REPORT OF
THE MATERNITY AND
INFANT CARE SCHEME
REVIEW GROUP
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PREFACE

The events of pregnancy, birth and infancy, which are the subject of the care scheme under review, are of the utmost importance to us all. Advances in medical knowledge and practice, combined with changing attitudes, require that arrangements for the provision of maternity care must be continually reviewed.

The Irish service was last reviewed in 1980. Much of the valuable recommendations made at that time have been given effect. The present Review Group examined that report and, to the extent that recommendations then made have not been acted upon, incorporated them in this report.

The views and rights of mothers were of course paramount in the consideration of the members of the Group and issues of choice, privacy, consent and information were considered and appropriate recommendations made.

The approach to maternity care has been the subject of much debate in recent times here in Ireland and to a greater extent in the United Kingdom. In the Irish context, the Review Group had available to it the 1992 study by Marie T. O'Connor on "Women and Birth" and the 1993 Report to Government of the Second Commission on the Status of Women. In the United Kingdom the Second Report of the Health Committee of the House of Commons on "Maternity Services" (The Winterton Report) and the comments and responses thereon by bodies both in the United Kingdom and Ireland were invaluable sources, which were supplemented by the Report of the Expert Maternity Group "Changing Childbirth". Each one of these reports is required reading for anyone involved in forming or implementing policy on maternity care.
The Review Group has not attempted any replication of the larger reports of the United Kingdom. It was established to review the current services and the members were moved to complete a review and make recommendations in a fairly short time. This was done within their own resources of time and their participation provided valid perceptions of all the players in the current scene.

On behalf of the Review Group, I would like to thank the Minister for Health for giving us the opportunity to participate in a process towards improving care for mothers and infants, and to thank all those organisations and individuals who went to the trouble of making submissions - both oral and written - to the Group. These assisted greatly in the formulating of opinion within the Group and found expression to one degree or another in our report.

On my own behalf, I wish to thank the organisations which made members available to sit on the Review Group, and also the members themselves who were unstinting in their contribution of time and attention in achieving the objective of completing their report within a year. In particular, I want to thank our indefatigable secretary Paul Howard whose work in research, at our meetings, and in preparing the report was invaluable.

The members of the Group hope that their recommendations will be acceptable to the Minister and the other parties involved and not least to the mothers and infants of Ireland who must be the focus of maternity care, and who must feel they are in control of what is happening to them and are able to make decisions about their needs, based on full discussion with the professionals involved.
In terms of current national spending on health services the recommendations in this report will not generate significant extra costs and the pilot projects recommended, which will be important for future policy and which were at the heart of much of the Review Group’s thinking, should not be unduly costly in a service which is so important to the whole community.

Peter McQuillan
Chairman
April, 1994
Chapter One

INTRODUCTION

1 TERMS OF REFERENCE

1.1 The Maternity and Infant Care Scheme Review was initiated by the former Minister for Health, Dr John O'Connell T.D., with the following terms of reference:

"To review the role of the Maternity and Infant Care Scheme in the context of maternity services generally and to make recommendations to the Minister as is considered appropriate."

1.2 MEMBERSHIP

The membership of the Review Group was as follows;

Chairman

Mr. Peter McQuillan

Members

Dr. Peter Boylan, National Maternity Hospital.
Dr. Gerard Cummins, Irish College of General Practitioners.
Ms. Nora J. Cummins, Institute of Community Health Nursing.
Ms. Maura Foran, Health Boards.
Dr. Elizabeth Griffin, Coombe Women's Hospital.
Ms. Dora Hennessy, Department of Health.
Dr. Peter Keogh, Irish Medical Organisation.
Dr. James Kiely, Department of Health.
Dr. Tom Matthews, Faculty of Paediatrics.
Dr. Madeleine McCarthy, Council for the Status of Women.
Ms. Anna Monaghan, Irish Nurses Organisation.
Ms. Berna O'Hanrahan, Council for the Status of Women.
Dr. Brendan Powell, Institute of Obstetricians and Gynaecologists.
Dr. James Reilly, Irish Medical Organisation.
Dr. A. N. de Souza, Health Boards.
Dr. Martin White, Irish Medical Organisation.
Mr. Paul Howard, Department of Health, acted as secretary to the Group.

1.3 Proceedings

The first meeting of the Review Group was held on the 17th February, 1993. It was agreed to attempt to complete the review within twelve months. The main Review Group met on 14 occasions. Further meetings were held by Sub-groups to discuss particular issues.

Advertisements were placed in the national newspapers inviting submissions. In the event, a total of 129 submissions were received and these are listed in chapter 12.

Papers on issues of concern to the Review Group were prepared and submitted by individual members or by groups of members, to facilitate consideration of key points and to assist in compiling the report.

The draft report was considered by the Review Group at a meeting in January, 1994 and approved in its final form on 23rd March, 1994.
Chapter Two
THE SCHEME

2.1 Legislation

The Legislation in regard to the provision of services for mothers and children is contained in sections 62 and 63 of the Health Act, 1970 as follows;

Section 62 (1) A health board shall make available without charge medical, surgical and midwifery services for attendance to the health, in respect of motherhood, of women who are persons with full eligibility or persons with limited eligibility.

(2) A woman, entitled to receive medical services under this section may choose to receive them from any registered medical practitioner who has entered into an agreement with the health board for the provision of those services and who is willing to accept her as a patient.

(3) When a woman avails herself of services under this section for a confinement taking place otherwise than in a hospital or maternity home, the health board shall provide without charge obstetrical requisites to such extent as may be specified by regulations made by the Minister.

Section 63 (1) A health board shall make available without charge medical, surgical and nursing services for children up to the age of six weeks whose mothers are entitled to avail themselves of services under section 62.

(2) Services under this section shall be provided for a child by any registered medical practitioner whom the parent of the child has chosen, who has entered into an agreement with the health board for the provision of those services and who is willing to accept the child as a patient.
In addition, section 61 (1) of the Health Act, 1970 states that a health board may make arrangements to assist in the maintenance at home of a woman availing herself of a service under section 62, or receiving similar care, or a dependant of such a person.

The Chief Executive Officer of the health board will determine whether a charge is levied in respect of any assistance provided under section 61.

2.2 Background to Legislation

The service provided for in the Act is largely a continuation of the scheme implemented under the Health Act, 1953, which was initially introduced for the lower income groups in 1954. As a consequence of the Health (Amendment) Act, 1991 women are no longer required to provide financial information to establish eligibility for services under the scheme.

The 1953 Act was enacted at a time when hospital confinements were less frequent and hospital in-patient accommodation for all mothers would not have been available. Referral by the general practitioner or "urgent necessity" was a prerequisite.

2.3 Services Available Under Current Scheme

The services available from the general practitioner free of charge to women under the current scheme are as follows:

1. Initial examination, to be made as near as possible to the sixteenth week of pregnancy, but not later than the twenty-eight week of pregnancy;

2. Five ante-natal examinations in addition to the initial examination (Where possible, at least one of these examinations should be carried out in each of the last three months of pregnancy);
3 Such other examinations and ante-natal care as the medical practitioner considers necessary;

4 Attendance at the confinement (if the medical practitioner considers it necessary, or if his/her services are called for by a midwife attending on the patient);

5 Attendance on at least one occasion in the week following the delivery;

6 Such other examinations and post-natal care within the period of six weeks after the delivery as the medical practitioner considers necessary;

7 An examination (including a bi-manual pelvic examination, if the general practitioner considers it necessary) at or about the end of the sixth week after delivery;

8 The taking of any specimens required for investigation;

9 Provision up to the age of six weeks in respect of each child whom he/she has agreed to accept as a patient, of such medical and surgical services (including at least one examination of the child) as can be appropriately given by him/her.

2.4 A medical practitioner is entitled to refuse to accept any particular patient, but he/she is not entitled to refuse to accept all patients of a particular class.

2.5 Obstetrical requisites, known as the "maternity pack" are provided in the case of domiciliary confinements.

2.6 The agreements with general practitioners and midwives are generally based on the pre 1970 form. The fees payable are advised by the Department of Health and the amounts paid are based on the level of service provided.

2.7 Midwifery services (consisting of initial antenatal visit, attendance of confinement and any other necessary care during the pregnancy, labour or lying-in period) are provided for under the scheme. Where a domiciliary birth is involved these services are provided, where available, either through health board domiciliary midwives or private
midwives who have entered into an agreement with the health board for the provision of services.

2.8 Instead of/or as well as availing of the ante-natal services provided under the scheme by general practitioners, women may also avail, free of charge, of outpatient ante-natal services provided at public maternity hospitals, regional hospitals and general hospitals.

2.9 USAGE OF SCHEME NATIONALLY.-1992

(a) In 1992, 27,809 women availed of services under the Maternity and Infant Care Scheme. This figure excludes women who had spontaneous abortions or miscarriages and represents 54% of the total number of births.

(b) 22,426 women, representing 81% of the users of the scheme had six examinations. 2,380 women (8%) had five examinations. 2,987 women (11%) had four or less examinations and 16 had no examination.

(c) 22,985 (83%) women had their first examination at or earlier than 4 months, 1,895 (7%) at 5 months, 1,990 (6%) at 6, 7 or 8 months and 1,023 (4%) during the final month.

(d) 27,033 or 99.5% of women in the scheme gave birth in hospital, 90 (0.33%) births took place in private maternity homes and 44 (0.16%) took place at home.

(e) Amongst the babies of women using the scheme there were 27,143 live births, 142 stillbirths and 61 deaths in the first week.

Additional information regarding the usage of the scheme is contained in appendix I.
2.10 PROPOSED REVISED SCHEME

The current range of services available under the scheme, as outlined earlier in this chapter, was examined by the Review Group.

* the Review Group considers it essential that each expectant mother is seen by a medical practitioner as early as possible in pregnancy and remains under medical and midwifery supervision throughout the ante-natal and post-natal periods.

Also, it is important that a woman is made aware of the other choices regarding the level and type of care that is available to her, where she receives this care and how and by whom this care is provided.

It goes beyond the remit of the Review Group to make specific recommendations regarding the level of remuneration of general practitioners and midwives providing services under the scheme. However, it is clear that consideration should be given to revising the level of remuneration, particularly in view of the additional responsibilities recommended in this report. Some of the difficulties associated with the present scheme are due to the level of remuneration and this must be addressed if the proposed revised scheme is to be successful.

