ANMF (Vic Branch) Submission to the Victorian Department of Health and Human Services

New design, service and infrastructure plan for Victoria’s maternity and newborn services – proposed system design reforms

13 April 2015
Introduction

The Australian Nursing and Midwifery Federation (Victorian Branch) [ANMF (Vic Branch)] represents nurses and midwives who provide care and treatment to women and babies across the full continuum of care including antenatal, labour and birthing, postnatal, neonatal intensive care, maternal and child health, mental health and community health. Our members work in both the public and private sectors and in bed based and non-bed based services. ANMF (Vic Branch) is in regular contact with nurses and midwives who provide direct services to women and their families and therefore we are well placed to provide a clinician’s perspective of current issues facing maternity and newborn services.

ANMF (Vic Branch) welcomes the opportunity to provide advice to inform the development of the New design, service and infrastructure plan for Victoria’s maternity services – proposed system design reforms.

ANMF (Vic Branch) believes that any reforms to maternity and newborn services must incorporate improved safety and improved clinical and psycho social outcomes for mothers and babies.

To address identified issues within current services, ANMF recommends that system drivers should be:

1. Improved primary health outcomes

2. Risk minimisation;
   • Resources
   • Education
   • Governance

3. Collaborative, multidisciplinary models of care
### Pregnancy Care (antenatal)

| Primary health foundations | 1. Clearly defined and resourced programs administered during the antenatal period are known to provide lifelong benefits to population health and well-being. Current pregnancy care includes:  
| | • Breast feeding  
| | • Quit smoking  
| | • Family violence  
| | • Mental health risk screening  
| | • Child safety  
| | • Vaccination  
| | • Oral health  
| | • Preparation for discharge post birth  
| | - Most antenatal clinic templates do not provide sufficient time to allow midwives to maximise the benefits to individual women and society in general of full application of primary health care principles  
| | 2. Pregnancy and birth is a time in a woman’s life when vulnerability is heightened and empowerment is an opportunity. It is critical that sufficient numbers of midwives are available to provide personalised treatment, advice and care to all women during pregnancy and birth. Of particular importance is the screening for and preventing of family violence. |

| Risk minimisation, education, governance, resources | The following measures require strengthening / implementing:  
| | 1. Early confirmation of pregnancy and commencement of antenatal care.  
| | 2. Ongoing triage and screening during the antenatal period to ensure that women will be provided with the correct level of monitoring and surveillance of the pregnancy. This is critical to decreasing the risk of adverse outcomes during labour and birth.  
| | 3. Design and develop fit for purpose assessment areas. Many birth suites act as pseudo emergency departments and outpatient services which is not optimal for women to be assessed in a timely manner and provided with safe care.  
| | 4. Multi service, multidisciplinary education and clinical audit opportunities utilising appointed midwifery educators and clinical midwife consultants.  
| | 5. Proper recognition, including payment for midwives when attending out of hours audit meetings.  
| | 6. Appoint clinical support midwives to work in antenatal clinics to provide support and guidance to graduate and student midwives.  
| | 7. Antenatal clinic schedules require change to allow for earlier booking-in visits and increased time per visit to enable midwives to attend to all health service mandated antenatal care including primary health initiatives.  
| | 8. Midwife Unit Managers to be appointed to all antenatal clinics. |

| Multi-disciplinary collaboration with a focus on continuity of care and carer | The following measures require strengthening / implementing:  
| | 1. Communication between health services and GPs, including the desirability of diagnosis of pregnancy and commencement of antenatal care prior to 12 weeks gestation.  
| | 2. Clear policies regarding midwifery and medical roles and ample |
opportunity for two way consultation and referral.

3. System design provides for formal and informal communication between health service providers to ensure clarity and consistency of approach.

4. Mental Health nurses and midwives collaborate with midwives in the provision of mental health education and information to women, mental health risk screening and referral and treatment.

5. Mental health nurses educate midwives regarding the antenatal risk screening process.

6. Maternity and Newborn Education sessions are open to all midwifery, nursing and medical staff involved in the care of women and babies.

7. Ongoing education about primary health care measures provided to medical and midwifery staff by health services.

Access to service as close to home and family as possible taking account of safety

1. Antenatal and postnatal care provided by midwives and GPs in small rural communities.

2. Shared care protocols established between larger and smaller services.

Labour and birthing (intrapartum)

Primary health foundations

The mother baby bond impacts on lifelong relationship capacity:

1. Early initiation of breastfeeding is key to successful breastfeeding to 6 months.

2. Sufficient midwives and medical staff must be available to ensure that all births are conducted in consultation with the mother and following her informed consent.

