


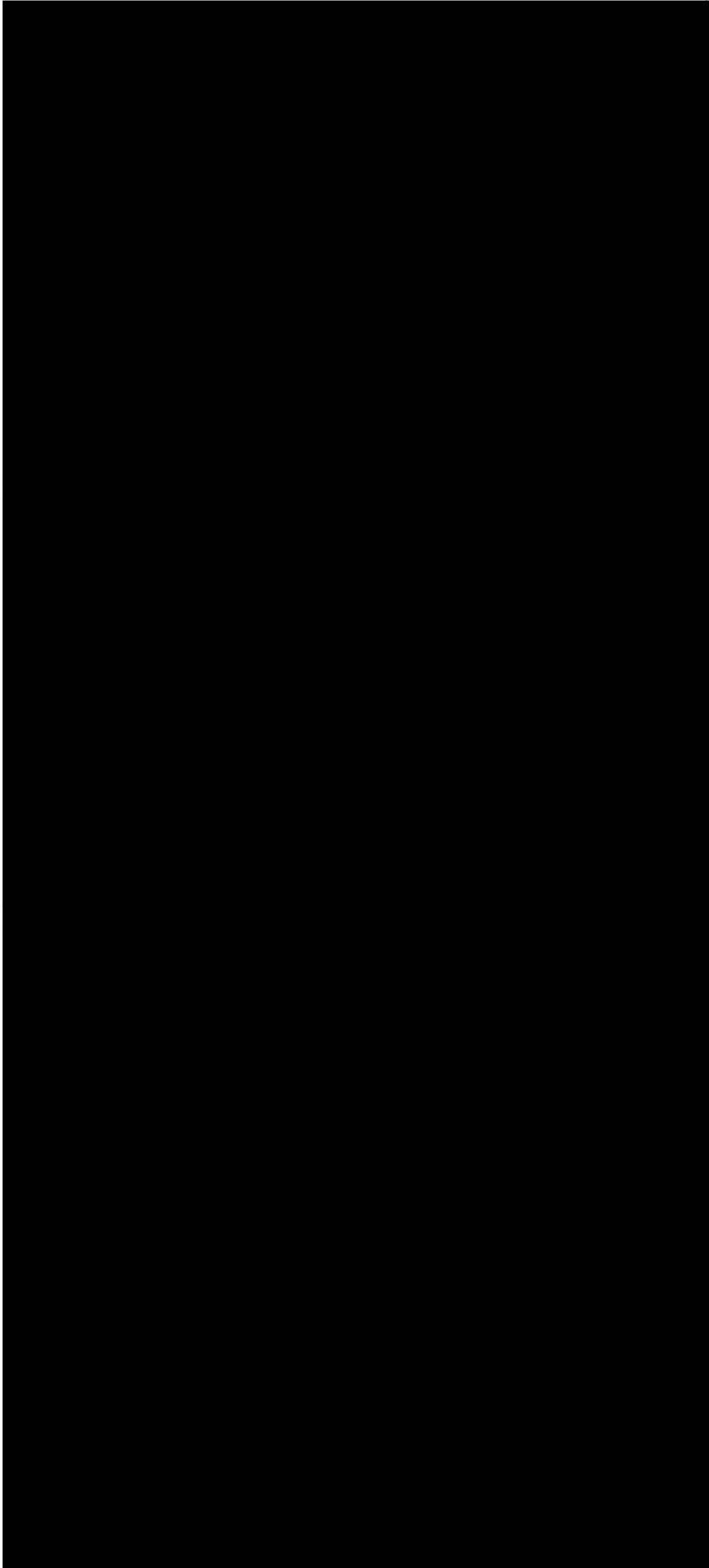


	<p>Aims: Model aims to assist women to focus on factors that support maternal health and wellbeing and aims to give women a greater sense of coherence which is a predictor for improving women's birth outcomes</p>	<p>currently Core midwifery and CatCH programs are following this pathway. For review at completion of 2018</p>  <p>Salutogenic midwifery - Women and Birth.mh</p>	
<p>Discharge summaries</p>	<p>KPI- Reports from Medical Records that compliance with D/C summaries being received in Medical records with 24 ours of discharge from Hospital.</p>	<p>All notes are returned to Medical records within 24 hours of discharge (business Ours) with a completed discharge summary</p> <p>Ongoing- monitoring of KPI reports and managing of process</p>   <p>DSRR 05-02-2018 DSRR 30-07-2018 to 28-10-2018 WYC.to 28-10-2018 WYC.</p>	<p>Clinical Handover</p>






Midwife Clinical Coaches – Birthing Aim - The aim of this Quality Improvement Project is to introduce a program to improve clinical learning support for Graduate Midwives as well as developing	Recruitment and Retention strategy	Complete: <ul style="list-style-type: none">• RM level 2 to complete coaching training SDU through capability• Assign a Clinical Midwife Coach to each New Graduate Midwife in 2017- 18	Recruitment and retention
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<p>supportive learning skills for midwives providing clinical coaching; this program will initially be run over a 12 month period.</p>		<p>Ongoing</p> <ul style="list-style-type: none"> ➤ Develop program to roll out in ANW/PNW 2019 	
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<p>Urinary retention</p>		<p>Ongoing/ registered:</p> <p>Guideline for maternity- complete Auditing process</p> <p>Improve CALD women's experience of childbirth education</p> <ul style="list-style-type: none"> • Interpreter present at Childbirth education • Mandarin speaking pilot group 	<p>Standard 1 Governance</p>
<p>CALD women and childbirth Education</p>		<p>Ongoing</p> <ul style="list-style-type: none"> • The target for TCH recruitment per year is 2240 – to date 1530 women have been registered into the trial. This equates to 68% of the target. Registration has been increasing month by month from 45% in Jan 2018 to date 82% 	<p>Partnering with consumers</p>
<p>My baby's Movements - Prevention of Stillbirth CHWC-Lead - Dr Boon Lim</p>			<p>Research NHMRC</p>

	 <p>MBM Update April2018.docx</p>	
<p>Purple Crying CHWC-Lead Investigator- Prof. Deb Davis</p>	<p>Ongoing/</p> <ul style="list-style-type: none"> • Decision made by Maternity Services Advisory Group in 2015 to introduce it in its original form • Launch will be in November 2016 • Funding for TCH from COSTCO for 2 year Calvary and John James are also committing for a year • Training Health staff completed in Nov 2016 (Midwives, MACH nurses, hospital doctors/ nurses, paediatricians, GPs) • GPs, NGOs working with young families, Child & Family Centre workers can access training now. • Funding achieved for a Research Assistant to assist with evaluation with Prof Davis, commencing February 2017 • Research Nurse reappointed ethics underway 	<p>Research ACT Health Practice Development Grant</p>
<p>Asthma in Pregnancy- <i>Breathing for Life</i> CHWC Lead – Dr Michael Peek</p>	<ul style="list-style-type: none"> • Ongoing/ • Research midwife appointed 	<p>Research</p>
<p>Gestational Diabetes- TOBOGM CHWC - Dr Chris Nolan</p>	<ul style="list-style-type: none"> • Ongoing/ 	<p>Research</p>

	<ul style="list-style-type: none"> • Research midwife appointed 	
Dr Kecskes and ANU in collaboration with Neonatology and Maternity	<ul style="list-style-type: none"> • Donor Breast milk and women grieving after loss 	
EPAU	<ul style="list-style-type: none"> • Vitamin D in early pregnancy and prevention of Miscarriage 	

Guideline Current	CURRENT STATUS	Comments	Being worked on (by whom) & Date sent
Antepartum Haemorrhage (APH) Guideline	Valid till 10/12/18	Approved 27/6	
Anti D Administration	Valid till 1/09/2021		
Assessment of the Newborn	Valid till 1/10/2021		
Bath use during Labour and Birth	Valid till 1/09/2022		
Birth Requiring the Presence of a Neonatal Medical Team Member	valid till 1/11/2020		
Bladder mgt. In the intra/postpartum care	Valid		
Breastfeeding Clinical Guideline	Valid till 1/03/2019	IR approved 27/6/18	
Breech presentation	Valid till 1/10/2022		
Care of the Well baby	Valid till 1/02/2021		
Collection of Cord Blood for the Purposes of Private Cord Blood Banking	Valid till 1/10/2021		
Cord Blood Collection of for Blood Group, Direct Coombs Test (DCT) and blood gas sampling	Valid till 1/07/2019		
Early Onset Group B Streptococcus Disease (EOGBSD)	Valid till 1/07/2021		
Eligibility for CMP	Valid till 1/07/2018	IR with E Chatham for signing Have asked Policy for a 6 month extension due to continuity review- APPROVED now due 1/12/18	