2.11 COMBINED CARE

Combined care means that the expectant mother is under the care of both her general practitioner and hospital obstetrician and her care alternates between the two. The Review Group agrees that the system of combined care is the best and most convenient form of ante-natal care for the majority of mothers.
The Review Group endorses the schedule for visits and advice as proposed by the Irish College of General Practitioners and the Institute of Obstetricians and Gynaecologists and contained in the combined obstetric card (see appendix II).

2.12 SCHEDULE OF VISITS

* The schedule of visits recommended by the Review Group is

(i) before 12th week of pregnancy - first visit to general practitioner
(ii) before 20th week of pregnancy - first visit to hospital
(iii) 24 weeks - general practitioner
(iv) 28 weeks - general practitioner (hospital if its a first pregnancy)
(v) 30 weeks - general practitioner
(vi) 32 weeks - hospital
(vii) 34 weeks - general practitioner
(viii) 36 weeks - hospital
(ix) 37 weeks - general practitioner
(x) 38 weeks - hospital
(xi) 39 weeks - general practitioner
(xii) 40 weeks - hospital

It may be necessary for the woman or for the general practitioner or the obstetrician to change this schedule.
2.13 ANTE-NATAL SERVICES

In the operation of the present scheme, there would appear to be a degree of confusion, both on the part of general practitioners providing the service and women availing of the scheme, regarding the range and level of service which is to be provided to enable the general practitioner to fulfil the terms of his/her contract with the health board.

In this regard the following recommendations are made;

* an information booklet should be produced and made available both to doctors on entry to the scheme and to women using the service so that both will be aware of the nature and range of the services available under the scheme.

* provision should be made to include the diagnosis of pregnancy as part of the scheme and the cost of the pregnancy test kit should be reimbursable as part of the remuneration paid in respect of the scheme.

* general practitioners should ensure that a specified range of blood tests is carried out, as appropriate. The results of these blood tests should be made available to the hospital clinics. In order to prevent the unnecessary repeating of these tests, it is recommended that the general practitioner should send along the original copies of the blood reports and that these should be included with the combined obstetric card.

* information generated during the ante-natal process should be accurately and comprehensively recorded and transmitted to the hospital where delivery is to take place after it is collected in accordance with the agreed format contained in the combined obstetric card. The onus for this is on the general practitioner.
• treatment and advice in respect of the pregnancy and recognised complications of pregnancy should be provided by general practitioners as part of the scheme.

• consideration should be given to providing special payments in respect of major conditions such as diabetic care during pregnancy where this places extra demands on the general practitioner.

• it should be made clear in the information booklet that services, including drug and other treatment, in respect of illnesses which occur coincidental with but not related to pregnancy should not be provided as part of the scheme, free of charge.

2.14 CARE OF THE NEW BORN

Interpretation of the current scheme would suggest that there is unlimited care available to the infant up to the age of six weeks from the general practitioner. This was formulated at a time when the utilization of general practitioner services was much more limited than in recent years. It is clear that general practitioners have not been able to provide services on this basis in the recent past. Many general practitioners take the view that their commitment to the infant under the Maternity and Infant Care Scheme should be for a defined number of visits, with defined aims for care.

A corner stone of general practice is the continuity of care and the Maternity and Infant Care Scheme is a key element in this. It is important that continuity is maintained as soon as is practicable when the mother and new born infant leave the hospital. This facilitates a set agenda for anticipatory care with very defined aims. It would include areas such as growth, developmental review,
establishing parameters that would facilitate care for episodic illness and achieving designated goals in areas such as immunisation.

To facilitate these aims it is essential that a data base be established soon after discharge from hospital and that the general practitioner becomes familiar with the mother's experience while in hospital, her management of the newborn, her health status and that of her baby.

* The Review Group recommends that there should be two designated visits for the baby:

(a) within two weeks of birth  
(b) at six weeks of age

(a) The visit within two weeks would re-establish the link between the mother and the general practitioner and introduce the baby to this setting. It would enable the general practitioner to complete a data base, review hospital care, screening status, growth parameters and any current difficulties in management that the mother might have. It would be essential at this visit to discuss the options for immunisation so that decisions could be finalized at the six week visit and before the first immunisation at age two months.
(b) The six week visit would be a general health review and developmental examination and would give a second opportunity for percentile measurements. It would be a suitable time for review of current management such as feeding practices and any particular difficulties the mother and baby might be having and would also enable the parents to decide with the general practitioner on the proposed immunisation schedule.

It is essential for infant well-being and planned care that information and data is exchanged between primary care and directors of the public health programmes. A simple format that includes information on percentile measurements and developmental status at six weeks should be returned by the general practitioner to the Director of Community Care/Medical Officer of Health on completion of the Maternity and Infant Care Scheme.

2.15 POST-NATAL CHECK FOR MOTHERS

The Review Group recommends that a post-natal examination of the mother should be carried out by the general practitioner at six weeks. This will ensure that the general practitioner is provided with the opportunity to offer advice to the mother in relation to family planning and to provide follow-up management in relation to relevant issues which may have been raised during the term of the pregnancy e.g. rubella immunisation for rubella-negative women.

* a post-natal examination of the mother should be carried out by her general practitioner at six weeks.

While it is recommended that the examinations of the infant and the post-natal examination of the mother are carried out by the woman's general practitioner, they may be carried out at hospitals by arrangement.
Chapter Three

LOCATION OF BIRTHS

3.1 The Review Group notes that it is Department of Health policy that, on medical grounds, the delivery of babies should take place in consultant-staffed maternity units. This policy is in line with the recommendations of the Comhairle na nOspideal Report, Development of Hospital Maternity Services, which examined in detail the objectives of health care in relation to maternity services. It is generally accepted that this policy has been responsible for the marked decrease in the level of maternal, perinatal and infant mortality. The annual "State of the World's Children" report from UNICEF seems to indicate that Ireland is now the safest country in the world for women giving birth, with a maternal mortality rate of 2 per 100,000 births - the lowest of the 145 countries reported upon.

The Review Group also notes that it remains the view of the Institute of Obstetricians and Gynaecologists and the Royal College of Gynaecologists that the best place for delivery is where full emergency services are immediately available and accessible.

The Review Group fully endorses these views.

3.2 HOSPITAL BASED SERVICES

Many women are extremely satisfied with the care and treatment which they receive in hospital both during and after their pregnancy. However, based on the submissions to the Review, there is a growing demand by women for more freedom and choice with regard to where the delivery takes place, the level and type of intervention during labour, adoption of a birthing position of a woman's choice etc.
In order to reduce the risk of a woman undergoing a bad or negative experience while in hospital, which may impact on the level of demand for births at home, the Review Group recommends the following:

* adherence to the Patients Charter published in 1992 with particular reference to individual appointments for attendance at out-patients clinics.

* the establishment of a Charter for Pregnant Women.

* an assurance of a friendly atmosphere in hospitals where the dignity and autonomy of the mother is respected.

* openness with regard to information giving.

* a flexible approach to the length of time spent in hospital. This should be decided by the appropriate medical and midwifery personnel in consultation with the mother.

* the provision of creche facilities for older children at maternity clinics.

* the provision of hot meals to mothers who choose to avail of them following delivery.

The recommendations contained in Chapter 4, The Mother’s Voice, are also relevant in this regard.
3.3 HOME BIRTHS

Under section 62 of the Health Act, 1970, a woman is entitled to receive free medical, surgical and midwifery services in respect of motherhood. However, at present health boards are generally experiencing difficulties in providing services for home confinements. This situation has arisen because of the trend towards hospital confinements over the past 20-25 years. As a result the post of community midwife has virtually disappeared and general practitioners, who provide services under the Maternity and Infant Care Scheme, no longer have regular experience in the practice of delivery and are very reluctant to attend on home births. Because of this many general practitioners will not agree to accept a woman for medical services if she indicates that she intends to have a domiciliary confinement. In addition, general practitioners may find it difficult to secure medical indemnity insurance to cover attendance on home births.

In some areas no general practitioners will agree to provide services where home confinement is intended. The same is true for public health nurses. In these circumstances, health boards find it difficult to provide a service for domiciliary births.

There is however undoubtedly a demand from a small number of women to give birth at home. While it is known that there were 184 intentional home births recorded in 1991¹, it is difficult to assess the true demand for births at home because of the absence of domiciliary services on a nationwide basis.

¹ Planning Unit, Department of Health.
3.4 The Review Group recognises that when a decision is made by a woman to give birth in her own home, health service personnel should respect that decision and make provision for the mother and baby. The underlying objective of the Maternity and Infant Care Scheme continues to be:

(a) a safe outcome of a live and healthy mother and baby
(b) a satisfied and happy family unit.

The Review Group examined reasons why a woman might opt for a birth at home. Submissions to the Review Group suggest one of the main reasons is the desire on the part of a woman for a positive experience of birth in friendly familiar surroundings where she retains full control of her environment, her body and all procedures. Other important reasons are (a) previous negative experiences of childbirth in a hospital environment which may have been due to the woman’s perception of an unfriendly atmosphere, (b) an unwillingness on the part of hospital personnel to provide adequate information to her regarding many aspects of her pregnancy, (c) procedures carried out without adequate and informed consent and (d) removal of her dignity and autonomy.

3.5 * In response to these issues, the Review Group recommends that the following pilot projects be established and evaluated.

3.5a PILOT PROJECT I HOME ENVIRONMENT IN A MATERNITY HOSPITAL.

Accommodation be set aside at a number of maternity hospitals to facilitate delivery in a homely non-clinical environment where the mother would have freedom to move around and her partner and children would be welcome. Hospital support would be available for any emergencies that might arise. The mother and her baby would stay in or at the hospital only for a limited period of time before returning home.
While a birth in these circumstances would not be a home birth, such an arrangement may prove desirable for those women who would wish to have a delivery in a homely atmosphere but who would be afraid for whatever reason not to be close to hospital services.

3.5b **PILOT PROJECT II**

**MODIFIED DOMINO APPROACH**

It is recommended that a pilot domino project should be established. The Domino approach (Domiciliary Care In and Out of hospital) would allow the midwife and/or the general practitioner to monitor the mother throughout her pregnancy, be with her in hospital and to continue to provide her with care when she returns home. This approach would give the mother continuity of care, facilitate a hospital-based birth and provide an early return home from hospital.

It is recommended that this pilot domino project should be established for a period of two years.

This project would have the advantages of a hospital-based delivery and a community approach to ante and post-natal care. Ante natal care would be provided in the community by hospital-based midwives (and/or general practitioners at the choice of the mother) with hospital support available for any emergencies that might arise. Delivery would take place in hospital with assistance provided by the team of midwives who provided the ante-natal care and/or the general practitioner and hospital-based medical staff at the choice of the mother.
3.6 While these pilot projects, together with the recommendations at paragraph 3.2, may resolve some of the issues and may reduce the demand for home births, the Review Group recognises that there would continue to be a small number of women who, regardless of policy or professional advice, would insist on having a home birth.

