Review of Lumsden Rapid Births

26 May - 26 June 2019

Final Report

15 October 2019

Reviewers:

Sue Bree

Robyn McDougal

Review of Lumsden Rapid Births

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Purpose

The purpose of the review, initiated by Southern DHB (SDHB), was to consider the circumstances surrounding four rapid birth events (including the overall network of support available at the time), to determine the possible impact from the changes to the primary maternity infrastructure in Lumsden.

The reviewers were given no mandate to consider any aspects of decision-making by the SDHB which resulted in the transition of Lumsden Primary Birthing Unit to a Maternal and Child Hub.

Background

SDHB has concerns that in a six week period, four rapid births took place in the Northern Southland region, and that each birth occurred outside of the planned place of delivery as a result. Following the transition of the Lumsden Primary Birthing Unit to a Child and Maternal Hub in April 2019, concerns have been raised suggesting that the changes to the primary maternity infrastructure have impacted negatively on the care of women and babies in the area. Accordingly, SDHB are committed to ascertaining that the changes that have been made in the area are not adversely affecting outcomes for mothers and babies.

The four events, which each took place outside of their anticipated place of birth reported and to be reviewed are:

- A rapid birth in an ambulance en route to Southland Hospital (26 May 2019)
- A rapid birth in the Lumsden Maternal & Child Hub (5 June 2019)
- A rapid birth in the car park outside the Lumsden Maternal & Child Hub (21 June 2019)
- A rapid birth in the Lumsden Maternal & Child Hub (26 June 2019)

REVIEW PROCESS

The New Zealand College of Midwives was approached by SDHB for recommendations of midwives to undertake the review. Of the names put forward, Sue Bree and Robyn McDougal agreed to participate. Each has extensive experience as a midwife Lead Maternity Carer (LMC) providing midwifery services in rural New Zealand.

Local arrangements for the review, including a proposed timetable, were arranged by SDHB. Relevant clinical records of the women who consented to be interviewed were provided by SDHB and the LMC midwife in Lumsden. In addition, the reviewers were provided with a copy of 'Creating an Integrated Primary Maternity System of Care across the Southern District" which is the decision document outlining the changes to the provision of rural maternity services in Northern Southland.

Additional information made available included

- Closure of the Lumsden Maternity Primary Birthing Unit; Submission to Parliamentary Health Select Committee by Northern Southland Community, Northern Southland Health Limited, Fiordland Medical Centre, Lead Maternity Carers, Te Anau Medical Trust, Lumsden Community Board, Te Anau Community Board.
- Statement from St John's Officer at the scene of one of the rapid births

The following people were interviewed during the course of the review:

- Two of the four mothers who had rapid births in May and June 2019
- SDHB Director of Midwifery
- St Johns Territory Manager
- SDHB Maternity Quality Safety Programme Facilitator seconded to Primary Maternity System Improvement
- Self-employed community midwife providing LMC services in Lumsden
- Self-employed community midwife providing LMC services in Te Anau
- Back-up midwife from Te Anau

Unfortunately, only two of the four women who had rapid births consented to be interviewed. The reviewers acknowledge their right to do so while also being cognisant that their lack of participation places limitations on the strength of this review.

The reviewers visited the Maternal and Child Hubs in both Te Anau and Lumsden. Interviews with women took place in their homes.

As stated, this review was not to explore the decisions of SDHB in the reconfiguration of primary maternity services in Southland. This was repeatedly stated in the introduction to each interview, however, in undertaking the review it was inevitable and important to consider the context in which midwives work and women give birth, including the impact of environmental factors in the Southland region. At the time of the review, the outcome of the Health Select Committee findings regarding the closure of Lumsden as a primary birthing unit was pending.

THEMES

Understanding of the function of a Maternal and Child Hub

It is noted that there is no National Service Specification for Maternal and Child Hubs and there was consistent confusion amongst all people interviewed as to what exactly constituted a Hub. Opinions ranged from "anything the community wanted it to be" to a site which could act as a resource centre for information. The DHB described it as a location where the community could access midwife antenatal clinics, Plunket services, B4 school checks etc. in addition to a facility where *emergency* births could safely take place. In particular, both of the mothers were very unclear and one told the reviewers she had gained most information about the Hubs via Facebook.

