

# Review of homebirths in Western Australia

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Undertaken for the Department of Health WA



August 2008

Review Team Members and Report Authors  
Professor Caroline Homer  
Dr Michael Nicholl



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## 1. Executive summary

The Department of Health Western Australia commissioned this *Review of Homebirths in Western Australia (WA)* in December 2007. The aim of the review was to review homebirths in WA, especially to assess essential health outcomes including morbidity and mortality. The review was to identify any concerns with the practice of homebirths in WA and recommend ways in which the safety of homebirths could be improved.

The review was not directed to question the future of homebirth programs in WA, but was to make recommendations to optimise the safety of mothers and babies who choose homebirths. It is evident that the Department of Health WA recognises the importance of midwifery continuity of care models through ongoing support of the Community Midwifery Program.

The reviewers recognise pregnancy, labour, birth and parenting as significant and meaningful life events and acknowledge the right of consumers to access safe maternity care and quality maternity services. Continuity of care and consistent information is essential to the provision of culturally sensitive and appropriate care. Collaboration between health workers at all levels, plus the development of a competent and flexible workforce, are critical factors in ensuring safe services and the availability of a range of models of care.

It is evident that homebirth has had a difficult past in WA. The Community Midwifery Program (CMP) was established as a means for women to access a community-based homebirth model. Over more than a decade though, maintaining professional indemnity insurance, access to hospital-based referral networks, relationships with hospital-based providers and administrators have been challenging. Independent practising midwives (IPM) are private providers for whom, under current legislation, the public health system has no jurisdiction or control. Independent practising midwives have lost professional indemnity insurance and are currently practising outside of the mainstream health system. A lack of access to referral to imaging and pathology tests for IPMs has meant a lack of communication and handover at times. The current regulatory system for midwives has the ability to monitor practice and conduct audits of practice however the WA Nurses and Midwives Board has chosen not to exercise this ability unless disciplinary action occurs. The numerous challenges that have occurred and the lack of process to address these at systematic level have amplified the concerns around homebirth. It is the reviewers opinion that homebirth is more likely to be unsafe if it is marginalised and out of the mainstream service.

The review has identified that the CMP has the potential to provide a safe service. Indeed, in the past two years, the effectiveness, quality and safety of the CMP has improved considerably. While there is still work to be done, the desire and intent to provide a safe and effective service is certainly present and the current progress needs to be built upon.

Systems in relation to homebirth need to be strengthened. The policies and guidelines about eligibility for homebirth in the CMP need to be clarified and reinforced. Midwives in both the CMP and from independent practice must be aware of the need to 'protect the homebirth model'. This means that guidelines and policies need to be developed, adhered to and monitored. This also means being cautious and conservative in decision making to ensure that confidence can be rebuilt in homebirth.



There were a number of barriers which interfere with communication and the potential for improvement in homebirth services. For example, the investigation and feedback following a perinatal death after a homebirth may totally exclude the primary carer (the homebirth midwife) and the family. Current legislation prevents direct communication and feedback to non-medical practitioners and there is no capacity for communication with the parents.

This review has highlighted a number of other significant issues for childbearing women and maternity services in WA that impact on homebirth. It is encouraging that the latest state government policy document is supportive of a direction that is woman centred and in line with national and international evidence and trends. It is our impression however that some women are choosing homebirth in WA as there are limited options in relation to access to midwifery continuity of care, waterbirth, support for vaginal birth after caesarean section or access to birth centre environments. It seems apparent that the maternity systems are, for some women, too medicalised and restrictive, and do not meet their needs. It is our impression that some women, who in other models and systems would not be 'eligible' or recommended for homebirth, seem to be choosing this option as a surrogate means to access midwifery continuity of care and waterbirth. This issue was apparent in both metropolitan and rural areas. The reviewers believe that the choice to give birth at home or in water will continue, as will the choice to have a vaginal birth after a caesarean section. Therefore, developing systems to support safe and satisfying systems of care that provide childbearing women with a diversity of options is essential.

## 1.1. Recommendations

The recommendations are presented according to each of the terms of reference. As homebirth is part of the wider maternity system in WA, broader issues relating to maternity service provision are addressed under the final term of reference.

**1. Investigate the clinical experiences and health outcomes of mothers and babies accepted for homebirth by the Community Midwifery Program or midwives acting independently in Western Australia between 2000 and 2007. As a minimum, the investigation is to include mortality of mothers and babies; and emergency transfer of mothers or babies to hospital care at any stage of pregnancy, including during the post-partum period.**

**Rec 1:** Perinatal deaths in women choosing homebirth, particularly those that are determined or suspected to have occurred during the intrapartum period, be considered a sentinel event and subjected to Root Cause Analysis (RCA) by the appropriate clinical governance body for the service involved.

**Rec 2:** Midwives who work in homebirth practice and offer Complementary and Alternative Medicines (CAM) be appropriately educated and credentialed in their use.

**Rec 3:** All ambulance requests for assistance at homebirths be classified as Priority 1 by the WA St John's Ambulance Service.

**2. Establish what policies, protocols, standards and quality assurance mechanisms exist and the current clinical practices of midwives and medical practitioners who manage planned homebirths and review these against current best practice.**

**Rec 4:** The Statewide Homebirth Policy (2001) should be reviewed as a matter of urgency.

**Rec 5:** The Women's and Newborns' Network develop policy with respect to the roles and responsibilities of childbearing women who choose homebirth, their support people and doulas in labour and CMP/independent practising midwives when women are transferred to from homebirth to hospital.

**Rec 6:** The Women's and Newborns' Network develop policy in relation to women who choose homebirth and decide not to undertake selective antenatal tests and/or recommended management practices in pregnancy, labour and birth. This includes:

- screening for group B streptococcus and diabetes
- management of the third stage of labour
- decisions regarding newborn care including vitamin K, neonatal immunisations, newborn screening tests

**Rec 7:** The process of developing and implementing the guidelines for the CMP must be expedited as a matter of urgency. In particular, the guidelines for clinicians must include clear direction in relation to:

- Entry criteria for the CMP.
- Processes for consultation and referral and specific planning and documentation of decisions.
- Criteria for transfer to hospital.
- Roles and responsibilities of midwives after transfer to hospital.
- Criteria for observations in labour and standards for documentation.

**Rec 8:** The WA Department of Health implements a more robust system for maintaining the currency of the list of current practising independent midwives who provide homebirth services. Consideration should be given to this role being transferred to the WA Nurses and Midwives Board in the future.

**Rec 9:** The method of investigation employed by the Perinatal and Infant Mortality Committee (PIMC) for home and hospital births could be strengthened by adopting the Perinatal Society of Australia and New Zealand (PSANZ) methodology of investigation, categorisation and reporting of perinatal deaths.<sup>1</sup>

**Rec 10:** The WA Government amend the *Health Act 1911* Part XIII B – Perinatal and Infant Mortality Committee to enable the consideration of, and action upon, broader system-level issues in their reporting including identification of contributing factors that are amenable to organisational change at home and hospital births.

<sup>1</sup> The Perinatal Mortality Special Interest Group of the Perinatal Society of Australia and New Zealand. (2004). Clinical Practice Guideline for Perinatal Mortality Audit, PSANZ



**Rec 11:** The WA Nurses and Midwives Board should consider legislation to ensure that midwives who provide homebirth services have access to professional indemnity insurance in order to maintain registration.

**Rec 12:** The WA Nurses and Midwives Board should consider a system of requiring annual Midwifery Practice Review or other forms of continuing professional development for renewal of registration for independent practising midwives.

### **3. Make recommendations as to**

- 1. ways in which the practice of homebirths could be improved to ensure optimum clinical practice and optimum health outcomes;**
- 2. ways in which women accepted for homebirth are prepared for the possibility of transfer to hospital if required;**
- 3. ways to precisely identify planned home births in routine data collections;**
- 4. the need for an ongoing audit of safety and patient outcomes, including the key indicators to be monitored.**

**Rec 13:** A formal facilitated risk assessment of the Community Midwifery Program be undertaken utilising AS/NZS 4360: 2004 to ensure that adequate controls are in place and to identify any additional controls not covered by the terms of reference of this review.

**Rec 14:** Documentation standards for the CMP must improve in line with legal and professional guidelines.<sup>2</sup> This includes:

- Documentation of the counselling and recording of the decision made by women in relation to antenatal screening including alternative strategies and management plans.
- Education programs need to be designed and implemented to address deficiencies in the standard of clinical documentation.
- Continuation of regular audits of the standard of documentation with the outcomes presented back to the CMP midwives.

**Rec 15:** Information for women who choose homebirth needs to be developed by the CMP in collaboration with the Women's and Newborns' Network. This should include information about

- Entry criteria for homebirth
- Safety and risks of homebirth
- Consultation and referral processes which may lead to hospital transfer

**Rec 16:** A process for ongoing evaluation and annual reporting of outcomes and experiences of women who access the CMP needs to occur. This includes:

- A satisfaction survey to be undertaken independently on a regular basis.
- A robust and independent mechanism to manage complaints.

<sup>2</sup> See ANMC National Competency Standards for the Midwife (2006) for details on standards relating to documentation

**Rec 17:** The Perinatal Data Collection should be revised to provide a vehicle whereby women's choices and the outcomes of different models of care (eg. planned homebirth) can be tracked and reported. A minimum data set is included in Appendix F. The outcomes should include morbidity for women who choose a home and hospital birth so that accurate comparisons can be made. The process for collating and publishing the outcomes from the Perinatal Data Collection should be appropriately resourced to ensure that the reports are published in a timely manner.

**4. Review the ongoing professional development and clinical governance of midwives who conduct planned homebirths and recommend any improvements.**

**Rec 18:** All midwives, including independent practising midwives, need to be aware of the access to, and avail themselves of the opportunities for, continuing professional development including the management of obstetric and neonatal emergencies.

**Rec 19:** Before the end of the current memorandum of understanding (MOU) between the CMWA and the NMAHS, the relationship between the CMP and its major stakeholders need to be explored to ensure that all elements of quality (including safety) are optimised. Clarification about the various clinical, administrative and governance roles and responsibilities needs to occur.

**5. Make any additional recommendations that would assist in ensuring that planned homebirths in Western Australia are managed according to best clinical practice.**

**Rec 20:** A Community Midwifery Program could be established in the South West area (Bunbury and Busselton) as this area currently has women accessing homebirth outside the public health system.

**Rec 21:** All stakeholders be informed regarding homebirth and respect the choices that women make.

**Rec 22:** All stakeholders recognise that women will exercise their choice to use water during labour which may also include a choice to give birth in water at homebirths and hospital births. To achieve this:

- policies and protocols to support the use of water for labour and birth should be developed and implemented.
- training and support should occur for midwives caring for women who use water during labour and birth.
- ongoing audit and evaluation should occur.

**Rec 23:** All stakeholders recognise the need for strategies to address women's decisions in relation to their next birth after a caesarean section (NBAC) and develop models of care that support vaginal birth after caesarean section, particularly access to information, continuity of carer and a respect for women's capacity for decision making.

**Rec 24:** Hospital-based midwifery continuity of carer models (midwifery group practices) be established for women of all risk factor status so that women could have access to continuity and do not choose homebirth only as a means to access continuity.



## 2. Introduction

The Department of Health Western Australia commissioned this Review of Homebirths in Western Australia (WA) in December 2007. The aim of the review was to review homebirths in WA to assess essential health outcomes including morbidity and mortality. The review was to identify any concerns with the practice of homebirths in WA and recommend ways in which the safety of homebirths can be improved.

The review was not directed to be questioning of the future of homebirth programs in WA, but was to make recommendations to optimise the safety of mothers and babies who choose homebirths.

## 3. Background

The 12<sup>th</sup> report of the Perinatal and Infant Mortality Committee (PIMC) recommended a review of homebirths in WA, based on the finding of a higher mortality rate in term babies whose mothers were in a planned homebirth program compared to that of babies whose mothers were cared for in a planned hospital program.

Analysis of the mortality of term babies whose mothers chose home birth for the years 2000-2004 showed that the mortality of babies in a homebirth program was 6.7/1000 total births, compared to a term perinatal mortality of 2.1/1000 total births in planned hospital births at term gestation during the same period.

The 12<sup>th</sup> report states, on page 76:

*The information presented from the WA 2000-04 analysis shows that the choice of home birth would appear to have put 'low risk' women into a 'higher risk' category of perinatal death, although possible demographic differences in the group of women who chose home birth compared to those women who chose a hospital birth have not been examined. In addition, there is no information available to the Committee regarding morbidity outcomes for women who had a home birth. A formal review of home birth outcomes in WA may answer some of these questions.*

In December 2007, the WA Department of Health announced that it had commissioned such a review. This report is the result of the review.

There are around 200 planned homebirths in WA each year (<1%) and this proportion has been relatively stable over the past 15 years. In WA, planned homebirths can be managed by the Community Midwifery Program or by independent midwives.

### 3.1 Community Midwifery Program

The Community Midwifery Program (CMP) started as a pilot program in 1996, to provide primary midwifery services for home and hospital births. In 1997, management of the Program was transferred to Fremantle Community Midwives WA Inc., which subsequently became Community Midwifery WA (CMWA).



In 2000, the increasing cost of professional indemnity led to the midwives being employed by the Department of Health WA (Community and Primary Care) to allow access to indemnity by RiskCover (the government insurer). Although employed by the Department of Health WA, the midwives remained professionally responsible to the CMWA.

In 2004, the Women's and Children's Health Service became the employing body for the CMP. In 2006 the North Metropolitan Area Health Service (NMAHS) became the employing body and has remained so. In October 2007, a Memorandum of Understanding (MoU) setting out the clinical governance of the program was signed by the CMWA and NMAHS.

### **3.2 Independent Midwives**

Midwives providing homebirths and not employed as part of the CMP are termed 'independent practising midwives' (IPM). Prior to 2005, some IPMs may also have worked part-time for the CMP, but this is no longer possible and the two systems are completely separate.

## **4. Review outline**

### **4.1 Governance**

The review was coordinated by the Chief Medical Adviser (CMA), Public Health (Dr Margaret Stevens) who also chaired the steering committee. The CMA was acting for the Department of Health WA on behalf of the Director General.

The CMA was supported by a policy officer (Ms Sylvia Griffiths) and the officer who manages the Midwives Registry and supports the statutory mortality committees (Ms Vivien Gee).

The report of the reviewers is the property of the Director General of Health. The final Terms of Reference were approved by the Director General.

### **4.2 Terms of Reference**

1. Investigate the clinical experiences and health outcomes of mothers and babies accepted for homebirth by the Community Midwifery Program or midwives acting independently in Western Australia between 2000 and 2007. As a minimum, the investigation is to include mortality of mothers and babies; and emergency transfer of mothers or babies to hospital care at any stage of pregnancy, including during the post-partum period.
2. Establish what policies, protocols, standards and quality assurance mechanisms exist and the current clinical practices of midwives and medical practitioners who manage planned homebirths and review these against current best practice.



3. Make recommendations as to
  - ways in which the practice of homebirths could be improved to ensure optimum clinical practice and optimum health outcomes;
  - ways in which women accepted for homebirth are prepared for the possibility of transfer to hospital if required;
  - ways to precisely identify planned home births in routine data collections;
  - the need for an ongoing audit of safety and patient outcomes, including the key indicators to be monitored.
4. Review the ongoing professional development and clinical governance of midwives who conduct planned homebirths and recommend any improvements.
5. Make any additional recommendations that would assist in ensuring that planned homebirths in Western Australia are managed according to best clinical practice.