The Review Group recognises the dilemma which confronts the Department of Health and the health boards at present in such cases. However, it is unacceptable that a woman should feel compelled to give birth alone or unassisted by a health professional or assisted by an unregistered person.

* to cater for women who cannot be persuaded to deliver in or at a maternity hospital/ unit, the Review Group recommends that each health board community care management put in place arrangements with the local maternity hospital/ unit to provide for a midwife to attend such home birth. These arrangements should be formalised and made known to users and providers.

Such an arrangement would ensure the availability of trained experienced midwives and the availability of hospital back-up in the event of an emergency.

In such cases appropriate post-natal care as outlined in the scheme would also be provided by the midwife.

* consideration should be given to the provision of appropriate training to hospital-based midwives to work in the community to provide the necessary services under the scheme.
3.7 EMERGENCY SERVICES

A number of submissions were made to the Review Group regarding the provision of "Flying Squad" and emergency services during pregnancy and domiciliary childbirth.

Emergency services may have to be provided for both planned and unplanned domiciliary births. The majority of emergencies that need to be dealt with include antepartum haemorrhage, threatened miscarriage, eclampsia, retained placenta, post partum haemorrhage, pre-term delivery, imminent delivery in unplanned domiciliary births, obstructed labour, cord prolapse and foetal distress.

The Flying Squad Service was introduced to provide surgical intervention to complete delivery outside of hospital. Surveys carried out in the U.K. showed that the call out rate was 1.3 to 2 per thousand deliveries and in over 80% of cases these retrospective reviews suggested that the call involved no more care than controlled transfer of the woman to hospital.

In the U.K., the Royal College of Obstetricians and Gynaecologists published a report in April, 1990 entitled, "The Future of Emergency Domiciliary Obstetric Services". The report suggested that the Flying Squad should be replaced by para-medical teams of ambulance personnel with extended training. The suggestion arose after several surveys had demonstrated a low Flying Squad call out rate, about two per thousand deliveries and very little need for operative delivery. But there remains a need for domiciliary blood transfusion and midwifery services.
One of the surveys described the Flying Squad as an expensive and potentially dangerous practice in modern obstetrics. In 70 cases that they analysed, where the Flying Squad was called, their assessment was that none of these calls was necessary and in 16 cases, the Flying Squad call had delayed treatment and had actually endangered life. The time taken by the Flying Squad was approximately three to ten times the time it would have taken a normal ambulance service to bring these patients to hospital.

The original aim of the Flying Squad service, i.e. to carry out domiciliary procedures and to transfer to hospital only those who needed further treatment, was not being adhered to and in all the U.K. reviews that were studied most of the women were transferred to hospital even though there was no residual problem.

The surveys also showed that 71% of the calls were before 09.00 or after 17.00 hours, which meant that most of the calls occurred when there were only "on call" staff in the hospital. Removing skilled and experienced staff increases the risks for those already under their care in the hospital. The average time a skilled doctor is away from hospital attending a call was 63 minutes with a maximum of 120 minutes.

While most of the surveys examined referred to urban areas, the Review Group believes that with an adequate ambulance service there is no need for a special Flying Squad service to be established even in rural areas.
Having examined the issue of the introduction of a Flying Squad service, the Review Group concludes that it is not necessary to develop a special Flying Squad service. Instead, it is recommended that

* the normal ambulance service in the local areas should be expanded and members of the ambulance team be trained to deal with obstetric emergencies and the safe transport of patients to hospital.

The Review Group notes that the report of the Review Group on the Ambulance Service, published in December 1993, recommends the introduction of an advanced training programme for ambulance personnel to include training in a paediatric department and labour ward and a pilot paramedical programme to further develop advanced life support skills.

3.7a The Review Group also recommends the following;

* general practitioners and midwives should be skilled in resuscitation and treatment of shocked patients and the resuscitation of the newborn.

* general practitioners should be provided with equipment to deal with obstetric emergencies. This equipment is listed at Appendix III.

* ambulances should be equipped to enable intravenous fluid replacement treatment to be provided by a doctor or a nurse with appropriate training.

* general practitioners and midwives or the para-medical team should have direct access to a hospital based obstetrician who could give telephone advice and to this end there
should be a designated line on each labour ward which is reserved for emergency use.
Chapter Four
THE MOTHER’S VOICE

4.1 It has been submitted that the mother’s voice is sometimes lost in the organised hospital situation and the Review Group feels that it is important to specify ways of ensuring that the mother’s rights are protected and her views taken into account. In particular these relate to situations where informed consent is required or choice may have to be made.

4.2 BIRTH PLAN

In submissions to the Review Group, many women expressed annoyance at the manner in which decisions are taken in hospitals and stated that they felt left out of the decision making process.

Women should be provided with the opportunity to discuss all aspects of the birth with hospital staff during ante-natal visits to the hospital. Towards this end and to facilitate the needs and preferences of a woman,

* the Review Group recommends use of a birth plan, such as that outlined in appendix IV.

The process of completing a birth plan during ante-natal visits to the hospital would provide an opportunity for discussion on the preferences of the woman during labour and childbirth and is designed to inform staff of a hospital of the preferred options of a woman during her stay in hospital.

* it is recommended that the options provided in the birth plan, including policy in the event of an emergency, should be explored during ante-natal visits to the hospital.
4.3 CONSENT FOR INTERVENTION

Informed consent can only be given in the light of full knowledge. It should never be assumed that a mother is aware of what various procedures entail. The Review Group recommends that

* clear information should be given by professionals when intervention is indicated and in the case of specific procedures being necessary these must be explained on a step-by-step basis.

* there should be an acceptance by professionals of the right of a woman to refuse an intervention.

A woman needs to be involved in the decision-making process during pregnancy, labour and childbirth, and her formal consent should be obtained for all specific interventions which have been explained to her.

* the use of technology should take place only with the full informed consent of a woman except in cases of emergencies.

4.4 RESEARCH / CLINICAL TRIALS

While it is recognised that research and clinical trials are essential to the advancement of improved practices, the Review Group recommends that

* the consent of a woman must be sought early in pregnancy if she is being requested to participate in research and/or a clinical trial.

* where a woman decides not to participate in research and/or a clinical trial, her decision must be respected.
4.5 PRESENCE OF STUDENT DOCTORS AND MIDWIVES

Some women and their partners may be unhappy about the presence of student doctors and midwives during labour. The good standards of obstetrical services available in Ireland are to a large extent the result of the education and training student midwives and doctors receive.

* it should be explained to the woman on admission that there may be students in the labour ward/ delivery suite, the reasons why the students may be there and that the woman has a right to refuse to participate in the teaching of medical and midwifery students.

4.6 USE OF EPIDURAL/ SPINAL ANALGESIA.

Epidural/ Spinal analgesia may be recommended by the obstetrician as part of obstetric management such as;

- in the reduction of blood pressure in cases of pre-eclampsia.

- malpresentation, such as breech, in order to prevent early expulsive efforts.

- where operative intervention is necessary.

The Review Group recommends that;
* epidural/ spinal analgesia as a form of analgesia in labour should be made available to a woman if she chooses.

* ante-natally, all possible risks and side effects should be openly discussed with the woman so that she makes her choice for epidural/ spinal analgesia having been fully informed. In addition, her consent should be obtained prior to administration.
where epidural/spinal analgesia is inappropriate or contra-indicated the reason for this should be explained to the mother.

* methods of analgesia, other than epidural, should be made available where appropriate.

4.7 COURTESY AND KINDNESS

Each mother’s experience of birth is unique. The attitudes of staff do affect the mother’s perception of that event. Kindness and courtesy impact positively on her experience and greatly facilitate her mothering role.

4.8 CLIENT REPRESENTATION IN HOSPITALS

Consultation with mothers is vital for the provision of a high quality maternity service. The Review Group recommends

* the establishment of client groups in maternity hospitals/units to plan and monitor services.

Each client group should have representation from recently confined mothers in the unit, as well as representation of senior management, medical and midwifery staff and a general practitioner representative. It is suggested that each group should be appointed for a maximum period of between 3 and 5 years.
Chapter Five

SPECIAL NEEDS

5.1 In this chapter, the review group addresses a number of issues, contained in submissions to the review group, which were of major concern to women but which it is felt are not directly related to the Maternity and Infant Care Scheme.

5.2 LEAVE TO ATTEND ANTE-NATAL CARE

The Review Group notes that under the Maternity Protection (Time off for Ante-Natal and Post-Natal Care) Regulations, 1981, an expectant mother is entitled to time off work to attend ante-natal and post-natal medical visits or care. Under these Regulations, a woman is entitled to time off work for medical or related appointments during the period of 14 weeks immediately after the confinement. Accordingly, it is important that all employers are fully aware of their obligations and employees of their entitlements with regard to attendance at ante-natal and post-natal clinics. In addition, the Review Group recommends that

* An expectant mother and her partner should be entitled to time off work to attend ante-natal classes.

5.3 REGISTRATION OF STILLBIRTHS

A number of submissions to the Review Group referred to the urgent need for the establishment of a stillbirth register to help parents to cope with the grief experienced at the loss of a new born. A number of maternity hospitals and units already operate in-house registers of their own.
The Review Group welcomes the enactment of the Stillbirths Registration Act, 1994 which allows for the comprehensive registration of stillbirths.

5.4 Genetic Counselling Service

A genetic disorder is any medical disorder which is due to a defect in a gene or group of genes. In many cases the risks of inheriting the gene involved can be accurately specified and the family provided with genetic counselling.

In this country, genetic counselling is available to a limited extent within paediatric hospitals and units and in obstetric hospitals and units. In addition, genetic screening and testing facilities are available in the major University Hospitals. Integrated medical genetic services do not exist in this country at the moment and many people travel to Belfast and overseas to obtain advice and counselling.

The Review Group welcomes the recruitment of a Consultant Medical Geneticist/Professor of Human Genetics to head up a medical genetic service which is to be based at Crumlin Hospital, Dublin. It is expected that the service will commence in 1994. The service, which will be backed by a medical genetics laboratory, will provide non-directive counselling i.e. decisions will be made by the patient in consultation with the counsellor having regard to the facts and the treatment options available.