3. All babies born by caesarean section require a midwife to be present in the recovery room to facilitate skin to skin contact and breastfeeding as soon as possible post birth. This midwife is additional to midwives rostered to care for women in the wards;
   - This is in place in many hospitals, for most elective caesarean section births

Risk minimisation education, governance, resources

To create capacity and improve safety:

1. In the absence of new birthing units in areas of known increased demand, early labour/pregnancy care centres must be sufficiently staffed to enable surveillance and support of the woman and baby during early labour;
   - This is not currently in place

2. A midwife in charge to be rostered to all birthing units with greater than 3 delivery suites. This midwife does not have responsibility for any woman in labour but is available to assist with emergencies and attend births as the second midwife.

3. Hospitals must have processes in place which will allow the provision of a sufficient number of midwives to enable all women to have 1:1 care in labour;
   - It is not possible to comply with hospital policies regarding the conduct of labour and birth if one midwife is caring for more than one woman in labour
4. A dedicated clinical environment and appropriately educated staff must be available for women with high clinical dependency conditions eg pre-eclampsia and severe post-partum haemorrhage. These patients are generally cared for in birth suites;
   - *It is a significant risk for acutely unwell pregnant or postpartum women to be cared for without close monitoring by anaesthetic and physician personnel and ICU qualified nurses, in conjunction with obstetric and midwifery staff.*

5. Hospitals must have in place policies to manage capacity and demand. Such policies must nominate specific triggers to enable a timely response including increased midwifery staffing and/or transfer of care to another health service.

6. Every hospital birthing unit requires an appointed Midwife Unit Manager who is known, knowledgeable and accountable and maintains a contemporary knowledge of best practice evidence;
   - *Many maternity services require midwives to work in more than one area. Some midwives work in up to 6 different areas across a 4 week roster. This impacts negatively on the usual processes of communication and accountability and requires investigation as to how risk management can be enhanced in this model.*

7. Clinical Support midwives must be available at all times when graduate and student midwives are rostered.

8. Midwife educators must be appointed to all maternity and newborn services.

<table>
<thead>
<tr>
<th>Multi-disciplinary collaboration with a focus on continuity of care and carer</th>
<th>All maternity providers and systems of work operate seamlessly to put the woman and baby at the centre of the care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Maternity services must ensure that policies and procedures provide clarity to guide relationships between professionals including dispute resolution processes.</td>
</tr>
<tr>
<td>2.</td>
<td>Continuity of carer is a model of care which facilitates a personalised level of care. It is imperative that collaboration with other professionals is part of any system design which is focused on continuity.</td>
</tr>
<tr>
<td>3.</td>
<td>Other models of care can significantly reduce the number of midwives a woman sees during her pregnancy and birth. It is preferable a known midwife provides care during labour and birth but good antenatal preparation and postnatal care are equally important. In all models of care, multidisciplinary collaboration must be a design feature.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to service as close to home and family as possible taking account of safety</th>
<th>Some small rural services may not be able to offer safe birthing care:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Patient travel and accommodation assistance should be available when this is the case.</td>
</tr>
<tr>
<td>2.</td>
<td>Transparent benchmarking by health services against the DHHS maternity capability framework.</td>
</tr>
</tbody>
</table>
### Postnatal (postpartum)

<table>
<thead>
<tr>
<th><strong>Primary health foundations</strong></th>
<th><strong>Postnatal care in the home</strong></th>
</tr>
</thead>
</table>
| 1. Access to midwifery breast feeding support and information must be provided via midwife home visits, day stay centres and phone counselling for 6 weeks.  
2. Ongoing midwife mental health and physical health monitoring for mother and baby during the puerperium.  
3. Adequate referral and treatment options must be available during this time. | Inpatient capacity can be created through implementation of enhanced postnatal care in the home services. |
| **Risk minimisation, education, governance, resources** | 1. An educated and experienced workforce with appropriate vehicle and equipment infrastructure is required to provide postnatal care in the home. A sufficient number of midwives who are experienced enough to work independently in the community must be rostered;  
   ➢ *This is not currently the case* |
| 2. Please see attached Victorian Midwifery Homecare Group submission for more details about the escalating complexity and workload in this area. The VMHG recommends that, depending on travel time and complexity of the clinical needs, one midwife could ordinarily be expected to do 4 postnatal visits in one day, additional to phone calls and data entry that is required.  
3. Currently midwives visit between 4 and 5 women per day generally with up to 8 women visited on regular occasions.  
4. The health service must ensure that midwifery education services specific to postnatal care in the home will be provided to midwives working in this unit. |  |
| **Postnatal care in hospital** | 1. In integrated units (where birthing and postnatal units are co-located) midwives rostered to postnatal should not be routinely utilised to staff birthing suites;  
   ➢ *Serious risks exist when postnatal wards are left understaffed for periods of time, particularly when the midwife left on the postnatal ward is inexperienced or a student midwife. This is a regular occurrence in Victorian hospitals currently*  
2. Baby discharge checks performed by midwives.  
3. A retrospective audit of the effectiveness of midwife baby discharge along with the current number of midwives performing baby discharge would inform decisions around enhancing this practice.  
4. Ongoing education programs routinely conducted will enable midwives to achieve the necessary skill and confidence to perform baby discharge checks.  
5. Additional midwifery staffing is required when baby discharges are performed by midwives.  
6. A midwife educator must be available to develop and deliver midwifery |
## Multi-disciplinary collaboration with a focus on continuity of care and carer