### 4.3 Steering Committee

A Steering Committee was established for the purposes of facilitating stakeholder input into the review and providing advice and guidance to the reviewers.

The Steering Committee was chaired by the Chief Medical Adviser, Department of Health WA (Dr Margaret Stevens) and supported by a policy officer (Ms Sylvia Griffiths). The reviewers met with the Steering Committee to seek clarification on a number of issues.

## 5. Methodology

A descriptive evaluative approach was undertaken using primarily interviews with key stakeholders, an analysis of written material and an analysis of data from the Midwives Notification Data. An analysis of the information received was undertaken using the Australian Council on Healthcare Standards (ACHS) EQuIP 4 Functions, Standards and Criteria.<sup>3</sup>

### 5.1 Data collection

The reviewers visited Western Australia for one week in March/April 2008. During this time a number of interviews and focus groups were held with a range of stakeholders. In total, 84 people were interviewed, either in a group or one to one. The main stakeholders included:

- Consumers of the CMP and homebirth services
- CMP midwives and managers
- Independent practising midwives
- Representatives from CMWA (Management and the Board)
- Representatives from the Perinatal and Infant Mortality Committee (PIMC)

<sup>3</sup> Available from <http://www.achs.org.au/EQUIP4/>

- Obstetric, anaesthetics, paediatric and midwifery staff from KEMH
- Representatives from Maternity Coalition, Birth Choices Consumer Group, North Metropolitan Health Service, the Australian College of Midwives (ACM), the Royal Australian and New Zealand College of Obstetrics and Gynaecologists (RANZOG), Health Consumer Council, WA General Practice Network, State-wide Obstetric Support Unit (SOSU), Women's and Newborns Health Network, WA Nurses and Midwives Board
- Midwives, obstetricians and managers from regional/district hospitals including Rockingham and Bunbury
- Academics who provide midwifery education programs
- The WA Director General of Health
- Office of the Chief Nursing Officer and the Health Data Collections Branch (WA Health)

The reviewers also received a number of written submissions and responses in the form of emails in relation to the review. These included six (6) from independent practising midwives, one from a GP involved in homebirth practice in the past, eight from KEMH staff: four (4) from midwives and four (4) from registrars in obstetrics and gynaecology.

A number of documents were also reviewed. These included:

- Evaluation of the Community Midwifery Program 1997 to 2000 (Thorogood, Thiele & Hyde 2002)
- Role delineation of the Women's and Newborns Health Network and State-wide Obstetric Support Unit (Draft – March 2008)
- Overview of the North Metropolitan Area Health Service Clinical Governance Framework and Risk Governance System (January 2008)
- Series of quarterly activity reports to WA Department of Health from CMWA/CMP
- Memorandum of Understanding between CMWA and North Metropolitan Health Service (October 2007)
- Homebirth Policy and Guidelines for Management of Risk Factors (2001)
- 12th report of the Perinatal and Infant Mortality Committee of WA: Deaths 2002 to 2004
- 11th report of the Perinatal and Infant Mortality Committee of WA: Deaths 2000 to 2001
- Perinatal Statistics in Western Australia 2005
- Annual Report: Birthrights Healing After Caesarean Inc 2006–2007
- Newsletters: Birthrights Healing After Caesarean Inc 2007
- Draft midwifery guidelines for the well woman and a newborn from the CMP
- *Nurses and Midwives Act WA 2006*
- CMWA Annual Report 2005 to 2006
- CMWA Information Folder for Women
- Agreement between the Minister of Health and CMWA for provision of midwifery coordination and resource services 2006 to 2009



- Improving Maternity Services: Working together across Western Australia. A Policy Framework 2007
- Professional development records for CMP midwives (2007–2008)
- Community Midwifery Program: Clinical Responsibilities and Risk Management 2006
- Summary of the homebirth cases from the Perinatal and Infant Mortality Committee 2000 to 2006 (de-identified)
- Relevant documents from the WA St John's Ambulance Service including Policy 33: Priority Allocation
- Confidential reports from the evaluations conducted on the Birth Centre and Team Midwifery at KEMH
- Correspondence from the WA Nurses and Midwives Board in relation to regulation issues
- Correspondence from the Office of Safety and Quality in Health Care in relation to The Implementation of the National Open Disclosure Health Standard in WA Health Services
- Report from the CMP Clinical Advisory Group
- Final Report to Parliament on the Progress of Implementation of KEMH Inquiry Recommendations
- *Health Act 1911* Part XIII B – Perinatal and Infant Mortality Committee (Part XIII B inserted by Number 47 of 1978s.34.)
- Pregnancy Health Record (WA)

Data from the Midwives Notification Scheme were analysed in relation to the number of planned and actual homebirths, perinatal deaths and the transfers from home to hospital. The perinatal deaths from 2000–2007 were each reviewed using data provided by the PIMC. This did not include a review of original case notes or a discussion with the midwives and doctors involved in the cases.

Finally, homebirth in WA was analysed according to the ACHS EQUIP4 functions, standards and criteria used in the accreditation (EQUIP) process. This was undertaken to determine whether the CMP and the independent practising midwives who provide homebirth services were operating within a safe environment according to the ACHS standards.

## 6. Findings

The findings are reported according to the Terms of Reference. References to the associated recommendations are made throughout the findings. Some recommendations, however, address more than one Term of Reference. Additional key finding and recommendations, as requested in Terms of Reference 5, are outlined in the Executive Summary and in Section 6.4.

### 6.1 Clinical experiences and health outcomes of mothers and babies

*Term of Reference 1: Investigate the clinical experiences and health outcomes of mothers and babies accepted for homebirth by the Community Midwifery Program or midwives acting independently in Western Australia between 2000 and 2007. As a minimum, the investigation is to include mortality of mothers and babies; and emergency transfer of mothers or babies to hospital care at any stage of pregnancy, including during the post-partum period.*

In the years 2000–2007, between 234 and 153 women per year were reported to be planning a homebirth. The number of women planning a homebirth has increased in the past two years. The rate of transfer to hospital has steadily decreased from 24% in 2000 to 8% in 2007. It is likely that this reflects clearer guidelines about suitability for homebirth (Table 1).

The horizontal lines in Table 1 represent the three time periods in the history of the CMP. The three time periods were (1) 2000–2003 (when the CMP midwives were employed by the WA Department of Health but professionally responsible to the CMWA); (2) 2004–2005 (Women’s and Children’s Health Service as the employing body); and, (3) 2006–2007 (North Metropolitan Area Health Service as the employing body).

**Table 1: Planned and actual homebirths and transfer rate (2000–2007)**

Year	Planned homebirths	Actual homebirths	Number of women transferred to hospital during labour	Transfer to hospital (%)
2000	160	122	38	24%
2001	182	144	38	21%
2002	153	121	32	21%
2003	186	163	23	12%
2004	165	143	22	13%
2005	177	155	22	12%
2006	234	195	39	17%
2007	231	212	19	8%
<b>TOTAL</b>	<b>1488</b>	<b>1255</b>	<b>233</b>	<b>16%</b>



Given the manner in which the data are collected on planning versus actual homebirth, it is possible that the number planning is under-represented. It is possible that a considerably higher number were planning a homebirth through pregnancy but were transferred to hospital care prior to the onset of labour.

There have been no maternal deaths in women choosing homebirth during the time period 2000–2007.

### 6.1.1 Perinatal deaths

An analysis of the number of perinatal deaths<sup>4</sup> in women who were planning a homebirth was undertaken (Table 2). The data were analysed by all gestations and then by term gestation by the three time periods outlined above. The number of deaths is reported and the perinatal mortality rates (PMR) were calculated.

**Table 2: Perinatal deaths in planned homebirths (regardless of place of birth) by gestation**

	Perinatal deaths (all gestation)	Perinatal deaths (term gestation <sup>#</sup> )	PMR* (all gestations)	PMR* (term gestation)
<b>2000–2003</b>	10	7	14.68	10.28
<b>2004–2005</b>	5	3	14.62	8.77
<b>2006–2007</b>	0	0	0	0

\*Perinatal mortality rate (PMR): calculated by 1,000 total births

<sup>#</sup>Term gestation: 37 to 42 completed weeks

The reviewers made an assumption that women planning homebirth would be assessed as being 'of low risk of complications during labour' and thus potentially comparable with women at term attending hospital. We recognise that this assumption is contentious. Since 2000, women choosing homebirth were not necessarily 'low risk'. Until recently, there were no documented guidelines as to the inclusion or exclusion criteria for women accepted onto the CMP. There is no legislation that dictates that only low risk women may choose homebirth with an IPM. Other issues that will be highlighted later in this report have meant that women have chosen homebirth as they were unable to obtain midwifery continuity of care, waterbirth or VBAC. This means that the homebirth group are not homogeneously 'low risk' as in other models in Australia and internationally.

The reviewers used this surrogate marker of low risk, that is, term gestation. We recognise that term gestation (defined at between 37 and 42 completed weeks) does not control for risk factors. We also recognise that this does not assume that a hospital birth would have necessarily prevented a perinatal death. The comparison of term pregnancies is used as it could be assumed that most homebirths occur at term gestation.

<sup>4</sup> Perinatal deaths are defined as either stillbirth, neonatal or post-neonatal deaths. A stillbirth is defined as "death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation, or of 400g or more birthweight". A neonatal death is defined as the "death of a liveborn infant within 28 days of birth". A post-neonatal death is defined as the death of a liveborn infant occurring in the remainder of the first year (28–364 days) (PIMC Report 2007, page 100).

**Table 3: Comparison of PMR in planned homebirths and hospital births by gestation and year**

	Planned homebirth		Planned hospital birth (including FBC)	
	PMR* (all gestations)	PMR (term <sup>#</sup> gestation)	PMR (all gestations <sup>§</sup> )	PMR (term gestation <sup>§</sup> )
<b>2000</b>	18.75	18.75	10.69	2.22
<b>2001</b>	16.48	10.99	9.53	2.25
<b>2002</b>	13.07	6.54	9.26	2.21
<b>2003</b>	10.75	5.38	9.60	2.14
<b>2004</b>	18.18	6.06	9.70	2.42
<b>2005</b>	11.30	11.30	10.16	2.17
<b>2006</b>	0.00	0.00	9.62	2.16

\*PMR calculated by 1000 births

#Term gestation: 37 to 42 completed weeks

§Hospital births are not controlled for risk factors

For the years 2000–2006, the total perinatal deaths for babies born of all gestations was not statistically significantly different (OR 1.22; 95% CI 0.7-2.07;  $p>0.05$ ) between the planned homebirth and hospital birth groups. The total PMR in planned homebirths was 10.08 per 1,000 births and in planned hospital births it was 11.93 per 1,000 births. The hospital group does not control for risk and in this comparison includes all gestations. It is encouraging that there were no perinatal deaths reported in the planned homebirth group for 2006 and 2007.

For the years 2000–2006, the total perinatal mortality rate for babies born at term was statistically significantly different (OR 3.58; 95% CI 1.8-6.9;  $p<0.001$ ) between the planned homebirth and hospital birth groups. The total PMR in planned homebirths was 7.96 per 1,000 births and in planned hospital births it was 2.22 per 1,000 births. The hospital group does not control for risk factors.

There are a number of limitations in this analysis. Firstly, these data do not address the reasons for the deaths or whether they were avoidable or not. Secondly, the data combines CMP midwives with independent practising midwives and thus is it not possible to make statements about the PMR in either group. Thirdly, the use of the planned homebirth group rather than only actual homebirth does not imply that planning a homebirth is a risk in itself. On an intention to treat analysis, it is essential to use the denominator as the 'intention' rather than the 'actual'. Therefore, planning to have a homebirth and planning to have a hospital birth are the appropriate denominators. Nonetheless, we recognise there are deficiencies and limitations in the data collection systems and the number of planned homebirths may well be considerably underestimated. Finally, the numbers of women who plan homebirth is small and the numbers of deaths are small. This means that it is possible for a type 1 error in this analysis, that is, showing a difference when one would not exist given larger numbers.



### 6.1.2 Analysis of the perinatal deaths

The analysis of the perinatal deaths was undertaken using the data provided by the Perinatal and Infant Mortality Confidential Case Summary and a review of the medical records of the women. These summaries are completed by the investigator appointed by the PIMC and are from the written records only. No discussion with the family or care providers occurs in the Case Summary.<sup>5</sup> Therefore, the analysis is limited in its capacity to fully explore the issues, decision making and experiences of staff and women or many of the broader organisational or staffing issues. In addition, the Case Summary was not always completed fully. The health system does not routinely undertake Root Cause Analyses (RCA) on all perinatal deaths (see *Recommendation #1*).

In the analysis of deaths from 2000 onwards, the PIMC used a 'Preventability Scale' to determine and classify possible preventable factors. The preventability of an adverse event is defined as 'an error in management due to failure to follow accepted practice at the individual or system level and accepted practice is taken to be 'the current level of expected performance for the average practitioner or system that manages the patient'.<sup>6</sup> The 'medical preventability' scores are based on the preventability score used in the Quality in Australian Health Care Study.<sup>7</sup> This score has not been used previously to determine preventability of perinatal deaths (Figure 1).

**Figure 1: Preventability scale and explanation**

Preventability scale	Explanation
No preventability	1= virtually no evidence for preventability
Low preventability	2 = "slight to modest" evidence for preventability
	3 = Preventability not likely, less than 50-50 but close call
High preventability	4 = Preventability more likely than not, more than 50–50 but close call
	5 = Strong evidence for preventability
	6 = Virtually certain evidence for preventability

Details of the 19 deaths are outlined in Appendix C (Tables 5 and 6). The tables provide an analysis from the perspective of the reviewers on whether there were any deficiencies in care.

Of the 18 perinatal deaths and one post-neonatal death from 2000 to 2006, nine (9) had lethal congenital or chromosomal abnormalities; two (2) were premature (27 and 32 weeks gestation); two (2) had group B streptococcus which was reported as the attributing factor and three (3) were rated as having 'low' or 'no' preventability. Of the three (3) remaining deaths, there are questions as to preventability. These are the two (2) cases of hypoxic peripartum death (Cases 10 and 11); and the baby with shoulder dystocia (Case 17).

<sup>5</sup> The PIMC process is dictated in the *Health Act 1911* Part XIII B - Perinatal and Infant Mortality Committee (Part XIII B inserted by Number 47 of 1978s.34.) and outlined in more detail in Section 6.2.6 of this report.

<sup>6</sup> PIMC Report, 2007 (page 18)

<sup>7</sup> Wilson, R., W. Runciman, et al. (1995). "The Quality in Australian Health Care Study." *Medical Journal of Australia* 163(9): 458-71.



The reviewers assessed each death reflecting on the ACHS EQuIP 4 Functions, Standards and Criteria<sup>8</sup>. In relation to the Direct Delivery of Clinical Care, in a number of cases (with the benefit of retrospectivity), risk factors had been identified and could have been acted upon in a more timely fashion. The other issue identified was in relation to Systems Supporting Delivery of Care which included a delay in transfer to hospital and a delay in decision-making. There were four (4) cases of major congenital abnormalities or aneuploidy identified during pregnancy, in some cases early in the second trimester. These women remained in the CMP model and therefore are included in the statistics for the CMP. While this would have been highly beneficial for the women in terms of continuity of care provider, it raises questions of the risks to the program by continuing with this practice. This raises one of the fundamental questions about the CMP – is it a low risk model or is it about providing continuity of caregiver?

