New Zealand Rural Hospital Network

NEWSLETTER

February 2013

CHAIRPERSON'S REPORT

Welcome to the first newsletter of 2013 for the Rural Hospital Network (RHN). As the first quarter of 2013 speeds along we are gearing up for the New Zealand Rural General Practice Network (NZRGPN) Conference; Let's get connected, which is being held 14 - 17 March 2013. I urge you to consider attending this conference, to network with your rural colleagues and to ensure you are a part of the future planning of rural health delivery in New Zealand.

The RHN continues its work and the executive board held a face to face meeting in Wellington towards the end of last year. We worked on the annual plan and the way forward for the board and its members. One thing that was obvious was that we need your help and support. If any of you have an interest in being a board member then now is the time to seriously think about it. Our inaugural AGM will be held on Thursday 14 March at the NZRGPN conference. If you would like to be a part of the board then please contact me directly or any of the other board members that are listed on our website.

Prior to the AGM we are holding a meeting with topics of interest in regards to working in rural hospitals. Please check out the conference website through the link on our website.

Do you have an interesting story about your hospital or department that you work in, or maybe even health topics about your community? This newsletter is your newsletter and if you have anything at all that you would like published or shared with anyone else please let me know and we will consider it for publishing.

Maybe you have a topic you would like more information about again get in touch. Finally a reminder to you all that we are on facebook, so check us out.

It is with sadness that we farewell one of our inaugural members, Norman Gray was the Manager of Lakes Hospital – Queenstown. Norman was an integral player in getting this Network off the ground. Norman had an amazing knowledge and we would not be where we are today if it was not for Norman guiding us in those early days. Norman has returned to the USA and his passion and drive for rural issues will be missed. We wish Norman well for the future and look forward to seeing him back on this side of the world in the not too distant future.

We look forward to talking to you face to face at the conference next month – so hope to see as many of you there as possible.

Jen Thomas
Interim Chair
Rural Hospital Network

New Zealand Rural Hospital Network

RURAL MIDWIFERY IN OAMARU - PART 2

BY JENNIFER WRIGHT

LMC Midwife at the Oamaru Maternity Centre

The last issue of the New Zealand Rural Hospital Network newsletter Part 1 of this article discussed the Oamaru Maternity primary birthing unit. The article gave an overview of the Maternity Centre and discussed how we work. A group of three Oamaru midwives initially presented this topic in Dunedin as "Lessons from Rural Practice" at the workshop entitled, Midwifery Practice: Lowering our Caesarean Section Rate, on the 9th of February 2012. The workshop was an opportunity to discuss lowering the Caesarean rate that is quickly reaching 30%.

When we accepted the invitation to present we were not certain how our statistics would look. As a group effort we reviewed our births from 2011 in Oamaru and our transfers to Queen Mary Dunedin Public Hospital in labour and prepared our PowerPoint presentation. We were pleasantly surprised, but suspicious of our numbers. We went through the numbers again and again with calculator in hand and a whole room full of Midwifery Standards Review Data sheets. The numbers kept coming up the same.

Part 2 of this article will explore the ambulance transfers of women in labour, present our calculated caesarean rate and summarize our statistics regarding Caesarean Section and safety of our primary unit. We reviewed the births from the calendar year 2011 beginning in January and ending with December 31 2011.

Establishing a Caesarean rate for a primary unit involves looking at the ambulance transfers in labour. Oamaru Hospital does not have a surgical theatre, we do not provide epidurals, nor do we have obstetricians or paediatricians.

The ambulance is our link to Queen Mary Maternity at Dunedin Public Hospital and the next level of care. Part of being in a rural setting is helping our families understand how the process of transfer works if the service is needed. We usually advise that it can take up to 40 minutes to get an ambulance (usually 20 minutes or less) and then the one and a half hour drive. The drive can be shortened to a little over an hour with no traffic, good conditions and the lights going in a true emergency.

