

TRANSCRIPT

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

Inquiry into perinatal services

Melbourne — 27 November 2017

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Witness

Ms Mary McCarthy.

The DEPUTY CHAIR — I now call the next witness, Mary McCarthy.

Ms McCARTHY — Luckily I talk fast!

The DEPUTY CHAIR — You do not have to talk fast; we are good listeners! If you could just introduce yourself and begin your presentation, thank you.

Ms McCARTHY — Thank you. My name is Mary McCarthy. I am a midwife, a nurse and a unit manager of a women's emergency department in Victoria, and I have just come to talk about how we have developed up an obstetrics triage decision aid that we are rolling out at other services to see if we can improve access for women who present to health services with urgent problems.

I will just give you a little bit of an overview of the problem: it is that there is no standardised approach for women who present with a problem in their pregnancy. At most general hospitals, when you are under 20 weeks you go to the emergency department and when you are over 20 weeks you go to the maternity assessment unit or to some sort of thing that sits on the side of the birth suites. You get two different access points for your problem.

The problem when you go to the maternal assessment unit is it is run often by birth suite midwives who are all registered midwives but may or may not be registered nurses as well. The problem with them is that they are very good at making assessments for pregnancy-related problems but not for non-pregnancy-related problems if they have not had the training or do not have the expertise, like with chest pains or symptoms of meningitis and those sorts of things. There is also commonly not a structured approach. You arrive and you wait for your time to get seen. They take the person sitting before you, they assess that and then they come out and get you — so if you are the third or fourth person who arrives, you just have to wait until the first, second and third ones are done.

Conversely in the emergency departments you are triaged by a triage nurse, and the majority of them are nurses who have got no midwifery, and as we heard before, midwifery or obstetrics education is not even provided in nursing anymore. They actually do not have any understanding of pregnancy-related problems, so they have got the converse problem of what you have got when you go to the maternity assessment unit. They have difficulty recognising pregnancy-related problems. They are really good with your meningitis and your chest pains but they are not so good with your pre-eclampsia. They use the Australian triage score, which may not reflect the urgency of an obstetrics problem because it does not fit very well within the Australian triage scale.

What happens with us is that being an emergency department we have to fit into the Australian triage scale, which is what all emergency departments use. I am not sure if you are familiar with it. You know, it is when you get in the queue and you get triaged. Category 1 is an emergency; category 2 is you have to be seen within 10 minutes; category 3 is within half an hour; and categories 4 and 5 are as long as a piece of string. In our emergency department I tried to fit the Australian triage scale into the pregnancy assessment, and I really had a lot of challenges doing it; this was when it first got developed. It was very well assessed for its reliability, but at the end of it they had difficulty applying it to obstetrics, which is what I had. Over the years in trying to make us improve, I developed a triage tool for us to triage. With that, I managed to standardise the approach to triage in our department.

The triage scale is based on the Australian triage scale, and there are 10 common presenting problems, like PV bleeding and pain at greater than 20 weeks, headache in pregnancy and reduced movements in pregnancy. There are 10 presenting problems you can choose from and for each of them we embed a score. If you come in with a headache in pregnancy and if you have got blurred vision and epigastric pain, you get a category 2, which is looking for pre-eclampsia, but if you have got neck stiffness and photophobia, which is what you look for meningitis, you would get a category 2. It helps people to score a presenting problem.

Then what happened was I was able to demonstrate that we could standardise our approach. We got some funding from Better Care Victoria. We are just finishing up that project. We are going to use that to put it out into a general hospital and embed it into their emergency department for their maternity assessment unit. Then to get agreement on our triage scores, we have got an expert panel to do that with us.

We have just now finished the embedding of it, and we are doing the analysis right at this moment. But just in the maternity assessment unit, there was no data. There was no record of how long anybody really waits to get

any care, because it is not within any system. With an audit, we did an observation audit to show that the first-seen-by-a-midwife times varied from 3 minutes to 61 minutes and 33 per cent of women were seen within 15 minutes of arrival. We have now got up to 73 per cent of women triaged within 15 minutes of arrival. It means that they can work out their urgency and how long they should wait.

One of the areas we looked at was reduced fetal movement. So 28 per cent of the women who presented to the maternity unit have reduced movement and about 10 per cent of them are category 2, which means they would have no movement, and 85 per cent of them are category 3, which means they have reduced movement. It is really important with the movement that they actually get their monitor done, because every now and again it is a signal that they need treatment.

In the ED the data is still being analysed, but 70 per cent of women are now being triaged using the tool. When we looked at it, we looked at the nurses who were not using the tool: 20 per cent of them would have received a higher triage score if the tool was used, and for 20 per cent when you read their triaging, you could not actually give a score because they did not collect the appropriate information.

Our challenges were in the maternity unit, because we had to do a complete redesign. But also midwives do not understand the concept of triage, because they think triage is the whole assessment — the palpation, the VE and all that sort of stuff. In the ED, the challenges are that you have got to change their thinking, ‘Oh, she’s pregnant. You need to go and use the tool’. To achieve our change, we actually fed back to them all their near misses for them to understand and to explain why they would have got a higher score.

What is happening next is we are just about to complete the analysis. It has made an enormous difference to the services, particularly the maternity assessment unit. We are developing up software, which will be able to be scaled up within maternity services in Victoria. We are in the process of having that written.

The benefits of what we have done are that we think we have possibly got a standardised approach to pregnant and postpartum women coming with an urgent problem to a service, particularly in the rural areas, where you have got nurses who are triaging them having to make a decision — do they refer them on to an obstetric service because they do not have one in their local area?

We are looking at the possibility of developing up indicators for women who present because we have got no measures across Victoria for how long these women wait. We have just started measuring hours in our service, but we do not know what is out there and we do not know about the timeliness of the care or any measurement of the severity of the condition. What we really do not know is how long women routinely wait for assessment with an unscheduled problem. We are looking now at some services that have actually shown interest in using the tool to scale up. There you go.

The DEPUTY CHAIR — Thank you. That was very interesting. Where is your service?

Ms McCARTHY — Mercy Health. We did it down at Werribee.

The DEPUTY CHAIR — Fabulous. That is quite exciting.

Ms EDWARDS — I think you should get the Minister for Health to have a look at that fantastic initiative.

Ms McCARTHY — We have got some plans. We have just got to get the hard data out, and then we will be showing it to —

Ms EDWARDS — Hard evidence.

Ms McCARTHY — Yes.

The DEPUTY CHAIR — Excellent. Thank you.

Witness withdrew.