Endorsed private midwives	Valid till 1/08/ 2021		
EPAU- including Methotrexate and Misoprostol	Valid till 1/05/2020		
Fetal Surveillance including fetal scalp sampling	Valid till 1/12/2021		
Haematoma Management following Vaginal Birth	Valid till 1/12/2021		
HIV in Pregnancy	Valid till 1/11/2018	IR Approved 27/6/18 Sent to Sarah Martin (sexual health) 15/6/18 Replied 28/8. Going to Nat Meeting on 2.9 then on leave till 8 October-will look at it then	
Homebirth Publically Funded Trial Policy	Valid till 1/11/2019		
Homebirth Publically Funded Trial Procedure	Valid till 1/1/2019		
Hypertension in Pregnancy	Valid till 1/09/2022		
Induction of labour	Valid	Updated 15/11/18 as per CRC. "Review by MO on admission for IOL"	
Insulin infusion for Labour and Birth	Valid till 1/12/2019		
Low dose Aspirin in Pregnancy	Valid till 1/10/2020		
Maternity Assessment Unit	Valid till 1/07/2022		
Maternity Escalation Plan	Valid		
MIDCALL	Valid till 1/12/2021		
Non Elective Caesarean Section	Valid till 01/08/2022		
Obstetric Emergencies Clinical Guideline	Valid till 1/10/2018	Due for revision 2 nd IR APPROVED 27/6/18	
Obesity: Pregnancy, Labour, Birth and Postnatal Care	Valid till 22/04/2020	Nutrition Dept. currently working on this, would like our assistance Have discussed with J Nissen will update ASAP	

Placenta Praevia and Abnormally Invasive Placenta	Valid till 01/08/2021	
Perineal Care Procedure	Valid till 19/02/ 2019	
Pre-labour Rupture of Membranes (PROM) Management at Term	Valid till 1/07/2020	
Preterm Prelabour Ruptured Membranes	Valid till 1/07/2020	
Prolonged pregnancy	Valid till 22/04/ 2020	
Standing orders	Done and valid	
Step Ahead program AN	Valid till 1/10/2022	
Support person , role of in labour and birth	Valid till 1/10/2021	
	Valid till 01/10/2022	

<i>Home visits in labour (continuity)</i>	Initiation request sent to policy 12/4/2018, no response yet	Ash Grimes and Chris Fowler developing	
<i>Cholestasis</i>	Not initiated as yet	Complete to be sent to policy waiting to check about flow chart SENT to policy-comments received from policy sent back 4/9	
<i>Escalation for non - urgent Clinical Concerns: Women Youth and Children Division</i>	Initiation request sent 12/04/2018 no response yet	Liz Chatham approached Jenny to write, underway.	

List of themes to view Organisation wide and by Division Summary Report

Access to Care	Women Youth & Children	78 (n=42)
Big Dot Patient Experience Indicator	Women Youth & Children	85 (n=42)
Cleanliness	Women Youth & Children	88 (n=42)
Continuity and Transition	Women Youth & Children	77 (n=42)
Coordination of Care	Women Youth & Children	65 (n=42)
Emotional Support and Alleviation of Fear and Anxiety	Women Youth & Children	84 (n=42)
Hospital Environment	Women Youth & Children	72 (n=42)
Information and Communication	Women Youth & Children	64 (n=42)
Involvement of Family and Friends	Women Youth & Children	79 (n=42)
Medication	Women Youth & Children	68 (n=42)
National Core	Women Youth & Children	82 (n=42)
Patient Safety	Women Youth & Children	74 (n=42)
Physical Comfort	Women Youth & Children	72 (n=42)
Rights and Respect	Women Youth & Children	82 (n=42)
Workforce	Women Youth & Children	82 (n=42)

Other news:

RANZCOG accreditation- Passed -

Publically Funded Home Birth –Mid- trial desk top review planning in progress

Continuity of Care Review – expected this month

Level 3 review- due for completion December 2018



CANBERRA HOSPITAL
AND HEALTH SERVICES

Certificate of Achievement

This is to acknowledge that

Boon Lim, Deborah Davis, Penny Maher, Wendy Alder and Chris Fowler

have completed the quality improvement activity

Preventing Severe Perineal Trauma

Alison Kingsbury
Quality Improvement Program Director
Clinical Safety and Quality Unit
Quality, Governance and Risk Division

18 October 2018

Antenatal Identification of Risk Factors for Postpartum Haemorrhage

First antenatal visit 36 week antenatal visit

Demographics (√ applicable risk factors)	<input type="checkbox"/> Obesity (BMI >35) <input type="checkbox"/> Maternal Age >40 years <input type="checkbox"/> Asian/Hispanic
Maternal Medical Considerations	<input type="checkbox"/> Anaemia (Hb <9g/dL) <input type="checkbox"/> Medications (e.g. aspirin, heparin) <input type="checkbox"/> Hypertensive disorders <input type="checkbox"/> HELLP syndrome <input type="checkbox"/> Previous uterine surgery <input type="checkbox"/> Coagulation Disorders or therapeutic anticoagulation <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Risk of Sepsis
Fetal Considerations	<input type="checkbox"/> Macrosomia (EFW >95 th centile or AC >95 th centile) <input type="checkbox"/> FDIU
Uterine Factors	<input type="checkbox"/> Uterine Anomaly (fibroids, bicornuate uterus) <input type="checkbox"/> Polyhydramnios (AFI >30cm) <input type="checkbox"/> Uterine overdistension (e.g. multiple pregnancy)
Obstetric History	<input type="checkbox"/> Previous history of PPH <input type="checkbox"/> Placenta praevia (<2cm clear of cervical os) <input type="checkbox"/> Placental adhesive disorders (accrete/increta/percreta) <input type="checkbox"/> Nulliparous <input type="checkbox"/> Grandmultiparous (five or more previous births) <input type="checkbox"/> Multiple pregnancy <input type="checkbox"/> Antepartum haemorrhage (>20 weeks gestation) <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Next birth after caesarean (NBAC) <input type="checkbox"/> History of retained placenta (MROP) <input type="checkbox"/> History of abruption <input type="checkbox"/> History of uterine inversion <input type="checkbox"/> History of uterine rupture

Management on antenatal identification of risk factors for PPH

1. Explain, inform and educate the woman and her partner about active and physiological management of third stage
2. For Intrapartum management of women with identified risk factors recommend
 - a. Active management of the third stage of labour
 - b. IV cannula in labour
 - c. FBC and group and screen on admission in labour
3. Ensure antenatal optimisation of iron
4. Document antenatal PPH risk factor form completed in BOS
5. BOS – document in
 - a. Antenatal Management explanations given and interventions initiated; and
 - b. Intrapartum management risk factors identified and actions taken or to be taken intrapartum
6. Maternity Card – document if risk of PPH and discussed recommendations

7. Discuss and document transfusion options including any barriers to transfusion such as religious/cultural beliefs or the presence of red cell antibodies.

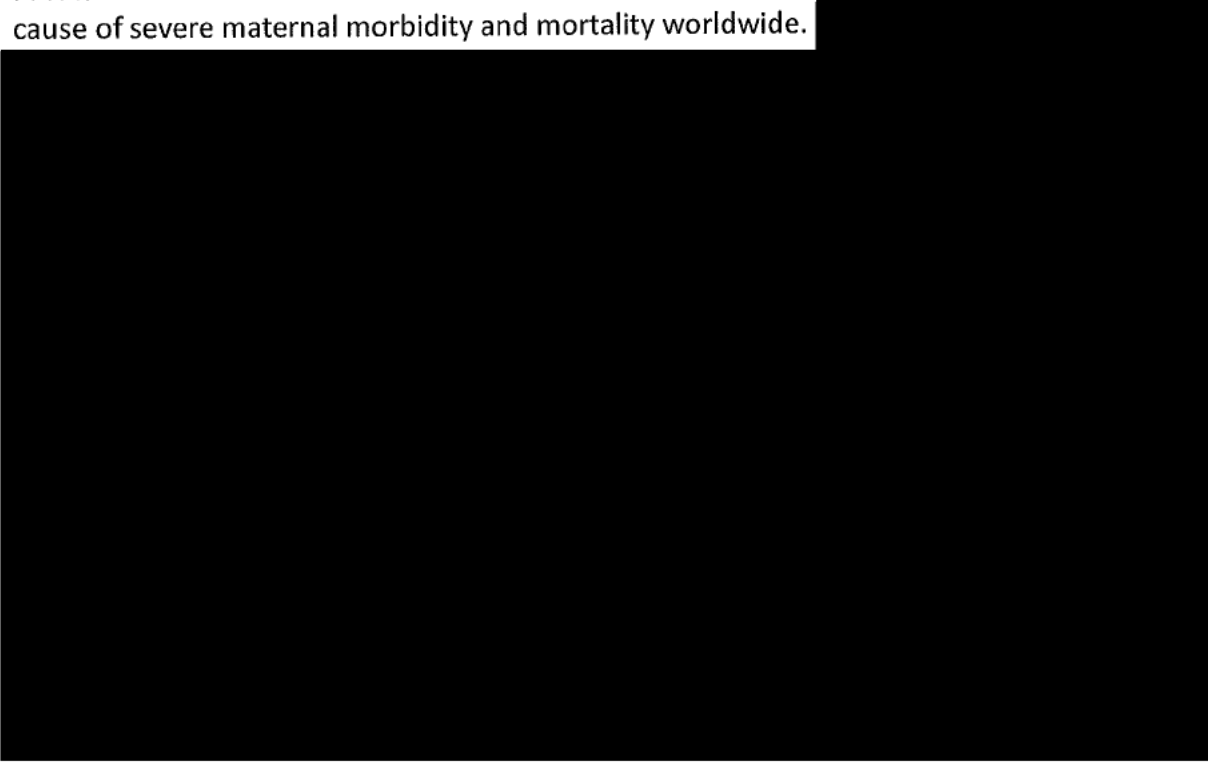
Project title**PPH DR – Stemming the Flow*****Project Details***

