Update on maternal morbidity review

Lesley Dixon and Leona Dann on behalf of the Maternal Morbidity Working Group

Key points:
• no blame on care delivery
• women’s stories
• clinical notes
• midwives on panels

The Maternal Morbidity Working Group was established in May 2016 to review severe maternal morbidity in New Zealand. The Maternal Morbidity Working Group is a subgroup of the Perinatal and Maternal Mortality Review Committee (PMMRC), which operates under the umbrella of the Health Quality & Safety Commission.

We (the Maternal Morbidity Working Group) have established regional review panels involving a number of disciplines, including hospital and community lead maternity carer (LMC) midwives. The regional panels will review cases of severe maternal morbidity such as sepsis. These reviews will identify potential improvements to maternity care and focus on processes and system factors. The reviews will not focus on individual clinician practice. The review findings will be used to develop recommendations and quality improvement initiatives with the maternity sector.

Midwives are essential to the maternal morbidity review process. If the case for a woman who received your care is selected for review, we will contact you to ask for some more information about her pregnancy. We will also ask you to help us to contact the woman (if appropriate) to ask for her story.

The purpose of this article is to update you on the progress of the Maternal Morbidity Working Group, and to ask for your support of our programme so that we can work together to ensure continued improvement in maternity care for New Zealand women.

Background to maternal morbidity reviews in New Zealand

There were 61,038 live births in New Zealand in 2015 (Statistics New Zealand). Most of these births followed healthy pregnancies. A very small proportion of pregnancies sadly resulted in the deaths of mothers and/or babies and these losses are of lifelong significance for the family and whānau. Every death is reviewed by the PMMRC to try to determine the factors involved and to identify opportunities to improve maternity services and help to prevent losses in the future.

The quality of maternity care in New Zealand is assessed in part, using maternal mortality statistics and birth outcome records (O’Malley, Popivanov, Fergus, Tan, & Byrne, 2016). But, as maternal deaths have decreased, severe maternal morbidity has become another measure of the quality of maternity care both in New Zealand and globally (Jayaratnam, Burton, Connan, & Costa, 2016; Knight, et al., 2016; Knight, et al., 2016). For example, the prevention of morbidity from severe maternal sepsis is a focus in Brazil and the United Kingdom (Acosta, Bhattacharya, Tuffnell, Kurinczuk, & Knight, 2012; Pitschker, et al., 2016).

With this increasing focus on maternal morbidity, the University of Otago established the Serious Acute Maternal Morbidity (SAMM) audit to review maternal morbidity in New Zealand.

This project was funded by the Ministry of Health. Following a pilot at a tertiary district health board (DHB), the audit was piloted in four DHBs in 2011–12, before being introduced to all 20 DHBs in 2013 (MacDonald, Galler, & Lawton, 2016).

The Maternal Morbidity Working Group

In March 2015, the Minister of Health announced that the SAMM audit would transition to the Commission under the umbrella of the PMMRC. The transition was completed on 30 June 2016, and the programme is funded until 30 June 2019. The Maternal Morbidity Working Group was established from representatives within the maternity sector to provide governance for the project. Our vision is ‘better maternity outcomes for New Zealand women’. Our aim is ‘to improve the quality and experience of maternity care for women, babies and family and whānau, informed by robust, consistent, reportable and women-centred maternal morbidity review’.

Future maternal morbidity review

The new review process builds upon the previous SAMM audit. Four maternal morbidity review panels have been established to cover the northern, midland, central and South Island regions. Nominations for panel members were sought through professional colleges, DHBs and previous SAMM panel members. The panels consist of midwives, obstetricians, intensivists, general practitioners and consumers. When each regional panel meets, it will have at least one self-employed LMC and at least one hospital midwife representative to help the context of midwifery care to be fully understood during the reviews by the multidisciplinary group. We received overwhelming interest from midwives to be involved in the panels which reflects a commitment to ensuring the best outcomes for mothers and babies.

It is not always possible to identify and review all women who experience severe maternal morbidity. The previous SAMM audit randomly selected a proportion of admissions to intensive care (ICU) and high dependency units (HDUs) for panel review. We will also select cases from ICUs and HDUs, but will focus on a small subset of maternal conditions. For the first year, the regional panels will review cases of severe maternal sepsis and unplanned peripartum hysterectomy. The subset of
The focus of reviews

Reviews of severe maternal morbidity are not about critiquing individual clinicians or apportioning blame. We appreciate that maternity services are complex and a woman’s health and her expectations are also often complex. We are using review tools to account for this complexity and these will help us make system-focused recommendations which are relevant to maternity services.