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Discharge planning should commence in the antenatal period and be an ongoing process.</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Medical, midwifery and paediatric staff work together with the woman and her family to determine the most effective way to deliver care to mothers and babies post discharge.</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Hospital midwives refer women to the Maternal and Child Health Line after hours. This is a great resource for Victorian women and their families.</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Handover of baby care to maternal and child health nurse according to local communication protocols. The Continuity of Care Protocol (currently under review by DHHS) between hospital maternity service providers and Maternal and Child Health Nurses is a valuable tool to ensure systems alignment and communication.</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Collaboration between larger maternity services with rural GPs and midwives, to ensure seamless care and appropriate transfer processes are in place.</td>
</tr>
</tbody>
</table>

## Access to service as close to home and family as possible taking account of safety

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Increase the availability of structured postnatal care in the home programs.</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Midwives to perform baby discharge checks and to create capacity by facilitation of early discharge. This also decreases the number of clinicians a mother will see on discharge which enhances continuity.</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Postnatal care must be provided by midwives and GPs in small rural communities.</td>
</tr>
</tbody>
</table>

## Neonatal (birth to 6 weeks)

### Primary health foundations

<table>
<thead>
<tr>
<th></th>
<th>Keeping mothers and babies together</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Supporting families</td>
</tr>
<tr>
<td></td>
<td>Promoting breastfeeding</td>
</tr>
</tbody>
</table>

### Risk minimisation, education, governance, resources

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **1.** | Provide physical spaces for the care of babies that will ensure nurses, medical staff and families are comfortable and safe;  
- Some nursery spaces are small with inadequate security and no safe exit arrangements and are not fit for purpose |
| **2.** | At all levels of neonatal care, provide sufficient nursing, midwifery and medical staff expertise and availability to meet all hospital policies and procedures relating to care of the neonate;  
- Current nurse staffing in level 4 and 5 nurseries for example is not sufficient to care for babies requiring high flow oxygen therapy and CPAP. At the same time unwell neonates co-located with their mothers in a postnatal ward are also not allocated sufficient numbers of nursing or midwifery staff to properly comply with the comprehensive clinical practice guidelines mandated by health services. Please see attached ANMF submission 10 August 2015 and ANMF Newsflash 22 |
<table>
<thead>
<tr>
<th><strong>March 2016 for further details.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Review the current funding model so that funding for neonates will be directly related to the clinical care required rather than the environment in which the care is delivered. This is critical to minimise risk created by the systemic inadequacy of current staffing levels.</td>
</tr>
<tr>
<td>4. In-charge nurse to be rostered to co-ordinate and assist in emergencies on all shifts in all nurseries, additional to the prescribed nurse:patient ratio.</td>
</tr>
<tr>
<td>5. Provide clinical nurse educator positions in all Level 5 and 6 nurseries on all shifts.</td>
</tr>
<tr>
<td>6. Access to clinical nurse educator in all other nurseries.</td>
</tr>
<tr>
<td>7. Clinical support nurses rostered all shifts to support graduate and student midwives and nurses in special care nursery and NICU units.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Multi-disciplinary collaboration with a focus on continuity of care and carer</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Create neonatal nurse practitioner roles in all health services to provide a consistent level of expertise and care provision. This initiative should not be confined to Level 5 and 6 hospitals. The Neonatal Nurse Practitioner role in less complex services can provide a consistent level of expertise and liaison with nurses, midwives and medical staff providing neonatal care in various environments.</td>
</tr>
<tr>
<td>2. Paediatric and obstetric medical staff to work closely with nursing and midwifery staff to provide consistent, safe and seamless care to the baby and the baby’s family.</td>
</tr>
<tr>
<td>3. Provide regular opportunities for nursing, midwifery and paediatric staff to consult and discuss individual cases and hospital policies relating to neonatal care;</td>
</tr>
<tr>
<td>➢ <strong>Philosophical differences between paediatricians and midwives and nurses is a reality in the current system. System wide improved opportunities for collegiate collaboration and dispute resolution are required to minimise the risks inherent in this situation.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Access to service as close to home and family as possible taking account of safety</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>To build capacity in health services outside the metropolitan area:</td>
</tr>
<tr>
<td>1. Provide education and upskilling opportunities to nurses, midwives and GPs in rural areas, including paid clinical experience opportunities in SCN and NICU.</td>
</tr>
<tr>
<td>2. Provide outreach services from high level NICU and SCNs to smaller services and home based care models.</td>
</tr>
</tbody>
</table>
Recommendations

