

Investigation report

Safety and quality of maternity services across Central Queensland Hospital and Health Service

June 2019



Office of the
**HEALTH
OMBUDSMAN**

Listen. Respond. Resolve.

Foreword

This report presents the findings of an investigation into the safety and quality of the maternity services provided at five facilities within the Central Queensland Hospital and Health Service catchment: Rockhampton, Gladstone, Biloela and Emerald Hospitals, and Theodore Multipurpose Health Service, between 2015 and present. Initially the investigation focused on complaints received about serious adverse outcomes for mothers and babies at Rockhampton and Gladstone Hospitals, but while investigating it became appropriate to expand the investigation to incorporate the five maternity services and Central Queensland's oversight of those services.

I have decided to make this report public as I consider that there are valuable insights into the provision of maternity services by Central Queensland and that may be applied more broadly across the maternity services network in Queensland. Some of the issues identified throughout the report are a good reminder for all health services offering maternity services to reflect on and ensure that they are testing their systems to drive continuous improvement.

To investigate the issues staff from my office obtained voluminous documentary information, undertook stakeholder and community meetings, met with relevant clinical staff, and observed processes in practice so as to have a complete picture of the maternity services landscape across the Central Queensland facilities. The culmination of these processes is reflected within the report.

This report identifies that Central Queensland has made a lot of progress over the last four years in improving its maternity services. It highlights areas for further refinement and improvement to ensure that Central Queensland is continuously improving its maternity services and governance processes.

I would like to thank staff from across Central Queensland for facilitating stakeholder visits, taking time away from their clinical responsibilities to enable my staff to have a detailed understanding of the maternity services environment. I would also like to thank the mothers, babies and families who shared their stories with my office enabling the systems to be improved. Finally, I would like to thank my staff, and particularly acknowledge Christine Stones, Senior Systemic Investigations Officer, for her hard work and professionalism in conducting the investigation and preparing this report.



Andrew Brown
Health Ombudsman

Safety and quality of maternity services across Central Queensland Hospital and Health Service

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Executive Summary

Overview

The Central Queensland Hospital and Health Service (CQHHS) provides health services across a catchment area that is almost double the size of Tasmania with half of the population. Providing services over this geographical expanse is challenging yet CQHHS currently consistently provides safe and quality maternity services and the communities serviced should feel confident in the care they are receiving. CQHHS has been on a journey to reach this level of safety as in 2015 and 2016 the task of delivering safe and high quality services across the CQHHS catchment appeared challenging. At this time there were major safety and quality issues occurring in the Rockhampton and Gladstone Hospital maternity services. The issues included a quick succession of serious adverse incidents (six incidents across facilities between May 2015 and February 2016), poor patient engagement and a fragmented workplace culture.¹ The overall trajectory of the health service was not sustainable and significant changes were needed to address the safety and quality of the maternity services to ensure appropriate outcomes for women and their babies.

Given the serious nature of the issues at Rockhampton Hospital, CQHHS initially focused on securing the safety of the service and commissioned an external review, which made 35 recommendations for improvement. Coinciding in April 2016, the Office of the Health Ombudsman (the office) both commenced an own motion investigation² and received complaints about the maternity services provided at Rockhampton and Gladstone Hospitals.

While the office's investigation was ongoing, CQHHS independently commissioned internal clinical reviews of five maternity services across Central Queensland, namely Rockhampton, Gladstone, Emerald, Biloela and Theodore. These reviews were completed between February 2017 and March 2018. Each review resulted in various recommendations that were accepted by CQHHS and a commitment was made to implement the recommendations in a timely manner.

The CQHHS internal reviews and previous complaints to the office about Rockhampton and Gladstone highlighted similar themes across the five maternity services. In October 2018 the office commenced an own motion systemic investigation into CQHHS maternity services. This investigation enabled the office to consider the broader application of the themes across the CQHHS maternity service and address any outstanding concerns holistically, which also aligns with CQHHS's strategic vision to take a Central Queensland-wide approach to the provision of services.

The scope of this systemic investigation, and consequently this report, was refined to seven key themes:

1. safety and quality governance

¹ CQHHS *Review into maternity care at Rockhampton Hospital 2016*

² Section 80(c) of the *Health Ombudsman Act 2013* (the Act) allows the Health Ombudsman to commence an investigation into another matter that the Health Ombudsman considers is relevant to achieving the objects of the Act, including public health and safety.

2. clinical incident management
3. classification and identification of maternal risk and subsequent escalation
4. liaison between emergency and maternity
5. models of care
6. staffing and skills mix
7. culture and communication.

In addition to the above, the following unique issues were identified:

- Gladstone Hospital: leadership across the health service, including role modelling of an appropriate safety and quality culture.
- Emerald Hospital: historical issues identified in relation to ensuring that women are at the centre of care decisions and not negatively impacted upon by internal cultural issues.
- Theodore Multipurpose Health Service (MPHS): confirmation of the Level 1 maternity service that commenced in early 2011, meaning planned birthing services would not be reinstated.

Over the course of the investigation it became clear, that since 2016, CQHHS has committed to an inward reflection on what was necessary to improve services by undertaking a focused and steady change effort. CQHHS is applying the right formula to its improvement journey—make the service safe, get the simple solutions working well and then refine the processes to continuously improve the safety and quality of the service and the supporting infrastructure—including clinical governance and clinical incident management. This improvement journey has resulted in safe and quality maternity services across the CQHHS catchment. Many of the services, when benchmarked against their peer facilities throughout Queensland and Australia, are performing within expected ranges or in some cases exceeding performance expectations despite high acuity patient cohorts and increasing demand on the services. These outcomes demonstrate the quality of care that is being provided to mothers and babies. The report makes a total of 11 recommendations and findings in relation to each maternity service and CQHHS (noting that not every facility required a recommendation), as discussed below.

Rockhampton Hospital maternity service

The Rockhampton Hospital maternity service is the sole Level 4 service within CQHHS and birthed 1,248 babies in 2018. When benchmarked against its peer facilities across Australia it is outperforming many services despite a high acuity patient cohort. The Rockhampton Hospital maternity service has made significant strides over the last three years, and is no longer the same service that it was in 2016 when the external review was completed. This was evident during an on-site stakeholder meeting in October 2018, where staff from this office observed a genuine commitment to providing a safe and high quality maternity service, which is continuously improving so as to provide the best care for the women of Central Queensland.

The office's main investigative findings are:

- The maternity service has embedded a culture where maternity risk assessing is business as usual during antenatal and intrapartum care, evidenced by a lack of serious incidents involving risk assessing as a contributory factor between April 2016 and January 2018.
- The models of care, particularly the midwifery group practice (MGP), are continuing to expand, with a view to developing an Indigenous MGP.
- Staffing has stabilised with a full complement of permanent obstetricians commencing in December 2018, and there is greater clarity and support in midwifery staffing to ensure that staff are not overburdened and can provide appropriate care.
- Significant cultural improvements have been implemented to transform the service.

The next phase for the Rockhampton Hospital maternity service will be to maintain the quality and pace of the change while splitting its focus to support the other maternity services across CQHHS to reach the same benchmark. This maternity service has the strategic and operational capability to continue on its journey and as such no recommendations are necessary.

Gladstone Hospital maternity service

The Gladstone Hospital maternity service is one of three Level 3 services within CQHHS and birthed 560 babies in 2018. It is the busiest Level 3 public maternity service in Queensland. Overall, the maternity service is safe; when benchmarked against its peer Level 3 facilities it performed within the expected ranges for a variety of maternity indicators and in some cases exceeded the benchmarks for a Level 3 service. However, the maternity service does have some challenges to overcome, and since June 2018 it has started to address these challenges head on, enabling the maternity service to refine and improve, particularly in relation to clinical governance and safety and quality processes.

The office's main investigative findings are:

- The categorisation and assessment of a woman's risk status both antenatally and during the intrapartum period is an area where there continues to be room for improvement, particularly in relation to the provision of telephone advice to women who contact the service, often in labour.
- Significant work has been undertaken between the emergency department and maternity service to improve collaboration and management of pregnant women between these services. The main area for further refinement is in relation to pregnant women who discharge themselves from the emergency department and re-present in a short timeframe.
- The level of staff is currently appropriate for the acuity and service demand. This will need to be an ongoing area of focus for the service as demand will likely increase, which will require a corresponding increase in staffing. This is being addressed by CQHHS through recruitment of 8.8 full time equivalent (FTE) midwives in the hospital and 2.8 midwives aligned with continuity of care models in accordance with the Queensland Government's election commitment.
- Leaders across the maternity service need to ensure that safety and quality role modelling is consistently displayed and supports staff in understanding the importance of safety and quality governance and processes. During an on-site stakeholder visit in October 2018, staff from this office

observed some disconnect between leadership and the maternity staff; specifically, staff did not appear to appreciate how their role contributed to safety and quality governance and processes, instead such functions were seen as burdensome. This was in contrast to other maternity services visited across CQHHS where the leadership and staff demonstrated a cohesive understanding of their part in securing sound safety and quality governance and processes.

In response to the above investigative findings I am making four recommendations along the following three themes:

- assessment and management of risk during the antenatal and intrapartum period, with particular focus on telephone advice and management (recommendations 1 and 2 outlined below in section 16.1)
- flagging and triaging pregnant patients in the emergency department who re-present within 48 hours of discharging themselves against medical advice (recommendation 3 outlined below in section 16.2)
- benchmarking the safety and quality leadership to identify the key areas for improvement (recommendation 4 outlined below in section 16.6).

The above findings and recommendations make it clear that a major area of focus for the maternity service needs to be on its staff, ensuring that they are engaged and prepared for the change that will likely be implemented over the next 12 months. This change needs to occur in an environment where staff contribute to and understand what is occurring rather than having change imposed on them without an explanation. In order for the maternity service to become a single and cohesive unit, the leadership team will need to role model the safety and quality culture that they want to see across the service. The changes will be challenging for both leadership and staff, requiring a shared commitment and energy. I am confident that the Gladstone Hospital maternity service has the necessary focus to progress this change and will be adequately supported by the CQHHS executive.

Biloela Hospital maternity service

The Biloela Hospital maternity service is another of the three Level 3 services within CQHHS and birthed 67 babies in 2018. The maternity service at Biloela Hospital is small and facing the same challenges as most rural health services throughout Queensland, namely skilled clinical workforce recruitment and providing a safe service within the allocated resourcing. Despite these challenges it is clear that Biloela Hospital is committed to improving and refining its service, being innovative within the scope of its capability level and resourcing availability.

The office's main investigative findings are:

- The safety and quality governance structure needs to be streamlined, with a rationalisation of the number of committees, their terms of reference and membership. With the low numbers of incidents and safety and quality matters it experiences, the maternity service would benefit from joint safety and quality meetings across the Banana Shire.
- The maternity service is trying to improve the options for women by exploring the introduction of GP shared care and a MGP.

- There was some stability in staffing in 2018 with the permanent appointment of a nurse unit manager and associate nurse unit manager. CQHHS has also made a significant investment to develop the Rural Generalist program and supports monthly visits from specialist obstetricians and gynaecologists, which has enhanced the medical workforce. However, sustainable midwifery and medical recruitment remains challenging.
- There is a supportive culture and multidisciplinary way of working.

In relation to the safety and quality governance I am making a recommendation (recommendation 5 outlined below in section 21.1) to ensure the streamlining of the committee structure for Banana sites is embedded as part of the clinical governance framework, which is aimed at limiting the gaps in the governance chain where issues have the potential to fall through.

Emerald Hospital maternity service

The Emerald Hospital maternity service is the third of the three Level 3 services within CQHHS and birthed 322 babies in 2018. The Emerald Hospital maternity service significantly changed between 2017 and 2018. The transformation of its relationships with consumers—forward-thinking decisions about models of care, and a shifting culture that is supporting safe and high quality outcomes in a multidisciplinary environment—all demonstrate a service that is committed to improving and meeting the demands of modern healthcare delivery.