Another issue identified during the review of the perinatal deaths was the use of a range of Complementary and Alternative Medicines (CAM), especially by midwives attending a labour and/or birth at home. There does not appear to be a process for ensuring that midwives have appropriate education or training in the use of these therapies (see Recommendation #2).

### 6.1.3 Analysis of transfers from home to hospital

Data from the Midwives Notification System (MNS) were extracted for women who had “antenatal care by midwives in private practice but who then gave birth in a hospital by year (2000-2007)”. This numbers, on average, 57 women per annum and excludes women who had antenatal care by midwives and then gave birth at home or in the KEMH Family Birth Centre (Table 4). These cases are transfers from midwife care to medical/hospital care. Not all were intended homebirths during the pregnancy and pre-labour time and of those who were, by the time labour commenced they were in the hospital system (e.g. antepartum haemorrhage before labour). Also, the quality of reporting of “intended place of birth at onset of labour” is dependent on the midwife in attendance at the birth who completes the notification.

These data are limited as they do not discriminate between intention during pregnancy to give birth at home (antenatal transfer) and intention during labour. In addition, the reviewers understood that the cases were women who had antenatal care by midwives in private practice (that is, IPMs) but who then gave birth in a hospital by year (2000–2007).

There are inconsistencies in the number of perinatal deaths in the cohort as compared with overall numbers of perinatal deaths. This raises questions about the accuracy of the data. Additional data provided to the reviewers on hospital births for homebirth women was also problematic as this is categorised by the name of the midwife not the model of care (e.g. CMP). Many of the IPMs have worked at some stage or other in the CMP and so it is impossible to determine whether births occurred as part of the CMP or as part of independent practice. Both these data sources highlight the inadequacy of the current data collection systems.

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<sup>8</sup> The ACHS Evaluation and Quality Improvement Program (EQuIP) is a framework for managing health services to ensure quality and safe care and services and for achieving quality improvement. One of the key components of EQuIP are standards that organisations work towards achieving. The EQuIP 4 standards are arranged under three functions: clinical, support and corporate.



**Table 4: Number of women who had antenatal care by midwives in private practice but who then gave birth in a hospital by year (2000–2007)**

Year	Number of women	Intended place of birth at onset of labour		
		Home	Hospital	Birth Centre
2000	59	17 (29%)	42 (71%)	0
2001	67	26 (39%)	41 (61%)	0
2002	51	20 (39%)	30 (59%)	1 (2%)
2003	50	18 (36%)	31 (62%)	1 (2%)
2004	50	20 (40%)	30 (60%)	0
2005	53	30 (57%)	23 (43%)	0
2006	65	43 (66%)	22 (34%)	0
2007	55	34 (62%)	21 (38%)	0
<b>Total</b>	<b>450</b>	<b>208 (46%)</b>	<b>240 (53%)</b>	<b>2 (0.5%)</b>

Of the women transferred, either antenatally or during labour, 14% had a history of a prior caesarean section. The most common reasons for transfer from home to hospital in the pre-labour or antenatal period were prolonged pre-labour rupture of membranes and premature labour.

The most common reasons for transfer during labour were fetal distress (n=43) and 'failure' to progress at >3cm cervical dilatation (n=31). Postpartum haemorrhage accounted for 48 transfers from home to hospital (23% of the women whose intended place of birth at onset of labour was home).

Of the women who were transferred to hospital but whose intended place of birth at onset of labour was home, 46% had a normal vaginal birth and 37% had an emergency caesarean section. Of the women who were transferred to hospital antenatally, 48% had a normal vaginal birth, 10% had an elective caesarean section and 30% had an emergency caesarean section.

These data confirm concerns in the entry and access criteria for homebirth in WA. It is possible that some of the women who commenced labour at home had risk factors that in a more stringent model would have meant they would have been transferred to hospital-based care earlier, possibly during pregnancy.

These data also confirm limitations in the Perinatal Data Collection as women's choices and the outcomes of different models of care (eg. planned homebirth) cannot be accurately tracked or reported. Accurate comparisons between women who choose homebirth early in pregnancy and those who choose hospital birth are difficult to make. The reports from the Perinatal Data Collection are also published some years after the year in which the births occurred again making ongoing tracking and decision making about outcomes and models of care, including planned homebirth, difficult.

#### 6.1.4 Ambulance transfers

As transfers from home to hospital, especially during labour, may require ambulance involvement, the communication and processes between homebirth services and the WA St John's Ambulance Service were reviewed. The Ambulance Service provided a written response to the Review.

There appears to be limited formal communication between the CMP and the St John's Ambulance Service. Priority to requests from a woman in labour or immediately postpartum requiring hospital transfer is determined on patient condition (*Policy 33: Priority Allocation*). A request would be considered a priority 'one' for example if "there is potential for the patient's life to be at risk". "Childbirth" is specifically listed as a priority one in this policy. Generally speaking, a woman in labour would not be dispatched as a priority one unless the birth is imminent, has taken place or if there was some reason to believe that the baby or mother's life may be at risk. If a woman was in labour without complicating factors and the birth was not considered imminent, the call would typically be allocated as a priority 'two'. There is a document to assist communications officers - Childbirth - Key Questions and Childbirth Flip Charts First Aid. If in doubt the communications officer should consult with the Manager State Ambulance Operations who has clinical experience (paramedic) for advice on the priority.

In the case of a Priority 'one', the hospital of choice would always be KEMH in the metropolitan area or the nearest facility in rural and remote areas. The Ambulance Officers can gain advice from KEMH and it would be followed. The reasons for time delays for Priority 'one' calls may include the immediate availability of a vehicle, that is, available resources and its vicinity to the call (*see Recommendation #3*). For example, the closest vehicle may be on the other side of the metropolitan area and in the case of the country a crew may have to be dispatched from as far away as the next town. For priority 'two' calls, there may be longer delays as an ambulance on a priority two can be diverted to do a priority one at anytime. This in theory can occur two or three times although the communication centre will normally ring the patient back to reassess the priority for upgrade to priority one in these cases.

The decision about the transfer to hospital is based on the assessment by the paramedic. They will usually transport women to the hospital that they have been booked into unless there are extraordinary circumstances, for example, uncontrolled postpartum haemorrhage, abnormal presentation or preterm labour and/or birth less than 32 weeks. If the birth were to be preterm, they would transport the woman and/or baby to the KEMH.

During transfer, the Ambulance Service stated that, depending on the circumstances, the midwife would travel with the ambulance and the Ambulance Officer/Paramedic would assist the midwife. The Ambulance Service does not have drugs apart from pain management drugs (e.g. Methoxyflurane and Fentanyl).

#### 6.1.5 Experience of women

A sample of women and their partners (n=20) were interviewed for the review, both one to one and as part of a group. The women spoke of the value of midwifery continuity of care and the importance of a known caregiver (*see Recommendation #24*). They also stated that a lack of access to other options, such as waterbirth and vaginal birth after a previous caesarean section, were also drivers to access the CMP and/or homebirth



(see *Recommendations #22; 23*). The CMP and independent practising midwives were highly praised in terms of providing midwifery care, support, advocacy and information. Partners reported feeling included in the information giving and decision making processes.

Women made statements like:

*The midwives respect our ability to make decisions.*

*The midwives built up our confidence that I could do it.*

*The midwives helped with fears particularly after a bad experience before.*

*Continuity is so important for us.*

The community-based setting of the CMP and the availability of home visits, antenatally and postnatally, were highly valued.

While most women seemed to 'book' into a hospital, or at least have a hospital visit during pregnancy with an obstetrician, this seemed somewhat ad hoc and unstructured. Women planning to have a homebirth did not receive a hospital tour and some reported arriving late at night and finding the environment overwhelming. The reviewers walked the path that women and their partners who were being transferred would take at the King Edward Memorial Hospital (KEMH) and were struck with the complexity of the environment and the challenge of traversing this while in labour.

Women interviewed were very aware of the issues of safety. However, many reported that they did not feel safe in a system that provided fragmented care. Women spoke of the lack of choices for them in WA and the lack of consistent information that was evidence-based (see *Recommendation #15*).

King Edward Memorial Hospital has not received any complaints from women in relation to the CMP. There were no reported legal claims from any of the adverse events in relation to homebirth transfers. There is currently one case of an investigation of the practice of an independent practising midwife before the WA Nurses and Midwives Board. This case was notified to the Board by a health service employee not a client.

Formal evaluation of the experiences of women who choose homebirth seems limited (see *Recommendation #16*). Women accessing the CMP are sent a short survey after the birth to record their experiences. These are sent back to CMWA. The response rate was difficult to determine but appears to be low. The reviewers were provided with a number of examples of the completed surveys, which on the whole, were very positive of the experience with the CMP. Some of the independent practising midwives reported that they asked or surveyed women about their experiences but this is seemed to be in an ad hoc and potentially identifiable manner.

### **6.1.6 Experiences of CMP midwives**

The CMP midwives were interviewed in a group at the CMWA. A number of issues were raised including the value of midwifery continuity of care; the support for the program and one another; the importance of the recent MoU and current employment arrangements for job security; and, the challenges of transfer to hospital.



The CMP model ensures that the midwives can work to their full scope of practice as a midwife. This was highly valued by the midwives. Continuity was also important as it ensured that midwives could develop meaningful professional relationships with women and their families. It was stated to the reviewers that issues of retention of midwives in the state would be improved if midwifery continuity of care models were implemented more widely (see *Recommendation #24*).

Transfers to hospital from homebirth situations were discussed at length. These vary, often depending on the hospital and on the individuals. Some relationships between CMP midwives/IPMs and hospital staff are better than others, which alters the nature of the transfer experience. The CMP midwives/IPMs were very clear that their allegiance was to the woman rather than the institution but recognised that at times this presented difficulties. There does not seem to be a policy around transfer (when, how, who) and this also creates some difficulties. There was also confusion about the various roles once transfer had occurred (see *Recommendation #5*).

CMP midwives have access to the emergency training (the program is known as In Time) at KEMH. This was seen as an important and useful strategy to assist with the management of emergency situations.

### **6.1.7 Experiences of independent practising midwives**

A meeting with seven (7) independent practising midwives (IPM) was conducted. In addition, written responses were received from six (6) IPMs. The IPMs were from metropolitan Perth and the south-west region of the state. A number of the IPMs had previously worked in the CMP. Some of these had chosen not to continue employment with CMP as they found it too restrictive and medicalised.

The IPMs initially provided their intention to practice as an independent midwife (name and registration details) to Department of Health WA through the Principal Consultant for Statutory Mortality Committees, Data Collection and Analysis. There is no requirement to notify the Department of Health WA once there is an intention to cease to practice (see *Recommendation #8*). There is no legislative requirement for IPMs to notify the WA Nurses and Midwives Board of an intention to practice.

After a homebirth, the IPMs complete the perinatal data collection forms as required by the Health (Notification by Midwives) Regulations 1994. The notification is to the Executive Director of Public Health, Department of Health WA. An additional form is also completed and sent to the Department of Health WA. This second form has additional information on the homebirth. The review found that this second form is not always fully completed and there is no legislative mandate for this to occur (see *Recommendation #8*).

All IPMs are functioning without professional indemnity insurance. The IPMs charge women for their services. It seems that many women use the 'Baby Bonus' from the Federal Government to pay for their IPM and homebirth.

Some of the IPMs have developed systems to assist with their homebirth work. For example, in the South West of the state (Bunbury and Busselton), the IPMs are also employees of the local hospital. When a homebirth client is in labour, the midwives arrange cover for their hospital duties. If they require transfer to hospital, they are usually employed by the hospital on a casual basis for the shift which allows them to continue to provide care



for the women. If they have been awake for many hours and are too tired to provide care, they hand over to the hospital midwives. These systems are ad hoc and informal and the midwives continue to practice without access to professional indemnity insurance. A CMP-type program in the South West of the state may ensure that these systems and processes can be streamlined and formalised (see *Recommendation #20*).

Some IPMs work in pairs or in systems where they provide back-up to one another. These systems are often arranged as needed and are not formal arrangements. Other systems include the homebirth women 'booking' in with the hospital during pregnancy in case transfer is required. It was reported that most women take up this opportunity but not all.

The IPMs reported that transfers to hospital are received by the hospital in different ways. The reception at the hospital often 'depends on who is there'. It was reported that some hospitals will not accept transfers from planned homebirths (e.g. Osborne Park). At most hospitals (e.g. KEMH), the IPMs generally become the support person as they do not have visiting rights at the hospitals and cannot provide midwifery care. These blurred roles can cause confusion and distress to IPMs and hospital staff at times (see *Recommendation #5*).

Access to prescribing rights and ordering of tests and imaging is difficult for IPMs. For the most part, midwives had developed relationships with GPs and this assists the process. However, this system is cumbersome and means that the IPMs often do not receive copies of the results and the women have to follow up the results themselves. This can hamper communication and effective handover of information.

The review of adverse events was also discussed. There seems to be no formal links between the hospitals and the IPMs in relation to the review of critical incidents or adverse events. In the case of a perinatal death being investigated by the Perinatal Infant Mortality Committee, no feedback is provided to the IPMs as they are not medical practitioners.<sup>9</sup>

Access to ongoing professional development opportunities seemed limited. The IPMs were unsure what access they had to ongoing education through KEMH (e.g. the In Time emergency program), although subsequent interviews with KEMH staff conformed that they did have access (see *Recommendation #18*). The IPMs were very unsure about the Australian College of Midwives' continuing professional development program (MidPLUS and Midwifery Practice Review). This may be because these are relatively new programs and there is uncertainty about them amongst many midwives in Australia.

The relationship between the IPMs and the CMWA or CMP was explored. Some of the IPMs were former members of CMWA. There is no formal relationship between these groups.

### 6.1.8 Experiences of hospital-based staff

On the whole, the experiences of hospital-based staff who were interviewed were positive towards the CMP midwives and, in the majority of cases, the woman and the midwife have been supportive and grateful of the assistance that coming to hospital could provide. It was acknowledged that, most of the time, the interactions with CMP midwives and women are appropriate and professional. Staff from KEMH spoke of effective and supportive relationships between the KEMH Labour Ward staff and the management of the CMP.

<sup>9</sup> The PIMC process is dictated in the Health Act 1911 Part XIII B - Perinatal and Infant Mortality Committee (Part XIII B inserted by Number 47 of 1978s.34.) and outlined in more detail in Section 6.2.6 of this report



The experiences of several hospital-based staff were coloured by some examples of poor outcomes and less than positive experiences in the past. The reviewers heard of a number of stories that related examples where women had been transferred to hospital (usually KEMH but also in rural areas) and had refused recommended interventions. These scenarios created great distress for all staff involved and no doubt, the woman and her family as well. It is not possible to quantify the number of these instances. It is likely that many of the same cases were relayed to the reviewers which possibly inflated the absolute numbers.

The hospital-based staff cited examples where they felt there was a lack of awareness by some CMP midwives/IPMs of the policy regarding indications for transfer of care to a hospital in general and a reluctance to 'give up' care while the woman was in hospital or to accept medical advice. This has caused some difficulties especially for junior medical staff. It was the opinion of a number of members of staff (medical and midwifery) that the CMP should transfer care to the hospital staff on admission in labour or if the woman becomes 'high risk'. There was evidence however of concerns about role confusion and a need for clarity (*see Recommendations #5; #7*).