1. Project aims:

Centenary Hospital for Women & Children is a member of Women's Healthcare Australasia (WHA) and we benchmark our performance in several areas against other level 6 member hospitals. Currently we are an outlier for all indicators measured in association with postpartum haemorrhage (PPH). The aim of this project is to reduce the incidence of PPH at The Centenary Hospital for all vaginal births by 50% by June 2018, leading to improvement in health gains and health efficacy. Whilst the target of the project will primarily be reduction in PPH associated with vaginal birth, we are also aiming to reduce the incidence of PPH at caesarean section through the introduction of antenatal and postpartum packages that will indirectly target caesarean section births.

2. Evidence supporting the need for change:

PPH is defined as >500ml of blood loss in the first 24 hours after birth. It is a leading cause of severe maternal morbidity and mortality worldwide.



Part of the proposed project is to analyse birth data over a 3 month period to determine at risk groups according to demographics and obstetric risk factors specific to Centenary Hospital for Women and Children. It will also define the cause of PPH at CHWC, the four main recognised causes being the 4 Ts i.e. uterine atony (Tone), trauma from childbirth (Trauma), retained pregnancy tissue (Tissue) or thrombophilias (Thrombin). From review of current literature, there are several recent publications attesting to an increasing incidence of PPH. Further comment is made on the primary cause of PPH being a uterine atony with severe adverse outcomes noted. An initial audit of data of the birthing population at CHWC, showed an increasing prevalence of contributing demographic factors including advanced maternal age, increased BMI and maternal co morbidities.

Mixed management of the third stage of labour is well documented in literature as contributing to the increased occurrence of PPH.

3. Methodology

a. Target population:

The target population is all women birthing at CHWC, irrespective of model of care and all staff, obstetric and midwifery working at CHWC. The project proposes to introduce preventative screening methods, education to staff regarding risk factors, appropriate education by staff to women regarding risk, improved estimation of blood loss at birth and prompt recognition of the PPH with appropriate action and escalation. Delivered as a combined package, it is envisaged staff will be better informed to appropriately educate and advise women on the individual's risk regarding PPH.

b. Strategies and interventions:

An initial audit of 3 months of births at Centenary Hospital will provide data to address educational components of the package. The QI project has then been broken into 3 change packages with staff allocated to each change package.

The antenatal change package will primarily focus on educating staff to identify women at risk of PPH thus enabling appropriate education of these women regarding risk factors and how to reduce their risk of PPH complication. The antenatal change package will include the development of a screening tool to assess women at two points in the antenatal period for risk of PPH. This will enable timely counselling of women regarding risk factors and preventative measures for reducing the incidence of PPH.

The intrapartum change package will focus on evaluating and ongoing review of all women during the labour and birth process for risk of PPH, using the screening tool or a modified version on admission and intrapartum. Women at risk will be identified as early as possible to enable appropriate management processes to be engaged and reduce the incidence of PPH or limit the extent of PPH. This package will also focus on education of the appropriate management of third stage and fourth stages of labour to ensure evidence based practice are occurring. Identifying and addressing management of the fourth stage of labour will focus on improving estimation of blood loss at birth and earlier identification of increasing blood loss enabling prompt emergency treatment to be provided and appropriate escalation to occur thus reducing the severity of PPH.

The postpartum change package will focus on reviewing and ensuring current best practice is applied in all instances of PPH. This will reduce the severity of the PPH thus improving the recovery journey and time following PPH.

All packages will be presented to staff in a mandatory 4 hour education session. During this session staff will be provided with the evidence to support each of the change packages and up skill in current management practices.

Evaluation of strategies employed in enacting change will be through weekly review of birth data for PPH parameters. We also envisage in depth review of significant PPH instances for improving targeted learning updates.

c. The significance of the change in practice or process and health outcomes

Aside from the statistical data, there is a human and financial cost of this rising trend that ultimately will drive this project. The impact of significant postpartum haemorrhage on women is both immediate and long-lasting. The morbidity associated with PPH includes physical and psychological harm from management of PPH, increased length of stay, possible separation from baby and family if requiring management in theatre or admission to ICU/HDU, delayed lactation, post traumatic stress, ongoing fatigue, and increased length of recovery time after birth.

All these factors will be addressed with this QI project and improvement in incidence rates will result in positive health gains as we minimise harm for women, their babies and families and also for staff who are psychologically and emotionally affected in dealing with these adverse outcomes. Additionally arresting the increasing trend will contribute to gains in health efficacy with reductions in cost per admission, length of stay, reduction of loss of hours worked by staff due to psychological trauma and decreasing acuity of the maternity unit.

d. Timeline for the project including key steps / milestones within the 12 months:

Project team has already met and allocated staff to audit and change packages. Timelines have been set as follows:

May/June/July/August – review of change packages progress - underway

Sep/Oct – Completion of change packages and initial audit data collection

Nov – Roll out of education and change packages

Dec/Jan/Feb – consolidation of learning, ongoing education and finalising of introduced tools such as antenatal screening tool for PPH

Mar/Apr/May – post intervention data audit, ongoing review of PPH incidences, weekly data presentation and discussion at birth review meetings to keep project on agenda and forefront of staff awareness, monthly review of PPH incidences to enable ongoing targeting of education for improved outcomes

June – Finalise data, presentation of data

Wendy Alder, Alison Porteous

October 2017



Standard 7 – Blood and Blood Products

WRONG BLOOD IN TUBE: WBIT INCIDENTS MATERNITY ACTION PLAN

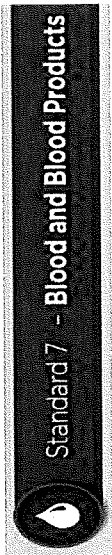
Issues	Action	Person(s) responsible	Due	Complete
<p>Introduction of Blood Gas Analyser (BGA) in Birthing</p>	<p>AIM: All specimens are correctly identified</p> <p>Training: All midwifery staff to undergo education in use of the Blood Gas Analyser, including trouble shooting and use of the guard to prevent vicarious scanning of other barcodes</p> <p>Training sessions planned daily at 1300 and 2100 in birthing, and also Birth Centre 6 & 20/11/18</p>	<p>ADOM, CMC, CMM CDMs Pathology</p>	<p>Commence 5/11/18</p>	
<p>Correct Pt ID entered</p>	<p>Default URN Mothers URN –year born/YY-baby 1(baby 2) e.g. XXXXXXXX-18-1 (still to be ratified by standard 5 and 7) plus 3 identifiers</p> <ol style="list-style-type: none"> 1. B/O mothers name 2. DOB 3. Gender <p>Same Pt.ID requirements with other Blood Gas Analysers – NICU and OT Staff education will include awareness of default baby URN and 3 Correct pt. ID requirements</p>	<p>M.O- NICU/O&G/ADONS OT & NICU/ ADOM, CMC Birthing Pathology</p>	<p>5/11/18</p>	



Standard 7 - Blood and Blood Products

WRONG BLOOD IN TUBE: WBIT INCIDENTS MATERNITY ACTION PLAN

Issues	Action	Person(s) responsible	Due	Complete
<p>Quality Assurance (QA)</p>	<p>Communication with OT and NICU teams Shared Business Rules for all Blood Gas Analysers- re Pt. ID for babies Posters displayed near BGA</p> <p>Audit</p> <ul style="list-style-type: none"> compliance of use of default Baby URN and 3 Identifiers, errors with data entry or vicarious scanning daily for first 2months review at Birthing/Birth Centre ward meeting and L3/4 meeting, Q&S Tier 3 O&G and Tier 2 Divisional Q&S meeting 	<p>CMC/CMM/CDM/ Birthing team</p>	<p>On commencement of use of BGA</p>	
<p>Prevention of Vicarious scanning</p>	<ul style="list-style-type: none"> Notice on wall for staff alerting them to issues: Avoid having other pt. barcodes near Scanner Staff are to keep area clear and free of clutter ISS notified of new area to be cleaned daily 	<p>CMM/CMC/CDM</p>		