The office's main investigative findings are:

- The embedding of robust clinical governance processes needs to remain an area of focus for the maternity service and executive leadership as there is still room for improvement in how clinical governance is approached, including that sufficient non-clinical hours need to be built into rosters to support staff in participating in clinical governance activities.
- The maternity service introduced a new hub and spoke³ model of care with Rockhampton Hospital providing specialist gynaecologist services in Emerald once per month. This came at some considerable expense to the maternity service but was considered necessary given the governance and logistical challenges of operating the flying obstetric and gynaecologist (FOG) model of care.
- The MGP lost three midwives in quick succession (over the course of a few months) providing an opportunity for the MGP to review its ways of working to ensure that all MGP midwives feel supported in their practice.

³ The 'hub and spoke' model of care is increasingly being used in the United Kingdom and United States where it was recognised that small rural facilities were under threat of closure and needed support from larger facilities within the network to provide services to their communities. The model is a method of organisation where a main 'hub' is established, receiving the most resources, and it is complemented by 'spokes', which tend to be satellite services that offer more limited services. This addresses more routine healthcare within local communities but provides for more complex care to be provided by the hub facility. Sourced from: Elrod et al, *The hub-and-spoke organization design revisited: a lifeline for rural hospitals*, BioMed Central, 2013.

- There is a 5.20 full-time equivalent vacancy in the maternity service and recruitment has been challenging, accounting for a significant proportion of leadership's time and resources. Rural recruitment remains a barrier for the service despite the quality of its reputation.
- A number of cultural initiatives have been introduced to improve the relationships across the service and between midwives and medical staff. This has resulted in significant improvements, however, the 2018 cultural survey identified that there was still room to grow in relation to creating a safe environment for staff to communicate their views.
- An internal review of the maternity service identified that women did not feel at the centre of care decisions. This finding was taken on by the maternity service and their consumer partnering and engagement has been transformed becoming arguably the best example of consumer engagement across CQHHS.

In a short period of time, in a small health service, the Emerald Hospital maternity service has overhauled its service and the passion the staff have for providing safe and high quality maternity care was demonstrable during an on-site stakeholder visit in January 2019. I note that some of the improvements that have been implemented are relatively recent, only having been introduced in late 2018, so it will be important for leadership to maintain its energy and focus on embedding improvements and refining processes to address the ongoing challenges of delivering care in a rural maternity service.

Overall, I do not consider that the maternity service requires any broad recommendations so I am making one technical recommendation in relation to the epidural service to support the maternity service in its continuous improvement journey (recommendation 6 outlined below in section 26.6.2). Similarly, there are some key observations about the clinical governance processes, staffing and culture that should assist in guiding the maternity service on where to commit its energy so that it continues to build upon its successes in providing a safe and quality maternity service.

Theodore Multipurpose Health Service

The Theodore MPHS is one of eight Level 1 maternity services across CQHHS, meaning it offers no planned birthing services. Prior to the 2010/2011 floods in Theodore it was a Level 2 service, offering planned birthing for low risk women; however, the floods damaged part of the MPHS meaning that planned births could not be undertaken at the facility. In October 2016, the flood repair work, including the availability of a birthing room, was completed. The community considered that access to the birthing room would result in planned birthing services being reinstated; however, in June 2018, CQHHS announced that, due to safety concerns, it would continue the Level 1 maternity service that had been in place since 2011.

While the Theodore MPHS does not offer planned birthing services it was appropriate for the office to include it within this report given that it was one of the five services chosen by CQHHS for the internal reviews completed between February 2017 and March 2018. The review identified major gaps in the capability of the Level 1 maternity service, recommending a complete redesign to ensure that it meets the requirements for a contemporary Level 1 service. These gaps were echoed by representatives from the community when they met with staff from this office in March 2019. I appreciate members of the Theodore community sharing their views with staff from my office as they provided useful insights and

perspectives into the significant challenges they face with the continuation of a Level 1 maternity service and views on the redesign of that service as a contemporary and fulsome Level 1 service.

The office's main investigative findings are:

- The implementation of the recommendations made by the internal review have yet to be commenced and need to be made a priority by the Theodore MPHS.
- The current models of care offered by the service do not support a contemporary Level 1 maternity service that meets the requirements of its service capability and any redesign of the antenatal and postnatal care options should be undertaken in close consultation with the community.
- There was no community consultation about the decision to maintain the Level 1 maternity service in Theodore, resulting in the community feeling unheard in relation to the various risks associated with having no planned birthing services in the town.

Based on CQHHS' response in other maternity services to implementing recommendations and securing a high quality service, I am confident that CQHHS and Theodore MPHS will undertake the work required to reach a reliable, safe and high quality Level 1 maternity service. However, given the difficulties between CQHHS and the community, the significant body of work to be completed, and delayed progress to date, I will maintain routine oversight of implementation of the review recommendations to ensure that they are actioned completely and in a timely manner (recommendation 7).

CQHHS

While responsibility for the provision of safe and high quality healthcare sits across all persons engaged within a health service, ultimate responsibility for ensuring that the health service meets this goal sits with the governing body, namely the CQHHS Board and board level committees. The Board and its committees are accountable for setting the strategic direction, testing the assumptions of health service management, and reviewing performance to ensure that it meets accepted standards. In investigating the various maternity services across CQHHS it became clear that overall the Board and its committees are soundly fulfilling their role as the strategic leader of CQHHS but that there were some ongoing areas for refinement to continue the sophistication and maturity of the governance and oversight processes in place across CQHHS.

The office's main investigative findings are:

- The CQHHS Board, board level committees, executives and consumers have driven the establishment of, and maintained continually improving and innovative, safe and high quality maternity services across Central Queensland, of which mothers and families, clinicians and the broader community should be proud.
- Across CQHHS there are no set expectations or consistent procedures in relation to managing the transfer of an MGP midwife's caseload if they were to depart the service, this is despite the experience of the Emerald, Gladstone and Rockhampton maternity services, which all had MGP midwife departures that occurred with limited notice.

- In developing recommendations in response to clinical incidents there is a limited requirement for ensuring clinician engagement in developing meaningful and implementable recommendations that address the root cause of the issue.
- After reviewing 14 serious clinical incident analyses, which included 170 recommendations and lessons learned, it became apparent that the majority of recommendations developed in response to incidents are categorised as low effect or impact. The recommendations need to be stronger to ensure that they are efficacious and worthy of the time and effort required to implement, monitor and evaluate them.
- CQHHS needs to ensure that it maintains its focus on escalating repeating issues when they arise across multiple incidents within a 24 month period, while the policies and procedures require this to occur there is scope for this aspect of the clinical incident management system to be refined.
- The CQHHS Board and its board level committees need to ensure they have robust oversight of the implementation of major recommendations to ensure that the safety and quality governance chain has appropriate levels of accountability and transparency in its reporting to the CQHHS Board.
- CQHHS has implemented some innovative benchmarking and performance tracking measures and now needs to grow the maturity of its trend analysis to include lower level incidents to identify potential areas for improvement before incidents occur.

In response to the above investigative findings I am making four recommendations in the following four areas:

- development of a policy for the transfer of care when an MGP midwife ceases with a service (recommendation 8 outlined below in section 33.1)
- ensuring that recommendations developed in response to incidents are done so with clinician engagement and securing benchmark levels for the proportion of low, moderate and high effect recommendations (recommendation 9 outlined below in section 33.2.1)
- continuing to refine the escalation processes for repeating issues across a 24 month period (recommendation 10 outlined below in section 33.2.2)
- providing for the CQHHS Board and its committees to have robust oversight of the safety and quality chain by auditing a sample of implemented recommendations (recommendation 11 outlined below in section 33.2.3).

The CQHHS Board and its committees are clearly engaged with the safety and quality governance processes, fulfilling their role as leaders in the process and setting the strategic direction from the top down. While the investigation identified some areas that would benefit from further refinement, the overall impression of the CQHHS Board is that it has contributed to turning around the maternity services to ensure that they are safe and support high quality outcomes for mothers and babies across Central Queensland. The CQHHS Board has also committed to making bold decisions to secure the future of the service even when such decisions may be difficult.

Adverse comment submission

Under the *Health Ombudsman Act 2013*, an entity must be given an opportunity to comment on a draft investigation report where that report is going to make adverse comment and the entity is identifiable.⁴ Due to the potential significance of this report for both CQHHS and maternity services in Queensland generally, the office undertook a multi-staged adverse comment process.

CQHHS' adverse comment submission made 36 comments in relation to this report. The office accepted a majority of these comments and welcomed CQHHS' input into the accuracy of the information being reported and the appropriateness of the recommendations being made. Accepted comments have been incorporated into the report and are not separately identifiable.

Commentary was provided in relation to three recommendations (recommendations 4a, 6, and 7) and on considering CQHHS' submission, I have decided to retain the recommendations. My reasons for retaining the recommendations are outlined in section 34 below.

Conclusion

While there have been sustained and significant changes across the CQHHS maternity services over the last three years, the human impact of the clinical incidents on the mothers, babies, families and clinicians is not to be diminished or forgotten. Going forward I am confident that CQHHS has learned from the heavy price of those incidents and improved its planned birthing services to such an extent that, as far as practicable, the issues highlighted through those incidents will not recur. I look forward to partnering with CQHHS to monitor its progress along its continuous improvement journey to ultimately maintain and refine the excellent care being provided to mothers and babies across CQHHS.

⁴ Section 86(3) of the *Health Ombudsman Act 2013*.

1. Background

1.1 Issues arising in the maternity services across Central Queensland Hospital and Health Service

Between May 2015 and August 2016, there were seven serious maternal incidents at Rockhampton Hospital. The first five of these incidents, from May 2015 to February 2016, prompted Central Queensland Hospital and Health Service (CQHHS) to commission an external review into the maternity services provided at the facility. The review was conducted in April 2016 and made 35 recommendations for service improvements and redesign at Rockhampton Hospital. At this same time issues were emerging within the maternity service being provided at Gladstone Hospital.

Given the seriousness of the issues at Rockhampton Hospital, CQHHS initially focused on securing the safety of the service. Subsequently, between February 2017 and March 2018, CQHHS commissioned internal reviews of five maternity services across Central Queensland, namely Rockhampton, Gladstone, Emerald, Biloela and Theodore. Each of these reviews resulted in various recommendations that were accepted by CQHHS and a commitment made to implement the recommendations in a timely manner.

In April 2016, around the same time that the issues arose in Rockhampton and Gladstone Hospitals, the Office of the Health Ombudsman (the office) both commenced an own motion investigation⁵ and received complaints about the maternity services provided at these facilities. Since this time, the office has continued to receive complaints about the maternity service at Gladstone Hospital; receiving five complaints in total.

The CQHHS internal reviews and complaints to the office highlighted similar themes across the five maternity services so in October 2018, the office commenced an own motion systemic investigation into CQHHS maternity services. This investigation enabled the office to consider the broader application of the themes across the CQHHS maternity service and address any outstanding concerns holistically, which also aligns with CQHHS's strategic vision to take a Central Queensland-wide approach to the provision of services.

While this report will be addressing five maternity sites across Central Queensland, it is important to note that Rockhampton Hospital has dramatically improved and does not require further intervention by the office for future refinement. Gladstone, Emerald, Biloela and Theodore are still progressing in their improvement journey and have areas for growth and maturity.

1.2 Meaning of a systemic investigation

In addition to managing health service complaints about individual health service providers, the office may also undertake investigations into systemic issues. A systemic issue relates to the potentially poor

⁵ Section 80(c) of the *Health Ombudsman Act 2013* (the Act) allows the Health Ombudsman to commence an investigation into another matter that the Health Ombudsman considers is relevant to achieving the objects of the Act, including public health and safety.

operation of a system, process or practice as opposed to individual actions of a person that occur within the system. Some examples of systemic issues include:

- a system change that is not operating as expected
- a lack of a policy or procedure
- a lack of a clear structure to support functions or other necessary practices
- a practice, policy or procedure that is not compliant with best practice, guidelines and/or legislative requirements
- an identified area for improvement in a system, policy or procedure, which could have a positive impact on patients and/or other persons accessing the system or implementing the policy and procedure.