The Review Group recommends that

* a genetic counselling service should be made accessible to all people who need it as soon as possible.
5.5 **DENTAL SERVICES FOR EXPECTANT MOTHERS.**

5.5a **Health Board Services for Adults**

Medical card holders and their dependants are eligible for dental treatment provided by the health boards. Health Board dental services are provided at present by dentists employed by the boards and to a limited extent by private dental practitioners under arrangements made with health boards.

All areas provide emergency treatment for the relief of pain and infection. The provision of an adult dental service falls short of what is required. Pregnant and nursing mothers are afforded a priority within the limitations of the existing service.

A programme for the phased development of the dental services is being prepared. Particular attention is being paid to the provision of an adequate service for adult medical card holders and to the position of priority categories within this group such as pregnant and nursing mothers.

* The Review Group recommends that in any future discussions on the development of dental services for medical card holders, pregnant and nursing mothers should be considered a priority group for treatment.

5.5b **Department of Social Welfare's Dental Treatment Benefit Scheme**

The Department of Social Welfare's Dental Treatment Benefit Scheme is a scheme under which a person may qualify for assistance towards the cost of dental treatment. To qualify for benefit a person must satisfy income and PRSI contribution conditions.
Since 1987 the Department of Social Welfare Treatment Benefit Scheme allows a "dependant" spouse of an eligible person to qualify for treatment benefit. Pre 1987 only qualifying persons and pregnant spouses of eligible persons were qualified to receive benefit.

A person who is supported by a spouse can obtain treatment benefit on his/her income and PRSI record provided he/she satisfies the qualifying conditions.

* the Review Group recommends that expectant and nursing mothers should have priority access to dental treatment through the Department of Social Welfare’s Dental Treatment Benefit Scheme.

5.6 MOTHERS WITH SPECIAL NEEDS
The Review Group feels that the services provided under the scheme meet the needs of mothers generally but some groups of mothers may have special needs which should be dealt with as flexibly and adequately as possible. It is important that services reflect the requirements of women with special needs. These women may be found among (a) single mothers (b) travellers, (c) people with a mental handicap (d) people with a physical disability and (e) people with significant illnesses such as AIDS/ HIV.

The Review Group recommends that

* service providers should ensure that the requirements of women with special needs are recognised and dealt with as flexibly as possible.

* care should be planned jointly with the woman and any appropriate specialists according to her individual needs and wishes, in the same way as for other pregnant women.

* women with special needs should be provided with support services, including home help, as required.
5.7 **SCREENING FOR METABOLIC DISORDERS**

The Report of the Metabolic Disorders Working Group which reported to the Minister for Health in 1993 recommended that screening for metabolic disorders must be considered an integral part of the management of newborn infants. Screening involves the co-operation of many agencies i.e. community care teams in health boards, maternity hospitals, the National Neonatal Screening Laboratory at Temple Street Hospital and general practitioners.

In relation to early discharges from hospital, the Working Group recommended that the nurse/midwife discharging the infant from hospital before the test has been carried out should ensure that the mother is clear about the following matters;
- the importance of the test
- when it should be done
- that the test should be carried out
  - (i) at the maternity hospital, or
  - (ii) by a public health nurse, or
  - (iii) by a general practitioner

The recommendations of the Report of Metabolic Disorders Working Group in relation to early discharges from hospital are contained in Appendix V of this report.

5.8 **CERVICAL SCREENING**

A number of submissions to the Review Group recommended that cervical screening should be carried out as part of any revised scheme.

The Group is aware that the Cervical Screening Committee is examining all aspects of the cervical screening service and its report is expected in the near future.
Chapter Six

LIAISON AND ADMINISTRATIVE ARRANGEMENTS

6.1 There should be close liaison between the various groups providing care under the scheme. Good communication is an essential part of good medical care. In this chapter, recommendations are made aimed at improving the level of communication between the various health professionals and agencies providing services under the scheme.

6.2 Liaison between the hospital and the general practitioner.

* the application for services under the scheme should always be made through the woman's general practitioner and this should be brought to the woman's attention by hospital staff.

* where a woman is referred to hospital, the general practitioner should ensure that all relevant medical and other details are contained in the combined obstetric card and that this information is supplied to the hospital.

* hospitals should ensure that they are aware of the name and address of each woman's general practitioner and that a letter is sent to the general practitioner with all relevant medical and other details on the outcome of the pregnancy.

* where this is not already the practice, arrangements should be made for periodic meetings of general practitioners with hospital staff, eg. study days or conferences, to promote and improve liaison.
6.3 Liaison between hospital and the Director of Community Care/Medical Officer of Health.

* the Director of Community Care/ Medical Officer of Health (D.C.C./M.O.H.) should be notified immediately of all births in hospitals and ensure that the public health nurse visits the mother and baby within twenty four hours of discharge from hospital. It is particularly important that Directors are informed about the health status of each baby and in particular babies with serious morbidity such as congenital abnormalities. It is important also that there is rapid notification of perinatal deaths to the Director.

* the D.C.C./M.O.H. should be informed of any case where the six week examination of the infant is carried out by a hospital. The results of these examinations should be notified to the Director in an agreed format with particular attention being paid to any abnormalities found.

* the D.C.C./M.O.H. should notify the hospital, in an agreed format, of any significant abnormalities which are found during developmental examinations.

* the D.C.C./M.O.H. should visit maternity hospitals with a view to establishing closer links with the obstetricians and paediatricians and to discuss methods of improving communication between the service providers. This is particularly important because of the relatively short period mothers now spend in hospital after the birth.
6.4 **Liaison between the D.C.C./M.O.H. and the general practitioner**

* any abnormalities found by the general practitioner at the six week examination of the infant should be supplied, in an agreed format, to the Director.

* where any examination of the infant is carried out by an Area Medical Officer, a copy of the report must be sent to the infant’s general practitioner. The general practitioner should also be informed of any problems which are discovered during visits by the public health nurse.

6.5 **Role of the public health nurse**

At present, the degree of involvement of the public health nurse in the provision of ante-natal care varies from area to area.

When an expectant mother applies for services under the Maternity and Infant Care Scheme she should be informed of how to contact the public health nurse and the public health nurse informed of the woman’s name, address and phone number.

* the Review Group recommends that where a mother indicates in the application form for services that she wishes to be contacted by the public health nurse during her pregnancy, there should be an agreed level of service provided by the public health nurse.

Services provided by the public health nurse would include;

(a) health information relating to pregnancy and to the post pregnancy period, parentcraft and advice on
dealing with problems of the normal infant and child. This information could be provided on a one-to-one basis or through organised clinics depending on the area.

(b) attendance at ante-natal clinics organised by obstetricians from local maternity hospitals/units.

(c) metabolic screening of infants.

(d) early and frequent visits to mothers with special needs.

It is recognised that public health nurses are well placed to identify deviations from the norm in the development of each baby. At present, they refer those babies to either the general practitioner or the Area Medical Officer or both for further care.

* it is recommended that the public health nurse should refer infants under six weeks with abnormalities to the infant’s general practitioner.

* it is suggested that a public health nurse should be assigned the responsibility of ensuring that all discharges are notified promptly to the public health nurses working in the community.

6.6 Role of the domiciliary midwife

The Review Group recognises the essential role of existing midwives who are providing a domiciliary service to a small group of women. It is recommended that

* domiciliary midwives should continue to liaise closely with other health professionals. All domiciliary births attended by midwives should be notified immediately to the Director of Community Care and Medical Officer of Health.
Many submissions to the Review stated that many women wishing to give birth at home find that they are not in a financial position to do so because of the significant difference between the fees charged by the midwife and the level of payment made by health boards.

The Review Group recommends that

* the level of payment made to midwives who provide domiciliary services on behalf of health boards should be reviewed.

6.7 ADMINISTRATIVE PROCEDURES

6.7a Combined Obstetric Card

The Review Group examined the combined obstetric card, (see appendix II), as produced by the Irish College of General Practitioners and the Institute of Obstetricians and Gynaecologists. The Review Group recommends

* use of the combined obstetric card, which has been introduced on a pilot basis, should be established on a national basis as soon as possible.

6.7b Improved Application Form

Arising from the Health Amendment Act, 1991, any woman who is ordinarily resident in Ireland is entitled to avail of services under the Maternity and Infant Care Scheme. The Review Group is satisfied however that it is necessary that a written application, (see appendix VI) be made to the local health board for the following reasons;
(a) The applicant must show that she has been accepted for services by a general practitioner and that the general practitioner who has accepted her has a contract with the health board for provision of services under Section 62 and 63 of the Health Act, 1970.

(b) The health board must ensure that the applicant meets the residency requirements for eligibility for health services.

(c) Early application to the health board facilitates provision of information to the applicant on services available under Section 62 and 63 of the Health Act.

(d) Each health board, which is responsible for providing services under Section 62 and 63 of the Health Act must have access to all statistical information to monitor and review the scheme and also to establish its financial commitments on an ongoing basis.

The Review Group recommends that

* the revised application form for services, as outlined in appendix VI, should be introduced.

* in recognition of the important role of the public health nurse in health promotion during pregnancy, it is recommended that a section should be included in the revised application form for services, which is filled in by the woman and her general practitioner, requesting consent from the mother for contact to be established with the public health nurse.
6.8 BETTER PROCEDURES.

The Review Group is satisfied that improved agreed administrative procedures recommended throughout this report would ensure that:

- each expectant mother is aware of the need for, and the procedure for applying for the services to which she is entitled under Section 62 and 63 of the Health Act.

- each medical practitioner who wishes to provide services under Section 62 and 63 of the Health Act is aware of the procedure for entering into a contract for the provision of the services and of his/her responsibilities under such contract.

- the health board is aware of all persons availing of maternity services and is provided with all statistical information on a timely basis.

- claims from general practitioners for fees for services provided are made to and paid by the health boards within the period specified at paragraph 7.7(d).

The following procedures are recommended.

(a) Doctors Agreement

* any doctor who wishes to provide Maternity and Infant Care Services under Section 62 and 63 of the Health Act, must enter into an agreement with the health board.

* general practitioners should complete an application form which should inter alia give details of registration with the Medical Council and medical defence cover.
* the health board should satisfy itself that there is no reason why a general practitioner should not be given a contract with the health board for providing maternity services.

* the health board should issue the general practitioner with an agreement form and a copy of the terms and conditions of the agreement.

* the health board should send a copy of the signed agreement to the general practitioner together with a supply of application forms for services under the scheme, combined obstetric cards and relevant information leaflets.

(b) **Midwives Agreement**

* midwives who wish to provide services under Section 62 of the Health Act must enter into an agreement with the health board.

* when the agreement is signed by the health board a copy incorporating the terms and conditions of the agreement should be sent to the midwife.