The Hub in Te Anau is currently located in the general emergency room of the medical centre. A new resuscitaire was on site and a cardiotocograph machine arrived the day the reviewers visited. The clinic of the local practising midwife is not co-located in the medical centre. Despite the substantial investment by SDHB in equipping the Hub, all midwives interviewed were concerned that it would very rarely be utilised, as any unplanned births in Te Anau would likely take place in a woman's home.

Rurality
As in some other regions of New Zealand, the rural nature of Northern Southland inevitably poses specific demands on the provision of maternity services. While the main roading network may be of a high standard, the reviewers were informed of the challenges of weather and tourism which sometimes influence the ease of making car journeys. Helicopter availability can also be impaired by weather, such was the case on the night of one of the births reviewed.

The distance some women in Northern Southland need to travel whilst in labour is not insignificant. The reviewers heard from both mothers and midwives that this is not only challenging in terms of profound discomfort but also a genuine source of anxiety for them, as while they do not want a roadside birth, they equally do not want to travel the long distance to their planned place of birth in presumed labour, only to be advised to make the journey home again if labour is deemed not to have established. The offer of accommodation in this situation may be regarded a solution yet still adversely disrupts employment and child care responsibilities.

Labour
Despite knowledge and skills of both midwives and mothers, the process of a normal labour can be unpredictable. Some women reliably repeat individual aspects of labour with subsequent children while for other women, each labour can be quite different. This is the nature of pregnancy and birth.

Both of the mothers interviewed were advised, and accepted, the need to give birth to their second baby at the secondary maternity facility at Southland Hospital. Based on the maternity history of each woman, this approach is usual practice throughout New Zealand. Appropriate planning had taken place in conjunction with their midwife. This included sound advice on the women's response to early labour. The advice was heeded but each of their labours progressed at such a rate that giving birth in Invercargill was not to be. There was absolutely no indication that either of these women had surreptitiously planned a Lumsden birth in advance of the onset of labour.

Although the two other mothers who had given birth at Lumsden were unable to be interviewed, the reviewers were informed that they too experienced labours of a very short duration.

In line with descriptions of the vagaries of labour as outlined above, there will always be babies born in unintended locations. This is not an infrequent event, especially in rural areas, however the frequency that this does occur is the measure of an accessible maternity service.

Impact on Women and Families / Whānau
The reviewers were informed of some of the effects on childbearing women and their families following the closure of Lumsden as a birthing facility.

Some women are planning to have a home birth out of necessity rather than preference. This is mainly due to their experience of a short labour previously; their anxiety at having to travel further to reach an available birthing facility and not wanting to give birth on the side of the road.

Other women are having unplanned homebirths following an assessment in labour by their midwife before leaving home. If neither the midwife nor woman is confident that there is enough time to travel the extra distance to a birthing unit, they will collectively decide to stay put.

Staying with relatives in close proximity to the planned place of birth is a choice for some women. The ease of this is dependent on partner employment responsibilities and other on-going family commitments at home, as the necessary duration of the stay is relatively unknown.

The inability to have a postnatal stay in Lumsden has resulted in women opting to discharge home earlier than planned in order to be closer to their families. Other birth units available for inpatient postnatal care were described as being too far away for family visits, especially for farming families. Cost implications were also mentioned. The quality of postnatal care directly influences the transition to motherhood and the success of breastfeeding and should not be underestimated.

The reviewers were informed that these altered decisions regarding place of birth and length of postnatal stay go largely uncounted so the true impact may be unknown. If not for the possibility of women having a local midwife to support unplanned homebirths, there would have been increased numbers of babies born in transit.

Midwives

The three Southland midwives interviewed during the review process expressed a clear commitment to the women and families in the area but remain concerned about what they described as inequity to access to services for the rural women in the areas they cover.

The reviewers were made aware of the recruitment and retention strategies which have been instigated by the SDHB throughout Southland however isolation remains a key factor for these rural midwives. Midwives to back up those in Te Anau and Lumsden are at least 45 minutes away and they therefore rely heavily on local medical and ambulance staff for support. Both of these services were utilised on the occasions of the births assessed during the review. The Territory Manager for St John has the view that there is a risk of St John's being considered the back up to the maternity service in the absence of midwives and the Lumsden unit being closed for birthing.