WRONG BLOOD IN TUBE: WBIT INCIDENTS MATERNITY ACTION PLAN

Issues	Action	Person(s) responsible	Due	Complete
<p>Reduce number of WBIT and Specimen Mislabelling in Maternity, specifically:</p> <p>*Newborn request/specimen for Group and DCT, and</p>	<p>AIM: 100% staff compliance with Pt Identification and specimen labelling Guidelines in maternity for Newborn request/specimen for Group and DCT and transfusion requests</p> <p>Newborn request/specimen for Group and DCT</p> <p>All midwives and medical officers are aware that the baby's labels are not available before Newborn Gr.& DCT blood test is required. Correct labelling includes: Handwritten Each 3 identifiers MUST match the specimen and the form. Correct 3 identifiers are:</p> <ul style="list-style-type: none"> • B/O mothers name • DOB • Gender 	<p>CMIM/CMC/CSM/CDM/team leaders</p>	<p>Ongoing</p>	



WRONG BLOOD IN TUBE: WBIT INCIDENTS MATERNITY ACTION PLAN

Issues	Action	Person(s) responsible	Due	Complete
<p>*Maternal Transfusion requests and Specimens:</p>				
<ul style="list-style-type: none"> All staff awareness All Staff education 	<p>Posters in education HUB/Birth Centre education room/PNW/ANW Reminder/discussion at handover Agenda item at ward/area meetings Incidents are discussed with the staff member involved</p> <p>Education to include:</p> <ul style="list-style-type: none"> Pt Identification Specimen Labelling SOP Bloodsafe: Clinical Transfusion Practice elearning CHHS Pt ID elearning Obtain certificates and place in L&D file Report completion rates to CMC/CMM/ADOM monthly Report completion rates to ED, DONM and O&G Clinical Director quarterly 	<p>CSM/CDM CMM/CMC/T/L CMM/CMC CMM/CMC</p> <p>CMC/CMM/CSM/CDMs</p>	<p>October 2018</p> <p>October - December 2018</p>	



Standard 7 - Blood and Blood Products

WRONG BLOOD IN TUBE: WBIT INCIDENTS MATERNITY ACTION PLAN

Issues	Action	Person(s) responsible	Due	Complete
<ul style="list-style-type: none"> WBIT reporting and monitoring 	<p>WBIT/Pathology Data reporting for each area to be available on Quality Boards for each Maternity area each month</p> <p>Discussed ward/unit results at each ward/unit meeting</p> <p>Report and monitor at Q&S O&G tier 3 monthly</p>	<p>ADOM/CMC/CMM</p> <p>CMM/CMC</p>	<p>monthly</p>	
<ul style="list-style-type: none"> Orientation of new Staff 	<p>Update orientation packages to include eLearning and reading of SOP:</p> <ul style="list-style-type: none"> Pt Identification Specimen Labelling SOP Blood safe: Clinical Transfusion Practice eLearning CHHS Pt ID eLearning Obtain certificates and place in L&D file 	<p>CMC/CDM</p>	<p>October 2018</p>	
<ul style="list-style-type: none"> Role modelling by champions 	<ul style="list-style-type: none"> Identify champions to support staff to use correct processes 	<p>CMC/CMM/CDM</p>	<p>October 2018</p>	



WRONG BLOOD IN TUBE: WBIT INCIDENTS MATERNITY ACTION PLAN

Issues	Action	Person(s) responsible	Due	Complete
<ul style="list-style-type: none"> Audits of staff compliance rates with correct processes described in Pt Identification Specimen Labelling SOP: for -Gr and DCT for baby's after birth -Transfusion requests and Specimens 	<ul style="list-style-type: none"> Develop audits for monitoring compliance with Pt Identification Specimen Labelling SOP Inform staff will be audited Gr and DCT for baby's after birth -Transfusion request forms Undertake audits at least 5+ per week Report audits at ward meeting/ quality board and Q&S meeting O&G Identify situations or peak times that contribute for non-compliance Review systems/resources in response to these Report to DONM 	<p>ADMO/CMM/CMC/CSM/CD M /Champions</p>	<p>Weekly</p>	
<ul style="list-style-type: none"> Zero Tolerance of staff not using correct process as per Pt Identification Specimen Labelling SOP 	<p>Zero tolerance if incorrect process is witnessed-</p> <ul style="list-style-type: none"> counsel staff member perform audit of process repeat education package 	<p>ADMO/CMM/CMC/CSM/CD M /Champions</p>	<p>ongoing</p>	



WRONG BLOOD IN TUBE: WBIT INCIDENTS MATERNITY ACTION PLAN

Issues	Action	Person(s) responsible	Due	Complete

MATERNITY REFERRAL MANAGEMENT

The Women Youth and Children (WYC) Business Rules document is to be read in conjunction with the ACT Health Ambulatory Care Operations Manual, Sept 2017 ([Ambulatory Care Operations Manual](#)).

This document articulates the standardised process for management of maternity referrals in the Division of Women Youth and Children.

MANAGEMENT OF REFERRALS

Standard: There is a single point of access for maternity referrals.

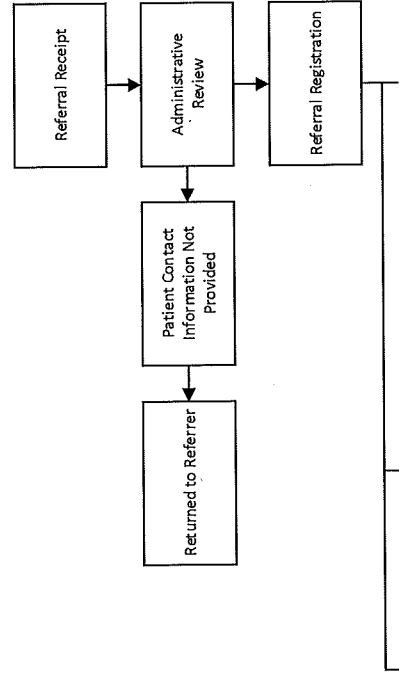
A referral is a request for a service or consultation to treat or provide advice on a consumer's specific health care needs. The duty of care for the consumer remains with the referrer until the time of the first actual appointment.

In addition to being a request for service, referrals are also used as a trigger for billing eligible consumers and for eligible services. However, first and foremost as a public health system the referral is a request for service.

REFERRAL INTAKE

Standard: A consistent approach to the management of referrals to ambulatory services exists across CHHS irrespective of service type or location.

Intake is the process of receiving and managing a referral to the point of appointment. The following steps comprise the intake process.



Women Youth and Children Intake Business Rules

If a referral is received without sufficient information, the intake midwife should contact the patient and/or GP to obtain relevant information prior to adding the referral to the waitlist. Incomplete referrals (a referral with insufficient information) will be returned to the GP by the Administrative Staff with a letter attached advising why the referral has been returned.

Adequate information required for a referral to be processed should include:

- Expected Due Date
- Chosen Model of Care
- Previous Obstetric History
- G's and P's
- Pathology/Imagine Results

FIGURE 2 GENERIC INTAKE PROCESS

Referral Source

A referral from a General Practitioner or Specialist is required, with self-referral only in exceptional circumstances, and on a case by case basis. Exceptional circumstances may relate to women with language or communication barriers or other complex issues. This is to ensure women are cared for by a primary health provider until at least the time of their pre assessment consultation, and to obtain a full medical history. Referrals will initially be received by Central Health Intake via the eReferral system or rightfax. Central Health Intake will:

- receipt referral (*note the three day KPI for referral registration, this will be monitored by the Central Health Intake team and if identified that KPI is not being met, referral registration will return to the Administration Team within Women, Youth and Children until KPI can be met again.)
- Place referral on clinical portal at the patient level, under the specialty of obstetrics (NTANS: Alison Porteous)
- Referral status will be set as 'created'.

Note: Central Intake does not provide clinical management of, or information to, referrers or consumers. Where there is insufficient information to register a referral in portal, referral will be emailed to WYC generic inbox (Maternity Intake) for WYC Intake Midwife to arrange follow up. The phone contact for Intake enquiries is the WYC Booking and Scheduling team administration in the first instance on 5124 7625. If additional support is required contact the Administration Manager on 5124 7677.

Setting referral status as 'created' triggers the next stage of referral management. At this stage, and on each business day, the WYC Intake Midwife will:

rules need to be put in place as to who covered this role when the intake midwife is away, on personal annual or extended leave) Brittany Kent to follow up with Karen Feichney.

- search 'referrals to be registered' by the specialty 'obstetrics'
- identify Model of Care using agreed terminology below
- change referral status to triaged
- record category status as 'null'
- monitor generic inbox for referrals for follow up

Women Youth and Children Intake Business Rules

- Return inappropriate referrals (for other services) to 'ACT Health, Central Outpatient – Referrals' generic inbox. These must also be notified by calling 5124 2415 so that the referral can be actioned in a timely fashion.