(c) **Application for Services**

* hospitals should advise women that application for services under the Maternity and Infant Care Scheme should be made through their general practitioner.

* when pregnancy is confirmed the general practitioner should advise the expectant mother as to her eligibility for maternity services under the Health Act and arrange for the completion of the revised application form by the applicant for early submission to the health board.
the health board should record date of receipt of application and if in order, send letter of approval for services to applicant without delay, together with a leaflet setting out details of services available under the scheme. The name and telephone number of the public health nurse should also be given.

the health board should advise the general practitioner that the applicant has been approved for services. The general practitioner should also be advised that, unless there are special circumstances, payment will not be made for services provided more than 28 days before the date of application for the service or for claims received more than twelve months after the completion of the service to the application.

a procedure should be introduced to allow for the retrospective application for services in the case where a woman does not wish details of her pregnancy to become known until a certain stage.

where the woman has indicated in the application form that she wishes to be contacted ante-natally by a public health nurse, the health board should advise the public health nurse in the area where the applicant resides.

(d) Payment for Services Provided

the general practitioner should submit claims for payment to the health board within one month after the services to the mother and infant are completed.

the health board should arrange for payment to issue not later than one month from date of receipt of completed claim.
(e) **Statistics**

* the health board should extract all required statistical data from the claim form and submit it to the Department of Health on a timely basis. To ensure the accuracy of the statistics, the health board should ensure that all information is available to it. As this is only possible if all general practitioners have submitted claims the health board should follow up on all outstanding claims before completing the statistics.

(f) **Monitoring of Uptake of Service**

* the health board should monitor the uptake of the service and try to establish why some mothers do not avail of the service.

* in the event of the uptake being unacceptably low or if a high percentage of mothers are late in availing of the service, the health board should undertake a programme of promoting the service.

6.9 **Terms and conditions of agreement between health boards and registered medical practitioners.**

The Review Group recommends that

* a revised form of agreement be agreed by the Department of Health, health boards and general practitioners.

* provision should be made in the agreement for the transmission of medical records to another general practitioner e.g. in the event of a woman changing address.

* provision should be made for medical practitioners who have contracts under the GMS scheme to write a prescription for required drugs and medicines, and for the issue of special prescriptions by doctors who have not got a contract under the GMS scheme to prescribe on a special form for medical card holders.
provision should be made for the submission of the woman’s medical records to the DCC/MOH in the event of the agreement being terminated.
Chapter Seven

HOW TO PROMOTE THE SCHEME

7.1 Survey of current usage of scheme

In order to promote better usage of the scheme, a limited survey of the present use of the scheme was carried out. All births in a Community Care Area for a three month period were checked to determine what percentage of mothers were using the scheme.

The survey showed that 46.8% of medical card holders had availed of the scheme. There was a 71.85% uptake by mothers in category 2. However the survey indicated that only 36.84% of single mothers who gave birth had used the scheme.

15 of the mothers who did not avail of the scheme and who did not have medical cards were contacted. The majority, 9 (60%), were not aware they were eligible as they were not eligible in previous pregnancies. 3 (20%) had opted to attend at the hospital only.

The survey was extended to doctors to determine their awareness of eligibility and usage under the scheme. A questionnaire was sent to 47 doctors. 36 (76.59%) responded. Of these 33 were aware that all women were eligible, and all these doctors promoted the scheme both among their private and G.M.S. clients. 31 said that they were involved in the care of their clients during pregnancy, but 5 replied that they were involved only sometimes.

A similar questionnaire was filled by 16 doctors in a Dublin area; twelve utilised the scheme for all clients, one did not use it for G.M.S. clients, two used it sometimes for the private clients and one sometimes for G.M.S. clients.
These two surveys could be somewhat biased, because the doctors who answered the questionnaire might not be representative of all the doctors in the area, as there would be a greater proportion of non-response among doctors who do not use the scheme.

Among the doctors who did not always utilise the scheme the reasons for not using it were: inadequate remuneration, too much paperwork, difficulty with shared ante-natal care, hospital satellite clinics, lack of knowledge of non-consultant hospital doctors about the scheme so that women are booked in hospital for total ante-natal care.

The results of this survey indicate that there is still a lack of awareness on the part of both mothers and professionals of the scope of the scheme.

The Review Group suggests that the most cost effective way of increasing awareness and early usage of the scheme would be through the provision of better information to women and greater promotion of the scheme and makes the following recommendations:

* women should be made aware that they can avail of services under the scheme from any general practitioner who has a contract with the local health board.

* posters and leaflets giving details of the scheme should be made available at doctors’ surgeries, maternity hospitals, health centres and pharmacies.

* hospital doctors should be made aware of and provided with details of the scheme.
* discussions should be held with the manufacturers of pregnancy testing kits to consider the feasibility of placing an information leaflet on the scheme in the pack.

* all sex education programmes in schools should include information on the Maternity and Infant Care Scheme to ensure that young people are aware of and access all of the services available at an early stage during pregnancy and after pregnancy.

7.2 Maternity Cash Grant

The Review Group examined the Maternity Cash Grant in the context of its effectiveness in promoting greater usage of the scheme.

The Maternity Cash Grant was first introduced on 1st January, 1954 under section 23 of the Health Act, 1953. The level of the grant was set at £4.00 and was payable in respect of each confinement which resulted in a livebirth or a stillbirth to women in the lower income group. Under section 64 of the Health Act, 1970 the grant was increased to £8.00 for each confinement.

It has not been changed since then.
The Review Group recommends that payment of the Maternity Cash Grant to medical card holders should cease on the basis that there is no evidence that the payment of the grant serves any useful purpose with regard to encouraging people to avail of the scheme.

* it is recommended that payment of the Maternity Cash Grant of £8.00 to medical card holders should cease. In cases of hardship, health boards should consider providing assistance under the supplementary welfare allowance scheme.
8.1 It is agreed that health promotion in the wider sense is beyond the scope of this Review Group. Aspects of health promotion that are relevant and beneficial to the health of the mother and her baby are considered.

The health promotion needs of a woman may change as her pregnancy progresses. Matters such as nutrition including vitamin supplementation, lifestyle issues such as smoking, alcohol, drug abuse and specific health issues such as rubella immunity status, previous and current medical problems, are all vital to the successful outcome to a planned pregnancy. Good preventive care will include the provision of advice and information on these matters.

8.2 PRE-PREGNANCY PLANNING

The Review Group recommends that a planned pre-pregnancy visit undertaken in a primary care setting should be introduced. Future mothers could be informed of this service through the educational institutions, target literature and contact at primary care level for other issues.

The Review Group recommends

* as part of the scheme, a planned pre-pregnancy consultation should be introduced to provide a woman with the opportunity to seek medical advice from an appropriate health professional. A method of remuneration should be considered for this service.

* the Health Promotion Unit of the Department of Health should produce information leaflets on the scheme for distribution to all pregnant women through educational institutions, health centres, doctors' surgeries and workplaces.
8.3 ADVICE DURING AND AFTER PREGNANCY

* the importance of early ante-natal care for mothers requires to be highlighted.

* the Health Promotion Unit of the Department of Health should produce a simplified information booklet for distribution to all pregnant women.

* health promotion should be provided early in pregnancy in the areas of nutrition, alcohol and avoidance of drugs and smoking.

* the information contained in the 'general advice towards a healthier pregnancy' section of the combined obstetric card, see appendix II, should be brought to the mother's attention by her general practitioner.

* general information leaflets regarding pregnancy and services available should be made available in educational institutions, health centres, doctors' surgeries and in workplaces.

* more information should be made available regarding food hazards and occupational hazards in pregnancy.

8.4 BREAST FEEDING

The Review Group is aware that the National Committee to Promote Breastfeeding will focus on the following issues in its report:

- breastfeeding policy in hospitals

- breastfeeding policy at community level including the role of voluntary support groups

- the training of health professionals
- the promotion of support for breastfeeding in the wider community

- targets, implementation and monitoring of the policy

The Review Group would be fully supportive of any initiatives designed to promote and support breastfeeding in this country.
Chapter Nine

TRAINING REQUIREMENTS

9.1 The status of existing general practitioners in the scheme with regard to their training, experience and qualifications in obstetrics is unknown. The Review Group considered this matter and recommends that

* general practitioners should have formal training in obstetrics before entering the scheme.

* the appropriate level of training required for future involvement in the scheme should be agreed between the Institute of Obstetricians and Gynaecologists and the Irish College of General Practitioners. Discussions on establishing such an agreement should commence as soon as possible.

* a formal certification procedure should be introduced to indicate that a general practitioner entering the scheme has completed the appropriate level of training. This certificate would be a required condition of entry to the scheme.

9.2 Training of paramedical personnel to deal with obstetric emergencies.

The level of training of paramedical staff at present varies, but does not include any significant training in dealing with obstetric emergencies. Five health boards still use nurses to varying extent in the ambulance service, but the level of their training also varies.
The report of the Review Group on the Ambulance Service, published in December 1993, recommends the introduction of an advanced training programme for ambulance personnel to include training in a paediatric department and labour ward and a pilot paramedical programme to further develop advanced life support skills.

* the advanced training programme for ambulance personnel, as recommended in the report of the Review Group on the Ambulance Service, 1993, should include training in dealing with shock due to blood loss in a mother and resuscitation of the baby.

* members of the ambulance team should be trained to deal with obstetric emergencies.
Chapter Ten

Evaluation of Revised Scheme

10.1 Evaluation of health services is an essential element in all good health systems. Evaluation refers to a particular stage in the planning cycle when data is collected, analysed and interpreted to ascertain whether or not a set of pre-determined objectives relating to the service have been achieved, usually within a specific time period.

10.2 This process requires that those evaluating a programme or a service

(i) specify or describe the service to be provided, in this case all the elements which go into making up the Maternity and Infant Care Scheme.

(ii) define the elements to be evaluated, in this case such matters as

(a) coverage; the proportion of the eligible population which has access to the service. The recent extension of the scheme to all eligibility categories means that all pregnant women, meeting the residential requirement, who wish to avail of the scheme have, in theory, access to the scheme.