There were a number of common points of contention in relation to care of women who are transferred to hospital. These, if they occur, were around resistance to the use of prophylactic syntocinon to prevent postpartum haemorrhage, wanting 'more time' before obstetric intervention occurred, and lastly exerting pressure on junior paediatric staff who wished to admit the baby to the neonatal special care nursery for observation.

It seems likely that the philosophical approach and beliefs of the hospital-based staff and homebirth women and midwives came into conflict. The two philosophies - one being stated as "the purpose of the exercise is to have a baby - it does not really matter how it is born so long as it is safe" versus one in which "childbirth is more than just a physical experience and that the process is as important as the outcome". These two ends of the spectrum conflict with one another especially after transfers to hospital (*see Recommendation #21*). During this review, examples were given of some junior obstetric staff, theatre nurses and midwives who had left their profession in the past because of conflicts and a high workload in relation to homebirth women. It seems unlikely that these were in large numbers however the stories prevail and continue to be remembered and retold.

It seems clear, however, that there remain some difficulties between the CMP/IPMs and the hospital staff. It was said to the reviewers that "KEMH staff do not trust anyone who has not worked or trained at KEMH". This view prevailed among a number of interviewees. This culture is problematic for ongoing development of both services and for recruitment and retention.

## **6.2 Policies, protocols, standards and quality assurance mechanisms**

Term of Reference 2: Establish what policies, protocols, standards and quality assurance mechanisms exist and the current clinical practices of midwives and medical practitioners who manage planned homebirths and review these against current best practice



### 6.2.1 Statewide maternity policy and guidelines

The new policy document, *Improving Maternity Services: Working together across Western Australia – A Policy Framework 2007*, was reviewed in relation to homebirth. This policy document has a number of important objectives in relation to this review including:

- Objective 4.1: Support women to choose how and where they give birth by providing high quality information and evidence-based clinical advice, ensuring that the information is accessible.
- Objective 4.2: Increase the capacity for midwives to provide one-to-one care to women throughout pregnancy including labour and childbirth, facilitating greater individual support, enabling continuity of carer.
- Objective 6.1: Increase the opportunity for both the community and health professionals to be involved in the planning, development and provision of local maternity services.
- Objective 7.4: Recognise and support the role of the non government sector in providing advocacy, support and education to women and their families.

These objectives recognise many of the issues that are highlighted in this report.

The Women's and Newborns' Health Network and the Statewide Obstetric Support Unit (SOSU) have been established in the last two years. The Women's and Newborns' Health is led by an obstetrician and a neonatologist. One of the roles of the Women's and Newborns' Health Network is to "develop protocols to ensure efficiency, effectiveness and safety in the delivery of women's and newborns' services" (page 36). We support the need for this activity. Many of the protocols are from KEMH and may or may not have been adapted for local needs. This reliance on one institution to provide guidance around clinical practice guidelines or protocols is problematic, as other service providers may not feel able to contribute.

There seems to be a lack of protocols in relation to women who may decide not to undergo recommended antenatal screening tests (eg. ultrasound, diabetes testing) and how clinicians can address the needs of these women and the necessary documentation (see *Recommendation #6*). This is especially important for homebirth services as these decisions may be more likely to be seen in this group of women. It is essential that the protocols that relate to women who choose homebirth include wide consultation as they are developed to ensure that these issues and others are considered.

The Women's and Newborns' Health Network also hopes to develop information for all women in the future and plans to have a website for women to access. There is already a Women's Information Resource at KEMH with a 1800 toll free number. This will be drawn upon in the development of new information for women. Information for women about homebirth would be important to include in such a resource (see *Recommendation #15*).

The Statewide Obstetric Support Service (SOSU) was established as a result of recommendations from the *Western Australian Statewide Obstetrics Services Review* released in 2002. The unit has been in operation for more than two years but has suffered from significant recruitment issues. In November 2007, the current Midwifery Director was appointed. There are two part-time Medical Directors and one full time administrative person. One of the roles of SOSU is the provision of education to maternity service

providers and to assist with the implementation of Network policy at a facility level. SOSU is also involved in reviews of maternity services within WA.

The relationships and linkages between the Network and SOSU were unclear to the reviewers. The document, *Role delineation of the Women's and Newborns Health Network and State-wide Obstetric Support Unit (Draft – March 2008)*, provides an explanation of the specific roles of the Network and SOSU. The communication channels and linkages in relation to specific services (in this case, homebirth services) is not articulated clearly.

### 6.2.2 WA Homebirth Guidelines

The initial policy on homebirth in WA (1991) was reviewed in 2001. A revised policy, *Homebirths Policy and Guidelines for Management of Risk Factors 2001*, was released as a result of consultation and review. This policy is said to offer support and guidance to midwives who care for women who choose homebirth. The policy states that community-based midwives are accountable for their midwifery practice and are required to refer to this updated policy to ensure their practice meets both public and professional expectations. The policy includes the procedures for the care of the childbearing women and her child and guidelines for the management of risk factors. The policy and guidelines do not seem to highlight which women should be, or could be, offered homebirth. The guidelines state that homebirth is a safe option for women at low risk of complications but the definition of *low risk of complications* is not clear. The document does highlight the need for the midwives to report, both her intention to enter into private practice as a midwife and, information about homebirths.

In practice, it seems that this lack of clarity regarding access criteria has meant that some women have been accepted into homebirth services that may not be suitable using low risk criteria. It seems likely that some women have chosen homebirth simply because there is no other midwifery continuity of care available.

The current policy provides limited information for women (*see Recommendation #15*). There is also no clarification about the role of an IPM when transfer to hospital is required. The trust between a woman and her midwife means that, even if midwives take the role of a support person on transfer to hospital, the woman will often turn to her IPM for clarification. This can cause some difficulties for some hospital-based staff. Clarification of these issues would be helpful (*see Recommendation #5*).

Issues around safety need to be addressed in a revised policy (*see Recommendation #4*). This includes the number of hours that a midwife can work (e.g. safe hours policy, OHS). The overall policy and guidelines requires urgent updating and strengthening. Information for women about homebirth needs to be included in future editions.

### 6.2.3 CMP Guidelines

The development of Guidelines for the CMP is in progress and the reviewers were shown a number of guidelines, many of which are in the draft stages (*see Recommendation #7*). The process of guideline development for the CMP needs clarity. The CMWA currently is involved in reviewing the guidelines developed through the CMP. The reason for this is said to be to ensure that the guidelines are written in accessible language for women. Care needs to be taken to ensure that issues of midwifery practice continue to be developed by midwives and maternity service providers in line with best available evidence.



Women are provided with very little written information on the criteria for access to homebirth or the potential for consultation, referral or transfer to hospital in labour. There is no standard information booklet or pamphlet about homebirth. This means that women are often uncertain about the need for hospital transfer and/or birth and this may contribute to the antagonism that they feel if transfer in labour is required (*see Recommendation #15*).

A number of systems have been put in place at King Edward Memorial Hospital (KEMH) in an attempt to improve communication and collaboration between the CMP and the hospital. One of these strategies is an antenatal visit with one of the senior obstetricians at KEMH. This however appears to be a discretionary process and varies in timing. Some people indicated that the visit occurred as late as 36 weeks gestation while others said it occurred much earlier in pregnancy.

The use of a woman held record by the CMP midwives, which is the same record that is used at KEMH and other hospitals in WA, is another strategy that is useful for consistency and communication. There were concerns, raised about the quality of documentation in some of the records. The reviewers were provided with a number of examples of records from the CMP and identified limitations in the standard of documentation. In particular, documentation of the counselling and recording of the decision made by women in relation to antenatal screening including alternative strategies and management plans were limited (*see Recommendation #14*).

Transfer from home to hospital also raised issues in relation to guidelines and policies. There is a lack of clarity about the criteria for transferring from a homebirth to hospital. The process also varies. Generally, the midwife at the homebirth telephones the hospital to advise them of the transfer. It seems rare that the midwife calls to consult prior to the decision to transfer. The first point of contact is usually the senior obstetric register. If there are difficulties or conflicts, the consultant obstetrician is also called. There is then a lack of clarity about which midwife is responsible for the care of the women once transferred to hospital (that is, CMP midwife or hospital-based midwife). There has been antagonism in the past at the point of transfer and during ongoing hospital care although this seems to have improved in the last 12 months as many of the midwives on the CMP were previously staff at KEMH. Nonetheless, the process of transfer needs to be strengthened and be less dependent on individuals and more on systems that are effective (*see Recommendation #5*).

#### **6.2.4 Data collection in relation to homebirth**

Data collection and record of IPMs is limited. A list is kept at the WA Department of Health that has been maintained for more than 40 years. Names come onto the list (usually when a birth registration from a new IPM arrives at the Department) but are rarely removed. This means it is difficult to know who is actually practising as an IPM at any one time. The current *Nurses and Midwives Act of WA* also cannot determine the number of practising midwives in the state or specifically, the number of IPMs (*see Recommendation #8*).

Data in relation to CMP women also need clarity. It is unclear whether the current perinatal data collection systems include intended or actual model of care. This means that it is difficult to report the outcomes of women who were booked with the CMP, regardless of place of birth (*see Recommendation #17*).

### 6.2.5 Quality assurance/quality and safety systems

A number of systems exist in WA to address quality and safety issues including in homebirth. These include the Perinatal Infant Mortality Committee, which is a statutory committee of the Department of Health WA. At the level of the CMP, a Clinical Advisory Group has been established to monitor quality and safety issues that occur in the community. At the WA public hospitals, an adverse event/incident monitoring system, known as AIMS, is used to collect data on adverse events that occur in the hospital system. This is then followed by classification of the event and investigation, through local means or with a formal Root Cause Analysis (RCA). At a state-wide level, the practice of midwives is legislated by the *WA Nurses and Midwives Act* through the Nurses and Midwives Board of WA. Complaints to the Board are acted upon through an investigation. These many systems operate independently and rarely refer to one another for information nor do they draw upon one another's findings in any deliberations.

The next section outlines each of the current systems in relation to homebirth in WA.

#### (a) PIMC process

The Perinatal Infant Mortality Committee (PIMC) was reconstituted in 2000. The PIMC is a Statutory Committee established under the *WA Health Act 1911*<sup>10</sup> and reports to the Minister of Health in WA.

The PIMC has an educational role. The *WA Health Act* states that the Functions of the Committee includes to determine whether in its opinion the "stillbirth or death ... might have been avoided and may add to the determination such constructive comments as the Committee deems advisable for the future assistance of medical practitioners and nurses"<sup>11</sup> (page 306). Since reconstitution, the PIMC has released two reports<sup>12</sup>, both of which have been reported to be highly useful for maternity service providers and policy makes in WA.

The permanent membership of the PIMC is defined by the *WA Health Act*. Whilst the membership is augmented by co-opted members as required, the permanent membership seems reflective of the health system of the time when the Act was proclaimed and does not reflect the multidisciplinary nature of health services and maternity care in the current context.

The process by which the PIMC undertakes 'investigations' is also determined in the *WA Health Act (1911)* under the specific provisions enacted in 1978. The Act states that 'An investigator undertakes a review of the records associated with the deaths'. In the case of the perinatal deaths, the current investigator is a general practitioner who also works as a GP obstetrician at KEMH. There is also an obstetrician investigator appointed by the Minister although the obstetrician does very little investigation. The investigator of the paediatric deaths is a retired paediatrician. A high level of confidentiality in relation to the findings of the investigations is dictated by the *WA Health Act*.

<sup>10</sup> *WA Health Act. Part XIII B – Perinatal and Infant Mortality Committee (Part XIII B inserted by Number 47 of 1978s.34.)*

<sup>11</sup> *Part XIII B – Perinatal and Infant Mortality Committee (WA Health Act 1978). Printout produced 5 August 1996.*

<sup>12</sup> 11<sup>th</sup> and 12<sup>th</sup> Editions of the PIMC report



Only clinical written records are reviewed during the investigation. It appears that there is no particular documented process used to analyse the deaths or the situations surrounding the cases (see *Recommendation #9*). Once the review is complete, the assigned investigator presents a summary of the case/s to the PIMC using the PSANZ Cause of Death criteria. The PIMC considers the report and assigns a 'preventability scale (1 to 6)'. The Preventability Scale has not been validated in perinatal health for the assessment of perinatal deaths. A series of recommendations are made for educational purposes and a letter of feedback prepared.

Feedback is made in the form of a letter written only to the attending medical practitioner (as dictated by the Act). The letter is confidential and the medical practitioner is not able to share the contents with anyone. This level of confidentiality is mandated in the Act. In the case that a woman received solely midwifery care, then no feedback would be provided to the midwife. If it was determined that a medical practitioner did provide some care (even if it were minimal), the medical practitioner would receive the letter from the PIMC but would be allowed to divulge its contents to the midwife involved. The reviewers were told by some clinicians that the letter to the medical practitioner seems to have limited benefit as it was often vague, does not address system-wide issues and is confidential (see *Recommendation #10*).

The baby's family does not receive any direct information as a result of this process. Their recollection of the events is neither used nor are they informed that a formal investigation took place or that recommendations and feedback were made.

### **b) CMP's Clinical Advisory Group**

The Clinical Advisory Group (CAG) was established by the CMWA. The Terms of Reference for the CAG are provided in Appendix B. One of the Terms of Reference is to:

*To meet on an as-needs basis to review cases resulting in unexpected Program outcomes and develop recommendations relating to clinical practice, policies and procedures in response that assist in the maintenance of good clinical practice*

The CAG only reviews deaths or incidents that occur at home. The CAG recommendations are reported to the Board of the CMWA. Deaths that occur in hospital are reviewed through the health system's quality programs/AIMS system.

The process of addressing the recommendations and 'closing the loop' in terms of changes seems unclear. It seems that at times this is undertaken well but that other times there are deficiencies in the process and outcomes, especially if the recommendations about the CMP are counter to the philosophy of the CMWA. The limitations in this process highlight the challenges with recommendations going to a Board that does not have management or employment responsibilities. There is a lack of clarity around the lines of accountability and clinical governance (see *Recommendation #19*).

### **c) Incident monitoring – AIMS**

The incident reporting system used is known as AIMS. AIMS is a computerised system for collecting, classifying, analysing, managing and learning about things that go wrong in health care. CMP midwives complete an AIMS notification in the event of an adverse event. The definition of an adverse event is unclear. Trigger reporting systems are not used. If an adverse event occurs at KEMH, the AIMS report is discussed with the CMP manager by the



Clinical Midwifery Consultant (CMC) in the Labour and Birth Suite (KEMH) and the midwife concerned. The adverse event is then taken to the Obstetrics and Gynaecology Outcomes Review Committee. This committee meets monthly and is covered by qualified privilege and therefore confidential CMP midwives are generally not invited even if there was a CMP event.

Root Cause Analyses (RCA) seem to be a common event. The reviewers were told that only a few KEMH managers were trained in Root Cause Analysis.

Adverse events, including perinatal deaths that occur with IPMs at home are not reported through a formalised system such as AIMS. The public health system does not have jurisdiction over the clinical governance of IPMs.

#### **d) Regulation of midwives**

A new *Nurses and Midwives Act* in Western Australia was enacted in 2006. The Act determines who can be registered as a midwife and the process of renewal of registration. It is the process of renewal that is of interest to this Review in relation to assessment of ongoing competence (Part 4, Division 1, Section 35). In the Act, renewal of registration requires payment of a fee and there are criteria and statements about the payment processes.