The office categorises systemic issues into three streams based on population impact, namely:

- **Stream 1:** These are issues that have the potential to impact persons at a single facility or within a single service line in a local area and can be resolved directly with the facility. These issues, while important, will have a minimal impact beyond a local community utilising the services of the facility or engaging with the service line.
- **Stream 2:** These are issues that have the potential to impact persons across facilities within a single region or geographical location and can be resolved by engagement with a single key stakeholder responsible for the facilities. These issues, while serious, are likely to have less potential for widespread impact outside of the locality in which they occur.
- **Stream 3:** These are issues that have the potential to impact persons across facilities throughout Queensland and require a coordinated response by multiple stakeholders to address any identified issues. The issues are likely to be the most complex, with the potential to have the greatest impacts or impact the largest numbers of persons.

In undertaking systemic investigations the office is able to provide an independent viewpoint on the issues it observes and engage with the key stakeholders to make recommendations to address issues, respond to trends and/or refine processes. Investigating systemic issues requires a more strategic and proactive approach through:

- engaging with the stakeholder to effectively define and capture issues and securing their commitment to co-design
- implementing constructive recommendations for change that are appropriate and effective in their operating context.

The office's investigation into the CQHHS maternity services is a Stream 2 systemic investigation because the issues impact facilities across the CQHHS catchment.

2. State-wide and national maternity services frameworks

The provision of maternity services is governed by a multitude of both state and national committees and networks, underpinned by state and national standards, benchmarks and other guidelines governing consistent, safe and appropriate maternity services.

2.1 State and national maternity standards, guidelines and benchmarks

The major state and national standards, guidelines, benchmarks and key initiatives that apply to and impact on the provision of maternity services across CQHHS include:

- Clinical Services Capability Framework for public and licensed private health facilities (CSCF)
- Queensland Health clinical guidelines
- Variable Life Adjustment Display (VLAD) flags for extraordinary trends in clinical maternity data
- National Safety and Quality Health Service Standards setting accreditation benchmarks across eight key areas in a health service (National Standards)
- National Maternity Services Plan 2010 to 2016
- National Framework for Maternity
- National Strategic Approach to Maternity Services
- National Core Maternity Indicators 2016
- Women's Healthcare Australasia (WHA) benchmarking.

An overview of these state and national standards, benchmarks and guidelines is outlined in **Appendix 1**.

2.2 State and national networks

Additionally, there are a number of state and national networks currently in place to guide, provide expert advice and oversee consistency across maternity services at the state-wide and national levels. These networks include:

- Queensland Maternal and Perinatal Quality Council
- State-wide Maternity and Neonatal Clinical Network
- Maternity Services Forum
- Rural Maternity Taskforce
- Council of Australian Governments (COAG) Health Council.

An overview of these networks and forums is outlined in **Appendix 2**.

3. Health service

3.1 Health service overview

The CQHHS was established as a statutory body on 1 July 2012.⁶ It has a foot print extending from 'Gladstone in the south, inland to the Southern and Central Highlands and north along the Capricorn Coast'⁷; this is some 117,000 square kilometres. The CQHHS oversees six hospitals (Biloela, Capricorn Coast, Emerald, Gladstone, Moura, and Rockhampton), 10 multi-purpose health services and outpatient clinics, and two aged care facilities.⁸ In 2018, the catchment population of CQHHS was estimated at 242,600 persons⁹ and is expected to grow 20 percent by 2030 with a 68 per cent increase in the aged population over the next 10 years.¹⁰ The catchment population has a number of risk factors, including higher than average rates for daily smokers, obesity and risky drinkers.¹¹

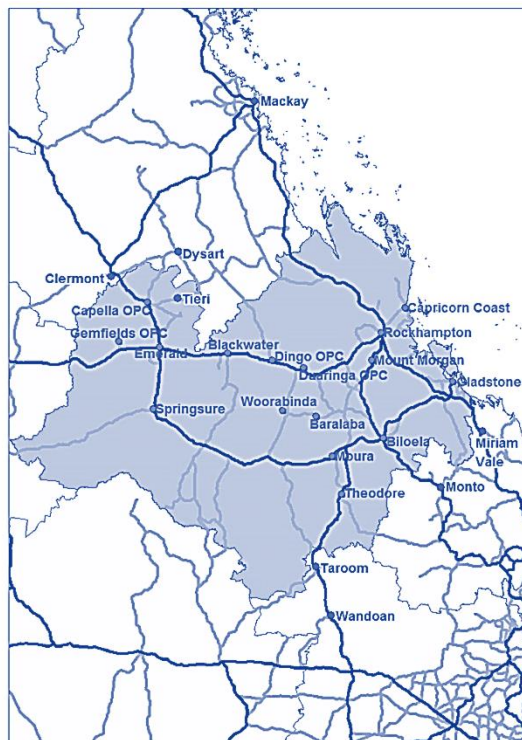


Figure 1 Central Queensland Hospital and Health Service catchment

⁶ Prior to this time there was the Central Queensland Health Service District (CQHSD).

⁷ Central Queensland Hospital and Health Service, 2017-2018 Annual Report.

⁸ Ibid

⁹ Ibid

¹⁰ Central Queensland Hospital and Health Service, *Destination 2030: Delivering Great Care for Central Queenslanders*, October 2017.

¹¹ Central Queensland Hospital and Health Service, 2017-2018 Annual Report.

The CQHHS is managed by the CQHHS Board; with a Chief Executive overseeing management of the service and reporting to the Board on various matters impacting upon the service. The Chief Executive is supported by various Executive Directors as per the organisational chart in Figure 2. The maternity services are managed within the reporting lines to the executive directors of the Rockhampton Hospital, Gladstone and Banana, and Rural and District-wide Services, with support from the executive director, Nursing and Midwifery; Quality and Safety.

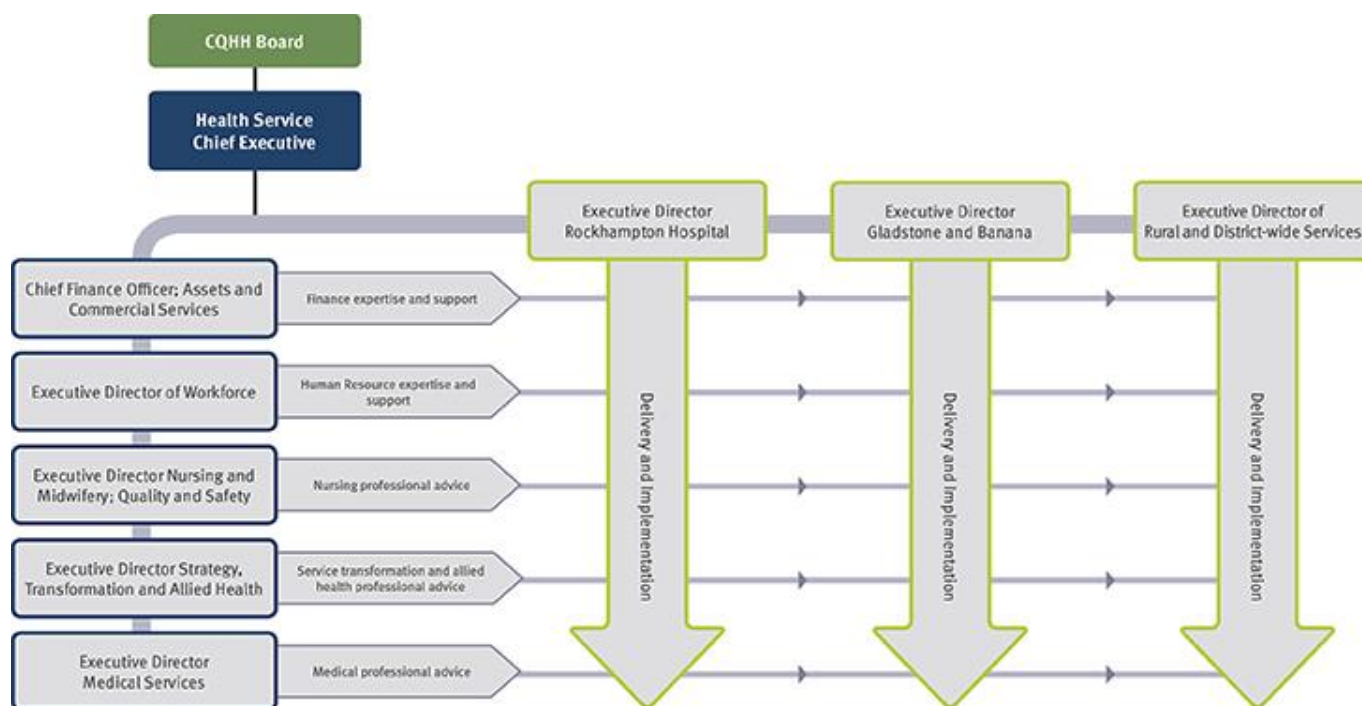


Figure 2 Central Queensland Hospital and Health service executive governance structure¹²

Given the diversity and size of the CQHSS catchment, the birthing services range from Level 1 to Level 4 as per the CSCF; a CSCF self-assessment was completed by CQHHS in June 2017.^{13,14} The breakdown of services is:

- one CSCF level 4 facility
- three CSCF level 3 facilities
- eight CSCF level 1 facilities.

The CSCF level dictates the types of services that can be safely provided at the individual facility. The specific elements of each CSCF level will be discussed in relation to the individual facilities in sections

¹² <https://www.health.qld.gov.au/cq/about/leadership/our-structure>

¹³ Under the *Hospital and Health Boards Act 2011*, each HHS must undertake a baseline self-assessment against the CSCF and then notify the Department of Health of the completed self-assessment.

¹⁴ https://www.health.qld.gov.au/_data/assets/pdf_file/0028/444619/cscf-selfassess-sum-centralqld.pdf

8.1, 13.1, 18.1, 23.1 and 28.1 of this report. There were 2,143 babies delivered across CQHHS in 2017–18.¹⁵

3.2 Destination 2030: Great Care for Central Queenslanders

Since the beginning of 2017, CQHHS has been on a strategic journey, setting goals to support the health of Central Queenslanders. This work commenced with the refinement of CQHHS' values, which saw six values become four focused statements that are a golden thread running through CQHHS' approach to health service delivery. The values are:

- *'Care: We are attentive to individual needs and circumstance*
- *Integrity: We are consistently true, act diligently and lead by example*
- *Respect: We will behave with courtesy, dignity and fairness in all we do*
- *Commitment: We will always do the best we can all of the time.'*¹⁶

Building upon and operationalising these values, CQHHS embarked upon a project to set a long-term strategic direction for the provision of healthcare in Central Queensland. Following significant consultation with staff, patients, consumers, special interest groups and partners in the community, CQHHS released *Destination 2030: Great Care for Central Queenslanders* (the strategy) in October 2017. The key goal of the strategy *'is for Central Queenslanders to be amongst the healthiest in Australia and for [the] health services to be amongst the best in the country'*.¹⁷

The strategy outlines the key deliverables to reach the goal and these are centred around five key strategic objectives, namely:

- *'Great Care, Great Experience: Safe, compassionate care, delivered to the highest standards, close to home, with consumers at the heart of all we do*
- *Great people, Great place to work: Great staff in great teams with a culture of supporting and investing in our people's future*
- *Great Learning and Research: Great place to learn, research and shape the future of healthcare*
- *Great Partnerships: Working collaboratively with our partners to deliver great care and improve the health of Central Queenslanders*
- *Sustainable Future: Securing the future of great healthcare with efficient, effective, affordable and sustainable services.'*¹⁸

¹⁵ Central Queensland Hospital and Health Service, 2017–2018 Annual Report.

¹⁶ Central Queensland Hospital and Health Service, *Destination 2030: Delivering Great Care for Central Queenslanders*, October 2017.