(b) equity; the distribution of resources according to the health needs of the population. The matter to be evaluated here is whether there is an equitable geographical or population based distribution of general practitioners who provide services under the scheme so that all women who wish to can exercise their right of access in a convenient manner, in their own area of residence and whether the service provided by each general practitioner is uniform in content.
(c) **quality of care**; the technical quality of the service delivered, which can be a reflection of the training and competence of the professionals involved, and the appropriateness with which their skills and other resources such as technology are applied. This aspect of the scheme is to be evaluated primarily in the context of systematic medical audit of such matters as:

(i) adherence to the agreed schedule of visits (see paragraph 2.12)

(ii) the proper carrying out and accurate recording of each examination incorporating the indicators set out in the record of pregnancy as outlined in the combined obstetric card (see appendix II)

(iii) appropriateness of action taken in response to the outcome of each individual examination

(iv) proper management of any complications arising

(v) appropriateness of communication between the general practitioner and hospital services in providing care to individual women

(d) **client satisfaction**; in this context the overall emotional, psychological and all round well-being of the women availing of the scheme is of unique importance and so requires a separate and unique place in the evaluation mechanism. The quality of service, as outlined in paragraph 10.2(c) above, are of obvious and fundamental importance to a woman’s satisfaction with the scheme. In addition, the quality of the personal interaction between the woman and those
providing care in the scheme and the degree to which her independence is recognised, are central to the woman's sense of satisfaction. Each of the points in chapter four of this report i.e.

- birth plan
- consent for intervention
- research/ clinical trials
- presence of student doctors and midwives
- use of epidural/ spinal analgesia
- courtesy and kindness
- client representation in hospitals

can be used as a check list to evaluate this aspect of care.

(e) **efficiency and effectiveness**; these two aspects form an integral part of any evaluation in the health services and relate to the ability of the service to achieve the outcomes it has set itself for the expenditure of the least amount of resources.

10.3 Each of the elements, outlined in paragraph 10.2, can be measured using agreed criteria and by defining specific standards to be reached.

10.4 **Evaluation Methods**

A variety of methods exist which can be used to evaluate the interventions used in health services. The method used is determined usually by the specific type of questions to be answered and the information requiring to be generated. Techniques such as randomised controlled trials, case control studies, confidential enquiries into maternal deaths and perinatal conferences are well known and accepted evaluative tools in maternal and infant care.
These techniques are particularly applicable to the type of intervention which have been and continue to be developed in maternity care e.g. episiotomy, foetal monitoring, actively managed care etc. The implementation of any such future intervention should follow only after the most rigorous and scientifically validated clinical trials.

10.5 Another approach to evaluating effectiveness is to systematically examine the three major components of a programme - the structure, process and outcome.

- **structure**; the availability of physical and human resources and the organisational arrangements made for their utilisation.
- **process**; the type and quality of the professional and technical inputs into the service.
- **outcomes**; the measurement of such indicators as maternal or child morbidity and mortality, bearing in mind the major effect on the individual of other factors outside health service provision.

10.6 These references draw attention both to the need for evaluation and some of the issues relevant to the process. It is difficult to overemphasise the point that techniques and interventions should not be adopted as common practice without significant evidence that they are both necessary and beneficial. Organisational alterations to the provision should also be evaluated. Evaluation mechanisms should be developed by both providers and users of the Maternity and Infant Care Scheme.
Chapter Eleven

SUMMARY OF MAIN RECOMMENDATIONS

Chapter Two - THE SCHEME

1  it is essential that each expectant mother is seen by a medical practitioner as early as possible in pregnancy and remains under medical and midwifery supervision throughout the ante-natal and post-natal periods. (Section 2.10)

2  The recommended schedule of visits during pregnancy is

(i) before 12th week of pregnancy - first visit to general practitioner
(ii) before 20th week of pregnancy - first visit to hospital
(iii) 24 weeks - general practitioner
(iv) 28 weeks - general practitioner (hospital if its a first pregnancy)
(v) 30 weeks - general practitioner
(vi) 32 weeks - hospital
(vii) 34 weeks - general practitioner
(viii) 36 weeks - hospital
(ix) 37 weeks - general practitioner
(x) 38 weeks - hospital
(xi) 39 weeks - general practitioner
(xii) 40 weeks - hospital (Section 2.12)

3  an information booklet should be produced and made available both to doctors on entry to the scheme and to women using the service so that both will be aware of the nature and range of the services available under the scheme. (Section 2.13)

4  the diagnosis of pregnancy should be part of the scheme and the cost of the pregnancy test kit should be reimbursable as part of the remuneration paid in respect of the scheme. (Section 2.13)
5 general practitioners should ensure that a specified range of blood tests is carried out, as appropriate. The results of these blood tests should be made available to the hospital clinics. In order to prevent the unnecessary repeating of these tests, it is recommended that the general practitioner should send along the original copies of the blood reports and that these should be included with the combined obstetric card. (Section 2.13)

6 information generated during the ante-natal process should be accurately and comprehensively recorded and transmitted to the hospital where delivery is to take place after it is collected in accordance with the agreed format contained in the combined obstetric card. The onus for this is on the general practitioner. (Section 2.13)

7 treatment and advice in respect of the pregnancy and recognised complications of pregnancy should be provided by general practitioners as part of the scheme. (Section 2.13)

8 consideration should be given to providing special payments in respect of major conditions such as diabetic care during pregnancy where this places extra demands on the general practitioner. (Section 2.13)

9 it should be made clear in the information booklet that services, including drug and other treatment, in respect of illnesses which occur coincidental with but not related to pregnancy should not be provided as part of the scheme, free of charge. (Section 2.13)

10 there should be two designated visits for the baby:
   (a) within two weeks of birth
   (b) at six weeks of age (Section 2.14)

11 a post-natal examination of the mother should be carried out by her general practitioner at six weeks. (Section 2.15)
Chapter Three - LOCATION OF BIRTHS

12 there should be adherence to the Patients Charter published in 1992 with particular reference to individual appointments for attendance at out-patients clinics. (Section 3.2)

13 a Charter for Pregnant Women should be established. (Section 3.2)

14 there should be an assurance of a friendly atmosphere in hospitals where the dignity and autonomy of the mother is respected. (Section 3.2)

15 there should be openness with regard to information giving. (Section 3.2)

16 there should be a flexible approach to the length of time spent in hospital. This should be decided by the appropriate medical and midwifery personnel in consultation with the mother. (Section 3.2)

17 creche facilities should be provided for older children at maternity clinics. (Section 3.2)

18 hot meals should be provided to mothers who choose to avail of them following delivery. (Section 3.2)

19 as part of a pilot project, accommodation should be set aside at a number of maternity hospitals to facilitate delivery in a homely non-clinical environment. (Section 3.5a)

20 a pilot domino project should be established. (Section 3.5b)
to cater for women who cannot be persuaded to deliver in or at a maternity hospital/ unit, each health board community care management should put in place arrangements with the local maternity hospital/ unit to provide for a midwife to attend such home birth. These arrangements should be formalised and made known to users and providers. (Section 3.6)

consideration should be given to the provision of appropriate training to hospital-based midwives to work in the community to provide the necessary services under the scheme. (Section 3.6)

the normal ambulance service in the local areas should be expanded and members of the ambulance team should be trained to deal with obstetric emergencies and the safe transport of patients to hospital. (Section 3.7)

general practitioners and midwives should be skilled in resuscitation and treatment of shocked patients and the resuscitation of the newborn. (Section 3.7a)

general practitioners should be provided with equipment to deal with obstetric emergencies, as outlined at Appendix III. (Section 3.7a)

ambulances should be equipped to enable intravenous fluid replacement treatment to be provided by a doctor or a nurse with appropriate training. (Section 3.7a)

general practitioners and midwives or the para-medical team should have direct access to a hospital based obstetrician who could give telephone advice and to this end there should be a designated line on each labour ward which is reserved for emergency use. (Section 3.7a)
Chapter Four - THE MOTHER'S VOICE

28 the use of a birth plan is recommended. (Section 4.2)

29 options provided in the birth plan, including policy in the event of an emergency, should be explored during ante-natal visits to the hospital. (Section 4.2)

30 clear information should be given by professionals when intervention is indicated and in the case of specific procedures being necessary these must be explained to a woman on a step-by-step basis. (Section 4.3)

31 there should be an acceptance by professionals of the right of a woman to refuse an intervention. (Section 4.3)

32 the use of technology should take place only with the full informed consent of a woman except in cases of emergencies. (Section 4.3)

33 the consent of a woman must be sought early in pregnancy if she is being requested to participate in research and/or a clinical trial. (Section 4.4)

34 where a woman decides not to participate in research and/or a clinical trial, her decision must be respected. (Section 4.4)

35 it should be explained to the woman on admission that there may be students in the labour ward/ delivery suite, the reasons why the students may be there and that the woman has a right to refuse to participate in the teaching of medical and midwifery students. (Section 4.5)

36 epidural/ spinal analgesia as a form of analgesia in labour should be made available to a woman if she chooses. (Section 4.6)
ante-natally, all possible risks and side effects should be openly discussed with the woman so that she makes her choice for epidural/spinal analgesia having been fully informed. In addition, her consent should be obtained prior to administration. (Section 4.6)

where epidural/spinal analgesia is inappropriate or contra-indicated the reason for this should be explained to the mother. (Section 4.6)

methods of analgesia, other than epidural, should be made available where appropriate. (Section 4.6)

client groups should be established in maternity hospitals/units to plan and monitor services. (Section 4.8)

Chapter Five - SPECIAL NEEDS

an expectant mother and her partner should be entitled to time off work to attend ante-natal classes. (Section 5.2)

a genetic counselling service should be made accessible to all people who need it as soon as possible. (Section 5.4)

in any future discussions on the development of dental services for medical card holders, pregnant and nursing mothers should be considered a priority group for treatment. (Section 5.5a)

expectant and nursing mothers should have priority access to dental treatment through the Department of Social Welfare's Dental Treatment Benefit Scheme. (Section 5.5b)

service providers should ensure that the requirements of people with special needs are recognised and dealt with as flexibly as possible. (Section 5.6)
care should be planned jointly with a woman with special needs and any appropriate specialists according to her individual needs and wishes, in the same way as for other pregnant women. (Section 5.6)

women with special needs should be provided with support services, including home help, as required. (Section 5.6)

Chapter Six - LIAISON AND ADMINISTRATIVE ARRANGEMENTS

the application for services under the scheme should always be made through the woman's general practitioner and this should be brought to the woman's attention by hospital staff. (Section 6.2)

where a woman is referred to hospital, the general practitioner should ensure that all relevant medical and other details are contained in the combined obstetric card and that this information is supplied to the hospital. (Section 6.2)

hospitals should ensure that they are aware of the name and address of each woman's general practitioner and that a letter is sent to the general practitioner with all relevant medical and other details on the outcome of the pregnancy. (Section 6.2)

where this is not already the practice, arrangements should be made for periodic meetings of general practitioners with hospital staff, e.g. study days or conferences, to promote and improve liaison. (Section 6.2)

the Director of Community Care/ Medical Officer of Health (D.C.C./M.O.H.) should be notified immediately of all births in hospitals and ensure that the public health nurse visits the mother and baby within twenty four hours of discharge from hospital. (Section 6.3)
53 the DCC/MOH should be informed about the health status of each baby and in particular babies with serious morbidity such as congenital abnormalities. (Section 6.3)