Section 42 (2) of the Act states that: “Subject to subsections (3) and (4), the Board is to cancel the registration of and direct the registrar to remove from the register the name of a midwife if the Board is satisfied that the midwife –

- (a) has not practised midwifery in the preceding period of 5 years; and
- (b) has not maintained current knowledge and skills in midwifery at an approved level.”

The assessing of current knowledge and skills is determined at an employer level and captured in the annual “Assessing of continuing professional competence audit” which randomly selects 5% of nurses and midwives from the register to provide evidence of professional competence to the Board. Nothing in the Act actually says “audit” but s101 states the Board can make rules and states “(d) regulating the practice of midwifery by a midwife and the manner of carrying on the practice”.

The Act makes statements about professional indemnity insurance. For example, Part 4, Division 1, Section 32 (page 24) states that the Nurses and Midwives Board may impose conditions as conditions of registration in relation to professional indemnity insurance. One of these conditions states that that the nurse or midwife must hold professional indemnity insurance either individually or as part of their employment. The other condition relates to the fact that the professional indemnity insurance must meet the minimum terms and conditions approved by the Board. The Board has not chosen to impose either of these conditions to date, however, they are in the process of developing guidelines which may say that all nurses and midwives need professional indemnity insurance if they provide care that carries a fee for service to them directly. Statements about professional indemnity insurance are now part of ‘template legislation’ which will mean that there will be consistency across similar disciplines (see *Recommendation #11*).



The current regulatory system for midwives has the ability to monitor practice and conduct audits of practice however the WA Nurses and Midwives Board has chosen not to exercise this ability unless disciplinary action occurs. In relation to complaints or reports of unprofessional conduct:

*“The Board is empowered under the Nurses and Midwives Act 2006 to receive and investigate complaints in respect of a person who is a nurse or midwife or was a nurse or midwife at the time of any alleged offence. The complaint may originate from a number of sources, usually from an employer or another nurse or midwife, however members of the public, the Office of Health Review, Coroner, Corruption and Crime Commission and other health professionals may submit complaints”<sup>13</sup>*

Once a complaint is received, the Board will instigate a formal investigation and process to manage the complaint.

### 6.3 Ongoing professional development and clinical governance

*Term of Reference 4: Review the ongoing professional development and clinical governance of midwives who conduct planned homebirths and recommend any improvements*

#### 6.3.1 Clinical governance

There is a long and complicated history as to why the current management and governance arrangement are in place. Initially, CMWA managed the CMP as a self employing non-government organisation. This changed in 2001 when the midwives lost professional indemnity insurance and the WA Department of Health took on the liability and the employment contracts of the midwives. In the past seven years, a number of management and clinical government structures have been developed and utilised.

The current coordination and management approach through the Memorandum of Understanding was signed in October 2007. While it is not legally binding it seems to present the best way forward. Clinical governance therefore is undertaken by the North Metropolitan Area Health Service. Issues such as clinical care, accreditation and human resources are administered through the North Metropolitan Area Health Service. CMWA has carriage of the philosophy of the CMP and also manage the Pregnancy and Childbirth Centre.

As stated in Section 6.2.6, the CMP has a Clinical Advisory Group which reviews adverse events and clinical guidelines within the program. There are also a number of frameworks that are used to ensure all risk management and governance issues are addressed. These include AIMS reports and a risk register. Currently AIMS reports go to the CMP manager through to the CMWA manager and to the Executive Director of SOSU. This process seems unnecessarily convoluted at times.

It is evident to the reviewers that a great deal of work has been undertaken in the last twelve months in relation to clinical governance, risk analysis and the development of effective frameworks. The Memorandum of Understanding seems to have made some of

<sup>13</sup> From [http://www.nmbwa.org.au/1/1100/50/professional\\_conduct.pm](http://www.nmbwa.org.au/1/1100/50/professional_conduct.pm)

the issues clearer although there is still a need for ongoing and future clarification about the various clinical, administrative and governance roles and responsibilities (see *Recommendation #19*).

A formal facilitated risk assessment of the Community Midwifery Program has not been undertaken utilising the Australian and New Zealand Standard (AS/NZS 4360: 2004). This is an important and useful process to undertake as a means to ensure that adequate controls are in place to ensure the quality and safety of the model of care (in this case, homebirth/CMP) and to identify any additional controls that could be implemented to ensure optimum clinical practice and optimum health outcomes (see *Recommendation #13*).

Independent practising midwives are private providers for whom, under current legislation, the public health system has no jurisdiction or control and therefore limited clinical governance. The IPMs state that they follow the Australian College of Midwives' Midwifery Guidelines for Consultation and Referral however this is not mandated. As described earlier (Section 5.2.6 (d)) the WA Nurses and Midwives Board is in the process of developing guidelines which may say that all nurses and midwives need professional indemnity insurance if they provide care that carries a fee for service to them directly. The reviewers believe that care needs to be taken in the implementation of restrictive legislation for IPMs. It is likely that women will continue to choose the services of IPMs and stringent regulation could result in unregistered midwives providing care.

### **6.3.2 Ongoing professional development**

It is recognised that midwives who work in the CMP need to have effective links with the hospital service in order to build trust and relationships. It was suggested that CMP midwives need to undergo a hospital-based orientation (in addition to their CMP orientation) and spend some time each year working in the hospital system, probably in labour ward, to ensure that they maintain their skills in the event of a transfer. The Review recognises that the reciprocal would also be true. These processes would build relationships between the two programs. Opportunities for rotation into the CMP by midwives in the hospital would provide ongoing professional development for both groups and would ensure that hospital-based midwives developed a clear understanding of community-based midwifery and of the CMP.

There are currently limited shared education programs or meetings between CMP, IPMs and hospital-based midwives. The Australian College of Midwives WA (ACM-WA) provides some education programs which all midwives are invited to. However, within the employment systems there seems to be limited opportunities for shared meetings or processes to build relationships, trust and understanding.

Access to the emergency training program at KEMH (In Time) is available to CMP midwives. There is a lack of clarity about whether this is also available to IPMs – IPMs reported that it was not, whereas clinicians at KEMH reported that it was available (see *Recommendation #18*).

Formal systems of peer review and audit are limited within the current systems for CMP midwives. Most peer review seems to occur at the weekly meetings and are of an informal nature. Formal mechanisms for ongoing peer review are non-existent for IPMs.



There are currently no legislated frameworks to mandate ongoing continuing professional development for midwives across Australia. National regulation and registration of nurses and midwives is currently in the planning phase through the Council of Australian Governments (COAG).<sup>14</sup> It is possible that the future regulation of nurses and midwives includes mandatory continuing professional development. This will be of advantage to all health systems including the CMP and IPMs in WA (see Recommendation #12).

## 6.4 Additional key findings

*Term of Reference 5: Make any additional recommendations that would assist in ensuring that planned homebirths in Western Australia are managed according to best clinical practice.*

During this review, it was evident that there were a number of additional issues which impact on the safety and quality of homebirth services in WA. Homebirth services are part of the broader maternity service (both public and private) and therefore cannot be seen in isolation from the broader context of maternity service provision. This review has also highlighted inconsistencies in the reasons that women choose homebirth in this state and this may account for some of the outcomes. Many of these issues have already been discussed during this report. They centre around the desire that women have for access to models of care that meet their needs. In particular, women told the reviewers of the desire for access to midwifery continuity of carer, the use of water in labour and birth (either in hospital or at home) and desire for support for vaginal birth after a previous caesarean section.

Recommendations 20 to 24 are presented under Term of Reference 5 which requested *additional recommendations that would assist in ensuring that planned homebirths in Western Australia are managed according to best clinical practice.*

## 6.5 Review of performance based on EQUiP principles

In formulating this report, the reviewers wished to use objective criteria to assess the performance of the existing models of care supporting birth at home and an established framework in which to develop the responses to the terms of reference. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has stated its support for the use of standards to underpin accreditation programs and the Australian Council on Healthcare Standards (ACHS) provides guidance in the use of standards as the basis for assessing performance. The ACHS Evaluation and Quality Improvement Program (EQUiP) is a framework for managing health services to ensure quality and safe care and services and for achieving quality improvement. One of the key components of EQUiP are standards that organisations work towards achieving.

<sup>14</sup> In March 2008, COAG took a major step towards improving Australia's health system by signing an Intergovernmental Agreement on the health workforce. This agreement will for the first time create a single national registration and accreditation system for nine health professions: medical practitioners; nurses and midwives; pharmacists; physiotherapists; psychologists; osteopaths; chiropractors; optometrists; and dentists (including dental hygienists, dental prosthetists and dental therapists). The new arrangement will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce. For example, the new scheme will maintain a public national register for each health profession that will ensure that a professional who has been banned from practising in one place is unable to practise elsewhere in Australia. (see <http://www.coag.gov.au/meetings/260308/index.htm#health>)



The EQUiP 4 standards are arranged under three functions: (1) clinical, (2) support and (3) corporate. The clinical function encompasses continuity of care, access, appropriateness, effectiveness, patient safety and consumer focus. The support function includes quality improvement and risk management, human resources management, information management, population health and research. The corporate function embraces leadership and management as well as safe practice and environment.

Whilst this framework is primarily focused on acute facilities, the reviewers have utilised it to frame the findings of the review. The following discussion is an attempt to organise the analysis and recommendations within this framework. Appendices D and E provide matrices that map the recommendations with the *EQUiP 4 Functions, Standards and Criteria*.

As IPMs are outside the remit of the public health system, they are not included in this analysis. We recognise this is a limitation of this section of the report.

### 6.5.1 Direct Delivery of Clinical Care

**Access** to homebirth through the CMP is driven primarily by community-based communication. Whilst the program is publicly funded, there is no widespread mainstream acknowledgment of its existence nor its promotion as an option as a model of care to appropriate women. Through interviews with women and their partners, access to homebirth through the CMP, whilst superficially is about birth in a home like environment, appears to be more about access to continuity of care/carer, use of water in labour and birth, and the ability to pursue a vaginal birth after a previous caesarean section.

**Entry** criteria, until recent times, have not been sufficiently robust to enable rigorous audit. Whilst there has been documentation regarding entry criteria there has been considerable discretion both at the point of entry and at medical review, which may not take place until 36 weeks gestation.

**Referral** to the CMP is generally by self-referral with some women referred by general practitioners. Cases were encountered where women who did not want to follow medical advice in the hospital setting were referred to independently practising midwives.

**Continuity of Care** is provided through the CMP and women and their partners report a high level of satisfaction with the continuity of care and carer provided.

**Appropriateness** of care has been compromised by the lack of rigour around access and entry criteria, the lack of effective midwifery continuity of care models in the hospital system, the antagonism of the hospitals with respect to the use of water in labour and birth, the perception of poor support for women wishing to pursue a vaginal birth after previous caesarean section, and the ineffective management of women who elect not to follow 'standard' management protocols. Review of transfers and cases of perinatal loss through the CMP indicate that women with identified risk factors have been accepted onto the program or been able to continue on the program when significant risk factors for adverse fetal outcome were identified. Whilst this continuity of carer is beneficial to the individual women and families, it has been to the detriment of the overall program.



**Effectiveness** of care through the CMP is difficult to establish. The CMWA website states the aim of the CMP is 'to meet the needs of women and their families by providing them with continuous midwifery care throughout their pregnancy, labour, birth and the early postnatal period'. This is reinforced in the welcome letter given to women accepted onto the program that states 'our aim is to ensure that your pregnancy and birth are wonderful positive experiences for you and your baby'. If the effectiveness of the program is thus gauged by women's satisfaction with the experience of childbirth then it could be said to be highly effective. If, however, effectiveness is gauged by perinatal mortality alone, then its effectiveness in the past has been less than optimal. There is evidence that in the past two years, considerable efforts have been made to address issues in the effectiveness of care which have been successful (no perinatal deaths reported in women choosing homebirth for 2006 and 2007).

**Patient safety**, until recent times, has not been a stated priority for the CMP. The focus on the experience of childbirth has meant strong advocacy for women and their families but not always for the unborn baby. The increased perinatal loss rate at term, even correcting for fetal anomaly, has been partially addressed by stronger access, entry and selection criteria, however, a stronger statement about safety needs to be explicit in the program.

**Consumer focus** is clearly a high priority for the CMP. The CMP through CMWA are strong advocates for women and their families. The governance structure of the CMWA and its direct relationship with the CMP ensures consumer participation at every level of care.

With respect to the provision of high quality care throughout the care delivery process there are numerous areas for improvement. The assessment system that ensures that the current and ongoing needs of women and their babies needs to be strengthened. Whilst care is planned and delivered in partnership with women and their partners, the focus is often on the birth experience rather than on the best possible outcomes for mother and baby. Whilst women are informed of the consent process there is confusion about roles and responsibilities at some levels of the care process. The evaluation of care is not rigorous. The processes for consultation / referral / transfer are not sufficiently robust to allow proper audit. The systems for ongoing care of women and their babies are uncoordinated and ineffective. Handover between different clinicians needs to be seamless with clear expectations for the desired outcomes. The pregnancy, labour and birth records are not generally comprehensive with evidence of missing information and poor record keeping particularly during labour and birth.

With respect to consumers/women/communities having access to health services and care appropriate to their needs, it is concerning that many women are not primarily accessing the CMP or independently practising midwives with the desire to birth in the home environment. Access to continuity of carer models needs to be expedited together with a supportive framework for labour and birth in water and vaginal birth after caesarean. The existing Family Birth Centre and Team Midwifery Models at KEMH are ineffective with only slightly more than half of FBC booked women giving birth with the model and with only 25% of team women having their birth attended by a midwife from their own team.

Whilst midwifery-led models of care are appropriate across a wide spectrum, the fragmentation and ineffectiveness of existing models needs urgent attention so that women and their families are provided with appropriate care and services. There is clearly a case for the provision of midwifery-led models of care and this includes birth at home, however,



there is the need to ensure that health care and services are appropriate and delivered in the most appropriate setting.

The care provided through the CMP needs to focus on both mother and baby outcomes. Care needs to be planned, developed and delivered on the best available evidence and in the most effective manner.

There needs to be a greater focus on the provision of safe care. There is no evidence of a rigorous risk assessment of the existing model of care. The Australian / New Zealand Standard (AS/NZS:4360 2004) provides a robust framework by which risks may be identified, analysed, evaluated, treated and monitored and this framework has been successfully utilised in risk assessment of other maternity models.

With respect to the CMP there is a clear commitment to consumer participation. Input is sought from consumers and the community in planning, delivery and evaluation of the program. This, however, needs to be strengthened through better clinical practice guidelines, policies and pathways, more robust evaluation and greater clarity around roles and responsibilities. When adverse outcomes occur, acknowledgment of the adverse outcome, openness and timeliness of communication, recognition of the expectations of women and their families, an expression of regret, staff support and confidentiality, should be the basis of information provided to women and their families.

With respect to separation, the finalisation of care from the CMP needs to be supported by systems and documented guidelines to ensure it is appropriate and timely, coordinated, and addresses the specific needs of women and their families.