Published Intake numbers: Phone: 5124 7625; Fax: 5124 5500.

Generic inbox: B-SServiceWCH@act.gov.au

Key performance indicators

Referrals will be allocated to a Model of Care, processed in ACTPAS and placed on the relevant waitlist within three business days of receipt by WYC. This process is audited weekly by the Administration Manager as well as the Team Leader of Booking and Scheduling.

Appointments will be scheduled by 14 weeks gestation.

Late referrals are considered those greater than 16/40 gestation

NAMING CONVENTION

Level 1 Model of Care – Required for all referrals

SUBSPECIALTY FREE TEXT	
Program	Portal entry
Continuity low risk	Continuity LR
Continuity *all risk	Continuity *AR
Core Midwifery	Midwife
Obstetric care	Obstetrician
GP Shared Care	GP
Home Birth	Home Birth (Catchment Map)
Fetal Medicine Unit	FMU
Consider Calvary	Calvary

*Although Continuity accepts 'all risk', from an Intake perspective women with an identified risk factor (and suitable for a Continuity model) are to be allocated to this all risk program. Continuity CMM will ensure women are allocated evenly from the low risk, and all risk waitlists.

Women Youth and Children Intake Business Rules

Women who are booked through the Core Model will be given information regarding the Continuity Model at the time of their first Pre-Admission appointment and added to the Continuity Waitlist if this would have been their chosen model of care.

Level 2 entry - additional information if required

BOOKING INSTRUCTIONS FREE TEXT	
Home Birth – ineligible	<ul style="list-style-type: none"> • Primipara • Wanting Water birth • Criteria Concerns • Out of Catchment Area • Changed Address • Personal Reasons
Continuity low risk – ineligible	<ul style="list-style-type: none"> • Previous Obstetric History • Current Obstetric History • General Medical History • Other Clinical <p>On waitlist Continuity LR</p>
Continuity all risk	On waitlist Continuity AR

Each business day, WYC administration will:

- Search 'referrals to be booked' by specialty 'obstetrics'
- Use the above naming convention information to register referral on ACTPAS
- Waitlist, and book appointment as per instructions, under the appropriate waitlist Model of Care.

Note: there is a 30 day search restriction in clinical portal for 'referrals to be registered' and 'referrals to be booked'.

INTERNAL REDIRECTION OF REFERRALS

The intention is for all routine maternity referrals to come via Central Health Intake. If a written referral is received within WYC, it is to be registered on portal following the same process as Central Intake (identified above). Women calling to self-refer are to be informed that a written referral from their GP or specialist should be faxed to 5124 5500.

TELEPHONE CONTACT

The published telephone number for information about maternity service referrals and appointments is the WYC Booking and Scheduling number 5124 7625. Once a woman has been allocated to a Model of Care alternate contact numbers will be provided as appropriate.

CONTINUITY ALLOCATION

Oversight of this allocation is the responsibility of the CMM Continuity and will aim to occur prior to 12 weeks gestation to facilitate midwives scheduling booking appointments by 14 weeks gestation.

The CMM Continuity will allocate women from the waitlist/s on a monthly basis commencing on or around the 20th day. These women will be allocated from the waitlist according to order of priority and length of time on waitlist, while taking into consideration an even distribution of workload across the month (guided by the Estimated Due Date and parity).

The CMM will change the clinician on the waitlist to the allocated midwife by editing the appointment details 'clinician in charge' through 'edit waitlist'. Comments may also be added/edited at this time.

Once the midwife has completed a booking appointment and provided booking paperwork, the continuity administrative support will complete the other required ACTPAS information through 'edit referral' and antenatal intake tab. They will then remove the woman from the continuity waitlist.

Women who remain on the Continuity waitlist/s one week after 14 weeks gestation will be given a booking appointment with Core Midwifery through Maternity Outpatients, but will be left on the Continuity Waitlist as may be allocated at a later stage of her pregnancy should a place become available. The wait list entry needs to be updated at the time of booking the booking appointment by the booking and scheduling team. The appointment type of the current waitlist needs to be changed from preadmission to continuing and add comments to the waitlist eg. Had PAC ANC (date). If a Continuity place becomes available, the waitlist will be updated as above.

It is the responsibility of the gaining service to cancel any appointments or contacts with Core Midwifery when a woman changes programs.

Eligibility for Continuity models includes that the woman is an ACT resident. Women who reside outside of the ACT may be accepted if all ACT residents are accommodated, and only then on a case by case basis under the direction of the Continuity CMM.

CONTINUITY LOW RISK ELIGIBILITY

Women seeking a place in low risk continuity should be advised that their suitability for this model of care can only be confirmed following assessment by a health practitioner.

A woman with a normal (low) risk pregnancy and for whom an uncomplicated labour and birth can be anticipated is eligible for low risk continuity, including.

- Absence of medical or obstetric risk factors that would require obstetric surveillance of labour and birth (see exclusion criteria below), and a
- Singleton pregnancy.

Women Youth and Children Intake Business Rules

Low risk women who develop conditions in the exclusion criteria after the time of booking may remain in the care of the Continuity midwife but will need to birth in the most appropriate setting.

Exclusion criteria:

A. Conditions requiring individual assessment and consultation	B. Agreed Exclusions at commencement of care
Anaesthetic Difficulties	
	Malignant hyperthermia or neuromuscular disease or family history of the same
Previous anaesthetic complications (e.g. difficult intubation (decision to be informed by anaesthetic consultation early in pregnancy)	
Auto immune disorder/Connective tissue disorder	
Inactive SLE without renal involvement or with skin/joint problems only	Active Systemic Lupus Erythematosus (SLE) or with major organ involvement or on
	Anti-phospholipid syndrome
Other autoimmune disease	Scleroderma
	Rheumatoid arthritis
	Periartiritis nodosa,
	Marfan's syndrome
Raynaud's disease	
	Other systemic rare conditions
Body Mass Index	
Pre pregnancy BMI of > 35 (Advise woman of recommendation for repeat BMI at 36 weeks and if >40 plan for birth in BS with CEFM)	Pre pregnancy BMI of <18 or BMI >40
Cardiovascular disease:	
Benign heart murmurs Palpitations	Arrhythmia, murmurs: recurrent, persistent or associated with other
Other cardiac disease	Cardiac valve disease Cardiac valve replacement Cardiomyopathy Congenital cardiac disease Chronic Hypertension Ischaemic heart disease Pulmonary hypertension
Drug dependence or misuse	
Recent history of alcohol or other drug misuse	Alcohol or other drug misuse – SUPS programme care
A. Conditions requiring individual assessment and consultation	B. Agreed Exclusions at commencement of care
Endocrine	
	Addison's Disease, Cushing's disease or other endocrine disorder requiring treatment
	Pre-existing Type I and Type II diabetes

Stable hypothyroidism	hyperthyroidism or unstable hypothyroidism
Gastro-intestinal	
Stable Inflammatory bowel disease including Crohn's disease and ulcerative colitis	
	Liver disease with abnormal LFT's
Haematological	
	Coagulation disorders including Von Willebrand's
	Decline blood products (JW)
	Haemolytic anaemia
	Hemoglobinopathies including sickle cell disease, Thalassaemia major
	Immune thrombocytopenia or other platelet
Atypical antibodies, which carry the risk of hemolytic disease of the newborn (decision to informed by 1 st Trimester assessment in FMU)	Rhesus antibodies
	History of Thromboembolic disorders
	History of Thrombophilia with previous obstetric complications or
	Anti-phospholipid antibodies and hereditary thrombophilia other than MTHFR mutation
Infectious diseases	
	HIV- infection
High risk carriers of Hepatitis-B and Hepatitis-C	Hepatitis B with positive serology
	Tuberculosis under treatment
Maternal age	
Age: Primiparous women >40yrs (Advise woman of recommendation for IOL with CEFM at 39 weeks)	Age <16yrs
Multiparous women > 40yrs with other risk factors and previous obstetric complications (Advise woman of recommendation for IOL with CEFM at 39 weeks)	
Neurological	
Other epilepsy	Epilepsy with medication or seizure within last 12
	Myasthenia gravis
	Previous cerebro vascular accident
	AV malformations
	Sub-arachnoid hemorrhage, aneurysms
	Muscular dystrophy or
	Myotonic dystrophy Multiple
	Spinal cord lesion (paraplegia or quadriplegia)
A. Conditions requiring individual assessment and consultation	B. Agreed Exclusions at commencement of care
Organ transplants	
	Any organ transplant
Perinatal Mental Health Problems	
	Puerperal Psychosis