54 there should be rapid notification of perinatal deaths to the DCC/MOH. (Section 6.3)

55 the DCC/MOH should be informed of any case where the six week examination of the infant is carried out by a hospital. The results of these examinations should be notified to the Director in an agreed format with particular attention being paid to any abnormalities found. (Section 6.3)

56 the DCC/MOH should notify the hospital, in an agreed format, of any significant abnormalities which are found during developmental examinations. (Section 6.3)

57 the DCC/MOH should visit maternity hospitals with a view to establishing closer links with the obstetricians and paediatricians and to discuss methods of improving communication between the service providers. (Section 6.3)

58 any abnormalities found by the general practitioner at the six-week examination of the infant should be supplied, in an agreed format, to the DCC/MOH. (Section 6.4)

59 where any examination of the infant is carried out by an Area Medical Officer, a copy of the report should be sent to the infant's general practitioner. (Section 6.4)

60 the general practitioner should also be informed of any problems which are discovered during visits by the public health nurse. (Section 6.4)
where a mother indicates in the application form for services that she wishes to be contacted by the public health nurse during her pregnancy, there should be an agreed level of service provided by the public health nurse. (Section 6.5)

the public health nurse should refer infants under six weeks with abnormalities to the infant’s general practitioner. (Section 6.5)

a public health nurse should be assigned the responsibility of ensuring that all discharges are notified promptly to the public health nurses working in the community. (Section 6.5)

domiciliary midwives should continue to liaise closely with other health professionals. (Section 6.6)

all domiciliary births attended by midwives should be notified immediately to the DCC/MOH. (Section 6.6)

the level of payment made to midwives who provide domiciliary services on behalf of health boards should be reviewed. (Section 6.6)

use of the combined obstetric card, which has been introduced on a pilot basis, should be established on a national basis as soon as possible. (Section 6.7a)

a revised application form for services should be introduced. (Section 6.7b)

any doctor who wishes to provide Maternity and Infant Care Services under Section 62 and 63 of the Health Act, must enter into an agreement with the health board. (Section 6.8a)
70 general practitioners should complete an application form which should inter alia give details of registration with the Medical Council and medical defence cover. (Section 6.8a)

71 the health board should satisfy itself that there is no reason why a general practitioner should not be given a contract with the health board for providing maternity services. (Section 6.8a)

72 the health board should issue the general practitioner with an agreement form and a copy of the terms and conditions of the agreement for providing services. (Section 6.8a)

73 the health board should send a copy of the signed agreement to the general practitioner together with a supply of application forms for services under the scheme, combined obstetric cards and relevant information leaflets. (Section 6.8a)

74 midwives who wish to provide services under Section 62 of the Health Act must enter into an agreement with the health board. (Section 6.8b)

75 when the agreement is signed by the health board a copy of the agreement should be sent to the midwife. (Section 6.8b)

76 when pregnancy is confirmed the general practitioner should advise the expectant mother as to her eligibility for maternity services under the Health Act and arrange for the completion of the revised application form by the applicant for early submission to the health board. (Section 6.8c)
the health board should record date of receipt of application and if in order, send letter of approval for services to applicant without delay, together with a leaflet setting out details of services available under the scheme. The name and telephone number of the public health nurse should also be given. (Section 6.8c)

the health board should advise the general practitioner that the applicant has been approved for services. The general practitioner should also be advised that, unless there are special circumstances, payment will not be made for services provided more than 28 days before the date of application for the service or for claims received more than twelve months after the completion of the service to the application. (Section 6.8c)

a procedure should be introduced to allow for the retrospective application for services in the case where a woman does not wish details of her pregnancy to become known until a certain stage. (Section 6.8c)

where the woman has indicated in the application form that she wishes to be contacted ante-natally by a public health nurse, the health board should advise the public health nurse in the area where the applicant resides. (Section 6.8c)

the general practitioner should submit claims for payment to the health board within one month after the services to the mother and infant are completed. (Section 6.8d)

the health board should arrange for payment to issue not later than one month from date of receipt of completed claim. (Section 6.8d)
the health board should extract all required statistical data from the claim form and submit it to the Department of Health on a timely basis. (Section 6.8e)

the health board should follow up on all outstanding claims before completing statistics for submission to the Department of Health. (Section 6.8e)

the health board should monitor the uptake of the service and try to establish why some mothers do not avail of the service. (Section 6.8f)

in the event of the uptake being unacceptably low or if a high percentage of mothers are late in availing of the service, the health board should undertake a programme of promoting the service. (Section 6.8f)

a revised form of agreement should be agreed by the Department of Health, health boards and general practitioners. (Section 6.9)

provision should be made in agreement for the transmission of medical records to another general practitioner, if necessary. (Section 6.9)

provision should be made for medical practitioners who have contracts under the GMS scheme to write a prescription for required drugs and medicines, and for the issue of special prescriptions by doctors who have not got a contract under the GMS scheme to prescribe on a special form for medical card holders. (Section 6.9)

provision should be made for the submission of the woman's medical records to the DCC/MOH in the event of the agreement being terminated. (Section 6.9)
Chapter Seven - HOW TO PROMOTE THE SCHEME

91 women should be made aware that they can avail of services under the scheme from any general practitioner who has a contract with the local health board. (Section 7.1)

92 posters and leaflets giving details of the scheme should be made available at doctors' surgeries, health centres and pharmacies. (Section 7.1)

93 hospital doctors should be made aware of and provided with details of the scheme. (Section 7.1)

94 discussions should/ be held with the manufacturers of pregnancy testing kits to consider the feasibility of placing an information leaflet on the scheme in the pack. (Section 7.1)

95 all sex education programmes in schools should include information on the Maternity and Infant Care Scheme to ensure that young people are aware of and access all of the services available at an early stage during pregnancy and after pregnancy. (Section 7.1)

96 it is recommended that payment of the Maternity Cash Grant of £8.00 to medical card holders should cease. In cases of hardship, health boards should consider providing assistance under the supplementary welfare allowance scheme. (Section 7.2)

Chapter Eight - HEALTH PROMOTION

97 as part of the scheme, a planned pre-pregnancy consultation should be introduced to provide a woman with the opportunity to seek medical advice from an appropriate health professional. A method of remuneration should be considered for this service. (Section 8.2)
the Health Promotion Unit of the Department of Health should produce information leaflets on the scheme for distribution to all pregnant women through educational institutions, health centres, doctors' surgeries and workplaces. (Section 8.2)

the importance of early ante-natal care for mothers requires to be highlighted. (Section 8.3)

the Health Promotion Unit of the Department of Health should produce a simplified information booklet for distribution to all pregnant women. (Section 8.3)

health promotion should be provided early in pregnancy in the areas of nutrition, alcohol and avoidance of drugs and smoking. (Section 8.3)

the information contained in the 'general advice towards a healthier pregnancy' section of the combined obstetric card, see appendix II, should be brought to the mother's attention by her general practitioner. (Section 8.3)

general information leaflets regarding pregnancy and services available should be made available in educational institutions, health centres, doctors' surgeries and in workplaces. (Section 8.3)

more information should be made available regarding food hazards and occupational hazards in pregnancy. (Section 8.3)

Chapter Nine - TRAINING REQUIREMENTS

general practitioners should have formal training in obstetrics before entering the scheme. (Section 9.1)
the appropriate level of training required for future involvement in the scheme should be agreed between the Institute of Obstetricians and Gynaecologists and the Irish College of General Practitioners. (Section 9.1)

A formal certification procedure should be introduced to indicate that a general practitioner entering the scheme has completed the appropriate level of training. This certificate would be a required condition of entry to the scheme. (Section 9.1)

The advanced training programme for ambulance personnel, as recommended in the report of the Review Group on the Ambulance Service, 1993, should include training in dealing with shock due to blood loss in a mother and resuscitation of the baby. (Section 9.2)

Members of the ambulance team should be trained to deal with obstetric emergencies. (Section 9.2)
Chapter Twelve

ACKNOWLEDGEMENTS

Submissions

Through the placement of a notice in the national daily newspapers on the 4th March, 1993, the Review Group invited written submissions from interested parties. In addition to presentations which were made to the Review Group by representatives of The Home Birth Centre, La Leche League of Ireland and the Patient Advisory Council of the Coombe Women’s Hospital, the Review Group are grateful for the written submissions received from the following:

Association for Improvements in the Maternity Services
Association of Lactation Consultants in Ireland
Barrett, Janet
Beamish McKennedy, Nora
Beatty, Deirdre
Best, Christine
Biersack-Leipert, L
Blake, Maggy
Bord Altranais, An
Bowler, D J
Brookes, Fiona & Rob
Brown, Sue
Butterly, Sis
Carroll, Mary
Clare Labour Party
Clohessy, L
Conlon, Marian
Cremers, Susy
Cronin Susan/Geraldine Mullins
Cummins, Frieda
Cunnane, Isabelle
Dempsey, Eithne
Dennison, Tine
Dowling Leask, C
Doyle, Anne
Duffy, Carmel
Dunlop, Gillian M
Dunwoody, Janet
Eastern Health Board
Egeter, Gabriele
Evans, Dawn
Fogarty, Madge
Fonde, Helen
Foster, Helen
French, S
Gallagher, Maria
Galt-McLoughlin, Alison
Garde, Denise
Grace, Karin
Gray, D
Greenford, Alison
Hancock, P G
Harmon, Lucy
Harper, Joy
Hasues, Ella
Herlihy, Moira
Hogan, Mrs
Home Birth Centre
Horan, Anne Marie
Howells, C G
Institute of Community Health Nursing
Irish Association for Improvements in the Maternity Services
Irish Childbirth Trust
Irish Medical Organisation
Irish Stillbirth & Neonatal Death Society
Jones, B S
Kearney, Lorraine
Kelly, Ann
Kerry Organisation for Improvements in Maternity Care
King, Carole B
La Leche League of Ireland
Lagden, Stephanie J
Lawler, Ruth
Lenz, Sabine
Mac Mahon, Louise
Maher, Patricia
Maywell-Smith, Fiona
McGarry, Bernie
McKadden, S
McKennedy, Mary
McLoughlin, Cliona
Meagher, Bridget
Midland Health Board
Miles, Wendy
Moloney O Riada, Geraldine
Mullins Geraldine/Susan Cronin
Murphy, John
Murphy, Nora
Murphy, Theresa
Nairn, Wendy & Richard
Nicholas, Christine
Nitting, Michaele
North Eastern Health Board
North Western Health Board
O’Connell, Collette
O’Connor, Amelice
O’Connor, Marie T
O’Dwyer, Dr Patrick
O’Leary, Maeve
O’Mahony, Eithne
O’Mahony, Ger
O’Mahony, Kay
O’Neill, Kim
O’Neill, Mary
O’Regan, Aine
O’Shaughnessy, Val
O’Sullivan, Elma
O’Toole, Elizabeth
Patient Advisory Council of the Coombe Women’s Hospital
Petcu, Elizabeth
Pitham, Cherry
Post-Natal Distress Association of Ireland
Prickett, Sue
Reed, Vicki
Reid, Diane
Rotunda Hospital (Social Work Department)
Ryder, Mary
Saddington, Dawn
Schulte-Kersten, Angela
Schwart, K
Sheahan, Clare
Sheehan, Mary
Shoosmith, T E
Sinnott, Kathryn
Snoek, Clodagh L
South Eastern Health Board
Southern Health Board
Stapelbraer, Anna
Storey, Linda
Superintendent Public Health Nurses (Southern Health Board)
Thompson, Claire
Tyrrell, Sandra
Ui Chonaire, Rhoda
Waldron, Michelle
Walton, Hayley & Russell
West, Geraldine
Western Health Board
Wilson, Anne
Woods, Dr Sheena
## APPENDIX I