1. **Adverse events**
   a. Establish health service based processes to ensure clinical audit review is an integral part of all midwives and nurses practice. Provide resources/time to achieve this.
   b. Midwife input to the development of maternity performance indicators and data attributes.
   c. All health services to review 12 months’ VHIMs/riskman data in generated by maternity services and provide a report to DHHS. Clinician engagement in VHIMs reporting must be improved.
   d. Appoint research midwives and nurses at all health services.

2. **Patient experience**
   a. State-wide survey of all mothers at discharge to be maintained and reported by an independent body. The Perinatal Services Advisory Committee and consumer representatives to provide advice in the design of the survey. Results to be reported as part of the Maternity Services Performance Indicators data set.

3. **Access**
   a. Improved access will be achieved via capacity building measures such as those listed above. However, unless nurses and midwives are properly educated and available in sufficient number to provide care in accordance with hospital policies, increased capacity measures will increase clinical risk.
   b. Midwives, nurses and rural medical staff to be supported to work together to develop location specific collaborative models of care eg define circumstances when postnatal and antenatal care can be provided in a rural community with birthing taking place in a larger hospital. Shared care policies and procedures to be developed along with Memorandums of Understanding relating to two way education and support opportunities.
   c. Care of mothers and babies can be delivered in alternative environments when the policy settings are developed with midwife and nurse input and provide staff and resources in a regulatory framework to ensure the safety of all concerned.
   d. The Victorian *maternity capability framework* requires review to align it with the *defining levels of care for Victorian newborn services* document.

4. **Prevention**
   a. Better utilisation of primary health principles to achieve major psycho-social benefits. Some examples are; mental health screening, referral and treatment, family violence screening and prevention, breast feeding education and support and quit smoking.
   b. Lactation services provided by midwives must be strengthened and breast feeding rates monitored.
   c. Provide a sufficient number of midwives to deliver the above programs in accordance with evidence and hospital policies.
   d. Research Nurses and Midwives to be appointed to all hospitals to review and analyse clinical data, compile reports and engage with nurses and midwives providing direct patient care.

5. **Education**
   a. Provide ongoing education and education resources to midwives. This requires appointment of midwifery educators and allocation of time for midwives to access education.
b. Provide resources to achieve a cohesive workforce which is engaged in supported review of practice and quality improvement.

c. Provide support to midwife graduates to achieve retention of our future workforce.

d. Appoint midwives and nurses to provide education, clinical support and research expertise in all maternity services.

6. Clinical leadership

a. The appointment of midwife unit managers with defined authority and responsibility is essential to improve governance in maternity and newborn services. Clear reporting lines are essential to ensure that risk is reported and managed in a timely fashion. A midwife unit manager must have a manageable, clearly defined area of responsibility that is known to all midwives who report to her. Health services must also have clear lines of escalation so that a midwife or nurse can escalate clinical concerns about an individual patient, or resource/capacity and demand concerns, to managers authorised to resolve the concern.

7. Occupational health and safety

The following priorities to be built into maternity and newborn system design:

a. Immediate and longer term critical incident support to nurses and midwives.

b. Fatigue prevention and management principles to apply within system procedures for example escalation procedures.


Attachments

• ANMF (Vic Branch) submission to DHHS Defining Levels of Care for Victorian Newborn Services 10 August 2015

• Victorian Midwifery Homecare Group letter to ANMF (Vic Branch) 16 March 2016

• ANMF (Vic Branch) Newsflash Care of unwell neonates 22 March 2016