	History of psychosis or other severe mental health issue requiring admission in the last
Renal disease	
	Abnormal renal function
	Previous Kidney Surgery with potential to impair kidney function during pregnancy
Recurrent UTI's with previous history of pyelonephritis	Glomerulonephritis
	Any renal disease requiring consultation with a renal newborn
Respiratory disease	
	Cystic fibrosis
	Severe lung function disorder
Mild to moderate asthma	Severe asthma on oral steroids
	Sarcoidosis
Skeletal problems	
Pelvic deformities due to (trauma, Symphysis rupture, rachitis)	Scheuermann's disease
Spinal abnormalities	Severe Kyphosis and Scoliosis with rods
History of developmental skeletal disorders	Spondylolisthesis
	Osteogenesis imperfecta
Pre-existing Gynecological disorders	
	Female genital mutilation
Fibroids	
Infertility treatment	Cervical amputation
	Myomectomy and Hysterotomy
	Uterine Anomalies: Bicornuate uterus/Unicornuate uterus, Uterine Septum, Uterus didelphus, vaginal septum, or other
	Pelvic floor reconstruction surgery/ continence procedures/ Fistula repair
IUCD in situ	
Single LLETZ	Cervical surgery like Cone biopsy /Multiple LLETZ in a primiparous women or without a subsequent term delivery newborn
Abnormal pap smear results requiring regular follow up during pregnancy	
	Trophoblastic disease last 12 months
A. Conditions requiring individual assessment and consultation	B. Agreed Exclusions at commencement of care
Previous Obstetrics History newborn	
	Previous Caesarean section
	Previous PPH of >1000mls
	Previous pre eclampsia or eclampsia or HELLP
	Autoimmune thrombocytopenia
	Previous ABO incompatibility and Rh iso immunization Active blood incompatibility

	Iso-immunisation (ant-red cell antibodies and ant-platelet antibodies)
	Previous cervical suturing / cervical weakness
	Previous perinatal death Previous neonatal encephalopathy
	Uterine rupture
Previous shoulder dystocia	
Previous obstetric cholestasis	
Grand multiparity > 5	
Previous placental abruption	
Congenital and /or hereditary disorder of a previous child	
	Previous history of placenta accreta
Previous third degree tear	Fourth degree perineal tear in previous pregnancy Persistent pelvic floor
Previous preterm delivery / PPRM @ <34 weeks	
Previous manual removal of placenta	
Previous cervical tear	
History of previous baby >4.5kg (Advise woman of recommendation for Ultrasound scan assessment of estimated fetal weight at 36 weeks and review of plan for place / timing / monitoring in labour and	
History of previous intra-uterine growth restricted baby (IUGR) baby <10 percentile	
Previous 3 x first trimester miscarriages without a term antecedent pregnancy	
Previous 1 X Second trimester miscarriage in the antecedent pregnancy	
Other	
	History of any malignancy within the last 2 yrs newborn Current malignancy
Indications in Present Pregnancy	
	Low PAPP-A of < 0.2
Thalassemia minor with significant anaemia at commencement of care (Hb <90)	

Entire policy entitled 'Eligibility for Birth Centre and Canberra Midwifery Program Care' can be found on the Policy and Clinical Guidelines Register at:

<http://inhealth/PPR/Policy%20and%20Plans%20Register/Forms/Documents%20starting%20with%20E.aspx>.

HOME BIRTH

Homebirth is described in this context as a planned event where a woman chooses to give birth at home, with care provided by a qualified midwife. Women who express an interest in home birth and meet the eligibility criteria should be offered a place on the waitlist. Women on the home birth waitlist will be assessed by the Continuity CMM, and reallocated to the most appropriate model of care if ineligible for home birth.

Women Youth and Children Intake Business Rules

Entire operational procedure entitled 'Homebirth: Publicly funded trial procedure' is available at:
<http://inhealth/PPR/Policy%20and%20Plans%20Register/Forms/Documents%20starting%20with%20H.aspx>.

Catchment map is available [here](#).

TERMS AND CONDITIONS OF THE ACT HEALTH HOMEBIRTH SERVICE

All women must meet the following general and clinical criteria:

General

1. Be between the ages of 18 – 40 years.
2. Live within the homebirth catchment area (as determined from information provided by ACT Ambulance service to be within 30 minutes travelling time of the Centenary Hospital for Women and Children). NSW residents are not eligible.
3. Have the capacity to provide informed consent and have signed a consent form.
4. Have current ambulance cover.
5. Live in a safe working environment for midwives including:
 - a. adequate lighting
 - b. electricity
 - c. access to clean hot water
 - d. pets that can be secured out of the birthing area
 - e. easy access to your home for any emergency vehicles
 - f. parking availability for 2 midwives
 - g. reliable phone access at all times
6. Agreeable to a home assessment by the homebirth midwife to assess suitability of the environment for birth.
7. Agreeable to accepting the midwife's advice about transfer to hospital care.
8. Have one or more birth supporters from family/friends who support the decision to have a homebirth and undertake to be available and present throughout labour, birth and recovery period.
9. Have the support of a partner (if applicable) to birth at home.

Clinical

Women must also meet the following medical/ obstetric criteria:

1. Meet all the current suitability criteria for acceptance onto the Canberra Midwifery Program.
2. Be healthy and have a Body Mass Index no greater than 35 at the 36 week pregnancy assessment.
3. Have had at least one, and not more than 4, previous healthy pregnancies and uncomplicated births and recovery periods.
4. Have a current uncomplicated pregnancy progressing normally.
5. Be more than 37 and not more than 42 weeks pregnant at the onset of labour.
6. Have regular antenatal care with a health professional in line with recognised guidelines.
7. Have registered their interest, and discussed their suitability, with the ACT Health Homebirth Service by 36 weeks of their pregnancy.
8. Have a single pregnancy with the baby in a head down position before labour starts.
9. Have attended a "suitability for homebirth assessment" joint appointment with their midwife and the homebirth service obstetrician on or before the 36th completed week of this pregnancy (or have one booked).
10. Wish to labour naturally and:
 - a. plan to use only non pharmacological analgesia during labour
 - b. understand that water immersion in labour is offered but not waterbirth
 - c. accept active management of the third stage of labour

Women Youth and Children Intake Business Rules

ACTPAS DATA ENTRY

When registering the referral on ACTPAS WYC administration will:

- Add Antenatal Care in the Action: section of the referral
- Complete the custom tabs at the referral level.

Add New Episode of Care Referral - [Redacted] [X]

Details | Clinical | Completion | Activity | Coding | Care Plan | Compensable Details | Antenatal Intake | Home [Left] [Right]

Referral Details:

Date received: 05/10/2018 Action: Antenatal Care

Date on letter: / / Priority: Not Specified

Date put on Referrers WL: / / Admin. cat.: ~ Not Specified

Referral source: GP Expiry Date: / /

Present Issue:

Referred By:

Main Code: SMIEFR

Provider No: 0818245F

Set Carer... Edit Carer... Use GP

Smith, Dr. Errol
Marsfield Ararat Medical Centre
133 Herring Road
Marsfield

Referred To:

Clinician: Dr. Obs Set...

Specialty: Obstetrics Set...

Staff Team: Not Specified Set...

Edit Patient... OK Cancel

Add New Episode of Care Referral - [Redacted] [X]

Details | Clinical | Completion | Activity | Coding | Care Plan | Compensable Details | Antenatal Intake | Home [Left] [Right]

Estimated Date of Delivery: 30/10/2018 Gestation (weeks): 7/40

Requested Model of Care: Core Midwifery Date Requested: 31/01/2018

Reason for Change: Not Specified Change Date: / /

Assigned Model of Care: Not Specified Date Assigned: / /

Primary Midwife:

Home Birth: Reason for Change: Date: / /

Would you have been interested in Home Birth had you known of the service? Not Specified

Would you ave been interested in Home Birth had you been eligible? Not Specified

Edit Patient... OK Cancel

Women Youth and Children Intake Business Rules

Following initial allocations, it is the responsibility of the midwife to change the Model allocation should this occur, and cancel any existing appointments or contacts if no longer required.

The GP HealthNet website has been developed to guide GPs on referrals across all CHHS services, WYC should ensure any changes to their referral eligibility criteria or processes are updated on this website by contacting the GP HealthNet Administrator.

The ACT Health internet page provides information to consumers on services including those for which they can self-refer. WYC should ensure any changes to their referral eligibility criteria or processes are updated.

APPOINTMENT BOOKING

- Standard:** Appointments are managed to optimise clinical outcomes.
- Standard:** An intention to attend is to be established prior to booking an appointment.
- Standard:** Appointments are to be structured so that only one consumer can be booked against an appointment slot.

Booking Appointments

The waitlist function in ACTPAS will be utilised to manage lists of women waiting for appointments. This function will replace previous spreadsheets or hard copy referrals held in folders. Appointments therefore need to be booked from the waitlist to ensure equity of access and currency of the wait list. Once Continuity availability is exhausted, women waiting for a place on the program will remain on the Continuity low risk, or the Continuity all risk waitlists and appointment type changed to continuing. If a place becomes available it is the responsibility of the Continuity midwife to cancel the waitlist entry, and any associated appointments.