The midwives place enhanced focus on early labour care, factoring in the need for women to travel to a facility further away to give birth. Sound advice is provided to women antenatally to make contact earlier than they may otherwise have done. Early assessments are done either in the women's home or at the Lumsden Hub. Sometimes this will confirm that the woman is not actually in labour and the visit reverts to one of providing reassurance or, as is the focus of this review, the labour is too advanced to proceed to the planned place of birth. The implications of needing to travel in labour are similarly managed and the midwives tend to travel in convoy with the woman.

A feature of the practice of all rural midwives in New Zealand is the requirement to travel greater distances than their urban counterparts and this is acknowledged in payment to LMCs under the Section 88 Notice. The midwives interviewed confirmed that their travel demands have increased substantially due to the need to travel further to provide labour and inpatient postnatal care; the lack of postnatal facilities in Lumsden and subsequently, the earlier discharge home from hospital than previously. They are grateful that SDHB staff in Southland Hospital do not require them to provide daily postnatal visits there. During those times when the midwives are out of area other women in their caseload are without access to midwifery care.

If a woman planning to have her baby in Southland Hospital opts to go to Invercargill towards the end of the pregnancy to await the onset of labour, the Lumsden and Te Anau midwives need to travel to Invercargill weekly for antenatal visits. This is demanding but the alternative is loss of continuity of care for the woman and loss of income for the midwife if she was to transfer care to a midwife in Invercargill.

In light of the essential nature of collegial support, the reviewers explored the quality of relationships between the midwives. All were adamant that they would back each other up in any circumstances however there appeared to be underlying issues which prevented them from working in a fully cohesive manner. This mainly stemmed from a lack of delineation in the areas they covered. In rural areas where caseloads are smaller and income subsequently less, caseload disparity can arise, and this is what appears to be the case in Te Anau. The need for sustainable practice by limiting travel demands by one midwife as well as respect for women's choice by the other, are factors contributing to this. All midwives mourn the lack of contact with each other which generally took place at Lumsden in the past. It was these encounters which afforded them the opportunity to discuss any clinical concerns and could contribute to establishing functional working relationships.

Conclusion

In relation to the circumstances associated with the two births assessed during this review whereby women were forced to give birth in unintended locations, the reviewers conclude that both of these outcomes were unavoidable. Contributory factors for both incidents are identified as the unforeseen rapid progress of each labour. An additional contributory factor pertaining to one woman was the lack of essential equipment available in the Lumsden Hub in the presence of specific risk factors which could constitute the need for full resuscitation capacity.

It is apparent that midwives providing a maternity service to women in Northern Southland have made adjustments to their practice in light of the changes which have taken place recently in order to keep mothers and babies as safe as the significant rurality permits.

Recommendations

- Enhanced and on-going communication with the community regarding the functions of a Maternal and Child Hub. The need for informing the public of the rationale regarding the closure of Lumsden Maternity Centre as a place to give birth and receive a postnatal inpatient stay appears to still exist. Opportunities for regular feedback from women should be prioritised.
- Formal back-up arrangements for the midwives to enable regular time off and for study leave. While this is in place for the Te Anau area and an interim arrangement has been made for the Lumsden midwife, this needs to be embedded as business as usual as a way of retaining a rural midwifery workforce.
- Accurate data collection to capture the number of women who have unplanned homebirths or who opt for a homebirth instead of giving birth in Lumsden as their first choice. This could be gained by reporting mechanisms set up between LMC midwives and SDHB.
- A facilitated meeting(s) with LMC midwives in the Northern Southland region with the aim of improving working relationships and reaching agreement on the geographical boundaries they each cover. While SDHB has no jurisdiction on such matters in a self-employment context, it is none-the-less a professional issue impacting on sustainability of midwifery practice which is in the best interests of the DHB to consider. It is recommended that the New Zealand College of Midwives be approached to assist with this.
- Midwifery leadership within the DHB which overtly demonstrates the understanding of a symbiotic relationship between the self-employed midwifery workforce and the DHB employed workforce. Both are interdependent. Although the overall quality of the maternity service rests with the multidisciplinary team, the primary maternity service is wholly reliant on midwives. Strong inclusive midwifery leadership will therefore be necessary for shaping the future planning of the maternity service.

