New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

Consultation on Draft Newborn Observation Chart and Newborn Early Warning system

Feedback from: New Zealand College of Midwives
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The New Zealand College of Midwives is the professional organisation for midwifery. Members are employed and self-employed and collectively represent more than 90% of the practising midwives in this country. The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues. Midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and well-being.

New Zealand College of Midwives
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22 August 2019

To: NEtaskforce@acc.co.nz

Dear NE Taskforce

Consultation on Draft Newborn Observation Chart and Newborn Early Warning Score

Thank you for providing the College of Midwives an opportunity to provide feedback on the draft Newborn Observation Chart (NOC) and Newborn Early Warning Score (NEWS). Midwives provide the majority of maternity care in New Zealand and there is a midwife present at the birth of each baby. It is midwives who undertake the majority of newborn assessments so it is important to ensure that the newborn observation chart and newborn early warning system meets the needs of midwives nationally. We have consulted with our members and would like to provide the following feedback.

1.0 Executive Summary

Consultation with our members has identified that whilst most are cautiously supportive of the newborn observation chart they consider changes are necessary for it to become incorporated into midwifery practice.

Essentially the chart is attempting to do 3 things:

1. Provide a national observation chart for all early neonatal assessments

2. Provide guidance and a place to record additional observations for babies at increased health risk

3. Ensure a consistent early warning system to identify and treat a baby whose health is deteriorating

Our members are supportive of having a nationally consistent chart where early routine neonatal assessments can be documented. They were also supportive of the vital observations of respiratory rate, work of breathing, temperature and heart rate as important baseline observations and an essential component of routine assessment but were concerned at the inclusion of feeding, colour, and behaviour within the vital observations chart because these are open to subjectivity.

Our recommendations are:

- That the observations of feeding and jaundice be removed from the chart

- That the additional observations of oxygen saturations, blood glucose, lactates, and newborn scalp check be labelled *additional observations as required following risk assessment*

- That the requirement to repeat the initial observations prior to transfer/discharge from a maternity facility be removed

Our members identified that the chart is 'very busy' and needs simplifying, and that this could be achieved by:

- Setting out the NOC as two sections – one titled routine observations (for the routine baseline observations), and one titled additional observations as required following risk assessment.

- Removing unnecessary words

- Simplifying instructions and referring to DHB guidelines where possible.

2.0 Substantive submission

2.1 College consultation process

The College has consulted with its members through our electronic portal, which enables all members to provide individualised feedback within a systematic process. All members are alerted to the need for feedback on a certain issue and a timeframe is provided. We asked our members to provide feedback on several different aspects of the documents – firstly the 8 routine observations, secondly the risk assessment and additional observations and thirdly the form itself and the early warning system. We provide the responses under those headings.

2.2 Newborn Health Assessment Observations

Members were asked whether they agreed with the 8 observations identified in the NOC as being necessary for all babies. The majority agreed with having respiratory rate, work of breathing, temperature and heart rate as important baseline observations for all babies and considered that these observations are a routine part of the newborn assessment. Therefore having a national observation chart where these could be recorded would be useful and would be well utilised.

There were concerns raised about the following observations: colour, behaviour, feeding and jaundice. Members raised the concern that behaviour, and feeding were subjective measures, lacked consistency and differ dependent on the age of the baby. However, they also identified that they were often useful indicators of health.

The jaundice section is problematic and caused some discussion –the NOC chart is a data record, and the jaundice observation is an advisory only. It was suggested that the jaundice section be moved to the back page as an advisory. Alternatively if it is to remain as an observation there should be separate boxes to complete to support assessment.

Feeding is an especially complex area to navigate as a routine simple assessment due to the variations in normal neonatal behaviour and variables such as sucking ability, milk transfer and milk availability etc. Midwives undertake a full breastfeeding assessment and identify a feeding plan dependent on the initial feed following birth and the continued feeding pattern in the first few days. This involves the quality of the feed, frequency of feeds, neonatal behaviour, and neonatal output. The feeding plan can change from hour to hour dependent on the mother and baby dyad and there can be major variation in feeds from one feed to the next. Whilst we understand that poor feeding behaviour can be a sign of sepsis and can also lead to poor neonatal health, our members are concerned that including feeding within the newborn observation chart as poor or normal does not recognise the complexity of a full breastfeeding assessment and that time needs to be taken to undertake a full breastfeeding assessment. They also questioned the rationale for including this parameter in a document that is designed to identify a baby who is rapidly deteriorating.

Members did not agree with the need to repeat a neonatal assessment prior to transfer or discharge from a maternity facility. They observed that if they had concerns about the baby's health prior to transfer/discharge then of course they would undertake a full assessment but felt it was unnecessary for all babies as a routine, and would add to their workload without a perceivable benefit. Retrievals from primary units were not identified as being problematic for other regions. The risk assessment process is expected to identify babies at increased risk who need additional observations, and should reduce the chances of babies being discharged or transferred inappropriately.

Parental concerns

Members were supportive the criterion of parental concern but also identified that escalation within 30 minutes may be problematic in rural and some provincial units.

Risk Assessment and additional observations

The majority of midwives agreed with the additional observations for babies at increased risk although there were concerns raised about doing some of these additional observations in a primary unit and the resources/equipment that would be required. The members also raised the question as to what evidence is being used to identify the frequency of additional observations.

Questions were raised about the advice related to measuring oxygen saturation identified on the form (for 3 minutes on the foot). There are different guidelines on how to undertake pulse oximetry as a health screen.

- Capital and Coast guideline – sensor placed on right hand and either foot – no time limits applied

- Star ship hospital – Pulse oximetry feasibility trial – either foot –no time limits applied

There is a need for consistency and we would suggest stating: *either foot and until a clear reading is recorded.* Our rationale is that there is no need for pre and post ductal readings and if the oxygen saturations are less than 95% then the midwife will keep the oximeter on the foot longer to ensure a valid result and will also repeat the test or escalate if it does not reach 95%.

General feedback – on chart and NEWS

Concerns were raised about the escalation pathways and the availability of paediatric/neonatal staff especially in rural and provincial areas. There needs to be clarification that the escalation pathway will be individualised to the context of the DHB services. We suggest that level 2 and 3 should read 'escalate according to local policy'. When asked about the general layout and clarity of the chart midwives identified that it was 'very busy' with a lot of information on one form. They identified the need to simplify the form and reduce the volume of words where possible. This could be done by:

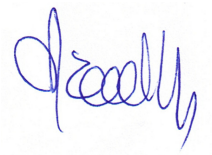
- removing feeding from the chart
- Separating into sections – routine observations and additional observations with clear labelling
- Moving the jaundice observation onto the back page
- Removing additional words – perhaps referring to DHB guidelines– rather than detailing specific expectations
- Change staff initials to clinicians signature/initials

Feedback on the form included comments on the use of plural (60's) for heart and respiratory rate – this is an unusual way of identifying the rate and feedback indicated a preference to change to a single number which corresponds with the lines on the chart.

Midwives also identified that there are currently a large number of forms that they are 'required' by the DHB to complete following the birth and that this form would be welcomed if it limits/reduces the number of other forms that were required to be completed. We suggest that as part of the introduction of this form that DHBs are required to review current maternity DHB documentation requirements to reduce unnecessary duplication of information requirement. We would also support digital data collection which could automatically populate forms so that data is entered once only.

Midwives identified that the NOC/NEWs was a useful tool to help identify babies becoming unwell but that it was important that clinical skills, assessment and critical thinking were also valued. We hope this feedback is of value and that the changes recommended are implemented.

Yours sincerely,



Alison Eddy
Chief Executive