¹⁷ Ibid

¹⁸ Ibid

To enable the achievement of the strategy, CQHHS has developed and will develop roadmaps for 2020, 2025 and 2030. Each roadmap sets deliverables for the five financial years falling within the roadmap. Some of the roadmap projects completed to date include:

- developing a Central Queensland telehealth strategic plan to secure the provision of health services closer to home
- developing a strategy to support the increasing health and wellbeing of the Woorabinda community, focusing on youth consultation and smoking cessation
- developing patient experience and consumer engagement strategic plans
- implementing a research development program with partner universities
- launching the ‘10,000 lives’ smoking cessation program with key community partners.

3.3 CQHHS committees

CQHHS and the individual facilities have a series of committees that have varying responsibilities and terms of reference. Some of the committees are required under the *Hospital and Health Boards Act 2011* (HHB Act), while others have been established by CQHHS and the individual facilities to manage the safety and quality and clinical governance for maternity services across the health service. Figure 3 is the current committee structure for the maternity services across CQHHS. This will be expanded upon in relation to the clinical governance of each facility in sections 8.3, 13.3, 18.3 and 23.3 of this report.

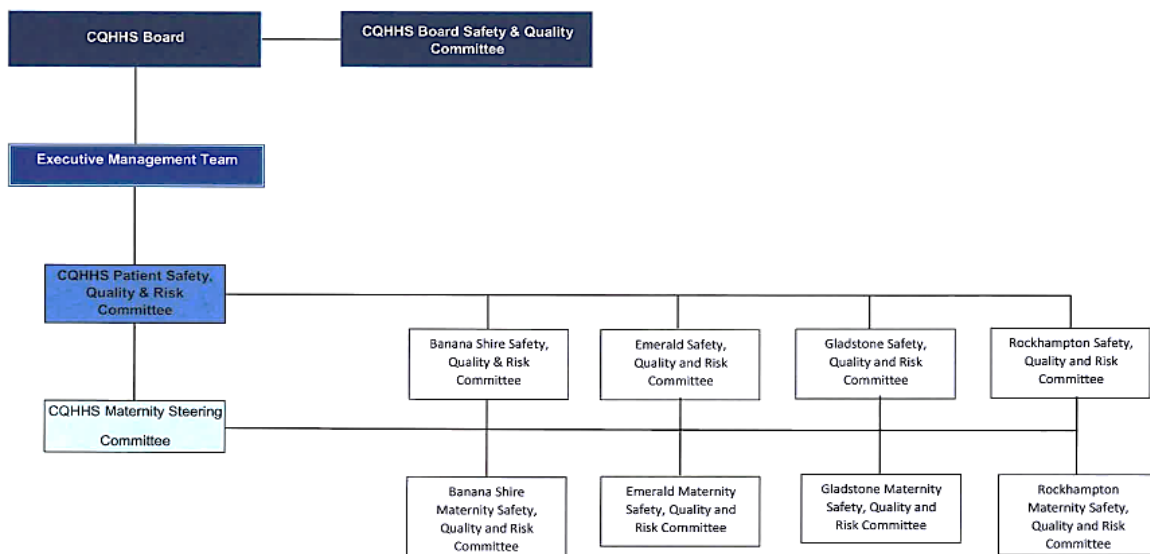


Figure 3 Central Queensland Hospital and Health Service maternity committee structure

4. Investigation scope

The scope of this office's investigation into the maternity services provided across CQHHS has been dynamic, responding to various events including new complaints, corresponding evidence from CQHHS, and internal and external reports about the maternity services. After analysis of this material, the scope of this investigation was refined to seven key themes:

1. safety and quality governance
2. clinical incident management
3. classification and identification of maternal risk and subsequent escalation
4. liaison between emergency and maternity
5. models of care
6. staffing and skills mix
7. culture and communication.

Additionally, issues relating to specific facilities will be explored as follows:

- **Gladstone Hospital:** leadership across the health service, including role modelling of an appropriate safety and quality culture.
- **Emerald Hospital:** historical issues identified in relation to ensuring that women are at the centre of care decisions and not negatively impacted upon by internal cultural issues.
- **Theodore Multipurpose Health Service (MPHS):** confirmation of the Level 1 maternity service that commenced in early 2011, meaning planned birthing services would not be reinstated.

While there were some unique issues arising from the various individual complaints, when these issues were considered in the context of the broader systemic themes, the office concluded that the complainants' concerns would be appropriately and more fulsomely addressed through recommendations made in this report.

5. Inquiries by this office

5.1 Investigative inquiries

During the investigation the office obtained, reviewed and analysed a significant amount of information relevant to the issues identified with the CQHHS maternity services. A list of these documents can be found in **Appendix 3**.

In addition to documentary analysis, staff from the office also:

- observed a coronial inquest into the death of Baby M in February 2016, which was undertaken in Gladstone from 21 to 23 August 2018. This included an informal visit with staff from Gladstone Hospital and speaking with the family of Baby M¹⁹
- attended a series of stakeholder meetings at both Rockhampton and Gladstone Hospitals from 15 to 17 October 2018, including observing business as usual processes and speaking with clinical staff
- attended a series of stakeholder meetings at Emerald Hospital from 8 to 9 January 2019, including meeting with consumers
- attended a meeting with representatives of the community in Theodore on 12 March 2019.

5.2 Adverse comment process

Under the *Health Ombudsman Act 2013*, an entity must be given an opportunity to comment on a draft investigation report where that report is going to make adverse comment and the entity is identifiable.²⁰ Due to the potential significance of this report for both CQHHS and maternity services in Queensland generally, the office undertook a multi-staged adverse comment process. Commentary on CQHHS' adverse comment submission is discussed in section 34 below.

6. Report structure

As this report covers five different facilities and CQHHS it is structured within chapters to assist readers to understand the broad themes and how they apply in the specific context of the health service. The chapters are as follows:

- theme introduction, which outlines the definitions and key elements that are assumed when discussing the themes in healthcare in Queensland
- Rockhampton Hospital, which addresses the themes in relation to its maternity service
- Gladstone Hospital, which addresses the themes in relation to its maternity service
- Biloela Hospital, which addresses the themes in relation to its maternity service
- Emerald Hospital, which addresses the themes in relation to its maternity service
- Theodore Multipurpose Health Service (MPHS), which addresses themes in relation to the appropriateness of the supporting infrastructure of the current service to underpin a Level 1 maternity service
- CQHHS, which addresses the oversight of the maternity services.

¹⁹ https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/582066/cif-baby-m-20180921.pdf

²⁰ Section 86(3) of the *Health Ombudsman Act 2013*.

Theme introduction



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Listen. Respond. Resolve.

7. Theme introduction

As noted above in the investigation scope, there are seven key themes that were common across CQHHS maternity services. Underpinning each of the seven themes there is a series of definitions and key elements that are assumed when discussing these topics in healthcare in Queensland. Therefore, below is an introduction to the general elements of these themes. Each facility chapter will then discuss how the themes have manifested in the specific context of the individual hospital. In relation to clinical governance and clinical incident management, these themes will be discussed in connection with the CQHHS-wide oversight of the maternity services.

7.1 Clinical governance

Clinical governance is defined by the Australian Commission on Safety and Quality in Health Care (the Commission) as *'the set of relationships and responsibilities established by a health service organisation between its state or territory department of health, executive workforce, patients, consumers and other stakeholders to ensure good clinical outcomes'*.²¹ Traditionally, responsibility for clinical governance rested with individual clinicians, who were expected to provide safe and quality care. While this is still a key component in the provision of safe and high quality care, the complexity of the health landscape has meant that in recent years there has been an increased recognition that clinical governance is the responsibility of a variety of persons involved with providing healthcare. This responsibility extends from front line staff to the board of a hospital and health service (HHS), each having a role in securing good clinical outcomes and ensuring that, where possible, the system operates appropriately to minimise instances of preventable patient harm.

Clinical governance is inextricably linked with the overall corporate governance of a health service, and is equally *'important as financial, risk and other business governance'*.²² It is important for management to understand that:

- *'decisions about other aspects of corporate governance can have a direct affect [sic] on the safety and quality of care [and vice versa]*
- *governing bodies are ultimately responsible for good corporate (including clinical) governance*
- *governing bodies cannot govern clinical services well without the deep engagement of skilled clinicians working at all levels of the organisation'*.²³

²¹ Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, 2017.

²² Ibid

²³ Ibid

Due to the structure of HHSs in Queensland, clinical governance is managed and implemented throughout various levels, starting with the service line area safety and quality committee, which may report to a directorate or hospital-wide safety and quality committee, which then reports to the board safety and quality committee. The CQHHS governance structure was outlined in section 3.3 above.

This report will explore the adequacy of the clinical governance being implemented in each facility from the maternity service through to the hospital-wide safety and quality committees.

7.2 Clinical incident management

It is a reality of healthcare that incidents do occur and these can have significant impacts on patients, families, clinicians and organisations. The hallmark of a safe organisation is where it has a robust response to incidents; ensuring, as far as practicable, that incidents do not recur. A clinical incident management system is a key component that will impact on a health service's capacity to respond to and address incidents in an appropriate and meaningful way.

Incident management in Queensland is taken to incorporate:

- *'[identifying] and [treating] hazards before they lead to patient harm (pro-active)*
- *[identifying] when patients are harmed and promptly [intervening] to minimise the harm caused to a patient as a result of the incident (reactive)*
- *[disclosing] a clinical incident resulting in patient harm (pro-active and reactive)*
- *[ensuring] that lessons learned from clinical incidents are communicated and applied by taking preventative actions designed to minimise the risk of similar incidents occurring in the future (pro-active and reactive).'*²⁴

Actions taken in response to an incident are rarely undertaken in isolation of each other but are interconnected. Figure 1 (below) is a representation of the main steps that should occur during incident management. Standard 1 of the National Standards also emphasises the importance of these steps in incident management.²⁵

²⁴ Queensland Health, *Best practice guide to clinical incident management*, first edition, June 2014.

²⁵ <http://www.nationalstandards.safetyandquality.gov.au/1.-clinical-governance/patient-safety-and-quality-systems/incident-management-systems-and-open>



Figure 4 Clinical incident management continuum²⁶

When evaluating clinical incident management systems throughout various systemic investigations undertaken over the past three years and relating to different health services (public and private), the office has found that the most common areas for improvement are:

- developing meaningful, high effect²⁷ and implementable recommendations in response to the causes of an incident
- ensuring the complete implementation of corrective actions, including evidence demonstrating implementation
- evaluating the effectiveness of the implemented actions to ensure that the measure addresses the cause of the incident.

²⁶ Queensland Health, *Best practice guide to clinical incident management*, first edition, June 2014 (Best Practice Guide).

²⁷ The Best Practice Guide outlines criteria for high, medium and low effect and effort recommendations. Generally, the stronger the recommended action the more likely that it will effect change to prevent the incident in the future. Anecdotally, health service organisations have tended to develop low effect recommendations, for example, drafting a new policy or training staff.

These issues have also been identified in the Commission's National Model Clinical Governance Framework, which seeks to address these concerns, and others, through an overarching governance framework.²⁸

This report will focus on the implementation (analysis process) and evaluation (follow through) phases of the clinical incident management system overseen by CQHHS.

7.3 Classification and identification of maternal risk and subsequent escalation

The Australian College of Midwives' (ACM) *National Midwifery Guidelines for Consultation and Referral* (referral guidelines) provide a rigorous set of clinical indicators to aid midwives in establishing a woman's risk status, which consequently impacts the type of care she should receive at the commencement of and throughout her pregnancy, including during the intrapartum period. Most health services have developed initial risk assessment tools, based on the referral guidelines, which support the initial categorisation of a pregnant woman's risk. Best practice recommends that a woman's risk status is assessed, updated and recorded at each antenatal visit. This enables variations in risk to be captured, escalated and communicated between clinicians.