A consumer focused approach is to be used for all appointment bookings. Consumers are to be contacted to ascertain their intention to attend the service/consultation and then offered an appointment. If the consumer is unable to be contacted by telephone then they need to be sent a letter informing them that they have been referred for maternity care and to contact the Booking and Scheduling Team on 5124 7625. By negotiating an appointment with the consumer there is a much higher likelihood of them attending the appointment. This will also facilitate updating the wait list simultaneously, and if the service is no longer required the referral can be cancelled and the waitlist entry removed.

Ideally, appointments should be made no more than 4 – 6 weeks in advance. Letters do not need to be sent to all women. If a woman requests a letter, and the appointment is greater than two weeks in the future a letter can be sent. Current postage time frames can be as long as two weeks. It is therefore not useful to send a letter for less than two weeks. Appointment scheduling is an integral part of the model of care, as such all appointment management is the responsibility of WYC. Central Intake will forward any booking queries to the WYC bookings team.

CHANGING PROGRAMS

Women may change programs for a variety of clinical or personal reasons. This will be managed in consultation with the woman, and ACTPAS will be updated accordingly by the most appropriate officer managing the reason for change. For women waiting for a place in a Continuity program, the waitlist will be closed once a woman reaches 40 weeks gestation.

This task will be the responsibility of the Administration team to change/update once advised of the change by the allocating midwives.

MANAGING URGENT REQUESTS

Referral for urgent review in the public system should be managed via a telephone call to the Obstetrics and Gynaecology Registrar on-call by calling 5124 2000 (both during, and after hours). The Registrar will decide whether to accept the referral as urgent on the basis of information provided verbally. If the registrar is unsure of the decision he/she will escalate to the consultant on-call. Written referrals and diagnostic results should be faxed to the FMU/Maternity Assessment Unit fax on 5124 3154.

Urgent requests need to be triaged promptly by the clinician and appointments booked as per the instructions from the clinician. When clinicians, including registrars, are discussing urgent referrals with GPs/referrers and request an urgent referral be sent, it is useful to flag this with the relevant administrative staff so they can be alerted to the referral.

FETAL MEDICINE UNIT

The Fetal Medicine Unit (FMU) regularly deals with time critical cases. Referrals for Fetal Medicine will continue in its current form (i.e. faxed referrals to FMU on 5124 3154, or doctor to doctor contact if urgent). If a referral is deemed inappropriate for FMU it will be referred via portal to the Intake midwife for triaging to the appropriate Model of Care. Accepted FMU referrals will be registered on portal after initial medical triage to ensure visibility of all women under care in WYC, and for auditing and reporting purposes.

Women receiving care through FMU but who also require or choose midwifery antenatal care through Core Midwifery or Continuity Programs should be added to a Waitlist at the time of their first appointment with the Fetal Medicine Unit. This will allow the patient the same opportunity to be allocated to the program.

CLOSING REFERRALS AND WAITLIST MANAGEMENT

Standard: Referrals will be actively closed.

The amount of open referrals in ACTPAS can significantly slow the functionality of ACTPAS, and impact reporting and searching functionality. Therefore all discharged consumers should have their referral closed. The ultimate decision to close a referral rests with the clinician, however administrative staff can close the referral on ACTPAS once advised to do so or when the woman has birthed.

Once an appointment has occurred the consumer must be removed from the waitlist. This will occur automatically in ACTPAS if the appointment was booked from the wait list and the consumer has been arrived, departed and occurred. For appointments made as a 'Contact', this automated function will not occur. It is the responsibility of the Midwife to remove the wait list entry when actualising the Contact in ACTPAS.

ACTPAS generated confirmation letter advising model of care will be forwarded to the referring clinician.

If a place becomes available in a continuity or home birth model, it is the responsibility of the receiving program to update the custom tabs, and ensure no activity (i.e. appointments or contacts) are noted against the woman from the losing program. If activity is noted, appointments or contacts must be cancelled.

*Wording on open referrals being closed by front reception after the woman has birthed; Brittany Kent to follow up with Steph' Edwards.

APPENDIX A – CONTINUITY ALLOCATION MODEL

Can you please confirm with Karen if this section is necessary?

This section is informed from the EBA, and will be allocated by the CMM:

Section 4: Level of Service

4.1 The Program outcome will equate to up to 40 births per FTE employee per year (excluding the contribution of the Clinical Midwifery Manager (CMM)), and will be dependent on the acuity and complexity of the client profile.

4.2 To achieve the target, approximately four clients per calendar month per FTE will be booked onto the Program. This takes account of clients who may exit the Program, for whatever reason, before the completion of 35 completed weeks' gestation.

4.3 Bookings will also take into account annual leave, personal leave and other duties. Where an employee, including those acting as CMM is scheduled to take leave or to perform work elsewhere in the Maternity Unit, no clients due to give birth during these times will be allocated to that midwife.

4.4 Part-time employees will contribute proportionately towards meeting a CCMs workload.

4.6 The number of bookings accepted will be the responsibility of the relevant Clinical Midwife Manager in consultation with the employees.

Continuity business conventions allocate 35-40 women per year, depending on acuity. This equates to 3-4 per month (alternating four one month, three the next). An even mix of primiparous and multiparous women should be allocated, and a mix of high risk/low risk for the all-risk Continuity program.

Managing leave:

For each week of leave taken, one less woman is to be allocated that month (i.e 3 weeks leave = 1 woman allocated only).

This is pro rata for part timers at the rate of:

- 0.8 FTE alternate 3/month then 4/month = 32/year
- 0.6 FTE allocate 24/year (2/month then 3/month)
- 0.5 FTE allocate approximately 2/month.

Part time staff should alternate the allocation of primiparous and multiparous women to have an even spread by the end of the year.

Graduates (from the EBA):

Level 1 developing midwives working in an area operating under the CCM as part of the Graduate Midwife Program are expected to undertake 75% of the equivalent FTE workload. This work is to be counted towards the overall level of the service.

Women Youth and Children Intake Business Rules

Continuity conventions: 1.0 FTE = 3 women/month in low risk, alternating 2 and 3/ month in all risk, dependant on acuity; 0.8 FTE alternating 2 and 3 / month in CMP etc.

ESCALATION PROCEDURE

In the event that there is a dispute about referral management which cannot be resolved by the Clinical Midwifery Managers, the Director of Nursing and Midwifery will be the final arbitrator.

Clear guidelines need to be written as to who escalates to who? Brittany Kent to follow up with Karen Faichney

ROLE OF THE INTAKE MIDWIFE

Lyn/Julianne – are you able to please complete this section?

If a referral is received without sufficient information, the intake midwife should contact the patient/GP to obtain all relevant details before adding the referral to the waitlist. Incomplete referrals that is a referral without enough detail will be returned by the Administration staff to the GP.

Adequate information required for a referral to be processed should include:

- Expected Due Date
- Chosen Model of Care
- Previous Obstetric History
- G's and P's
- Pathology/Imaging Results

In aiming that the woman and referral are appointment ready, also included should be copies of all available results, including, but not limited to Blood group & antibody screen, FBC, random glucose, Ferritin, HIV, Rubella, Hepatitis B & C, Syphilis, Thyroid function test, and a Mid-stream urine result, and any ultrasound results.

The Intake midwife will search for all Obstetric referrals in Clinical Portal by 'referrals by referrals to be registered' under the speciality of Obstetrics

The referral will be triaged as a 'cat Null' with respective booking instructions in the sub speciality field using the agreed terminology below.

Setting referral status as 'created' triggers the next stage of referral management. At this stage, and on each business day, the WYC Intake Midwife will:

(rules need to be put in place as to who covered this role when the intake midwife is away, on personal, annual or extended leave)

- Search 'referrals to be registered' by the specialty 'obstetrics'
- Identify the Model of Care using agreed terminology below
- Ring women where Model of Care is not clearly identified and discuss relevant choices
- Change referral status to triaged
- Record category status as 'null'
- Monitor generic inbox for referral follow up

Women Youth and Children Intake Business Rules

- Return inappropriate referrals (for other services) to 'ACT Health, Central Outpatient – Referrals' generic inbox. These must also be notified by calling 5124 2415 so that the referral can be actioned in a timely manner.

Published Intake numbers: Phone: 5124 7625; Fax: 5124 5500.

Generic inbox: MaternityIntake@act.gov.au

ADMINISTRATION

Stephanie Edwards to R/V

Below is a set of guidelines that the Women, Youth and Children Administration Team will work to.

Central Health Intake are taking receipt of Maternity and Gynaecology referrals as a PDF.

The CHI team will only '**part register**' a referral in Clinical Portal – this means that the referral will be placed under the patient (3 identifying factors on referral) under the relevant field e.g. Obstetrics or Gynaecology. It will **not** be registered in ACTPAS.

