AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB
Chief Executive's Office
Level 12
Building 1
Auckland City Hospital
PO Box 92189
Victoria Street West
Auckland 1142
Ph: (09) 630-9943 ext: 22342
Email: ailsac@adhb.govt.nz

17 December 2020

[redacted]

Re: Official Information Act request – Policies in force as at 12 July 2005

I refer to your Official Information Act request dated 2 December 2020 requesting the following information:

Could I please now request the following policies that were in force at 12/07/2005:

PP2808/PCR/013
PP2802/RBP/008
NMP200/SSM/058
NMP200/SSM/049
PP2800/PCR/001
NMP200/SSM/006
PP2808/RBP/032

Please find attached the following policies that were in force as at 12/07/2005.

- **PP2808/PCR/013** Early Pregnancy Assessment Clinic – Investigations
- **PP2802/RBP/008** Baby Weighing – Community *(previously classified as PP2802/PCR/008)*
- **NMP200/SSM/049** Maternal Fetal Medicine Team – Criteria for Referral at National Women's
- **PP2800/PCR/001** ACC Sensitive Claims Procedure

The two documents below have the same ID and were in force as at 12/07/2005. Both documents are attached.

- **NMP200/SSM/006** Fundal Height – Measurement of – Antenatal
- **NMP200/SSM/006** Fetal Haemoglobin – APT and Downey Test

The following document was not in place as at 12/07/2005. It was first issued in August 2005 and a copy is attached.

- **NMP200/SSM/058** Antenatal Growth Chart – Customised

The following document was located in our archives and unfortunately we do not have a record of when this was withdrawn and therefore unsure if this was in place as at 12/07/2005. A copy of the July 1999 issue is attached.

- **PP2808/RBP/032** Ultrasound Scan Policy

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

Yours faithfully

Ailsa Claire, OBE
Chief Executive of Te Toka Tumai (Auckland District Health Board)

FUNDAL HEIGHT - MEASUREMENT OF - ANTENATAL

RBP - Fundal Height Measurement

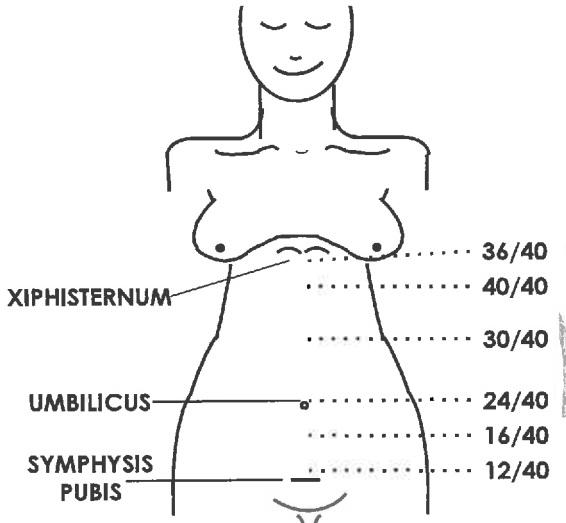
Recommended best practice Follow the steps below to measure fundal height.

Please Note: Fundal height measured in centimeters roughly corresponds to weeks of gestation from 24 weeks.

Step	Action
1	Encourage the woman to empty her bladder prior to assessment.
2	The assessment needs to be done with the woman in a supine position. The muscles of uterus and abdomen should be relaxed for accurate measurement.
3	Locate fundus. A visual estimate of gestation can be made according to fundal height (see diagram).
4	Place disposable tape measure centrally at upper border of the symphysis pubis. Measure the distance to the fundus in centimetres. Pressure is not to be applied on the uterus.
5	Whenever possible, the same clinician should obtain fundal height measurements throughout the pregnancy.
6	The identification of a large or small uterus may alert the clinician to the following possibilities: • uncertain gestational age • delayed or accelerated fetal growth • multiple pregnancy • oligohydramnios or polyhydramnios • transverse or oblique lie **N.B.** Consider ethnic/size variations.
7	Document measurement findings.