There are three levels of risk categorisation, namely:

- **Category A:** low risk that requires discussion between midwives or other health care providers
- **Category B:** moderate risk that requires consultation with a medical practitioner
- **Category C:** high risk that requires referral to secondary or tertiary care provided by specialist medical practitioners.²⁹

The referral guidelines note that '*where there are variations in the severity of a condition there may be more than one level recommended e.g. B/C; A/B/C*'.³⁰ It is general policy of most health services that where a woman's risk status sits across categories that the highest category is chosen to ensure that there is appropriate medical oversight. From that position a management plan can then be decided in consultation between the midwife and medical practitioner.

Across various systemic investigations into different maternity services, individual maternity complaints to the office, and anecdotal information from midwifery staff, the office has

²⁸ Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, 2017.

²⁹ Australian College of Midwives, *National Midwifery Guidelines for Consultation and Referral*, 3rd Edition, Issue 2.

³⁰ Ibid

observed a poor application of the referral guidelines in practice across Queensland, particularly in relation to:

- the appropriateness of the initial risk categorisation
- frequency and consistency of revised risk assessments
- escalation and/or transfer of care when the risk categorisation changes.

This report will focus on the adequacy of revised risk assessments and escalation of care in each facility.

7.4 Liaison between emergency and maternity

It is common for a pregnant woman to access hospital services via various pathways during her pregnancy. On some occasions this access will be in connection with health issues unrelated to pregnancy and will occur outside of the maternity setting. For example, pregnant women may access hospital services via the emergency department. Given the impact that non-pregnancy related issues can have on the health of mother and baby and the way in which pregnancy can impact on standard vital observations, it is important for the emergency and maternity departments to be engaged with each other to ensure the best outcomes for pregnant patients. This is particularly important in regional centres, like those falling within CQHHS, as for many pregnant women their main point of access for all services after hours will be via the emergency department.

This report will explore the interconnectedness of the emergency and maternity departments in their management of pregnant women in each facility.

7.5 Models of care

The Australian Government identified that women have different needs during the course of their pregnancy and as such they should be matched with a model of care that will ensure that they are '*at the right place, at the right time, with the right health professional*'.³¹ To ensure greater consistency of data collection and language around models of care, in 2016, the Australian Institute of Health and Welfare (AIHW) developed the Maternity Care Classification System, which includes 11 Major Model Categories³², namely:

1. Public hospital maternity care: antenatal, intrapartum and postnatal care is provided by hospital midwives and/or specialist obstetricians in various hospital settings.³³

³¹ <https://beta.health.gov.au/resources/pregnancy-care-guidelines/part-b-core-practices-in-pregnancy-care/providing-pregnancy-care-services>

³² Australian Institute of Health and Welfare, *Maternity Care Classification System: Maternity Model of Care Data Set Specification national pilot report, November 2014*, published 24 February 2016.

³³ Ibid

2. Team midwifery care: *'antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives in collaboration with [specialist obstetricians if there are] identified risk factors.'*³⁴
3. Midwifery Group Practice (MGP) caseload care: *'antenatal, intrapartum and postnatal care is provided within a publicly funded caseload model by a known primary midwife with secondary back-up midwife in collaboration with specialist obstetricians if there are identified risk factors.'*³⁵
4. Remote area maternity care: *'antenatal and postnatal care is provided in remote communities by a remote area midwife...or group midwives sometimes in collaboration with a remote area nurse and/or doctor.'* Intrapartum and postnatal care is provided by the appropriate regional hospital specialist obstetricians and/or midwives.³⁶
5. Public hospital high risk care: women with medically complex and high risk pregnancies receive antenatal, intrapartum and postnatal care provided by specialist obstetricians, including subspecialists such as maternal fetal medicine specialists, in collaboration with midwives. Women may be transferred to this model of care at any time during their pregnancy if their risk status changes.³⁷
6. Private midwifery care: *'antenatal, intrapartum and postnatal care is provided by a private midwife or group of midwives'* and may be provided in a number of different locations. This care may also be provided in conjunction with specialist obstetricians if there are identified risk factors.³⁸
7. Private obstetrician: antenatal, intrapartum and postnatal care is provided by a private specialist obstetrician in the hospital setting, supported by hospital midwives.³⁹
8. Private obstetrician and privately practising midwife joint care: *'antenatal, intrapartum and postnatal care is provided by a privately practising obstetrician and midwife from the same collaborative private practice.'*⁴⁰
9. Combined care: antenatal care is provided in the community by a private midwife or general practitioner (GP). Intrapartum and antenatal care is provided in public hospitals by specialist obstetricians and/or midwives.⁴¹
10. Shared care: antenatal care is provided by the midwife or GP in the community in collaboration with specialist obstetricians and/or midwives from the local hospital in

³⁴ Ibid

³⁵ Ibid

³⁶ Ibid

³⁷ Ibid

³⁸ Ibid

³⁹ Ibid

⁴⁰ <https://meteor.aihw.gov.au/content/index.phtml/itemId/559627>

⁴¹ Australian Institute of Health and Welfare, *Maternity Care Classification System: Maternity Model of Care Data Set Specification national pilot report, November 2014*, published 24 February 2016.

accordance with an established agreement. Intrapartum and postnatal care are usually provided by hospital midwives.⁴²

11. GP obstetrician care: antenatal care is provided by the GP obstetrician in the community, with intrapartum care provided by the GP obstetrician in a public or private hospital setting in collaboration with hospital midwives. Postnatal care is usually provided by hospital midwives.⁴³

The maternity services offered across CQHHS facilities involve a number of the above models of care. This report will consider the appropriateness of how some of these models are operating at each facility.

7.6 Staffing and skills mix

The issue of staffing and skills mix in the maternity service is perennial. It impacts health services to a greater or lesser degree depending on their ability to strategically manage staffing resources to their fullest extent. There is a significant body of literature both in Australia and internationally that links maternity staffing levels to the quality of outcomes for mothers and babies. Equally, the impact of the skill mix of staff on any shift can be considerable, particularly as junior midwives and doctors will require more support to handle complex cases, putting greater strain on the more experienced workforce. Acknowledging the importance of appropriate staffing, in 2018, the Queensland Government made an election promise to provide funding for 100 additional midwives across Queensland.⁴⁴

In Queensland, there are no set ratios for midwives working in the maternity service. In 2016, nurse-to-patient ratios were introduced for acute medical and surgical wards but this is yet to be extended to other areas of a health service.⁴⁵ This is not dissimilar to the position internationally, although the National Institute for Health and Care Excellence (NICE), in the United Kingdom, does outline recommended maternity staffing ratios such as women in established labour should receive one-to-one midwifery care.⁴⁶

While ratios have not been adopted for maternity services, the Queensland Health *Business Planning Framework* (BPF) is a tool available to health services to 'determine the nursing and midwifery staffing and skill mix levels that are needed to provide appropriate and safe care in different types of clinical settings'.⁴⁷ The BPF is supplemented by the *Maternity Services Addendum 2018*, which recognises the unique challenges and considerations that comprise staffing and resource allocations in the maternity service e.g. service complexity,

⁴² Ibid

⁴³ Ibid

⁴⁴

https://www.queenslandlabor.org/media/20197/alpq_nurse_navigators_midwives_policy_document_final.pdf

⁴⁵ https://www.health.qld.gov.au/_data/assets/pdf_file/0032/666419/npr-general-info-sheet.pdf

⁴⁶ NICE Guideline, *Safe midwifery staffing for maternity settings*, 27 February 2015.

⁴⁷ <https://www.health.qld.gov.au/ocnmo/nursing/nurse-to-patient-ratios/nurse-patient-ratios-faqs>

differing models of care, quality and safety, and education and service capacity development.^{48 49}

This report will explore the adequacy of the staffing and skills mix, in relation to both midwifery and medical staff, at each facility.

7.7 Culture and communication

There are a myriad of definitions for organisational culture but the majority are able to be divided between two key philosophical approaches; one sees culture as something that an organisation 'is' making it inseparable from the overarching organisation, the other sees it as something that an organisation 'has' making it possible to isolate, separate and change elements of the culture to be more effective.⁵⁰

Trying to change culture is a difficult challenge in complex healthcare environments due to the multitude of factors at play. However, the office has observed that where there is a poor response to adverse incidents or a lack of robust safety and quality processes, this often has at its root cause a culture in need of repair. Such cultural change should be driven from the top of the health service and filter down; individuals can have a significant impact on the capacity for a culture to improve. This is recognised by the National Health Service (NHS), United Kingdom, which identified six key components of a healthy culture, namely:

1. inspiring vision and values
2. goals and performance
3. support and compassion
4. learning and innovation
5. effective teamwork
6. collective leadership.⁵¹

This report will consider culture as something that a health service has and as such can be improved and addressed through targeted measures.

⁴⁸ Queensland Health, *Business Planning Framework: a tool for nursing and midwifery workload management – Maternity Services Addendum 2018*,

⁴⁹ CQHHS utilised the NICE guidelines in the development of their safe staffing model in 2016, prior to the BPF *Maternity Services Addendum* being released in 2018.

⁵⁰ Davies, HTO et al, *Organisational culture and quality of health care*, Quality in Health Care, 2000, pp 111 to 119.

⁵¹ <https://www.kingsfund.org.uk/projects/culture>

Rockhampton Hospital maternity service



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Rockhampton Hospital

8. Facility

8.1 Facility overview

Rockhampton Hospital, also known as Rockhampton Base Hospital, opened its doors in 1867. It is the largest facility in the Central Queensland catchment, with 304 overnight patient beds. The maternity ward has a total of 15 antenatal and postnatal beds, five birth suites and three assessment rooms. There is also a Special Care Nursery (SCN) with six cots to support unwell and premature babies.⁵² The SCN enables babies that need to be transferred to Brisbane for care to be stepped down to Rockhampton Hospital faster, limiting the amount of time that families have to spend away from home. In 2018, there were 1,248 births at Rockhampton Hospital.⁵³

The maternity and neonatal services at Rockhampton Hospital have been assessed by CQHHS as a CSCF Level 4 service.⁵⁴ This is the only Level 4 maternity service in the CQHHS area and supports a number of the smaller maternity services through a hub and spoke model of care. According to the CSCF modules for maternity and neonatal care, a Level 4 service is expected to provide:

- planned birthing of babies at 32 weeks gestational age or weighing 1,500 grams, where continuous positive airway pressure (CPAP) equipment is available onsite
- antenatal and intrapartum care for women with low or moderate risk pregnancies, and may provide high risk antenatal clinics as a satellite for higher level services
- documented processes with higher and lower level services for rapidly transferring women to ensure they receive the most appropriate care and management
- necessary equipment and expertise to capture fetal samples e.g. blood sampling, arterial and venous cord gases and lactate or pH
- timely access to registered medical practitioners with specialist qualifications in obstetrics and gynaecology, anaesthetics, and paediatrics. Additionally, a minimum of two registered midwives must be rostered onto the maternity ward and birth suite 24 hours per day.⁵⁵

8.2 Benchmarking Rockhampton Hospital's performance

When benchmarked against its peer Level 4 maternity services, Rockhampton Hospital consistently performed within the expected ranges for a variety of maternity indicators and in some cases exceeded the benchmarks for a Level 4 service. The data from the WHA benchmarking report for 2016-17 shows:

⁵² <https://www.health.qld.gov.au/cq/hospitals/rockhampton/services/maternity>

⁵³ <https://data.qld.gov.au/dataset/births-by-hospital/resource/7af8f98e-4f43-496b-b540-efa21bbe5e48>

⁵⁴ https://www.health.qld.gov.au/_data/assets/pdf_file/0028/444619/cscf-selfassess-sum-centralqld.pdf

⁵⁵ CSCF, Maternity Services, Module Overview, version 3.2 and CSCF, Neonatal Services, Module Overview, version 3.2.

