCDHB), thus supporting the DHB to meet its strategic goals and health care responsibilities.

#### Key Objectives

**1. To provide leadership and direction for nursing and midwifery staff to ensure the WCDHB meets its strategic and annual plan obligations.**

The Director of Nursing and Midwifery will:

**1.1** Encourage leadership potential and a culture of professional practice in WCDHB nursing and midwifery, the latter in conjunction with Clinical Charge Midwife and senior midwifery staff. Leadership and professional practice development will be achieved by meeting regularly with nursing and midwifery groups and working towards mutually agreed goals.

**1.2** Work with Executive Management Team (EMT), Nurse Managers, Clinical Charge Midwife, clinical leaders and nursing and midwifery staff to ensure appropriate clinical and operational input during the planning phase of the DSP and DAP.

Works with Nurse Managers, Clinical Charge Midwife, clinical leaders and nursing and midwifery staff to translate the DSP and the DAP objectives into nursing and midwifery service deliverables.

**1.3** Foster a culture of interdisciplinary cooperation and teamwork and works with general managers, clinicians and the WCPHO to develop models of care that support nursing and midwifery to work safely within their scope of practice.

**1.4** Develop a nursing and midwifery educational and development strategy that supports the WCDHB vision for a centre of rural excellence.

**1.5** Provide oversight and support for the Professional Development and Recognition Programme nurses and the Quality and Leadership programme for midwives.

**1.6** Support the introduction of and have ongoing commitment to the Nurse Entry to Practice Programme. Provide oversight to the introduction of the Midwifery Entry to Practice Programme and the Mental Health New Graduate Nursing Programme.

**1.7** Provide leadership, direction and support for enhanced and advanced nursing practice roles, ensuring they meet Nursing Council of New Zealand standards and registration and legislative requirements.

**1.8** Provide leadership and be responsible for the implementation of any legislative requirements relating to nursing and midwifery, the latter in conjunction with the Clinical Charge Midwife.

**1.9** Lead nursing and midwifery recruitment strategies for the WCDHB, aiming at minimising vacancies and ensuring a safe and effective level of nursing and midwifery service delivery at all times.

**1.10** Put in place a succession plan that aims at building a robust, appropriately educated, workforce of the future; considering particularly strategies that attract West Coast students and Maori into nursing and midwifery.

**2. To provide executive leadership and direction on nursing and midwifery services:**

- Works with the Chief Executive Officer (CEO), EMT and senior WCDHB clinicians to deliver the strategic plan for the organisation.
- Provides professional nursing advice to the CEO, EMT and senior WCDHB managers and clinicians.
- Works with the Clinical Charge Midwife and where appropriate, the New Zealand College of Midwives and the Chief Midwifery Advisor for the Ministry of Health to provide professional advice, to the CEO, EMT and senior WCDHB managers and clinicians around midwifery services.

The Director of Nursing and Midwifery will:

**2.1** Actively participate in and positively contribute to WCDHB governance, advisory and operational teams. Where requested the DONM will assume the responsibility for such a team.

**2.3** Undertakes effectively and efficiently other projects as directed by the CEO and or reasonably requested by other members of the EMT.

**2.4** Advise the CEO and EMT on nursing and midwifery related matters which have implications for the WCDHB. Included will be advice on areas of risk, and recommendations to mitigate such risks.

**3. To be responsible for the development and maintenance of nursing standards, policies and procedures within the WCDHB.**

The Director of Nursing and Midwifery will:

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**3.1** In partnership with Nurse Managers, Clinical Charge Midwife and mental health Area Managers be responsible for the development and reviewing / amending of nursing and midwifery standards and procedures that meet recommended best practice, legislative and professional requirements, and have regard for Te Tiriti O Waitangi.

**3.2** In partnership with Nurse Managers, Clinical Charge Midwife and mental health Area Managers ensure the monitoring and evaluation of nursing and midwifery standards and procedures, ensuring in collaboration with relevant managers that deficits are identified and any remedial action necessary taken.

**3.3** Identify potential key performance indicators related to nursing and midwifery and work in partnership with Nurse Managers, Clinical Charge Midwife and mental health Area Managers to develop and monitor indicators.

**3.4** Work with Manager, Quality and Risk and the WCDHB Clinical Quality Improvement team to identify opportunities for quality, supporting the DHB to attain excellence in health care delivery.

**4. To positively promote, advocate for and represent WCDHB nursing in external forums and meetings.**

The Director of Nursing and Midwifery will:

**4.1** Ensure networks and professional relationships are maintained with:

- Professional and industrial nursing and midwifery organisations
- Nurse Executives of New Zealand
- Maori providers / Runanga.
- Nursing and other relevant departments in tertiary educational institutions.
- Community groups / agencies.
- Chief Nurse Advisor and Chief Midwifery Advisor, Ministry of Health
- Nursing Council of New Zealand
- Midwifery Council of New Zealand
- Relevant directorates of the Ministry of Health

**4.2** Demonstrate culturally safe practice and be able to apply knowledge of the impact of inequalities on health outcomes and of the principles of Te Tiriti O Waitangi to relevant responses in nursing and midwifery services.