In 2011 we had 146 labours start in Oamaru at the birth centre or at home. There were 15 transferred to Dunedin by ambulance that resulted in a birth there. This gives us an overall transfer rate in labour of approximately 10%. Of the women transferred in labour 53% had a normal vaginal birth shortly after arriving at Queen Mary. Eight women were transferred in early labour with either slow progress of first stage, long latent labour or maternal exhaustion (figure 1).

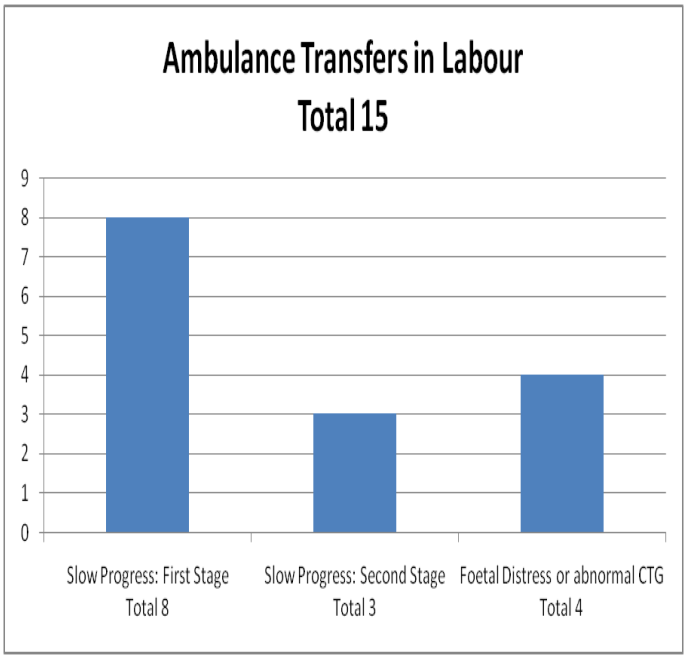

Figure 1

There were three women transferred with prolonged second stage and four that were transferred with abnormal CTG findings who were not in labour on evaluation but ended in birth at Queen Mary following transfer for Foetal Distress with either induction of labour or Caesarean.

The table below (Table 1) indicates the method of birth following transfer. Eight of the 15 women had normal vaginal births after transfer at Queen Mary, 4 had assisted births and 3 had Caesareans. This gives the Caesarean rate of **2%** for labours that began at Oamaru Maternity. This number really made us celebrate and then recalculate to make sure that was correct.

But, the statistic is limited in that it does not include all the women we look after. The women having homebirths or planned birth in Oamaru are low-risk healthy normal pregnancies. It does not account for our medically at risk pregnancies (gestational diabetes), elective and repeat Caesareans, postdates inductions, prolonged rupture of membrane inductions, planned Queen Mary births by choice and Vaginal Birth After Caesarean (VBAC) trials of labour. In order to calculate our overall Caesarean rate we must look at all the women we cared for in 2011. That total is 218 women with 72 intended Queen Mary Births (Table 2).

Total Women Looked after by Oamaru Maternity 2011

	Totals
Oamaru Births	131
Transfers resulting in birth	15
Queen Mary Planned Births	72
Total CS = 41	**218**

Table 2

In 2011 33% of the women looked after by Oamaru Maternity had their births in Dunedin. The Caesarean number is now 41 out of 218. The overall Caesarean rate is now **19%**. Another way to look at the number is that Caesarean Sections were the method of birth for 52% of the women who planned to birth in Queen Mary from Oamaru.

In order to understand these numbers and to consider how we can reduce the amount of women having Caesareans we explored the reasons for Caesarean Sections. As seen in Figure 2, (overleaf) the majority of our Caesarean Sections were Elective (73%).