- 34.2 per cent of women were giving birth for the first time
- 12.9 per cent of women were over the age of 35 when giving birth, compared to 17.64 per cent of women in the peer facilities (this same trend applied to women giving birth over 40 years of age)
- 5.6 per cent of women had a body mass index⁵⁶ (BMI) in excess of 40 at 20 weeks gestation, compared with 3.37 per cent across Level 3 to 5 facilities
- 43.2 per cent of women had an unassisted vaginal birth after the spontaneous onset of labour versus 29.26 per cent of women in peer facilities
- 11.6 per cent of selected primipara⁵⁷ women had an epidural, compared with 36.10 per cent of women in Level 3 to 5 peers hospitals
- 1.3 per cent of women who gave birth vaginally had a third or fourth degree tear, compared to 3.39 per cent in peer facilities
- 1.0 per cent of babies had an APGAR score⁵⁸ of six or less at five minutes versus 1.87 per cent across Level 3 to 5 hospitals.

In addition to the above, Queensland Health provided CQHHS with a report outlining a *'high-level summary of patient safety and quality performance measures relating to maternal care at Rockhampton Hospital'*. Some highlights of this report include:

- between September 2015 and March 2018, Rockhampton Hospital had two VLAD flags at upper level 1 and 2, demonstrating that they had better outcomes than the state average
- between 1 January 2016 and 11 June 2018, Rockhampton Hospital only had one extreme consumer complaint; this related to a neonatal death
- in 2017 there were no severity assessment code⁵⁹ (SAC) 1 incidents in the maternity service at Rockhampton Hospital.

⁵⁶ Body mass index is 'a measure for indicating nutritional status in adults. It is defined as a person's weight in kilograms divided by the square of the person's height in metres (kg/m²). For example, an adult who weighs 70 kg and whose height is 1.75 m will have a BMI of 22.9.' - <http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/a-healthy-lifestyle/body-mass-index-bmi>

⁵⁷ A primipara, also referred to as a primip, is a woman giving birth for the first time.

⁵⁸ An APGAR score is a method to quickly summarise the health of a newborn at 1, 5 and 10 minutes after birth. APGAR involves five criteria, namely appearance, pulse, grimace, activity and respiration. The score ranges from zero to 10. The lower the score the greater the likelihood that the baby requires medical attention and could have serious complications, particularly if the low score persists across the three testing times.

⁵⁹ Severity assessment codes (SAC) are applied to clinical incidents to determine the appropriate course of investigation. There are four SAC categories each of which includes all clinical incidents/near misses where the outcome is not reasonably expected from the healthcare. SAC 1 incidents involve death or likely permanent harm; SAC 2 incidents involve temporary harm; SAC 3 incidents involve minimal harm; and SAC 4 incidents involve no harm or a near miss. SAC 4 incidents were introduced by Queensland Health in line with the rollout of Riskman as the new incident management system.

8.3 Rockhampton Hospital committee structure

Rockhampton Hospital and the maternity service have two levels of safety and quality committees that are responsible for overseeing incident management, responses to complaints and trend analysis to support continuous improvement. Additionally, there are two leadership meetings that also consider complaints and clinical incidents. These meetings were implemented to ensure that leadership remained up-to-date and agile when managing complaints and incidents. Figure 4 shows the Rockhampton Hospital committee structure and how it feeds into the overall safety and quality governance structure of CQHHS.

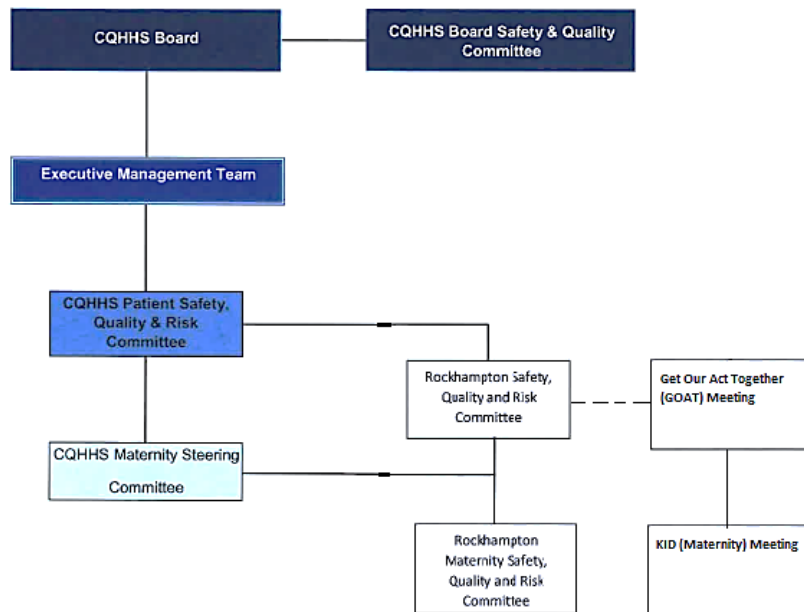


Figure 5 Rockhampton Hospital maternity committee structure

A summary of each of these committees and meetings is as follows:

- Rockhampton Safety, Quality and Risk Committee:** This committee meets monthly and is managed by the Rockhampton Business Unit, who are responsible for the oversight of serious clinical incidents. The committee reviews safety and quality issues from service lines across the hospital. Two of the key responsibilities of the committee are: the review of evidence and sign-off on the closure of SAC 1 incident recommendations, and the identification and consideration of incident trends to drive continuous improvement.
- Rockhampton Maternity Safety, Quality and Risk Committee:** This committee meets monthly and is chaired by a Clinical Midwifery Consultant. The meeting is held on the maternity ward to facilitate attendance by clinicians. The committee discusses topics such as governance systems, audit schedule and audits, risk management, and consumer participation and engagement. It is also the peak avenue for the maternity service to reflect on patient safety matters.

- **Get Our Act Together (GOAT):** The GOAT meeting is held weekly and attended by the Rockhampton Leadership Team, including the Executive Director, Rockhampton Hospital and directors from each service line throughout the hospital. The meeting was introduced to enable leadership to be more agile in responding to and managing complaints outside of the set monthly safety and quality committee meetings. The purpose of the meeting is for the leadership team to review and monitor all complaints (both from consumers and third parties such as this office), review and monitor all clinical incidents until closed, sign-off on the closure of SAC2 to 4 recommendations, and ensure that SAC levels are confirmed within three days of the incident being reported.
- **KID:** With the focus on the maternity service over the last three years it was decided that a KID meeting should be introduced, similar to the GOAT meeting, where the focus is on maternity SAC 1, 2 and 3 incidents. The KID meeting occurs weekly. It covers the progress being made towards closure of the recommendations and provides status updates to the GOAT meeting.

9. Maternity service reviews

9.1 External review

Between May 2015 and August 2016, there were seven serious maternal incidents at Rockhampton Hospital. The first five of these incidents, from May 2015 to February 2016, prompted the then Chief Executive of CQHHS to commission an independent review into the maternity service (the review).⁶⁰ The review was undertaken by three senior clinical experts from the Royal Brisbane and Women's Hospital, Proserpine Hospital and Nambour General Hospital.

The terms of reference for the review requested the provision of:

'...expert clinical advice regarding the treatment provided to the Patients in the Maternity Unit (Unit) at Rockhampton Hospital...[including making recommendations regarding] the ways in which the safety and quality of maternity services at Rockhampton Hospital can be maintained and improved, including identifying any systems and processes required to improve the standard of care and reliability'.

The review concluded that the maternity service needed to improve in a number of the main areas that comprise a contemporary and safe health service including, clinical incident management, clinical governance, triaging, risk assessing and escalating women and their care, appropriate staffing and skills mix, culture and communication, and clinical recordkeeping. It made 35 recommendations, all of which were accepted by CQHHS. All of the recommendations were implemented by January 2017; this involved a considerable amount of effort on the part of all maternity staff and the executive of both Rockhampton Hospital and CQHHS.

⁶⁰ The review was commissioned under section 124 of the HHB Act and as such is confidential. CQHHS released a public version of the review recommendations.

9.2 Gap analysis

With the release of the office's report, *Gold Coast University Hospital's response to adverse maternity events*, in March 2018, CQHHS decided to proactively undertake a gap analysis between the Rockhampton maternity service and the issues and recommendations made in the report. Rockhampton Hospital reviewed its processes, policies and procedures, identifying that in a majority of cases there were appropriate measures in place to address the gaps identified in the report. The office was provided with a copy of the gap analysis and supporting evidence and is satisfied that Rockhampton Hospital has the necessary processes relevant for its CSCF level and facility environment.

10. Complaints to the office

As noted in section 1.1 above, the office commenced an own motion systemic investigation into the Rockhampton Hospital maternity service. Additionally, the office has received 15 complaints about the maternity service at Rockhampton Hospital between June 2015 and December 2018.⁶¹ These complaints have taken various pathways through the office's jurisdiction as outlined in Table 1 below. The main issue identified across the complaints was professional performance.

Table 1 Rockhampton Hospital complaint outcomes

Outcome type	Number of outcomes ⁶²
No further action at intake	3
No further action after assessment	4
Referral to another government entity	4
Resolved via local resolution	2
Conciliation	1
Complaint withdrawn	1

It should be noted that the total number of complaints received by the office about the maternity service is statistically insignificant when compared to the approximately 5,092 births occurring at Rockhampton Hospital between 2015 and 2018.

⁶¹ The total number of complaints does not include complaints which are still pending an outcome.

⁶² There may be multiple outcomes for a complaint as it progresses through the office's jurisdiction.

11. Issues affecting maternity services at Rockhampton Hospital

The following sections provide a detailed analysis of the issues investigated by the office in relation to the Rockhampton Hospital maternity service.

11.1 Risk and escalation

In four of the seven serious maternal incidents referred to above in section 9.1, the incident reviews identified that there was a lack of an appropriate initial risk assessment, no reassessment of risk as the pregnancy progressed and during the intrapartum period, and poor escalation of care even when it was acknowledged that the risk status had changed. These findings were also highlighted by the review. This poor approach to risk was attributed to a failure in the culture to embed continuous risk assessing as a 'business as usual' process when providing antenatal and intrapartum care, which resulted in limited staff understanding of how to respond to and manage changes in risk. The two case studies below demonstrate the significance that an inaccurate initial risk categorisation and ongoing response to risk can have on the outcomes for mother and baby.

Case study of Patient A

Patient A was a 27 year old first time mother who had been admitted to Rockhampton Hospital for observations on several occasions throughout her pregnancy. In 2015, the maternity service was using the Maternity Risk Assessment Tool (MRAT), which had been developed from the referral guidelines. The MRAT was supposed to be completed at the initial booking-in appointment and then reassessed at 28, 34, 39, and 41 weeks gestation and when the woman presented in labour. The MRAT was only completed for Patient A during her booking-in appointment and she was categorised as low risk.

The categorisation of Patient A as low risk carried over into her intrapartum period, where her entire clinical picture, including previous attendances for antepartum haemorrhage (APH)⁶³, poor progression of labour, and abnormalities on the cardiotocography⁶⁴ (CTG), should have altered her risk status. Specifically, in early July 2015, at around 06:20, Patient A presented to the Rockhampton birth suite having experienced contractions of 2 every 10 minutes lasting for 45 seconds. Patient A was reviewed and discharged home with a plan to return if the contractions increased or there were reduced fetal movements. This was a missed opportunity to reassess

⁶³ Antepartum haemorrhage (APH) is defined as 'bleeding from or in to the genital tract, occurring from 24 weeks of pregnancy and prior to the birth of the baby' -

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_63.pdf

⁶⁴ Cardiotocography (CTG) is a type of intrapartum fetal surveillance that monitors the maternal and fetal heart rate. A CTG may be undertaken at various stages throughout a pregnancy and it is reviewed to ascertain if it is normal or abnormal, with corresponding escalation of care required for an abnormal CTG -

https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Intrapartum-Fetal-Surveillance-Guideline-Third-edition-Aug-2014.pdf?ext=.pdf

Case study of Patient A

Patient A's risk in light of her current presentation and past issues, as noted above, throughout her pregnancy. Patient A was 40 weeks pregnant.