FUNDAL HEIGHT - MEASUREMENT OF - ANTENATAL

Fundal Height Measurement: Diagram



FETAL HAEMOGLOBIN - APT AND DOWNEY TEST

Introduction

Objective

To ensure that the APT and Downey Test is correctly performed when clinically indicated.

Frequency

When required.

Associated documents

The table below indicates other documents and sources associated with this recommended best practice.

Type	Document Title(s)

FETAL HAEMOGLOBIN - APT AND DOWNEY TEST

APT & Downey Test - RBP

Recommended best practice Follow the steps below to test blood for fetal haemoglobin.

Equipment Required: 1 pasteur pipette
1 10mg Sodium Hydroxide (NaOH) tube (wax sealed red top) = Test
1 plain red top tube tube containing 10ml purified water = Control

(Sodium Hydroxide tubes are supplied by the Haematology Laboratory)

Step	Action
1	Collect small amount of vaginal blood in pipette.
2	Add 2 drops of blood to the plain top red tube containing 10 ml water and gently mix.
3	Pour half of the blood and water mix into the NaOH red top tube. Mix well and wait for one minute exactly (timing is critical).
4	After 1 minute, compare the Control (haemoglobin solution remaining in the plain red top tube) to the Test (haemoglobin solution in the NaOH red top tube). (See 'Interpretation' below.)
5	Document result.
6	**Interpretation: FETAL BLOOD** Test solution will remain bright pink (i.e. there will be no difference between the Test (red top NaOH) and Control (plain red) solutions.
7	**Interpretation: MATERNAL BLOOD** Test solution (red top NaOH) will turn greenish brown.
Note	Even fetal haemoglobin will denature (turn greenish brown) if left long enough. The APT and Downey test will only indicate if the sample is grossly maternal or grossly fetal blood. If there is any doubt, repeat the test and monitor baby's heart rate.

MATERNAL FETAL MEDICINE TEAM – CRITERIA FOR REFERRAL AT NATIONAL WOMEN'S

- **At Booking**
- **Transfers during Pregnancy / Puerperium**

At Booking

Obstetric history

- Previous perinatal loss x2
- Previous preterm delivery < 30 weeks x2
- Previously extremely low birth weight baby < 1000 gm
- Previous IUGR necessitating delivery < 32 weeks
- Placental abruption x 2
- 3 x first trimester miscarriages and/or 2 x second trimester miscarriages with: antiphospholipid antibodies and/or uterine abnormality and/or maternal medical problem and/or no previous live births / and < 40 years of age

Medical conditions

- Moderate/severe chronic hypertension (BP ≥ 160/100 or evidence end organ disease, or associated with previous pre-eclampsia and/or IUGR)
- Significant cardiac disease, e.g. moderate/severe valvula lesions/complicated congenital heart disease
- Prosthetic heart valves
- Organ transplantation, e.g. kidney, liver, heart
- Maternal HIV
- Major renal disease, e.g. Glomerulonephritis, reflux.
- Complicated thrombophilia
- Autoimmune disease, e.g. antiphospholipid syndrome, SLE with hypertension or end organ involvement
- Other major medical complications, e.g. cystic fibrosis
- Diabetes

Transfers during Pregnancy / Puerperium

- Preterm labour < 30 weeks
- Preterm premature rupture of membranes < 30 weeks
- Pre-eclampsia < 30 weeks or at any gestation with significant end organ involvement
- Complicated twins, e.g. twin to twin transfusion syndrome, severe growth discordance, major fetal anomalies
- High order multiple pregnancies
- Major fetal abnormality
  - Fetal medicine panel, assessment and follow up in fetal medicine clinic
- Congenital infections
  - Fetal medicine panel, assessment and follow up in fetal medicine clinic
- Severe medical disease including thromboembolismm, Marfans syndrome
- IUGR < 30 weeks or at any gestation with very abnormal umbilical Doppler studies
- Red cell (Rhesus clinic) or platelet alloimmunisation