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Outcomes of transfers in Labour

Reason for Transfer	NVB	Ventouse	Forceps	Caesarean	
Slow Progress First Stage long latent or maternal exhaustion	6	1	1	0	
Slow Progress Second Stage	2	0	0	1	
Foetal Distress or abnormal CTG	0	0	2	2	
Total	8	1	3	3	Total 15

Table 1

RURAL MIDWIFERY IN OAMARU - PART 2 CONTINUED

BY JENNIFER WRIGHT

LMC Midwife at the Oamaru Maternity Centre

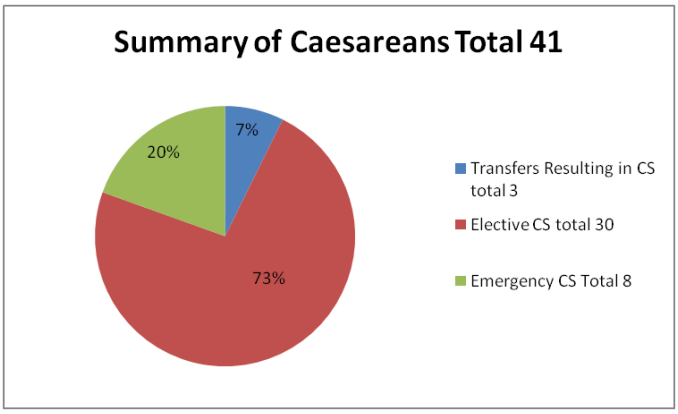

Figure 2

There were a total of 30 Elective Caesareans. An Elective Caesarean means it is scheduled in advance. The primary reason for Elective Caesarean was for repeat Caesarean (19 out of 41). This refers to women who have had a previous Caesarean and were advised and/or choosing to repeat the procedure. The other categories all make up primary Caesareans, the women may have had other births, but this was their first Caesarean. The next largest category in this group was for breech presentation (5 out of 41).

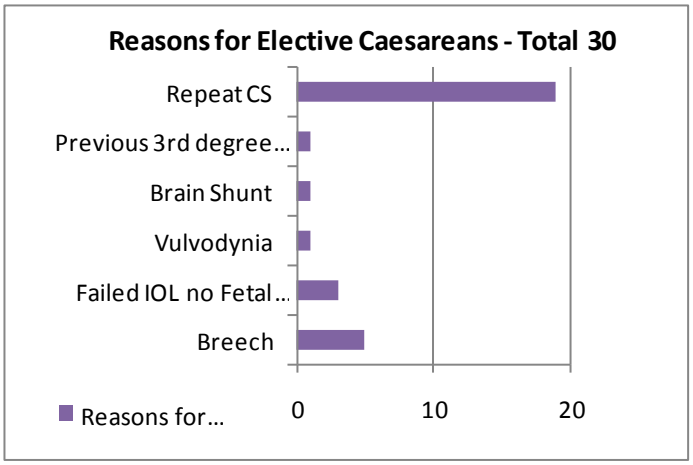

Table 3

There were eight Emergency Caesarean Sections (Table 4). The majority were for Inductions of labour with fetal distress. Interestingly we found inconsistency in calling a Caesarean Emergent or Elective in Failed Inductions of Labour in the absence of fetal distress. There were three classified as Elective and one Emergent.

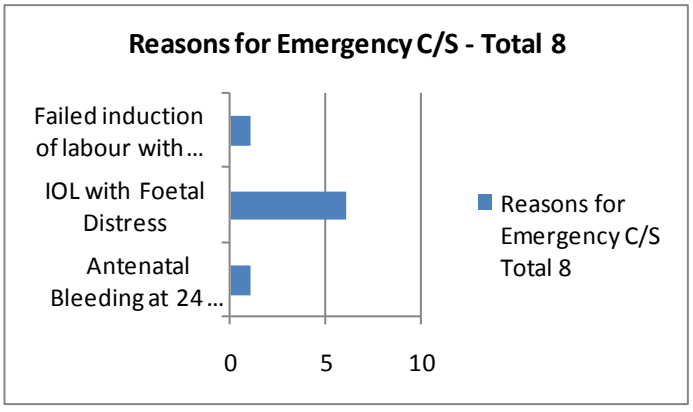

Table 4

Looking at the safety of our primary unit means more than just the Caesarean rate. We also evaluated our ambulance transfers for other reasons of women not in labour. There were 33 total ambulance transfers in 2011 (Table 5). There were five transfers for threatened premature labour (none of these resulted in birth). We had three women transfer with hypertension issues in pregnancy. We had four Neonatal transfers, three with signs of infection and one for bleeding post tongue-tie release in Dunedin.