### **6.5.2 Systems Supporting Delivery of Clinical Care**

The systems supporting clinical care delivery, quality improvement, risk management, human resources management and information management have all been underdeveloped. The Memorandum of Understanding between CMWA and the NMAHS in respect of the coordination of the Community Midwifery Program (October 2007) has attempted to redress this through the acknowledgment of the three areas for which NMAHS has non-delegable obligations and statutory responsibilities: accreditation, clinical governance and human resources management. The specific obligation in respect of the non-delegable matters, however, still splits most functions between CMWA and NMAHS which is both difficult to administer and monitor. The translation of this into sustainable systems and processes needs to be realised.

Previous governance arrangements resulted in a culture that did not support the delivery of safe care. There has not been a blame-free approach to the open reporting, assessment and clinical safety and this has been confounded by strained working relationships between CMP and Health (KEMH/NMAHS) which have impeded effective communication. Whilst governance arrangements have improved, the systems of continuous quality improvement rely heavily on qualified privilege which impairs communication to the CMP and in particular to individual non-medical clinicians. There is little evidence of a robust and integrated risk management policy and system to ensure that clinical and corporate risks are identified, minimised and managed. Incidents are managed in such a way, often through multiple parallel processes, that most often exclude those providing the care and almost always exclude the family.



The recruitment, selection and appointment system of midwives to the CMP has not been sufficiently robust in the past to ensure that the skill mix and competence of staff meets the needs of the program. Efforts have been made in the past two years to address this issue. The continuing employment and performance development system needs to be strengthened to ensure the skill and competence of all staff. Midwife support systems need to be strengthened.

Information management including records and data management is suboptimal. The fact that client notes (medical records) are the property of one entity (CMP) yet stored with the other entity (CMWA) is problematic. Health records should ideally be easily accessible. Whilst they can be accessed by NMAHS, the reviewing and reporting of data is undertaken by CMWA. Whilst there is nothing fundamentally wrong with self-reporting, the existing arrangement makes audit difficult. The medical records for women under the CMP were not cross referenced with other health records and patient information systems. Some records reviewed did not comply with professional standards and did not contain sufficient information to accurately outline the total needs and the care and the management of the woman and her pregnancy.

There are significant limitations in the systems to address the particular challenges for IPMs. There is a limited capacity to know who is currently practising and no legislative requirement for IPMs to register their intention to undertake homebirth practice. There are limitations in the data collection systems which means it is difficult to determine who are potential homebirth women (and whether they are CMP or IPM clients) in the MNS. In addition, 'intention to give birth at home' is poorly collected in the current data collection systems.

### 6.5.3 Review of Clinical Care

Whilst regular reporting on the activities of the CMP exist, there is a lack of coordinated clinical care review. Clinical data are collected and measured but are not subsequently evaluated with no evidence of benchmarking at any level against defined criteria or standards. Thus, historically, deficiencies have not been recognised and changes to policies and practices have been slow. The impact of any changes made has not been monitored. Clinical review activities have been limited and uncoordinated. No evidence of any completed or ongoing quality improvement projects could be found. Inadequate activities exist to identify, assess and minimise clinical risk. The introduction of changes to the CMP has tended in the past to be reactionary rather than there being a proactive system of clinical risk management.

### 6.5.4 Corporate Functions

The origins of the Community Midwifery Program and its relationship to CMWA and now NMAHS are complex. Irrespective of past or current arrangements there needs to be a clear strategic direction to ensure the provision of quality safe services. Before the end of the current contract between the Minister for Health and the CMWA for the *Provision of Midwifery Coordination and Resources Services 2006/2009* the current memorandum of understanding between CMWA and NMAHS needs to be reviewed and the relationship between the CMP and all its major stakeholders needs to be explored to ensure that all elements of quality (including safety) are optimised. Governance changes need to be



strengthened by formal structures and processes for credentialling and defining scope of practice. Contemporary clinical and corporate policies need to be expedited to assist the provision of quality care.

Safety management systems to ensure the safety, security and wellbeing of staff are non-existent. Waste and environmental management in the home environment are good. Current emergency transfer management in the home environment does not support safe practice and a safe environment. The ambulance service needs to be engaged to ensure that all ambulance requests for assistance at non-hospital births are classified as a Priority 1.



## 7. Discussion

It is evident that homebirth has had a difficult past in WA. The CMP was established as a means for women to access a community-based homebirth model. Over more than a decade though, maintaining professional indemnity insurance, access to hospital-based referral networks, relationships with hospital-based providers and administrators have been challenging. Independent practising midwives have lost professional indemnity insurance and are currently practising completely out of the mainstream health system. A lack of access to referral to imaging and pathology tests for IPMs has meant a lack of communication and handover at times. The current regulatory system for midwives lacks an ability to monitor practice or to mandate continuing professional development unless disciplinary action occurs.

Systems in relation to homebirth need to be strengthened. The policies and guidelines about eligibility for homebirth in the CMP needs to be clarified and reinforced. Midwives in both the CMP and independent practice need to be aware of the need to 'protect the homebirth model.' This means that guidelines and policies need to be developed, adhered to and monitored. This also means being cautious and conservative in decision making to ensure that confidence can be rebuilt in homebirth.

The review has identified that the CMP has the potential to provide a safe service. Indeed, in the past two years, the effectiveness, quality and safety of the CMP has improved considerably. While there is still work to be done, the desire and intent to provide a safe and effective service is certainly present.

There are a number of barriers which interfere with communication and the potential for improving homebirth services. For example, the investigation and feedback following a perinatal death after a homebirth may totally exclude the primary carer (the homebirth midwife) and the family. Current legislation prevents direct communication and feedback to non-medical practitioners and there is no capacity for communication with the parents.

This review has highlighted a number of additional issues for childbearing women and maternity services in WA. It is encouraging that the latest state government policy document is supportive of a direction that is woman centred and is line with national and international evidence and trends. It is evident that maternity services still have a way to go. It is our impression that some women are choosing homebirth in WA as there are limited options in relation to access to midwifery continuity of care, waterbirth, support for vaginal birth after caesarean section or care in a birth centre environment. It seems apparent that the maternity systems are, for some women, too medicalised and restrictive, and do not meet the needs of women and families. Some women, who in other models and systems would not be 'eligible' or recommended for homebirth, are choosing this option as a surrogate means to access midwifery continuity of care and waterbirth. This issue was apparent in both metropolitan and the South West rural areas of the state. Our belief is that the choice to give birth at home or in water will continue, as will the choice to have a vaginal birth after a caesarean section. Therefore, developing systems to support safe and satisfying systems of care that provide childbearing women with a diversity of options is essential.

If the mainstream maternity system develops 'alternative' models of care that meet women's needs, the demands for services outside the mainstream system may decline. Ultimately, this will mean that the clinical governance systems will be easier to manage as most, if not all, births will occur through the mainstream systems. There are benefits, in terms of clinical governance and safety and quality, if homebirth is seen as one part of the maternity mainstream service. Homebirth is more likely to be unsafe if it is marginalised and kept out of the mainstream service.

## 7.1 Recommendations

The recommendations are presented according to each of the terms of reference. As homebirth is part of the wider maternity system in WA, broader issues relating to maternity service provision are addressed under the final term of reference.

- 1. Investigate the clinical experiences and health outcomes of mothers and babies accepted for homebirth by the Community Midwifery Program or midwives acting independently in Western Australia between 2000 and 2007. As a minimum, the investigation is to include mortality of mothers and babies; and emergency transfer of mothers or babies to hospital care at any stage of pregnancy, including during the post-partum period.***

**Rec 1:** Perinatal deaths in women choosing homebirth, particularly those that are determined or suspected to have occurred during the intrapartum period, be considered a sentinel event and subjected to Root Cause Analysis (RCA) by the appropriate clinical governance body for the service involved.

**Rec 2:** Midwives who work in homebirth practice and offer Complementary and Alternative Medicines (CAM) be appropriately educated and credentialed in their use.

**Rec 3:** All ambulance requests for assistance at homebirths should be classified as Priority 1 by the WA St John's Ambulance Service.

- 2. Establish what policies, protocols, standards and quality assurance mechanisms exist and the current clinical practices of midwives and medical practitioners who manage planned homebirths and review these against current best practice.***

**Rec 4:** The Statewide Homebirth Policy (2001) should be reviewed as a matter of urgency.

**Rec 5:** The Women's and Newborns' Network develop policy with respect to the roles and responsibilities of childbearing women who choose homebirth, their support people and doulas in labour and CMP/independent practising midwives when women are transferred to from homebirth to hospital.

**Rec 6:** The Women's and Newborns' Network develop policy in relation to women who choose homebirth and decide not to undertake selective antenatal tests and/or recommended management practices in pregnancy, labour and birth. This includes:

- screening for group B streptococcus and diabetes
- management of the third stage of labour
- decisions regarding newborn care including vitamin K, neonatal immunisations, newborn screening tests.



**Rec 7:** The process of developing and implementing the guidelines for the CMP must be expedited as a matter of urgency. In particular, the guidelines for clinicians must include clear direction in relation to:

- Entry criteria for the CMP.
- Processes for consultation and referral and specific planning and documentation of decisions.
- Criteria for transfer to hospital.
- Roles and responsibilities of midwives after transfer to hospital.
- Criteria for observations in labour and standards for documentation.

**Rec 8:** The WA Department of Health implements a more robust system for maintaining the currency of the list of current practising independent midwives who provide homebirth services. Consideration should be given to this role being transferred to the WA Nurses and Midwives Board in the future.

**Rec 9:** The method of investigation employed by the Perinatal and Infant Mortality Committee (PIMC) for home and hospital births could be strengthened by adopting the Perinatal Society of Australia and New Zealand (PSANZ) methodology of investigation, categorisation and reporting of perinatal deaths.<sup>15</sup>

**Rec 10:** The WA Government amend the *Health Act 1911* Part XIII B - Perinatal and Infant Mortality Committee to enable the consideration of, and action upon, broader system-level issues in their reporting including identification of contributing factors that are amenable to organisational change at home and hospital births.

**Rec 11:** The WA Nurses and Midwives Board should consider legislation to ensure that midwives who provide homebirth services have access to professional indemnity insurance in order to maintain registration.

**Rec 12:** The WA Nurses and Midwives Board should consider a system of requiring annual Midwifery Practice Review or other forms of continuing professional development for renewal of registration for independent practising midwives.

### **3. Make recommendations as to**

- ***ways in which the practice of homebirths could be improved to ensure optimum clinical practice and optimum health outcomes;***
- ***ways in which women accepted for homebirth are prepared for the possibility of transfer to hospital if required;***
- ***ways to precisely identify planned home births in routine data collections;***
- ***the need for an ongoing audit of safety and patient outcomes, including the key indicators to be monitored.***

**Rec 13:** A formal facilitated risk assessment of the Community Midwifery Program be undertaken utilising AS/NZS 4360: 2004 to ensure that adequate controls are in place and to identify any additional controls not covered by the terms of reference of this review.

<sup>15</sup> The Perinatal Mortality Special Interest Group of the Perinatal Society of Australia and New Zealand. (2004). Clinical Practice Guideline for Perinatal Mortality Audit, PSANZ

**Rec 14:** Documentation standards for the CMP must improve in line with legal and professional guidelines.<sup>16</sup> This includes:

- Documentation of the counselling and recording of the decision made by women in relation to antenatal screening including alternative strategies and management plans.
- Education programs need to be designed and implemented to address deficiencies in the standard of clinical documentation.
- Continuation of regular audits of the standard of documentation with the outcomes presented back to the CMP midwives.

**Rec 15:** Information for women who choose homebirth needs to be developed by the CMP in collaboration with the Women's and Newborns' Network. This should include information about

- Entry criteria for homebirth
- Safety and risks of homebirth
- Consultation and referral processes which may lead to hospital transfer

**Rec 16:** A process for ongoing evaluation and annual reporting of outcomes and experiences of women who access the CMP needs to occur. This includes:

- A satisfaction survey to be undertaken independently on a regular basis.
- A robust and independent mechanism to manage complaints.

**Rec 17:** The Perinatal Data Collection should be revised to provide a vehicle whereby women's choices and the outcomes of different models of care (eg. planned homebirth) can be tracked and reported. A minimum data set is included in Appendix F. The outcomes should include morbidity for women who choose a home and hospital birth so that accurate comparisons can be made. The process for collating and publishing the outcomes from the Perinatal Data Collection should be appropriately resourced to ensure that the reports are published in a timely manner.

***4. Review the ongoing professional development and clinical governance of midwives who conduct planned homebirths and recommend any improvements.***

**Rec 18:** All midwives, including independent practising midwives, need to be aware of the access to, and avail themselves of the opportunities for, continuing professional development including the management of obstetric and neonatal emergencies.

**Rec 19:** Before the end of the current memorandum of understanding (MOU) between the CMWA and the NMAHS, the relationship between the CMP and its major stakeholders need to be explored to ensure that all elements of quality (including safety) are optimised. Clarification about the various clinical, administrative and governance roles and responsibilities needs to occur.

<sup>16</sup> See ANMC National Competency Standards for the Midwife (2006) for details on standards relating to documentation



**5. *Make any additional recommendations that would assist in ensuring that planned homebirths in Western Australia are managed according to best clinical practice.***

**Rec 20:** A Community Midwifery Program could be established in the South West area (Bunbury and Busselton) as this area currently has women accessing homebirth outside the public health system.

**Rec 21:** All stakeholders be informed regarding homebirth and respect the choices that women make.

**Rec 22:** All stakeholders recognise that women will exercise their choice to use water during labour which may also include a choice to give birth in water at homebirths and hospital births. To achieve this:

- policies and protocols to support the use of water for labour and birth should be developed and implemented.
- training and support should occur for midwives caring for women who use water during labour and birth.
- ongoing audit and evaluation should occur.

**Rec 23:** All stakeholders recognise the need for strategies to address women's decisions in relation to their next birth after a caesarean section (NBAC) and develop models of care that support vaginal birth after caesarean section, particularly access to information, continuity of carer and a respect for women's capacity for decision making.

**Rec 24:** Hospital-based midwifery continuity of carer models (midwifery group practices) be established for women of all risk factor status so that women could have access to continuity and do not choose homebirth only as a means to access continuity.