Antenatal growth chart - customised

Objective

To provide each pregnant woman with a customised graph that predicts the expected growth for her individual pregnancy. Using fundal height measurements plot the actual growth against the predicted growth

Frequency

As per recommended antenatal schedule (from 24 weeks)

Evidence Basis

A UK pilot study showed an increased detection of (Small for gestational age) SGA babies from 29% in the control group to 48% in the group with a customised growth chart. The "GROW" (Gestation related optimal weight) programme can now be applied to New Zealand ethnic groups. It is likely that there will be less intervention in babies that are physiologically small such as some Indian and Asian babies.

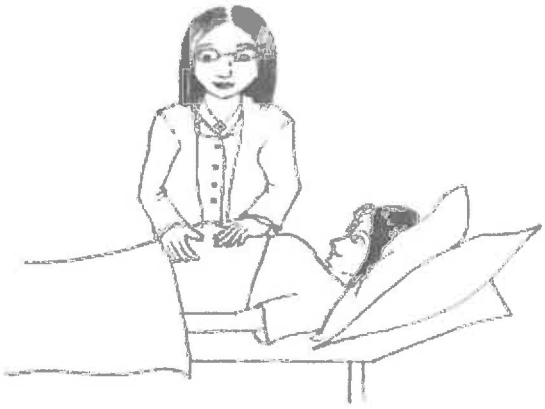
Accessing customised antenatal growth charts

- At booking interview record woman's: Weight; Height;
- ***(Exclude women with a booking weight over 100kg)***
- Record mothers ethnicity
- Record the LMP and EDD
- Record the weight and sex of previous babies.
- Press the start menu on your computer and select programs
- From the programs menu select GROW
- Select "enable macros"
- Complete the data requested. The programme will calculate the woman's BMI as well as appropriate fundal height measurements and estimated fetal weight for the current pregnancy.
- The customised chart will then appear on the screen. Enter the woman's estimated delivery date.
- Press print, the chart can be added to the woman's clinical record

Fundal Height Measurement

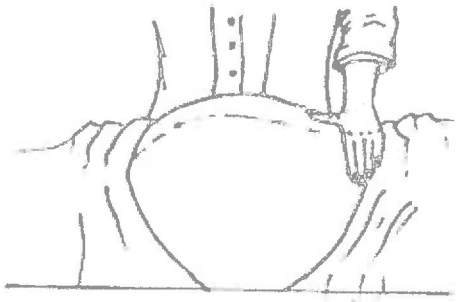
- Measure fundal height at each antenatal assessment from 24 weeks gestation.
- As part of the usual antenatal assessment and abdominal palpation, locate the fundus.
- Place the measure tape on the fundus and record the distance in centimetres to the symphysis pubis. (See diagram at www.perinatal.nhs.uk/
- Plot the measurement on the customised growth chart, and record the fundal height measurement in the antenatal records.
- Fundal height measurements below the 10th percentile or above the 90th percentile or deviations across the centiles should provoke referral for ultrasound assessment.
- Women at high risk of IUGR e.g. previous IUGR, chronic hypertension, antiphospholipid syndrome, gestational hypertension etc. should continue to have growth scans at regular intervals as before. Even though customised growth charts increase detection of SGA babies they still only detect approximately 50 % and ultrasound should remain the gold standard in high risk situations.