Patient A returned to the birth suite at 15:15 with stronger contractions and was found to be three centimetres dilated. On 10 July 2015, at 20:10, Patient A had a spontaneous vaginal birth. The baby had APGAR scores of 3 at 1 minute, 3 at 5 minutes and 5 at 10 minutes. The baby took its first spontaneous breath at 15 minutes; but showed signs of stage 2 hypoxic-ischemic encephalopathy (HIE).⁶⁵ If Patient A's risk had been properly assessed across the course of 10 July 2015 then this may have resulted in an expedited delivery of her baby during the first or second stages of labour.

The missed opportunities to respond to and escalate care were due to a continued belief that Patient A was low risk. Appropriately identifying and responding to risk during pregnancy is vital for securing safe outcomes.

Case study of Patient B

Patient B was a 20 year old woman with three previous confirmed pregnancies and one birth. At her booking-in appointment she was categorised as a lower risk B on the MRAT. This was despite Patient B having high risk factors (previous lower segment Caesarean section due to an abruption, intra-uterine fetal growth restriction, and previous APH) that should have resulted in her being categorised as a high risk C on the MRAT. These high risk factors were documented by both midwifery and medical staff within the MRAT but Patient B's risk status was not re-categorised, which impacted the management of her care.

At an antenatal appointment on 27 April 2015, Patient B was reviewed by a junior medical officer, not a consultant, despite her high risk profile. It was noted around this time that Patient B was '*High Risk and required follow up care at hospital*'. Despite this, Patient B continued to be cared for in a low risk environment.

On 16 July 2015 at 03:55, Patient B presented to the maternity service in labour. She had a category 2 Caesarean section; this should have been a category 1 given the immediate threat to the life of the neonate. At 05:19 the baby was born lifeless and resuscitation efforts were commenced, continuing for 32 minutes until the baby was declared stillborn. Patient B also suffered a massive post-partum haemorrhage following a placental abruption.

While it is not possible to ascertain whether the outcome would have changed if Patient B's risk status had been properly categorised, it is important that missed opportunities are minimised to secure confidence in the quality and safety of care being provided. In Patient B's case there were multiple opportunities throughout the antenatal period at her routine clinic appointments to have re-categorised her and ensure she received the care appropriate to her risk status.

⁶⁵ Hypoxic-ischemic encephalopathy is a '*type of neonatal encephalopathy caused by systemic hypoxaemia and/or reduced cerebral blood flow resulting from an acute peri partum or intrapartum event. It is a condition which can cause significant mortality and long-term morbidity.*' Source:

https://www.health.qld.gov.au/__data/assets/pdf_file/0014/140162/g-hie.pdf

In late 2015, ahead of the review, CQHHS had an MRAT Working Party which was reviewing the appropriateness of the MRAT and considering the types of risk assessment tools that were being used by other maternity services. This work culminated in the development of the initial midwife assessment (IMA), which is a two page risk assessment tool to guide a midwife through the relevant risk factors and their categories as per the Referral Guidelines. The IMA is supported by the CQHHS *Maternity Risk Assessment Tool (Initial Midwife Assessment)* procedure (the procedure), which was published in November 2016. The IMA and the procedure aim to create a consistent approach to risk assessment across the CQHHS maternity service.

The procedure is unambiguous in how the IMA is to be used and how the information from the IMA should be recorded in the patient's handheld pregnancy health record (the record). For example, a midwife should document the relevant risk code in the '*Midwife Risk Evaluation*' section of the record each time the risk is assessed, with formal assessments required at 36 and 40 weeks gestation. This section should also be updated as and when any new risks are identified during the antenatal period. When risks are identified and/or updated they are also required to be input into the '*Medical and Obstetric Issues and Management Plan*' in the record. Routinely and comprehensively completing these sections with the relevant risk information ensures that when clinicians review the patient they are cognisant of relevant risk factors and the risk categorisation, which will impact the woman's care pathway.

To ensure the IMA and a risk assessment culture is embedded, while also supporting compliance with the National Standards, there are 10 audits of the IMA annually. The audit results for April to December 2018, show that the IMA was utilised in 80 per cent of the cases audited. This is the lower level safe benchmark set by CQHHS so there is an ongoing opportunity for use of the IMA. In addition to the IMA, the Maternity Unit introduced the High Risk Case Conference, which is for the highest risk women (colloquially described as C++ women). The conference occurs each week and is multidisciplinary, attended by a range of clinicians and non-clinicians including, consultant obstetrician, consultant paediatrician, midwifery navigator, social worker and child safety officer. Due to the hub and spoke model at CQHHS, other maternity services can teleconference into the conference to discuss any high risk patients and receive advice about an appropriate management plan. The conference has been operating since around January 2017 and will be audited and evaluated to ascertain whether it needs to be refined going forward.

Between April 2016 and January 2018, there were no serious SAC 1 incidents in which a failure to appropriately categorise, re-categorise or escalate maternal risk has been identified as a contributing factor to a poor outcome. This suggests that the measures implemented by the Rockhampton Hospital maternity service have been effective at embedding a culture focused on making risk assessing 'business as usual' during antenatal and intrapartum care.

11.2 Emergency and maternity liaison

While the office did not identify any specific concerns with the liaison between the emergency department and maternity service at Rockhampton Hospital in the context of the incident reviews, this is a common area for improvement across Queensland maternity services. At Rockhampton Hospital the relationship between the two service lines is important because women below 20 weeks gestation will be

managed in the emergency department, if they present with pregnancy-related complications, so staff need to have some understanding of obstetric issues and feel comfortable seeking assistance from the maternity service.

During the on-site stakeholder visit in October 2018, the office's staff toured the emergency department. This put into context the geographic layout of the hospital and the distances between emergency and maternity, which are on different levels of the hospital. It is clear from the tour and discussions with relevant staff that the two service lines have refined their ways of working together to improve collaboration and increase the knowledge of the emergency staff in managing obstetric presentations. Some of the measures that have been implemented include:

- a senior medical officer covering the emergency department between 07:30 and 23:30 every day, including ensuring a pregnant woman is always seen by a senior medical officer before they are discharged
- one obstetric-focused training session each month during the protected medical training time
- mock scenarios including both emergency and maternity
- utilising the portable ultrasound scanner from birth suite in the emergency department, if required, and if it is unavailable then setting a standard that the woman will be admitted until a scan can be performed
- utilising the handover board and team leader handbook in birth suite to identify pregnant women in other areas in the hospital and making proactive contact with nursing and medical staff to ascertain if midwifery support is required.

The following case study provides an example of how the mock scenarios between emergency and maternity are being applied in practice:

Case study of mock scenario

On 11 October 2018, there was a mock scenario held between the emergency department and maternity service. The scenario utilised live actors and the staff involved were not aware of the scenario in advance. There were four scenario facilitators, being educators from maternity and emergency.

The mock situation involved a woman at 32 weeks gestation presenting to the emergency department, having had nausea, vomiting, abdominal pain and dizziness. The woman was also suffering from a severe headache. She had elevated blood pressure and intermittent seizures throughout the scenario until appropriate interventions were completed.

The scenario had six learning objectives:

1. undertaking a thorough patient assessment
2. recognising a medical emergency and escalating as per the protocol
3. providing supportive care to the patient and family
4. implementing the correct treatment for pre-eclampsia
5. stabilising the patient and preventing complications

Case study of mock scenario

6. demonstrating safe and effective interdepartmental and interdisciplinary communication.

Following the scenario staff held a debrief to discuss what went well and what could have been improved. Overall, the scenario was considered to be well managed and identified one area for improvement that was risk rated low.

These types of mock scenarios that involve multiple service lines are invaluable for applying, honing and refining key skills and relationships to ensure that in a real-life event staff are prepared for, and confident in, managing the situation.

11.3 Models of care

The Rockhampton Hospital maternity service offers the following models of care:

- public hospital care and public hospital high risk care
- MGP
- team midwifery
- shared care
- combined care
- remote area maternity care for Aboriginal and Torres Strait Islander peoples
- private midwifery care.

The below discussion will focus on MGP and shared care.

11.3.1 Midwifery Group Practice

In August 2014, Rockhampton Hospital launched the MGP model of care. In February 2016, this model was suspended by the then Chief Executive due to concerns with the safety and quality of the model. This coincided with the review of the maternity service. The MGP was reinstated in August 2016. From this date until present it has operated as an all-risk caseload model with a full-time midwife undertaking between 35 and 40 births per year. There is a large body of literature demonstrating the beneficial outcomes achieved through the MGP model of care due to the continuity of carer throughout a woman's pregnancy. This model also has a generally higher level of satisfaction for women as they can form a relationship with their midwife prior to birth.

As part of the on-site stakeholder visit in October 2018, staff met with members of the MGP and were advised that the model of care works as follows:

- There are two teams of three MGP midwives, with five positions filled and one vacant.
- Each midwifery team is aligned with an obstetrician enabling improved ways of working together and greater interdisciplinary collaboration.
- There are weekly case conferences between the midwives and the obstetrician.

- High risk women are booked into the relevant obstetrician’s antenatal clinic and a management plan is developed between the MGP midwife and obstetrician; if a woman’s risk changes or there are concerns about her progression then she can be referred back to the obstetrician’s clinic.
 - There will always be at least one MGP midwife attending antenatal clinics so the obstetrician can communicate directly with the MGP about relevant care plans and management.
- All of the MGP midwives will try to introduce themselves to each other’s women throughout the pregnancy, which is beneficial if an MGP midwife, other than the primary carer, has to deliver the baby.

The MGP representatives also advised that they have good relationships with the core midwives, feeling as though they are part of one team, supporting each other to achieve the best outcomes for mothers and babies. Staff from this office considered that this was demonstrated through the interactions between the Midwifery Unit Manager and MGP midwives, which seemed collegiate and consistent with the relationships observed between core staff.

The MGP representatives commented that they face some resistance from the local GP community in advising women about the model of care. The MGP midwives have taken to ‘cold-calling’ women to see if they are aware of the MGP model of care, explaining what it entails and advising them on how to be referred by their GP. The MGP is also considering allowing women to self-refer to the model to address the issues with GP referrals. The MGP representatives explained that the barrier with GPs appears to be in relation to the financial incentive for a GP to manage a woman’s pregnancy and also the high turnover of GPs in Rockhampton—the turnover rate is between 6 and 12 months.

It is clear that the Rockhampton Hospital maternity service is running a high quality MGP and there are plans to expand the service, including recruiting an Indigenous-focused MGP. This will be a gradual expansion as increasing resourcing in the MGP will impact on the resourcing available to the core maternity service. However, as more women birth via the MGP model there should be a corresponding decrease in demand on the core maternity services, balancing out the resourcing requirements.

11.3.2 Shared care

One area of risk for the maternity service comes from referrals from GPs. During the on-site stakeholder visit, representatives from the maternity service expressed the opinion that some higher risk women do not receive the best care possible due to a late referral from their GP to the hospital. In many instances this is not due to a woman’s late presentation to her GP but rather due to the GPs delayed referral to the maternity service. The maternity service is seeking to establish better relationships with the GP cohort to facilitate more timely referrals i.e. as close to 12 weeks gestation as possible. The office was advised that this is challenging due to the frequent changeover of GPs and hesitance on the part of GPs to engage. Some of the strategies being used by the maternity service to improve the referral rate are: providing an electronic referral form that works with the major GP software programs, and holding regular education and meet-and-greet forums, inviting all of the local GPs. These relationships will take time to mature but the efforts being made are focused on providing the best, shared care for mothers and babies.