Appendix 1

Terms of Reference

Review of Lumsden Precipitous/Rapid Births

Purpose

The purpose of the case reviews is to consider the circumstances surrounding four rapid birth events (including the overall network of support available at the time), to determine the possible impact from the changes to the primary maternity infrastructure in Lumsden.

The review is not a review of the midwifes practice, but rather a review of the circumstances that led to the rapid births to identify whether any further changes or support need to be considered in the light of the wider Primary Maternity Strategy. Recommendations from these events cannot be taken in isolation from consideration of equity across the entire region.

Background

Despite evidence suggesting that precipitous or rapid births occur in approximately 2 out of every 100 births, SDHB has concerns that in a six week period four rapid births took place in the Northern Southland region, and that each birth occurred outside of the planned placed of delivery as a result. Following the transition of the Lumsden Primary Birthing Unit to a Child and Maternal Hub in April 2019, concerns have been raised suggesting that the changes to the primary maternity infrastructure have impacted negatively on the care of women and babies in the area. Accordingly, SDHB are committed to ascertaining that the changes that have been made in the area are not adversely affecting outcomes for mothers and babies.

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Review Team

An independent expert reviewer with extensive experience providing rural maternity care will lead the review with support from a second independent expert reviewer, also an experienced rural midwife. Other expert advice may be identified as being necessary during the course of the review and may be requested of the DHB at the discretion of the lead reviewer.

Review Process, Parameters and Outputs

1) The reviewers will assess each birth separately in the first instance providing four reports so that no one report contains confidential information about the other;
2) The reviewers will have access to all relevant DHB documentation and other maternity records (with permission from the women and their LMC);

3) Women will be invited to contribute to the review by being interviewed at a place of their convenience. Involvement of partners/families or support people will be welcomed and involved in accordance with their wishes;
4) Interviews or written statements will be sought from those involved in providing care as relevant to the circumstances of each birth e.g. LMC midwife, St John Ambulance staff or volunteers, Obstetric staff, PRIME responder, back-up midwife or others as deemed relevant;
5) Interviews or written statements will be sought from relevant DHB staff responsible for the management of the Lumsden Maternal & Child Hub;
6) Draft reports will be prepared describing the findings of each case review including factors which may have contributed to or impacted on decision making and care of the women and babies involved;
7) A de-identified summary draft report will be prepared describing key findings, themes and recommendations identified from all four case reviews;
8) The reports will remain in draft when submitted to the CEO so points of accuracy can be checked. An opportunity will be provided to those who have been involved in the review process inviting them to comment or suggest corrections of matters of fact relevant to the report.

Review process
Although these are not adverse event investigations, there is benefit in utilising the recommended Health Quality and Safety Commission New Zealand root cause analysis and action process. Alternatively the *London Protocol* or a comparable structured process of systemic analysis framework should be used in carrying out the review.

Anyone involved in the review is entitled to have a support person present with them during the interview, or to seek advice or representation if they have any concerns about the review process. It is expected that the review will be a confidential process to the relevant parties.

Timeframe
The timeframe for submission of the draft reports is expected to be four weeks from the commencement of the review. The lead reviewer will keep the CEO or delegate informed throughout the review of any concerns, delays etc. and provide informal briefings as they consider necessary.

Distribution of final report/s
All those involved in the reviews, including the women interviewed, will receive a copy of the final report (or reports as relevant).

Copies of the final reports may be shared with the Ministry of Health, Southern DHB Commissioner and Executive Teams or others as relevant for the purposes of quality improvement and fulfilling governance or management responsibilities.

Out of scope
This is not a review of any individual's professional practice or a review of the primary maternity strategy "***Creating an Integrated Primary Maternity System of Care across the Southern District"*** or its implementation.

Meetings and resources
Southern DHB will provide relevant documentation, and organise, interviews and access to key personnel etc.