Fundal Height Measurement



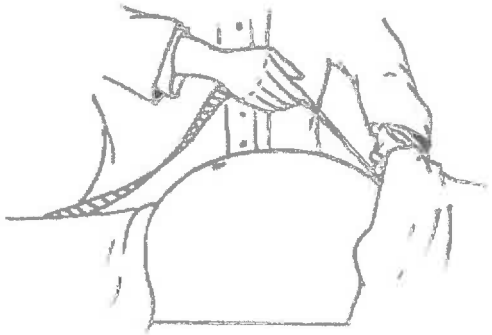
- Explain the procedure to the mother and gain verbal consent
- Wash hands
- Have a non-elastic tape measure to hand
- Ensure the mother is comfortable in a semi-recumbent position, with an empty bladder.
- Expose enough of the abdomen to allow a thorough examination

1. Mother semi-recumbent, with bladder empty.



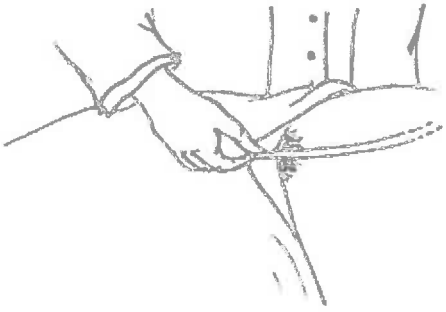
- Ensure the abdomen is soft (not contracting)
- Perform abdominal palpation to enable accurate identification of the uterine fundus.

2. Palpate to determine fundus with two hands.



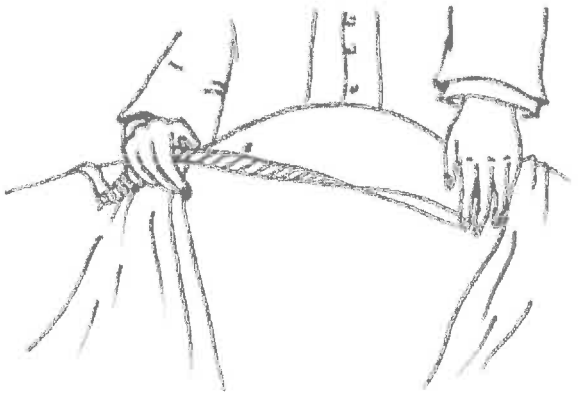
- Use the tape measure with the centimetres on the underside to reduce bias
- Secure the tape measure at the fundus with one hand

3. Secure tape with hand at top of fundus.



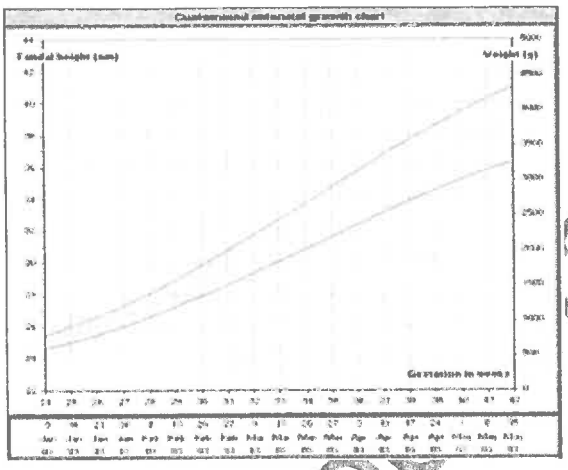
- Measure from the top of the fundus to the top of the symphysis pubis
- The tape measure should stay in contact with the skin

4. Measure to top of symphysis pubis.



- Measure along the longitudinal axis without correcting to the abdominal midline
- Measure only once

5. Measure along longitudinal axis of uterus, note metric measurement



Record the metric measurement and plot it on the growth chart.

6. Plot on customised chart, record in notes

Associated Documents

The table below identifies associated documents.

Type	Title/Description
Web site	This guideline should be read in conjunction with the practice guide at www.perinatal.nhs.uk/
Web site	www.gestation.net
Research Article	McCowan L, Stewart AW, Francis A, Gardosi J.A customised birthweight centile calculator developed for a New Zealand population. Aust NZ J Obstet Gynaecol. 2004; 44: 428-431
Research Article	McCowan L, Stewart AW. Term birthweight centiles for babies from New Zealand's main ethnic groups. Aust NZ J Obstet Gynaecol. 2004; 44: 432-435
Research Article	Gardosi J, Francis A. Controlled trial of fundal height measurement plotted on customised antenatal growth charts. B J Obstet Gynae 1999; 106:309-17

ACC SENSITIVE CLAIMS PROCEDURE

Introduction

Objective

To enable social work staff to facilitate a client claim for assistance under the ACC Insurance Act for medical treatment and/or counselling.