## 8. Appendices

### 8.1 Appendix A: Meeting timetable for the reviewers

#### MONDAY 31 March 2008

11– 3	Vivian Gee, Principal Consultant, Health Data Collections
3 – 4	Ros Elmes, Contract Manager, North Metro Health Service
4 – 5	Phil Della, Professor Nursing and Midwifery, Curtin University and Ruth Letts, Chief Nursing Officer, DoH

#### TUESDAY 1st April 2008

8.00 – 8.45	Tim Pavy, Head of Department Anaesthesia, KEMH
8.45 – 9.30	Ann Karczub, Medical Director State Obstetric Services Unit and Cliff Saunders
9.30 – 10.30	John Newnham, Chair, PIMC, Professor of Obstetrics and Catherine Douglass, Investigator PIMC
10.30 – 11.30	Christine Weir, Clinical Midwifery Consultant, KEMH and Margaret Beckitt, A/Clinical Midwifery Manger, KEMH
11.30 – 12.30	Karen Simmer, Head Neonatology/Clinical Lead, Women and Newborns Health Network 11.30 – 12 meeting to include Dr Andy Gill, Neonatologist;
12 – 12.30	Janet Hornbuckle, Women and Newborns Health Network
1 – 2	Graeme Boardley, Director Midwifery, KEMH and Philip Aylward, A/Area Executive Director
2 – 3	Amanda Frazer, Medical Superintendent, SCGH
3 – 4	Margaret Davies, Director, Nursing and Midwifery
4 – 5	Bunbury Obstetrician – Dr Di Mohen
5 – 6	Dale Reynolds, President, College of Midwives WA

#### WEDNESDAY 2 April 2008

8 – 9	Birth Choices telephone meeting
9 – 11	Karen Kruit, Manager Midwifery, SCGH/Coordinator, CMP
11 – 12	Louise Horgan, Chair Nurses Board and Robin Collins, CEO Nurses Board
12.30 onwards	Lunch and Afternoon at CMWA, Fremantle
	CMP women
	Linda Rawlings, CMWA, Executive Officer
	Bev Thiele, Chair, CMWA Board of Management
	CMP Midwives

**THURSDAY 3 April 2008**

8.00 – 8.30	Telephone call to CMP client
8.30 – 9.30	Diane Barr, Director of Nursing, Rockingham District Hospital
9.30 – 10	Deb Slater, Health Consumer Council and Michele Kosky
10 – 10.30	Deb Slater, Maternity Coalition and women who had chosen homebirth
10.30 – 1.00	Meeting and Lunch with Independent Midwives
1 – 2	CMWA Board Members
2 – 3	Chris Carter, State Manager, WA GP Network
3.10	Teleconference with Peter Groves, Manager of Government Industry Relations (HBF)
3.30 – 4.00	Meeting in DGs Office, 3B Dr Peter Flett, A/Director General, Department of Health and Dr Margaret Stevens
4 – 5	Kay Hyde, Midwifery Director, Statewide Obstetrics Support Unit
5 – 6	Dale Evans, RANZCOG, WA

**FRIDAY 4 April 2008**

8 – 9	Bunbury Hospital telephone meeting Kate Reynolds Nurse Manager, Obstetrics
9 – 10	Shelley Gower, Birth Rights
10.45 – 11.30	Jenny Fenwick, CMWA Clinical Advisory Group/Prof Midwifery Curtin University and Kay Hyde
10 – 10.45	Janice Butt, Nurses and Midwives Board & Coordinator PG Midwifery Program, Curtin University
11.30 – 1	Steering Committee Meeting

## 8.2 Appendix B: Terms of Reference – CMP Clinical Advisory Group

### **Name**

The group shall be known as the Clinical Advisory Group (CAG).

### **Purpose**

The Clinical Advisory Group provides a vital function for Community Midwifery WA's Community Midwifery Program and is integral to the Program's clinical governance processes.

The group's primary functions are:

1. To assist Community Midwifery WA's Board of Management with clinical advice, support and consultation in relation to the Community Midwifery Program's clinical guidelines, midwifery practice and Program outcomes.
2. To support Community Midwifery WA's Midwifery Coordinator in relation to the clinical management of the Community Midwifery Program.
3. To review the monthly outcomes of the Community Midwifery Program.
4. To participate in a collegial telephone/email network that provides clinical advice, support and consultation for the Community Midwifery Program.
5. To support and guide the Clinical Coordinator in the development of Evidence-Based Policy and Guidelines that meet the Program's aims of woman-centred care and informed choice.
6. To forward new and updated Clinical Policies and Procedures to the Board of Management for ratification, in accordance with CMWA's Clinical Policy Development Procedure.
7. To meet on an as-needs basis to review cases resulting in unexpected Program outcomes and develop recommendations relating to clinical practice, policies and procedures in response that assist in the maintenance of good clinical practice.
8. To refer breaches of guidelines, policies and procedures to CMWA Board of Management.

### **Relationship to CMWA Board of Management**

The Clinical Advisory Group represents a supportive, strategic alliance between CMWA and its partners and stakeholders. The Group provides timely, objective, clinical advice, support and consultation for CMWA's Community Midwifery Program and will make recommendations to the CMWA Board of Management in relation to clinical guidelines, midwifery practice and Community Midwifery Program outcomes.

### **Chair**

The Clinical Advisory Group will elect a Chair from its membership.



### **Membership**

Membership of the Clinical Advisory Group will be by invitation from CMWA for a term of 12 months and will consist of:

- 2 x Expert Midwife (Non CMWA)
- Obstetrician
- General Practitioner/Obstetrician
- CMWA Midwifery Coordinator (ex-officio).

### **Meeting Frequency**

The Clinical Advisory Group will meet on an as-needs basis. The Group will primarily maintain contact via email and telephone networks.

### **Operating Procedures**

- Meetings will be arranged on an as-needs basis by CMWA's Midwifery Coordinator.
- Case reviews will be conducted in a confidential manner and discussion of individual cases will not result in the identification of clients.
- The Clinical Advisory Group will invite input from appropriate practitioners and other stakeholders in order to fully review cases.
- Matters deemed by the CAG to be of a confidential nature will be recorded 'in camera' and will not be available for publication outside the Clinical Advisory Group and the CMWA Board of Management.

### 8.3 Appendix C: Summary of perinatal deaths (2000–2006)

Table 5: Summary of perinatal deaths 2000–2007 (PIMC Case Summaries available)

Case	Year of birth and code	Model of care	Comments	Type of death	Mortality classification using ANZACPM (PIMC)	Preventability score (PIMC)	Reviewers comments based on EQuIP functions, standards & criteria
1	2000 (100/00)	CMP	Planned homebirth – first baby. Healthy pregnancy. No screening for GBS. Commenced labour at home. Delay in 1 <sup>st</sup> stage. Transfer to Woodside Hospital. Emergency CS. GBS infection isolated at post-mortem.	Stillbirth	Not completed on form ?GBS infection	Low preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified – No screening for GBS (however this was policy at the time) <i>Systems supporting delivery of care:</i> Transfer time of 40 min; Use of homeopathy – unclear as to credentialling or training for this.
2	2000 (118/00)	Shared care – GP and IPM	Planned homebirth – second baby (first baby born at home in the UK). Healthy pregnancy. No screening for GBS. Spontaneous onset of labour. Normal fetal heart rate in labour (not listened for 30 minutes prior to birth at mother's request). Waterbirth – 2 midwives present. Baby made no respiratory effort – bag and mask resuscitation. Ambulance called. Transferred to hospital (from non-metropolitan area). Baby died 9 hours after birth. GBS infection isolated at post-mortem.	Neonatal death at 9 hours of age	Perinatal infection – GBS) (Cat 2.11)	Low preventability	<i>Direct Delivery Clinical Care:</i> No Risk factors identified - No screening for GBS (however this was policy at the time); Possible issues with fetal assessment in second stage

Case	Year of birth and code	Model of care	Comments	Type of death	Mortality classification using ANZACPM (PIMC)	Preventability score (PIMC)	Reviewers comments based on EQuIP functions, standards & criteria
3	2001 (124/01)	CMP	<p>Planned homebirth – first baby. Healthy pregnancy. Spontaneous onset of labour and spontaneous rupture of membranes at home. Visited by midwife in early labour (FHR 110–160/min). Midwife leaves and returns 2 hours later – no fetal heart heard. Transferred to hospital – Ultrasound confirms fetal death in utero. Labour augmented with syntocinon and progressed to normal birth (face presentation) – tight nuchal cord. No post mortem performed.</p>	Stillbirth	Not completed on form ? Peripartum asphyxia	Low preventability	<i>Direct Delivery Clinical Care:</i> Possible issues with fetal assessment in first stage although possibly understandable as seemed to be in early labour
4	2002 (019/02)	CMP	<p>Planned homebirth – first baby. Healthy pregnancy. Breech presentation diagnosed at 37 weeks. Two ECV's undertaken – both unsuccessful. Spontaneous onset of labour – transferred to hospital 4 hours in labour at home (cervix 7cm dilated). Fetal heart showing decelerations on CTG – parents reluctant to have CS. Much discussion and consultation - CS performed almost 3 hours later. Baby made no respiratory effort – considerable resuscitation efforts made. Baby died 15 hours later.</p>	Neonatal death at 15 hours of age	Hypoxic peripartum with intrapartum complications (Cat 7.1)	No preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified - breech at home <i>Systems supporting delivery of care:</i> Possible delay in transfer to hospital (75min transfer time); Possible lack of orientation and support for new midwives

Case	Year of birth and code	Model of care	Comments	Type of death	Mortality classification using ANZACPM (PIMC)	Preventability score (PIMC)	Reviewers comments based on EQuIP functions, standards & criteria
5	2003 (121/03)	CMP	Planned homebirth – third baby (36 years old). Antenatal screening (?NT scan) indicated high risk for chromosomal disorder. No further investigation undertaken on request. Gestational diabetes diagnosed at 28 weeks. Care in consultation with obstetrician. Ongoing regular antenatal care. Fetal death in utero diagnosed at 34 weeks. Induction of labour in metropolitan hospital. Baby's birth weight 1000gm. Postmortem showed multiple abnormalities including Trisomy 18.	Stillbirth	Congenital abnormality - chromosomal (Cat 1.5)	Not recorded – likely to be no preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified – high risk NTS and abnormal glucose screening <i>Systems supporting delivery of care:</i> Potential benefit in transferring care out of homebirth model due to aneuploidy – ie. protecting the model
6	2003 (170/03)	CMP	Planned homebirth – first baby. Healthy pregnancy. Reduced fundal height from 30 to 39 weeks (31cm at 39 weeks) although some discrepancy in the records – also recorded as 'term' fundus. Fetal death in utero diagnosed at 40 weeks. Induction of labour in metropolitan hospital. Baby's birth weight 2690gm. Postmortem showed multiple abnormalities including Trisomy 18.	Stillbirth	Fetal growth restriction (Cat 8.3)  ? congenital abnormalities - Trisomy 18.	Low preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified – discrepancy between fundal height and dates

Case	Year of birth and code	Model of care	Comments	Type of death	Mortality classification using ANZACPM (PIMC)	Preventability score (PIMC)	Reviewers comments based on EQuIP functions, standards & criteria
7	2004 (07/1/04)	CMP and GP shared care	Unclear whether booked homebirth as this woman was from a remote WA town and planned for transfer to tertiary centre at 36 weeks for birth. First baby. Routine antenatal care. Presented to local hospital at 32 with premature labour. Transferred to tertiary centre. Fetal death in utero diagnosed. Decided to travel home to remote town by private vehicle. Baby born en-route – returned to tertiary centre. Baby's birthweight 1120gm.	Stillbirth	Fetal growth restriction with evidence of uteroplacental insufficiency (Cat 8.1)	Not recorded – likely to be no/low preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified – preterm labour <i>Systems supporting delivery of care:</i> Potential risks in transferring home in private car and subsequent BBA
8	2004 (124/04)	CMP	Unsure from case summary as to planned place of birth. Previous caesarean section (first baby). Second baby – normal birth. This was her third baby. Admitted to hospital at 27 weeks with threatened preterm labour. Given Nifedipine and Celestone. Two days later while still in hospital – spontaneous rupture of membranes – complete breech presentation. Contractions commenced 5 hours later – fetal heart rate found at 60bpm. Progressed quickly to vaginal breech birth. Baby's birthweight 1400gms.	Stillbirth	Extreme prematurity with chorioamnionitis (hypoxic peripartum death)	Not recorded – likely to be no/low preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified – preterm labour <i>Systems supporting delivery of care:</i> Potential confusion between continuity model versus homebirth model

Case	Year of birth and code	Model of care	Comments	Type of death	Mortality classification using ANZACPM (PIMC)	Preventability score (PIMC)	Reviewers comments based on EQuIP functions, standards & criteria
9	2004 (248/04)	IPM	Planned homebirth. Third baby – both previous normal births. Healthy pregnancy, regular antenatal check-ups. At 39 weeks, she presented with absent fetal movements for 3 days. Fetal death in utero diagnosed. Induction of labour at local hospital. Baby's birthweight 3310gm.	Stillbirth	Unexplained with no examination of placenta (Cat 10.4)	No preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified – late ultrasound <i>Systems supporting delivery of care:</i> Potential risks in transferring home in private car and subsequent BBA
10	2005 (225/05)	CMP	Planned homebirth – second baby (vacuum extraction) Healthy pregnancy – routine antenatal visits with midwife and GP. Fundal height measured less than dates from 36 weeks (32cm at 39 weeks). Spontaneous onset of labour at 40 weeks. Midwife attended at home – fetal heart rate heard. Spontaneous rupture of membranes – difficult to locate fetal heart initially afterwards. Fetal heart rate heard 30 minutes later. Baby born one hour after SROM – pale and unresponsive. Ambulance arrived – baby transferred to hospital. No investigations performed to determine cause of death. Baby's birthweight 3000gms	Stillbirth	Hypoxic peripartum death with no intrapartum complications and no evidence of non-reassuring fetal status (Cat 7.1)	Not recorded – possibly Preventability Score 3-4	<i>Direct Delivery Clinical Care:</i> Risk factors identified – fundal height and dates discrepancy <i>Systems supporting delivery of care:</i> Late hospital booking

Case	Year of birth and code	Model of care	Comments	Type of death	Mortality classification using ANZACPM (PIMC)	Preventability score (PIMC)	Reviewers comments based on EQuIP functions, standards & criteria
11	2005 (321/05)	IPM with 2 GP visits and one obstetrician visit	Planned homebirth. Second baby (first baby born by caesarean section at 34 weeks due to APH). Healthy pregnancy. Spontaneous onset of labour at 38+6 weeks. Midwife arrived at 0730. Fetal heart heard during labour. Second stage commenced at 0900 – baby born at 0930 – no respiratory effort. Resuscitation commenced. Ambulance arrived and baby transferred to major metropolitan hospital. Diagnosed with HIE. Discharged home for palliative care aged 11 days. Baby died at 11 weeks of age.	Infant death	Hypoxic peripartum death – no causes (Cat 7.3).	Not recorded – possibly Preventability Score 3-4	<i>Direct Delivery Clinical Care:</i> Risk factors identified – VBAC; GBS positive on screening
12	2006 (058/06)	CMP	Spontaneous twin pregnancy – third and fourth babies. Routine US scan showed one baby to have lethal abnormality – renal agenesis. Referred to MFM specialists. Normal vaginal births at 39 weeks. Twin I liveborn and well. Twin II died at one hour of life as expected.	Neonatal death	Congenital abnormality – renal tract (Cat 1.3)	Not recorded – likely to be no preventability	<i>Direct Delivery Clinical Care:</i> Risk factors identified – Twins; congenital abnormality

CMP: Community Midwifery Program

IPM: Independent Practising Midwife

**Table 6: Summary of perinatal deaths 2000–2007 (No PIMC Case Summaries available)**

Case	Year of birth and code	Model of care	Comments	Type of death	Reviewers comments based on EQUIP criteria
13	2000 (164/00)	CMP	Planned homebirth. Second baby. Known Trisomy 18. Induction of labour at tertiary hospital	Unknown – ? stillbirth Lethal congenital abnormality	<i>Systems supporting delivery of care:</i> Potential benefit in transferring care out of homebirth model due to aneuploidy – ie. protecting the model
14	2001 (059/01)	CMP	Planned place of birth unknown. First baby. Known major hear defect and Trisomy 21 Spontaneous onset of labour at 30 weeks.	Unknown – ? stillbirth Probable lethal congenital abnormality	<i>Systems supporting delivery of care:</i> Potential benefit in transferring care out of homebirth model due to aneuploidy – ie. protecting the model
15	2001 (190/01)	CMP	Planned place of birth unknown. First baby. Trisomy 18 (unsure if known before birth) Born at home at 43 weeks gestation. Transferred to tertiary children's hospital and died 5 days later.	Neonatal death. Lethal congenital abnormality	<i>Direct Delivery Clinical Care:</i> Possible issues with post-dates management (43 weeks)
16	2002 (106/02)	CMP	Planned place of birth unknown. Fourth baby. Induced at 22 weeks gestation and born at tertiary hospital (unsure of reason)	Stillbirth. Prematurity – 22 weeks gestation	No issues identified
17	2005 (290/05)	CMP	Planned homebirth. First baby. Spontaneous onset of labour at 42 weeks gestation. Born at home – records suggestive of shoulder dystocia. Baby transferred to tertiary children's hospital and died 3 days later.	Neonatal death	<i>Direct Delivery Clinical Care:</i> Risk factors for shoulder dystocia identified – macrosomia, post-dates
18	2006 (116/06)	CMP	Unknown planned place of birth. Third baby. Known fetal abnormality – diagnosed at 16 weeks gestation. Baby born at 30 weeks gestation at tertiary hospital.	Unknown – ? stillbirth Probable lethal congenital abnormality	<i>Systems supporting delivery of care:</i> Potential benefit in transferring care out of homebirth model due to aneuploidy – ie. protecting the model
19	2006 (XX/06)	CMP	Limited information available. Known fetal abnormalities. Non elective caesarean section. Baby died at 8 days of age	Neonatal death. Congenital abnormalities.	<i>Systems supporting delivery of care:</i> Potential benefit in transferring care out of homebirth model due to aneuploidy – ie. protecting the model

## 8.4 Appendix D: Recommendations mapped against EQuIP 4

This Table maps the recommendations from this review against the EQuIP 4 Functions, Standards and Criteria.