Reviews will focus on systems and processes, and try to identify whether the morbidity was potentially avoidable. In addition, we will identify common themes between cases, and whether there are opportunities for quality improvement for future maternity care.

In addition to the external review panels, we will be working to support and improve local reviews of maternal morbidity, and you will hear more about this project soon. Local review provides an opportunity to strengthen collaboration between stakeholders such as the Maternity Quality and Safety Programme, the National Maternity Monitoring Group and the professional colleges.

The woman’s story

We value the woman’s (consumer’s) voice in our reviews, as she provides the context of her pregnancy and the care she received. We will contact women whose cases are selected for review in a sensitive and appropriate way, and we will offer them the opportunity to tell us their story. We won’t use their name, and we’ll make sure the woman isn’t identifiable. We won’t use their name, and we’ll make sure they have the opportunity to tell us their story. Your support will help us prevent additional anxiety or distress.

If you were the LMC for a woman whose case is selected for review, we will also ask you to send us your clinical notes of the case. These notes are kept confidential and are only viewed by Commission staff supporting the Maternal Morbidity Working Group, and by panel members outside your DHB. These Commission staff and panel members are all bound by strict confidentiality agreements, as agents under Schedule 59e of the New Zealand Public Health and Disability Act. For further information please see the ‘Frequently asked questions for health professionals’ resource on our website.

More information

You can find more information about the Maternal Morbidity Working Group on our website.

If you have any questions regarding the regional panels please contact Leona Dann, maternity specialist (midwife) at the Commission leona.dann@hqsc.govt.nz or Lesley Dixon, Maternal Morbidity Working Group member.

We would like to thank all midwives for their support of the maternal morbidity reviews. We look forward to working together to improve maternity care for New Zealand women.

References


Maternal conditions will be reassessed each year.

We recognise that some women experience morbidity but are not admitted to an ICU or HDU. Ministry of Health, DHB annual reports and previous SAMM audits found that postpartum haemorrhage was a significant cause of maternal morbidity. We will review the most severe postpartum haemorrhage cases, the ones that result in a peripartum hysterectomy. For the less severe levels of post partum haemorrhage the MMWG will work with the maternity sector to encourage and support local reviews of post partum haemorrhage.

The woman’s story

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We have some pamphlets available for you and women and their wha-nau who have been admitted to ICU/HDU with a maternity-related event. These explain our role in the maternity sector, the maternal morbidity review process and how the woman’s story fits into this.

Midwifery involvement in maternal morbidity review

As the majority of pregnant women receive some care from a midwife, your involvement in maternal morbidity review and quality improvement initiatives is invaluable. If you are or have been the LMC for a woman whose case is selected for review, we will contact you to ask for some more information about her pregnancy. We may ask you if the woman (or her family) has received our pamphlets on her discharge from ICU/HDU or if we need to send them to her. We will also ask you to advise the woman (if you are still providing care) that we may be contacting her in the future to ask for her story. Your support will help us prevent additional anxiety or distress.

If you were the LMC for a woman whose case is selected for review, we will also ask you to send us your clinical notes of the case. These notes are kept confidential and are only viewed by Commission staff supporting the Maternal Morbidity Working Group, and by panel members outside your DHB. These Commission staff and panel members are all bound by strict confidentiality agreements, as agents under Schedule 59e of the New Zealand Public Health and Disability Act. For further information please see the ‘Frequently asked questions for health professionals’ resource on our website.
Forum

Maternal Morbidity Working Group and regional panel membership

Working group
The working group provides governance of the maternal morbidity work programme. The Maternal Morbidity Working Group has 12 members and is co-chaired by Mr John Tait and Arawhetu Gray.

MMWG members:
- Arawhetu Gray (co-chair) – planning and funding, Capital & Coast DHB
- Mr John Tait (co-chair) – chief medical officer, Capital & Coast DHB
- Pauline Dawson – research midwife, Dunedin School of Medicine
- Dr Lesley Dixon – midwife, New Zealand College of Midwives
- Dr Matthew Drake – anaesthetist, Auckland DHB
- Prof Cindy Farquhar – clinical epidemiologist in obstetrics & gynaecology, University of Auckland
- Jim Green – chief executive officer, Tairawhiti DHB
- Dr Seton Henderson – intensivist, Canterbury DHB
- Dr Claire McLintock – haematologist & obstetric physician, Auckland DHB
- Linda Penlington – consumer representative
- Dr Craig Skidmore – gynaecologist and obstetrician, Hawke's Bay DHB
- Jenny Warren – consumer representative

The group is supported by Dr Leona Dann, maternity specialist, and Lisa Hunkin, policy analyst, at the Health Quality & Safety Commission.