Responsibility

All EDU Staff.

Frequency

- If the patient discloses that the pregnancy has occurred as a consequence of sexual assault.
- If the client discloses that they have been sexually abused and have not made a previous claim
- If the client is a non New Zealand resident and is pregnant as a result of sexual assault which has occurred in New Zealand.
- If the client is more than 12.6 weeks pregnant and is pregnant as a consequence of sexual assault/incest

Associated documents

The table below indicates other documents associated with this procedure.

Type	Document Title(s)
Board Policy	• Informed Consent
EDU Location Policy	• Referral Guidelines
ACC Policy	• Treatment Expenses Claims and Medical • Certificate ACC45 • Cover Determination Form ACC 290 • Request for Private Hospital Treatment Costs

Payment Re: Claims

- Payment is made on the recommendation of ACC Head Office in Wellington
- Payment may not be the full cost of the treatment
- ACC do not pay retrospectively.

Contact Details — ACC Sensitive Claims Office Contact details

- Phone: 0800 735 566
- Fax 04 918 7577

ACC SENSITIVE CLAIMS PROCEDURE

Recommended Best Practice

RBP

Follow the steps below - **for medical treatment if the client is more than 12.6 weeks pregnant and is pregnant as a consequence of sexual assault/incest.**

Step	Action
1	If the woman is living within the Central Auckland Healthcare boundary then she will be referred to Ward 37 for a second trimester termination.
2	If she is living outside the Central Auckland Healthcare boundary then she needs to be referred to her local Healthcare provider.

RBP

Follow the steps below - **to ensure documentation is complete - for counselling costs only.**

Step	Action
1	Discuss with the patient if she wishes to see a counsellor and if she is eligible to be covered by ACC. If she chooses to access counselling provide her with a list of ACC approved counsellors. The client needs to choose her own counsellor. She also needs to be told that ACC will not pay the full cost of the counselling.
2	All sexual abuse that does not occur in the workplace is covered by ACC, (but see (4) below)
3	If the sexual abuse occurs at work and the client is an employee then she has the choice of stating whether the abuse was work related. If she chooses to state that it is work related, then she is covered by the insurer chosen by her employer. If she chooses to state that the sexual abuse not is work related then ACC will cover her.
4	A self employed woman who suffers sexual abuse must apply to the insurance company she has selected, either ACC or another company, to cover counselling costs.
5	Sex Workers may be covered by their employer, if they pay her wages and have insurance. If not, then ACC will cover her. (but see (4) above if she is self-employed)
6	Rape Crisis (ph.366 7214) hold a file on appropriate counsellors and are happy to be used as a resource.
7	ACC, on request ,will send out counsellor lists to women.

BABY WEIGHING - COMMUNITY

Introduction

Weight gain or loss is an indication of wellness in the newborn.

Frequency

Twice in the first week of life then weekly.
Midwife should use their discretion and weigh more frequently if there are any specific concerns, feeding problems, low birthweight, or illness.

Documentation

Document weight in Clinical records and well child book.

Medical Assessment

A weight loss of 10% from birth weight or more requires medical assessment.

BABY WEIGHING - COMMUNITY

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EARLY PREGNANCY ASSESSMENT CLINIC - INVESTIGATIONS

Investigations

Blood Tests

- On referral of a new patient ask the referring doctor/LMC to fax all blood tests from this pregnancy along with referring letter.
- If no blood tests taken previously in this pregnancy ask the referrer to do first antenatal bloods and a BHCG prior to patients EPAC appointment.
- If first antenatal bloods were taken more than 3 weeks before EPAC appointment or if the patient has had vaginal bleeding since the first antenatal bloods were taken ask the referrer to do a FBC prior to patients EPAC appointment.
- On the day of the patients EPAC appointment, check all relevant blood test results received from referer. If not, check Concerto or ring Diagnostic Medlab or Southern Community Laboratory to request blood results.