	RECOMMENDATION FROM THE REVIEW	EQuIP 4 Functions, Standards and Criteria <sup>17</sup>
1.	Perinatal deaths in women choosing homebirth, particularly those that are determined or suspected to have occurred during the intrapartum period, be considered a sentinel event and subjected to Root Cause Analysis (RCA) by the appropriate clinical governance body for the service involved.	2.1, 2.1.1, 2.1.2, 2.1.3, 3.1,
2.	Midwives who work in homebirth practice and offer Complementary and Alternative Medicines (CAM) be appropriately educated and credentialled in their use.	1.1, 1.1.1, 1.1.2, 1.1.3, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.5.1, 1.6, 1.6.3, 2.2, 2.2.3, 2.2.4, 2.4, 2.4.1, 3.1, 3.1.3, 3.1.5,
3.	All ambulance requests for assistance at homebirths should be classified as Priority 1 by the WA St John's Ambulance Service.	1.1, 1.1.1, 1.1.2, 1.1.5, 1.1.6, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 2.1, 2.1.2, 3.1, 3.1.1, 3.1.4, 3.1.5, 3.2, 3.2.1, 3.2.4,
4.	The Statewide Homebirth Policy (2001) should be reviewed as a matter of urgency.	1.1, 1.2, 1.3, 1.4, 1.4.1, 1.6, 1.6.1, 3.1, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5,
5.	The Women's and Newborns' Network develop a policy with respect to the roles and responsibilities of childbearing women who choose homebirth, their support people and doulas in labour and independent practising midwives when women are transferred to from homebirth to hospital.	1.1, 1.1.1, 1.1.2, 1.1.5, 1.1.6, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.6, 1.6.2, 1.6.3, 2.2, 2.2.3, 2.2.4, 2.2.5, 2.4, 2.4.1, 3.1, 3.1.3, 3.1.4, 3.1.5, 3.2,
6.	The Women's and Newborns' Network develop policy in relation to women who choose homebirth and decide not to undertake selective antenatal tests and/or recommended management practices in pregnancy, labour and birth. This includes: screening for group B streptococcus and diabetes management of the third stage of labour decisions regarding newborn care including vitamin K, neonatal immunisations, newborn screening tests	1.1, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.6, 1.6.1, 1.6.2, 1.6.3, 2.1, 2.1.2, 2.2, 2.2.4, 2.4, 3.1, 3.1.1, 3.1.5,
7.	The process of developing and implementing the guidelines for the CMP must be expedited as a matter of urgency. In particular, the guidelines for clinicians must include clear direction in relation to: <ul style="list-style-type: none"> <li>■ Entry criteria for the CMP.</li> <li>■ Processes for consultation and referral and specific planning and documentation of decisions.</li> <li>■ Criteria for transfer to hospital.</li> <li>■ Roles and responsibilities of midwives after transfer to hospital.</li> <li>■ Criteria for observations in labour and standards for documentation.</li> </ul>	1.1, 1.1.1, 1.1.2, 1.1.5, 1.1.6, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.6, 1.6.3, 2.1, 2.1.1, 2.1.2, 2.2, 2.2.3, 2.2.4, 2.3, 2.3.1, 2.3.2, 2.4, 2.4.1, 2.5, 3.1, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5, 3.2, 3.2.1, 3.2.4,

	RECOMMENDATION FROM THE REVIEW	EQUIP 4 Functions, Standards and Criteria <sup>17</sup>
8.	The Department of Health WA implements a more robust system for maintaining the currency of the list of current practising independent midwives who provide homebirth services. Consideration should be given to this role to be transferred to the WA Nurses and Midwives Board in the future.	2.1, 2.3,
9.	The method of investigation employed by the Perinatal and Infant Mortality Committee (PIMC) for home and hospital births be strengthened by adopting the Perinatal Society of Australian and New Zealand (PSANZ) methodology of investigation, categorisation and reporting of perinatal deaths. <sup>18</sup>	2.1, 2.1.1, 2.1.2, 2.1.3, 3.1
10.	The WA Government amend the <i>Health Act 1971</i> Part XIIIB – Perinatal and Infant Mortality Committee to enable the consideration of, and action upon, broader system-level issues in their reporting including identification of contributing factors that are amenable to organisational change at home and hospital births.	2.1, 2.1.1, 2.1.2, 2.1.3, 3.1
11.	The WA Nurses and Midwives Board should consider legislation to ensure that midwives who provide homebirth services have access to professional indemnity insurance in order to maintain registration.	
12.	The WA Nurses and Midwives Board should consider a system of requiring annual Midwifery Practice Review or other forms of continuing professional development for renewal of registration for independent practising midwives.	1.1, 1.2, 1.3, 1.4, 1.5, 2.1, 2.2, 2.2.1, 2.2.3, 2.2.4, 2.2.5, 3.1, 3.1.4, 3.1.5,
13.	A formal facilitated risk assessment of the Community Midwifery Program be undertaken utilising AS/ NZS 4360: 2004 to ensure that adequate controls are in place and to identify any additional controls not covered by the terms of reference of this review.	1.1, 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.1.5, 1.1.6, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.5.1, 1.5.2, 1.6, 1.6.1, 1.6.2, 1.6.3, 2.1, 2.1.1, 2.1.2, 2.1.3, 2.2, 2.2.1, 2.2.2, 2.2.3, 2.2.4, 2.2.5, 2.3, 2.3.1, 2.3.2, 2.3.3, 2.4, 2.4.1, 2.5, 2.5.1, 3.1, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5, 3.2, 3.2.1, 3.2.3, 3.2.4, 3.2.5,
14.	Documentation standards for the CMP must improve in line with legal and professional guidelines. <sup>19</sup> This includes: <ul style="list-style-type: none"> <li>■ Documentation of the counselling and recording of the decision made by women in relation to antenatal screening including alternative strategies and management plans.</li> <li>■ Education programs need to be designed and implemented to address deficiencies in the standard of clinical documentation.</li> <li>■ Continuation of regular audits of the standard of documentation with the outcomes presented back to the CMP midwives.</li> </ul>	1.1, 1.1.8, 2.1, 2.2, 2.2.3, 2.2.4, 2.3, 2.3.1, 3.1, 3.1.5,

	RECOMMENDATION FROM THE REVIEW	EQUIP 4 Functions, Standards and Criteria <sup>17</sup>
15.	<p>Information for women who choose homebirth needs to be developed by the CMP in collaboration with the Women's and Newborns' Network. This should include information about</p> <ul style="list-style-type: none"> <li>■ Entry criteria for homebirth</li> <li>■ Safety and risks of homebirth</li> <li>■ Consultation and referral processes which may lead to hospital transfer</li> </ul>	1.1.2, 1.1.3, 1.1.6, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.6, 1.6.1, 1.6.2, 1.6.3, 2.1, 2.1.2, 2.2, 2.2.4, 3.1, 3.1.5,
16.	<p>A process for ongoing evaluation and annual reporting of outcomes and experiences of women who access the CMP needs to occur. This includes:</p> <ul style="list-style-type: none"> <li>■ A satisfaction survey to be undertaken independently on a regular basis.</li> <li>■ A robust and independent mechanism to manage complaints.</li> </ul>	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.6.1, 2.1, 2.1.1, 2.1.3, 2.2.3, 2.2.4, 2.3, 2.3.2, 2.3.3, 2.4, 2.4.1, 3.1,
17.	<p>The Perinatal Data Collection should be revised to provide a vehicle whereby women's choices and the outcomes of different models of care (e.g. planned homebirth) can be tracked and reported. A minimum data set is included in Appendix F. The outcomes should include morbidity for women who choose a home and hospital birth so that accurate comparisons can be made. The process for collating and publishing the outcomes from the Perinatal Data Collection should be appropriately resourced to ensure that the reports are published in a timely manner.</p>	1.1, 1.1.8, 1.2, 1.2.1, 2.1, 2.1.1, 2.1.2, 2.1.3, 2.3, 2.3.2, 2.3.3, 2.4, 2.4.1, 2.5, 2.5.1, 3.1,
18.	<p>All midwives, including independent practising midwives, need to be aware of the access to, and avail themselves of the opportunities for, continuing professional development including the management of obstetric and neonatal emergencies.</p>	1.1, 1.2, 1.3, 1.4, 1.5, 2.1, 2.2, 2.2.1, 2.2.3, 2.2.4, 2.2.5, 3.1, 3.1.4, 3.1.5,
19.	<p>Before the end of the current memorandum of understanding (MOU) between the CMWA and the NMAHS, the relationship between the CMP and its major stakeholders need to be explored to ensure that all elements of quality (including safety) are optimised. Clarification about the various clinical, administrative and governance roles and responsibilities needs to occur.</p>	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2.1, 2.2, 2.2.2, 2.2.3, 2.2.4, 2.3, 2.4, 2.4.1, 2.5, 3.1, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5, 3.2, 3.2.1, 3.2.3, 3.2.4, 3.2.5,
20.	<p>A Community Midwifery Program be established in the South West area (Bunbury and Busselton) as this area currently has women accessing homebirth outside the public health system.</p>	1.1, 1.2, 1.3, 1.4, 1.4.1, 1.6, 1.6.1, 3.1, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5,
21.	<p>All stakeholders be informed regarding homebirth and respect the choices that women make.</p>	1.1, 1.1.3, 1.1.6, 1.1.8, 1.2, 1.2.1, 1.6, 1.6.1, 1.6.2, 1.6.3,
22.	<p>All stakeholders recognise that women will exercise their choice to use water during labour which may also include a choice to give birth in water at homebirths and hospital births. To achieve this:</p> <ul style="list-style-type: none"> <li>■ policies and protocols to support the use of water for labour and birth should be developed and implemented.</li> <li>■ training and support should occur for midwives caring for women who use water during labour and birth.</li> <li>■ ongoing audit and evaluation should occur.</li> </ul>	1.1, 1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.5.2, 1.6, 1.6.1, 1.6.2, 1.6.3, 2.1, 2.1.2, 2.2, 2.3, 2.3.3, 3.1, 3.1.3, 3.1.5, 3.2, 3.2.1, 3.2.3,

	RECOMMENDATION FROM THE REVIEW	EQUIP 4 Functions, Standards and Criteria <sup>17</sup>
23.	All stakeholders recognise the need for strategies to address women's decisions in relation to their next birth after a caesarean section (NBAC) and develop models of care that support vaginal birth after caesarean section, particularly access to information, continuity of carer and a respect for women's capacity for decision making.	1.1, 1.1.1, 1.1.2, 1.1.3, 1.1.6, 1.1.8, 1.2, 1.2.1, 1.3, 1.3.1, 1.4, 1.4.1, 1.5, 1.6, 1.6.1, 1.6.2, 1.6.3, 2.1, 2.1.2, 2.2, 2.2.4, 3.1, 3.1.1, 3.1.3, 3.1.5, 3.2.1, 3.2.4,
24.	Hospital-based midwifery continuity of carer models (midwifery group practices) be established for women of all risk factor status so that women could have access to continuity and do not choose homebirth only as a means to access continuity.	1.1, 1.2, 1.3, 1.4, 1.4.1, 1.6, 1.6.1, 3.1, 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5,

<sup>17</sup> The EQUIP 4 Functions, Standards and Criteria are detailed in the first column in Appendix EAppendix E: EQUIP 4 mapped against Recommendations

<sup>18</sup> The Perinatal Mortality Special Interest Group of the Perinatal Society of Australia and New Zealand. (2009). Clinical Practice Guideline for Perinatal Mortality Audit, PSANZ

<sup>19</sup> See ANMC National Competency Standards for the Midwife (2006) for details on standards relating to documentation

### 8.5. Appendix E: EQUIP 4 mapped against Recommendations

This table maps the EQUIP 4 Functions, Standards and Criteria against the recommendations made as a result of the review.

EQUIP 4 Functions, Standards and Criteria		RECOMMENDATIONS																								
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	
<b>1. CLINICAL</b>																										
<b>1.1 Consumers/patients are provided with high quality care throughout the care delivery process</b>		✓	✓	✓	✓	✓	✓	✓				✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
1.1.1 The assessment system ensures current and ongoing needs of the consumer / patient are identified.		✓	✓	✓	✓	✓	✓					✓											✓			
1.1.2 Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.		✓	✓	✓	✓	✓	✓					✓	✓		✓								✓			
1.1.3 Consumers / patients are informed of the consent process, understand and provide consent for their health care.		✓										✓	✓			✓						✓				✓
1.1.4 Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.												✓											✓			
1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.				✓								✓														
1.1.6 Systems for ongoing care for the consumer / patient are coordinated and effective.				✓		✓						✓				✓						✓				✓
1.1.7 Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-













## 8.6. Appendix F: Minimum dataset for monitoring and audit purposes

The usual outcome data should continue to be collected. This will include:

- Gestation at first antenatal visit
- Complications in pregnancy
- Gestation at birth
- Onset of labour
- Mode of birth
- Complications in labour and birth (including postpartum haemorrhage)
- Perinatal mortality
- Admission to Special Care/Neonatal Intensive Care Nursery
- Congenital abnormalities
- Infant feeding initially, at discharge from hospital and at 6 weeks

Data on the selected model of care should be collected, preferably for all women, but particularly for women who choose homebirth. This should include:

- Preference for model of care at initial 'booking' visit
- Recommended model of care after initial booking' visit
- Intended model of care at end of pregnancy and onset of labour
- Reasons for transfer from intended model of care and timing

A series of key indicators in relation to transfer from homebirth model of care to hospital-based care during labour is also recommended. These should include:

- Timing of decision to transfer from home to hospital
- Reason for transfer
- Mode of transfer (ambulance, private car)
- Ambulance response time and priority
- Decision to assessment time at referral hospital
- Outcome of transfer – morbidity/mortality of mother and baby
- Length of hospital stay after transfer (mother and baby)



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