The referral status will be set to '**created**'

The referral will be part registered within 3 days of receipt. *(CHI have an expected KPI of 3 days)*

Note: If there are not enough identifying factors to identify a patient in the system, e.g. name changes etc. or the patient has not been registered in our system previously, the CHI team will forward the referral to the Booking and Scheduling Administration Team for full registration.

For referrals that are hand delivered into the service or that come through using the old method of entry will be fully registered by the Booking and Scheduling Administration Team and processed as the below details.

TRIAGE PROCESS

Stephanie Edwards to R/V

For the referral to be triaged the following steps will occur:

Note: Referrals needs to be triaged within 3 days of receipt. *(We have an expected KPI of 3 days to assign a Model of Care to a patient)*

Obstetrics

WY&C midwives will search for all Obstetric referrals in Clinical Portal by '**referrals by referrals to be registered**' under the speciality of Obstetrics

The referral will be triaged as a '**cat Null**' with respective booking instructions in the sub speciality field using the agreed terminology below.

Gynaecology

Triaging clinician for Gynaecology will search for referrals in Clinical Portal 2 ways by the speciality of Gynaecology:

'**Referrals to be registered**' – these referrals have been registered by the CHI team in Clinical Portal but not in ACTPAS

'**Referrals to be triaged**' – these referrals have been entered by the Booking and Scheduling staff into both Clinical Portal and ACTPAS

The current process will be maintained for triaging – using the category numbers 1, 2 & 3.

ADMINISTRATION BOOKINGS

Stephanie Edwards to R/V.

The Booking and Scheduling Administration team will then search for referrals by 'referrals to be booked' under each speciality. The referral will then be fully registered in ACTPAS.

If Obstetric referral – add the patient to the appropriate waitlist with the following information:

- Estimated due date (EDD) of the patient
- **Appointment by** (14 weeks gestation for preadmission)
- Model of care – Core, Continuity etc.

Note: All Obstetric referrals need to be added to a Waitlist as per the sub Speciality Category in Clinical Portal.

There are several waiting lists: **Core, Continuity All Risk, Continuity Low Risk, and Transfer to Calvary. (There might be a few others but they are not relevant)**

This will replace previous spreadsheets or hard copy referrals held in folders.

Appointments therefore need to be booked from the waitlist to ensure equity of access and currency on the waitlist, with the exception of contacts – but the patient will have to be removed manually from the waiting list.

All patients on this waiting list will have a Preadmission appointment booked at the standard 14 weeks gestation. It is the responsibility of the Model of care Administration to remove the patient from the waitlist if a preadmission appointment in the Antenatal clinic is no longer required due. For example if the patient has been picked up by the Continuity program, the Birth Centre Administration Officer is responsible for removing the patient from the waitlist.

If Gynaecology referral – depending on the triage category, an appointment will be booked at the time or the patient will be added to the Ambulatory Care Waitlist to be booked at a later time with the following information:

- Appointment by
- Triage category – if applicable
- Clinician to see – as per the referral
- Appointment type – Initial, procedure etc.

Below is a screen shot of adding a patient to the waitlist:

Women Youth and Children Intake Business Rules

Add Waiting List Entry - [REDACTED]

Waiting List Details | Priority History | Appointment Details | Coding Details | Booked / Suspend | Comments | Nursing

Referral Details

Referral date: 01/02/2018

Referred by: Smiley, Dr. Jennifer, Prov. No.: 0331

Referred to: Nissen, Ms. Julianne

Reason: Not Specified

Completion date: [REDACTED]

Provider date: [REDACTED]

Expiry date: 31/12/2018

Set Referral... Edit Referral...

Waiting List Details

Date on list: / /

Waiting start date: / /

Clinician: Nissen, Ms. Julianne Set...

Specialty: Registered Nurse Set...

List name: Not Specified

Priority: Not Specified

Admin. category: ~ Not Specified

Short notice

OK Cancel

Waiting Lists	
AN Continuity AR	All risk
AN Continuity LR	Low Risk
AN FMU	For Fetal Medicine Unit
AN Home Birth	Home Birth Trial

PROCESS FOR HIGH RISK/URGENT REFERRALS

Stephanie Edwards to R/V

If a referral is '**URGENT**' for example a referral into FMU, the referral still needs to be sent to CHI to be processed as normal but it needs to be marked as **URGENT** on the referral so CHI can fax it directly through to the appropriate department. A phone call is also needed between the referring clinician to the appropriate department to flag the patient and referral with staff.

POINTS TO REMEMBER**Stephanie Edwards to R/V**

- Clinical Portal only has a 30 day search option for 'referrals to be registered' and 'referrals to be booked'
- Referrals without enough details to be identified will be emailed directly to the WY&C generic Inbox ACT Health, Booking And Scheduling Service WCH B-SServiceWCH@act.gov.au
- If a referral comes through to the service that is not appropriate to WY&C, administration is to call Central Health Intake by calling 5124 2415 to notify as soon as possible so the referral can be actioned without further delay.
- Women calling to self-refer into the service are to be informed that a written referral from their GP or Specialist should be faxed to 5124 5500 unless there are extenuating circumstances in this instance, please call Julianne Nissen, Chris Fowler or Chris Wilson.
- Once an appointment has occurred the consumer must be removed from the wait list. This will occur automatically in ACTPAS if the appointment was booked from the wait list and the patient has been arrived, departed and occurred. If not, administration staff will need to manually remove the wait list entry and update the referral in Clinical Portal. This will need to occur for patients on the Continuity programs, midwives will advise the administration team when this needs to be completed.
- If a patient has selected to go onto a Continuity program, they will be added to a Continuity waiting list only – it is the responsibility of the Booking and Scheduling staff to check both the Core and Continuity waiting lists as if they haven't been allocated a spot on the program we will need to book them a preadmission in the Antenatal Clinic. This information can be found by looking at the 'appointment by' tab – if they are on the waiting list still after they are 14 weeks we will need to book a PAC appointment.

PROMPT Evaluation Sheet 2 November 2018

We would be grateful for your feedback on the PROMPT workshop

Please tick one of the boxes for each question.

Sepsis lecture	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
The session was relevant to me	√√√√√	√√√			
The content was relevant to my practice	√√√√√				

Comments: Perfect

Acute Uterine Inversion lecture	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
The session was relevant to me	√√√√√	√√			
The content was about right	√√√√√	√			

Comments: Rare but relevant 1:1500

Neonatal Resuscitation lecture	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
The session was relevant to me	√√√√√√				
The content was about right	√√√√√√				

Comments:

Teamwork and Communication lecture	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
The session was relevant to me	√√√√√√	√			
The content was relevant to my practice	√√√√√√	√			

Comments: Thanks Leon

Emergency drill Scenarios	Strongly agree	Agree	No opinion	Disagree	Strongly disagree	Drill not included
Uterine Inversion – this session was helpful and relevant to my practice	√√√√√√	√				
Sepsis – this session was helpful and relevant to my practice	√√√√√√	√				
Neonatal Resuscitation - this session was helpful and relevant to my practice	√√√√√√	√				

Comments:

- Very relevant

Oasis update	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
The session was relevant to me	√√√√√	√√			
The content was relevant to my practice	√√√√√	√			

CTG Workshop	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
The session was relevant to me	√√√√√√√	√√√			
The content was helpful for my practice	√√√√√√√	√			

Comments:

- Don't think watching the video is necessary having not seen it

Thank you for attending the PROMPT workshop.

We value your participation and your feedback and welcome any ideas or comments.

Comments:

- This workshop over 2 days would be a good opportunity to talk about workplace culture/respectful relationships etc. Perhaps during the team work/communication session
 - Love the entire day adequate time for question 5. Great selection of presenter especially B Darby. Great choice of topics
-

MY Baby's Movements Update 17 April 2018

Recruitment:

One year since recruitment for the MBM trial started (10/4/2017).

The target for TCH recruitment per year is 2240 – to date 1530 women have been registered into the trial. This equates to 68% of the target.

Registration has been increasing month by month from 45% in Jan 2018 to date 82%.

Consenting to download the app:

Women consenting to using the MBM App has increased from 17% in Jan2018 to 30% in June 2018.

Strategies to increase the consent rate were discussed at the recent PSANZ Conference in Auckland.

The main strategy is to encourage staff to ask at **each visit** how the App is going and give assistance if any problems are encountered.

News

Research Midwife's contract extended until May 2019 when the recruitment phase will be completed.

The latest MBM newsletter is due to be published this week and will a Canberra Hospital Midwife

Encouraging staff to undertake the MBM Elearning is ongoing.

A new brochure "Your Baby's Movements Matter" was launched at Psanz and should be available soon.

Any questions can be directed to Christine Burrows Research Midwife 6174 8655 or 0438 460 735.