Group and Rhesus Status

- Send sample to the lab at first clinic appointment if previous grouping is unavailable on Concerto or through Diagnostic Medlab or Southern Community Laboratories.
- Where the blood group is known, EPAC patients requiring an evacuation of the uterus do not require a current Group and Hold to be held at the Blood Bank. The exceptions to this are:
  - Low Haemaglobin (<90g/L)
  - Personal or family history of clotting/bleeding disorder
  - Previous positive antibody screen
- Cross match only if patient is haemorrhaging or on the advice of the Registrar or Consultant.

Portable Scan

The Registrar/Specialist, if competent to do so, must attempt a portable ultrasound scan before a formal ultrasound scan can be requested. If viability is not confirmed by portable scan (i.e. FH not seen), a formal scan can be arranged by the LMC if necessary. IF intrauterine pregnancy with FH confirmed, no further ultrasound is required.

Formal Scan

Where the Registrar and/or Specialist is unable to see a fetal heart beat on portable ultrasound a formal ultrasound scan must be performed before a diagnosis of failed pregnancy can be made.

MSU

Request if urine dipstix is positive (more than a trace) and/or symptoms of U.T.I.

Blood Cultures

On all pyrexial patients.

Swabs

- Where vaginal discharge is present
- On all pyrexial patients

Coagulation Test

Full coagulation screening to be done only when the platelets are below 100,000 or bleeding is excessive.

EARLY PREGNANCY ASSESSMENT CLINIC - INVESTIGATIONS

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ULTRASOUND SCANS

Purpose

First Trimester Ultrasound scans are provided upon referral from an authorised practitioner. This service does not include:

- routine ultrasound for confirmation of dates
- exclusion of multiple pregnancy
- pregnancy visit confirmed.

Scope

This service must include the examination of the mother by the specialist referred to, and the provision of a detailed report to the Referring Practitioner.

Associated documents

The table below indicates other documents associated with this policy.

Type	Document Title(s)
Royal Australian College of Obstetricians and Gynaecologists	Identified check list of Clinical Indications for an Ultrasound Scan in the First Trimester.

ULTRASOUND SCANS

Policy statement(s)

An Ultrasound Scan in the first Trimester may only be provided where one of the following indications exists.

- *Threatened Abortion* Scan at time of bleeding. If further bleeding thereafter, a repeat scan only if continuous wave Doppler Examination (Sonicaid) does not detect fetal heart tones.
- *Recurrent Abortion* (<two previous spontaneous abortions): Scan at 6-10 weeks. No repeat in the First Trimester unless fetal heart tones not heard on Doppler examination.
- *Clinical suspicion of ectopic pregnancy* Including previous tubal surgery, PID or previous ectopic and pregnancy in association with an IUCD.
- *Pregnancy following ovarian stimulation*: Pelvic mass (<3-4 cm) in association with pregnancy.
- *Prior to cervical suture*: If not previously performed earlier in the pregnancy.
- *Uterus not equal to dates*: Scan if discrepancy of four weeks or more.
- *Hyperemesis Gravidarium*: Patients who require admission should have a scan performed.
- *Prior to booking CVS or amniocentesis:* Only if real doubt about gestational age or if there are geographical considerations.
- *Very high risk pregnancy* (e.g. severe Rh, diabetes, previous IUGR, previous premature labours): Scan if any doubt about gestational age.
- *Previous fetal abnormality*: Patients where accurate knowledge of gestational age is critical, e.g. previous microcephaly or short limb dwarfism.
- Incomplete abortion (this was not identified in the RACO & G list).