Regional panels
Four maternal morbidity review panels have been established to cover the Northern, Midland, Central and South Island regions.

The regional panels will review cases of severe maternal morbidity. These reviews will identify potential improvements to maternity care and focus on processes and system factors. The reviews will not focus on individual clinician practice.

We have appointed a pool of members to ensure that each panel meeting has representation from all of the relevant disciplines. The panels consist of midwives, anaesthetists, obstetricians, intensivists, general practitioners and consumers.

Northern regional review panel members:
Name | DHB | Role
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Peter Stone | Auckland University | Chair
Annemarie Mitchell | Waitakere | Intensivist
Colleen Brown | Northern | Midwife LMC
Emma Farmer | Waitakere | Anaesthetist
Isabelle Eadie | Auckland | GP
Jennifer Blasingame | Northern | Obstetrician
Jennifer Taylor | Counties Manukau | Anaesthetist
Jonathon Casement | Auckland | Consumer
Juliet Walker | Auckland | Intensivist
Katy Konrad | Auckland | GP
Matt Drake | Counties Manukau | Obstetrician
Tikia Parke | Auckland | Obstetrician
Sharna Desai | Waitakere | Obstetrician
Sarah Wadsworth | Counties Manukau | Obstetrician
Stuart Tiller | Auckland | Obstetrician
Tim Parris-Piper | Waitakere | Obstetrician
Yvonne Hall | n/a | Obstetrician

Midland regional review panel members:
Name | DHB | Role
--- | --- | ---
Margot Norris | Bay of Plenty | Chair
Angela Freschini | Tairawhiti | Intensivist
Annette Forrest | Waitakere | Anaesthetist
Belinda Chapman | Taranaki | Obstetrician
Chris Rye | Waitakere | Intensivist
David Freschini | Tairawhiti | Anaesthetist
Diane Van de Meir | Tairawhiti | Midwife
Jackie Reetz | Waitakere | Midwife
Robert Martynoga | Waitakere | Midwife
Sharni Budd | n/a | Midwife
Brenda Howse | Taranaki | Midwife
Vicki Higgins | Bay of Plenty | Midwife

Central regional review panel members:
Name | DHB | Role
--- | --- | ---
Karen Daniells | Capital & Coast | Chair
Andrew Stapleton | Hutt Valley | Intensivist
Chloe Frei | Capital & Coast | Midwife
Craig Skidmore | Hawke's Bay | Anaesthetist
Douglas Mein | Capital & Coast | Midwife
Elaine Langton | Capital & Coast | Midwife
Frances Alloway | Capital & Coast | Midwife
Inez Schmidt-Rademacher | Capital & Coast | Midwife
Jennifer Green | n/a | Midwife
Julie Arthur | MidCentral | Midwife
Kirsten Gaerty | Hawke's Bay | Midwife
Lucetta (Lu) Read | Hawke's Bay | Midwife
Lucy Pettig | Whanganui | Midwife
Meg Wilson | Hawke's Bay | Midwife
Peter Abels | Hawke's Bay | Midwife
Rona Carroll | Hawke's Bay | Midwife
Sarah MacKinn | Hawke's Bay | Midwife
Siobhan Connor | MidCentral | Midwife

South Island review panel members:
Name | DHB | Role
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Helen Paterson | Southern | Chair
Anna Foae | Canterbury | Intensivist
Catherine Ben | Nelson Marlborough | Midwife LMC
Flora Gastrell | Nelson Marlborough | Anaesthetist
Janet Zyrini | Nelson Marlborough | Consumer
Jenny-Louise Coster | Nelson Marlborough | Obstetrician
Joanna Gullam | Nelson Marlborough | Obstetrician
Kate Nicoll | Nelson Marlborough | Obstetrician
Kim McFadden | Nelson Marlborough | Obstetrician
Louise Hitchings | Nelson Marlborough | Obstetrician
Lynda Exton | Nelson Marlborough | Obstetrician
Morgan Weathington | Nelson Marlborough | Obstetrician
Patricia McIntosh | Nelson Marlborough | Obstetrician
Rebecca Harris | Nelson Marlborough | Obstetrician
Richard Seigne | Nelson Marlborough | Obstetrician
Sam Burke | Nelson Marlborough | Obstetrician
Sarah Pezaro | Nelson Marlborough | Obstetrician
Sherif Mehrez | Nelson Marlborough | Obstetrician
Thomas Gough | Nelson Marlborough | Obstetrician

1 Representative from Lakes DHB to be confirmed

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