Reason for transfer	Number
Maternal Infection antenatal	1
Preterm Labour	5
Hypertension issues in Pregnancy	3
Antenatal vaginal bleeding	1
Severe postpartum hemorrhage	1
Planned QM birth unable to drive herself	1
Post-spinal headache	1
Complicated tear	1
Neonatal:	3
Infection, respiratory distress syndrome	1
Bleeding post tongue-tie release	1
Transfer in Labour	15
Total:	33

Table 5

Conclusion:

In order to reduce our Caesarean Section rate we have to evaluate our women birthing in Dunedin. The most obvious category to decrease would be the elective planned repeat Caesareans which made up the majority of the Caesareans in our practice. We should be encouraging more VBACs.

This study is limited to just one calendar year. Was 2011 a lucky year? Did we transfer more or less compared to other years? In order to fully understand the Caesarean Rate of our primary unit a larger study is needed, of perhaps looking at a full decade.

This brief look at 2011 has intrigued my interest in further study. This interest is reflected elsewhere. In the June 2012 issue of the New Zealand College of Midwives Journal there is an article entitled, "What evidence supports the use of free-standing midwifery led units (primary units) in New Zealand/Aotearoa?" Under implications for study is a call for more New Zealand based research of primary units. Oamaru Maternity is not a "free standing birth centre"; it is associated with the hospital but is a primary birth unit lead by midwives. It potentially holds more evidence of safety to support birth outside the tertiary units.

The reality of Oamaru Maternity is positively reflected in the evaluation of our Caesarean rate for 2011. In 2011 a woman's risk of a Caesarean Section if she started her labour in Oamaru was 2%. That is really incredible. Coming from my American background where the Caesarean rate is well above 30% and out of hospital birth is less than 1% of all births, encouraging normal healthy women to birth in primary units is a fantastic way to keep the Caesarean rate down. The primary units are important to normalize birth.

Being born in your community ***is*** important for support of the new mother, her other children, the father and to maintain community services. Rural birth is safe.

In summary I will share a philosophy statement that hangs in our birthing room, it says...

"To speak of birth, to touch people's heart and souls and to awaken that part of humankind that has forgotten that it Matters Enormously how a baby comes into this world…that is our task."

NEW ZEALAND RURAL GENERAL PRACTICE NETWORK CONFERENCE 2013

The Rural Hospital Network is participating in the 2013 New Zealand Rural General Practice Network conference to be held in Rotorua next month. The conference is being organised in association with the RHN and will take place from March 14-17 at the Energy Events Centre, Rotorua. Pre-conference workshops will be held on Thursday, March 14, with the conference proper held on Friday and Saturday, March 15 and 16. The conference theme is "Let's Get Connected".

The event content will cater for a wide number of health professionals working in rural areas including staff working in rural hospitals. Some examples of sessions include: rural maternity, impact of Information Technology on rural hospitals and practices, use of Ultrasound and CT technology in rural hospitals, electronic prescribing, acute wound management, patient transport, and the use of technology in the community. In addition there will be presentations on up to 10 research papers.

On March 14 during the pre-conference day, the RHN is planning a forum dedicated to staff working in rural hospitals to share ideas, discuss challenges and learn from each others' achievements.

RHN will be holding a forum from 1.00pm - 4.30pm and the inaugural annual general meeting will be held at 5.00pm. We invite all members of the RHN to join us at our inaugural AGM.

The RHN is excited to be involved in the Rotorua conference and hope that it will offer members both a learning and a networking opportunity. Please mark your calendar to join us at the conference between March 14 and 17, 2013. The conference details are accessible through the RHN website www.nzrhn.co.nz.