### TABLE 1 (ANTE-NATAL EXAMINATIONS)

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Number of women who had ante-natal care (excluding abortions/miscarriages)

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As % of overall tot: 3.68 1.50 2.06 3.24 6.82 82.70 100

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As % of overall tot: 3.68 1.50 2.06 3.24 6.82 82.70 100

ref: T2-1992
TABLE 4 1992

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% OF TOTAL 0.16 99.51 0.33 100.00

ref: T4 – 1992
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**GROSS TOTAL** 27143 142 51 12 2.6

**MORTALITY RATE:**

A Rate per 1000 live births under scheme, babies to scheme users who died under 5 weeks.

ref. TS-1992
1992

TABLE 6

DETAILS OF EXAMINATION

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APPENDIX III

RECOMMENDED EQUIPMENT FOR GENERAL PRACTITIONERS TO DEAL WITH OBSTETRIC EMERGENCIES

I.V. giving sets x 2
I.V. cannula size 16 x 2
I.V. cannula size 18 x 2
I.V. cannula size 20 x 2
Haemocel 500 mls x 2
Hartmann’s solution or normal saline solution 1000mls x 2
Syntometrine 1 ml x 2
Cord clamp x 2
Scissors and artery forceps
Cotton wool 100 grams and gauze swabs
Ambu-bag with paediatric face mask
Paediatric airway
Manual suction apparatus
Neo-natal thermal blanket
MATERNNITY SERVICE CLAIM

To HEALTH BOARD

I hereby claim fees as set out below in respect of Maternity Services afforded by me.

Signed: ___________________________ Date: ___________________________

Family Doctor

I certify that the forementioned services have been afforded by the Family Doctor

Signed: ___________________________ Date: ___________________________

Director of Community Care and Medical Officer of Health

Name of Patient: ___________________________

Address: ___________________________

Claim Form sent to Director of Community Care on ___________________________

MATERNNITY SERVICE CLAIM

To the Director of Community Care and Medical Officer of Health HEALTH BOARD

For Maternity Services Attended by me.

Name ___________________________ Ref No. ___________________________

Address ___________________________ GMS Yes | No ___________________________

D.O.B ___________________________

AND HER INFANT

LMP ___________________________ Blood Group ___________________________

Rh Factor ___________________________ HB ___________________________

Date ___________________________

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POST NATAI CHECK

Mother: WWY | BREAST |

Baby: Current Weight | BOTTLE |

Date of Delivery: HOME | HOSP |

Outcome: NORMAL | ABNOR | STILLBORN |
APPENDIX IV

PERSONALISED BIRTH PLAN

NAME ____________________________

HOSPITAL ____________________________

ESTIMATED DELIVERY DATE ____________________________

CONSULTANT/ TEAM/ MIDWIVES’ CLINIC/ G.P. ____________________________

1 COMPANION/SUPPORT PERSON

Who do you wish to be your companion during labour and do you wish him/her to be present for the birth of your baby?

2 PREVIOUS BIRTH EXPERIENCES

If this is not your first baby, how did you feel about your last labour? (please tick)

(a) good experience

(b) mixed experience

(c) bad experience

Comments: ____________________________

3 INTRODUCTION

(please tick)

I would prefer labour to start off naturally if at all possible even if I go overdue.

If I have to be induced I would like to discuss the method to be used (e.g. to have the waters broken, use of syntocinon drip etc.)
4 PREPARATION

Do you have strong feelings against (please circle)?
(a) perineal shaving  yes/no
(b) an enema  yes/no

Most hospitals/units no longer routinely perform non-essential practices as above.

5 LABOUR

During the early part of labour would you prefer?
(please tick)
(a) walking about
(b) resting in bed
(c) will wait and see

What method of pain relief do you prefer?
(You may tick more than one choice if appropriate)

(a) breathing and relaxation
(b) entonox (gas and oxygen mask)
(c) injection of pethidine
(d) epidural
(e) wait and see
(f) other (please explain)

6 VARIOUS PROCEDURES

Do you have strong feelings against (please circle)?
If the answer is YES to any of the questions below, please discuss your views with the midwife or doctor at your antenatal visit.

(a) episiotomy  yes/no
(b) acceleration of labour  yes/no
(use of syntocinon)
(c) ARM (having waters broken)  yes/no
(d) foetal monitoring  yes/no
7 DELIVERY
What kind of position would you like to use during delivery?

8 FEEDING
Do you intend to breastfeed your baby? (please tick)
(a) yes
(b) undecided

9 CAESAREAN BIRTH
No matter how straightforward your pregnancy is, the possibility of a caesarian section needs some consideration when making your birth plan.

If I have to have a caesarian section I would like to have (please tick)

(a) a general anaesthetic
(b) an epidural anaesthetic (please bear in mind that in the event of an emergency section, an epidural may not be an option)

10 SPECIAL REQUESTS OR PREFERENCES
If you have any further special requests or preferences please explain below
3.1 The nurse midwife discharging the infant from hospital before the test has been carried out should ensure that the mother is clear about the following matters:
- the importance of the test
- when it should be done
- that the test should be carried out:
  i) by the health nurse, or
  ii) by the public health nurse, or
  iii) by a general practitioner.

3.2 The superintendent public health nurse in the area in which the baby is born is considered by the Group to be the most appropriate person to be responsible for ensuring that infants who are discharged from hospital prior to their having the heel prick test, have the test carried out subsequently.

3.3 If the test is to be performed by a public health nurse, the following procedures should be followed:
 i) the ward sister should ensure that the appropriate superintendent public health nurse is notified that the test is to be carried out.
 ii) the superintendent public health nurse should keep a register of requests from hospital staff.
 iii) the superintendent public health nurse should request the appropriate public health nurse to perform the test and send the sample by post (and obtain a receipt of postage) to the National Neonatal Screening Laboratory at Temple Street Hospital.
 iv) the superintendent public health nurse should notify the maternity hospital where the birth took place that the test has been carried out.
 v) the National Neonatal Screening Laboratory will then process the sample and send a copy of all results to the maternity hospital and the superintendent public health nurse.

3.4 If the test is to be performed by a general practitioner, the following procedures should be followed:
 i) the superintendent public health nurse should contact the general practitioner to ensure that the test will be performed and the sample sent by post (and obtain a receipt of postage) to the National Neonatal Screening Laboratory at Temple Street Hospital.
 ii) the Laboratory will then process the sample and send a copy of all results to the maternity hospital, the superintendent public health nurse and the general practitioner.
 iii) the general practitioner should contact the superintendent public health nurse in cases of non-attendance by the parents.

3.5 The Group recommend that all early discharges be notified by hospitals to the superintendent public health nurse to enable the public health nurse to give priority to these infants. If it is not appropriate to carry out the test before discharge from hospital, the hospital should ensure that the infant is screened by appointment at the hospital subsequently on the appropriate day or alternatively notify the superintendent public health nurse that the infant has been discharged prior to the test being carried out.

3.6 In the case of travelling people, the infant may have moved out of the area before the test has been carried out. The Group recommend that the superintendent public health nurse be made aware of the circumstances at the earliest possible time so that particular care can be taken in the case of these infants.

3.7 The Group recommend that special care should be taken in the care of breast feeding infants to ensure that the test taken when feeding is established and that the test should be taken in accordance with the medical protocol as set out in Appendix 3.
APPENDIX VI

his form, when completed by applicant and doctor should be returned to:

SECTION A. TO BE COMPLETED BY THE APPLICANT.
I hereby apply for Maternity and Infant Services under the Health Act, 1970

NAME: ___________________________ DATE OF BIRTH: ________________
in block letters.

MAIDEN NAME: __________________

MEDICAL CARD NO. (if any): _______________

ADDRESS AT WHICH I NORMALLY RESIDE: ____________________________________________________________

Telephone No: __________________________

I apply to Doctor __________________________

(a) Accept me for medical and surgical services in respect of motherhood

(b) Provide medical and surgical services for my infant.

I HAVE NOT MADE ARRANGEMENTS FOR THESE SERVICES WITH ANOTHER MEDICAL PRACTITIONER.

I do/do not wish to be contacted by the Public Health Nurse during my pregnancy.

Signature of applicant: __________________________

DATE: ______________

SECTION B. TO BE COMPLETED BY THE DOCTOR.
I undertake to provide medical and surgical services for

(a) the person named above.

(b) the infant.

in accordance with the conditions laid down in the Agreement made between me and the Health Authority for the provision of services under Section 62 & 63 of the Health Act.

E.D.D.: ______________

Confinement will take place in __________________________

SIGNED: __________________________ MEDICAL PRACTITIONER.

ADDRESS: __________________________

DATE: ______________

SECTION C. FOR OFFICE USE ONLY.
APPLICATION APPROVED: DATE: ______________ COMMUNITY CARE ADMINISTRATOR

APPLICANT & DOCTOR NOTIFIED: DATE: ______________

P.H.N. NOTIFIED: DATE: ______________