11.4 Staffing and skills mix

Precipitating the incidents in 2015 and early 2016, there had been considerable discussions around the sufficiency and appropriateness of the staffing and skills mix in the Rockhampton Hospital maternity service, particularly in light of an increasingly complex patient cohort. In mid-February 2016, the tensions between staff and the CQHHS executive reached a critical point with the Queensland Nurses and Midwifery Union (QNMU) calling for a vote of no confidence in the then Chief Executive's leadership and management of understaffing issues. The vote passed and the QNMU wrote to CQHHS cataloguing a variety of serious staffing concerns.⁶⁶ The adequacy of staffing was also a central feature in the review recommendations released in June 2016. The following case study illustrates the issue with staffing and skills mix in 2015:

Case study of Patient A

A contributing factor to Patient A's baby's outcome was the inadequate level of staffing throughout the duration that Patient A was in the birth suite. This staffing was not impacted by any external factors but represented the standard staffing in the birth suite and maternity ward at that time. Specifically, in July 2015, the senior midwife on the morning shift was unable to check-in with the midwife in birth suite, in part because the senior midwife was covering multiple roles. Also, there was no consultant present at the morning handover due to unrecognised leave having been allocated without appropriate cover. On the afternoon shift, a student midwife was assigned to Patient A and the supervision of that student was sporadic and indirect, owing to the primary midwife assigned to Patient A needing to fulfil multiple roles. These included senior midwife, covering all of birth suite, primary midwifery carer of Patient A, and supervisor for two graduate midwives.

A lack of clarity between roles, responsibilities and escalating care meant that staff did not have sufficient capacity to review Patient A's presentation and make a fulsome assessment of her risk status and the care she required. This resulted in a prolonged labour and a poor outcome for the baby.

Understaffing in regional areas is not an issue that can be immediately rectified as it is challenging to attract suitably qualified and skilled staff to vacant positions across regional Australia. In Rockhampton's case this issue was compounded by the poor media coverage of the maternity service in 2016, as the quality of the service is an important factor in attracting staff. Despite these challenges, Rockhampton Hospital committed over the last three years to filling vacant positions and growing the maternity workforce for both midwifery and medical staffing.

11.4.1 Midwifery staffing

Rockhampton Hospital has implemented a number of measures to address the midwifery staffing to make sure that it is safe for mothers and babies. Some of these measures include:

- setting staff ratios for the birth suite, SCN and maternity ward, where possible. These are:

66

https://www.qnmu.org.au/QNMU/PUBLIC/MEDIA_AND_PUBLICATIONS/Media_release_uploads/2016/hospital_staff_call_urgent_action_mums_babies.aspx

- one-to-one care for a labouring woman
 - one SCN nurse/midwife to one baby if unstable or on assisted ventilation
 - one SCN nurse/midwife to two babies if they are on CPAP but otherwise clinically stable
 - one SCN nurse/midwife to four babies who are clinically stable
 - one-to-four/five care on the maternity ward during morning and afternoon shifts and one-to-seven care overnight
- establishing a centralised hub of midwifery and nurse navigators^{67,68}, eight of whom sit in CQ Community Health services. The midwifery navigator is closely linked to the maternity services team, supporting women with complex health care needs throughout their pregnancy, birth and postnatal journey
 - allocating three new MGP positions⁶⁹ to the Rockhampton Hospital maternity service
 - ensuring that there is a team leader rostered on to every shift, this role is supernumerary and coordinates and allocates the activity of the service, provides clinical supervision and assesses intrapartum care standards
 - greater support for graduate midwives through the clinical facilitator and clinical coach positions
 - dedicated midwifery educator for the Rockhampton Hospital maternity service
 - increased compliance with all staff inputting into Trendcare⁷⁰ every shift to build a better profile of the care hours versus staffing hours each shift; this has been built into the performance and development expectations of all staff.

The maternity service has clearly made a concerted effort to secure the staffing to ensure that there are sufficient numbers and skill mix on each shift. By March or April 2019, they are expecting to have full occupancy of midwifery positions. Additionally, there has been a commitment to ensuring that staff are not overburdened by multiple responsibilities, allowing them to focus on providing care. The case study below illustrates just one example of how Rockhampton Hospital has supported this approach.

⁶⁷ Funding for the navigator positions is provided by the Office of the Chief Nursing and Midwifery Officer, Queensland Health.

⁶⁸ *Nurse navigators are a team of registered nurses who provide a service for patients who have complex health conditions and require a high degree of comprehensive clinical care* Their key functions including, coordinating a patient's care across multiple health services, improving patient outcomes and facilitating system improvements- <https://www.health.qld.gov.au/ocnmo/nursing/nurse-navigators>.

⁶⁹ CQHHS was received 11.2 new midwifery positions following on from the Queensland Government's promise of 100 new midwives. The three new positions will be funded out of the 11.2 allocation.

⁷⁰ Trendcare is a workforce planning and workload management system that provides data about patient acuity and hours of patient care versus hours of rostered staffing. It can track the hours of care planned versus the hours of care actualised. Trendcare feeds into the Business Planning Framework and health services plan their forward funding and staffing requirements for the service.

Case study of Maternity Day Assessment Unit

In 2016/17, the maternity service acknowledged that there were some difficulties in sustaining one-to-one care when women were labouring due to unplanned antenatal visits. While there was a midwife rostered to attend to these unannounced women, the increasing workload of the service meant that this midwife was routinely pulled away to provide other clinical care.

In an effort to address this disruption and provide a better service to women, in February 2018, the maternity service established a Maternity Day Assessment Unit (MDAU) on the maternity ward for women at equal to or greater than 20 weeks gestation. The MDAU operates between 08:30 and 17:00, Monday to Friday. If women contact the MDAU outside of these hours the phone automatically reverts to the switchboard or team leader. Approximately 50 per cent of women presenting to the MDAU are self-referrals. The types of presentations vary but approximately 50 per cent are due to reduced fetal movement and of those women 90 per cent require no further care. The maternity service is pleased with these figures as it means that women are both aware of the MDAU and education around reduced fetal movement is reaching the community.

The benefit of the MDAU is that midwives are no longer pulled away from the birth suite. Further, the MDAU has a direct link with the antenatal clinics so can loop women back into the clinics to normalise their care. Finally, the MDAU midwives will check through the book for weekends and afterhours to see if they need to follow-up with any women in the community in relation to their care. One of the biggest gaps is ultrasound scans, particularly for rural women. This has been an effective and proactive service supporting Rockhampton women.

11.4.2 Medical staffing

At the on-site stakeholder visit in October 2018, Rockhampton Hospital representatives confirmed that as of 15 October 2018 the obstetric medical workforce was no longer being supported by locum positions. This is the first time in Rockhampton's recent history that it has not had to rely on a locum workforce to fill some vacancies in obstetric medical staffing. The establishment of a permanent team leads to a number of benefits, including more consistent ways of working between medical and midwifery staff, greater accountability and improved compliance with CQHHS and Rockhampton Hospital policies and procedures, and an increased capacity to be more strategic in the development of the maternity service as the staffing and skills mix is a known quantity.

In addition to securing permanent staff, the obstetrics and gynaecological team introduced a four-day roster of 10-hours per day with set clinic days. This provides consistency in rostering for the staff but also frees-up clinicians to assist on days when they are not rostered on clinics. It builds some redundancy and support into the rostering to enable the maternity service to better respond to times of pressure. In relation to the registrars, the maternity service introduced a colour coded system for incoming registrars, which provides a visual representation of their competency. They get rated on the extent of their experience in certain key procedures and clinical situations. This enables appropriate rostering of various levels of experience. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) suspended the placement of registrars at Rockhampton Hospital from 2017 due to the availability of the necessary procedures forming part of the training. One position will be reinstated in 2019 and three positions will be offered in 2020.

Longer term, the obstetrics team is looking to improve obstetric continuity of care, similar to MGP but for hospital-based care, and will assign portfolios to the obstetricians that align across all of the CQHHS facilities to start to build clinical networks. They are also advocating for a gynaecological nurse navigator to assist with managing a woman's care throughout gynaecological and obstetric issues; it is envisaged that this role could coordinate with the midwifery navigator, particularly for women who are non-compliant with antenatal care.

11.5 Culture and communication

In 2015 and 2016, the Rockhampton Hospital maternity service had significant workplace cultural issues, marked by mistrust and poor communication between staff and the CQHHS executive. This was not a culture only requiring repair but wholesale change, led from the top. As with all damaged cultures, they usually require a momentous event as a catalyst for change, which the maternity service had via multiple incidents, the review and a vote of no confidence. It was apparent to staff during the on-site stakeholder visit in October 2018 that there has been an extraordinary shift in the culture of the maternity service, which is continuing to be built upon. Staff observed a commonality in purpose, mission and values that runs like a *golden thread* from the CQHHS executive to front line staff.

This shared culture and improved communication has not occurred in a vacuum—it has taken a considerable amount of energy and a willingness from all staff to change. During the visit, staff from the office were advised that culture has become a key element in recruitment. The maternity service only wants to recruit staff that share the values of the service and will help it thrive; at times this has resulted in positions being left vacant until an appropriate candidate could be engaged. Making these types of decisions in a high-demand and difficult-to-recruit environment is brave and demonstrates a genuine commitment to cultural change.

The below case study demonstrates one of the key, innovative measures utilised by CQHHS to start to address the culture in the maternity service.

Case study of kaizen workshops

In early 2017, the Rockhampton Hospital maternity service held kaizen workshops⁷¹ across five full days. Staff attending the workshops were taken offline and backfilled with agency staff to ensure the whole maternity service could commit to the workshops. The Chief Executive, Executive Director of Nursing and Midwifery; Quality and Safety, and the Executive Director, Rockhampton Hospital also attended and contributed to the workshops. The workshops focused on opportunities and principles, challenges and cultural change, and staff frustrations and issues. They provided everyone with the opportunity to gauge the baseline of the maternity service prior to pursuing their shared improvement journey. At times the workshops were emotional as staff felt damaged by the actions of the CQHHS executive, particularly over the last two years, and needed to express their feelings in a raw and real way.

⁷¹ Kaizen workshops form part of the lean methodology for management. The workshop involves relevant staff coming together and identifying ways to improve processes; where they can be improved immediately the team should come together to make the change.

Case study of kaizen workshops

The workshops were also highly productive. During one of the improvement days staff tried to be innovative in the application of improvements. For example, some midwives wore pedometers during a birth and identified that over the course of a birth they could walk up to eight kilometres due to the layout of the maternity service. In order to reduce this walking time, moving commonly required items around the Birth Suites and Maternity Ward so that they were grouped together made a significant impact.

Staff also came together to create and name the WOMB room. This is a room on the maternity ward, adjacent to the birth suites, where staff have handover, undertake education and generally come together for meetings. Being on the ward it has increased staff attendance at non-clinical meetings and education because they can step in and out of the meeting or education as their clinical care duties allow.

The maternity service described the kaizen workshops as the acute phase in the change management process, whereby issues were identified, solutions explored and commitments made to implementing projects moving forward. The workshops gave all staff a voice, including junior staff. There were 21 projects identified from the workshops—these were voted on by staff and it was agreed that two would be implemented within the first year. Thirteen projects were then planned for implementation over the next three to five years, with seven having been completed to date.

Following on from the kaizen workshops, the maternity service held another four workshops, one per month over four months, each focusing on a specific topic e.g. antenatal care or SCN. The goal of each workshop was to have an open conversation around what makes clinicians feel safe in those clinical environments and how the maternity service could secure a safe service. The CQHHS executive were of the view that once the maternity service was safe it could be refined and move into a phase of achieving 'excellence'.

The above are just some of the steps that the maternity service has taken to improve its culture both amongst staff and between staff and the CQHHS executive. It is clear in meeting with staff and watching them interact that the maternity service has a healthy and positive culture. Staff are held accountable for their actions and feel safe to speak up when they may have concerns. It will be vital for the Rockhampton Hospital maternity service to maintain the culture it has developed and continue to be aware of the possible vulnerabilities of the culture, which need to be attended to as and when they arise.

12. Conclusion

The Rockhampton Hospital maternity service has made significant strides over the last three years, and is no longer the same service that it was in 2016 when the external review was completed. This was evident during the on-site stakeholder meeting in October 2018, where staff from this office observed a genuine commitment to providing a safe and quality maternity service, which is continuously improving so as to provide the best care for the women of Central Queensland. The maternity service has had considerable support and focus from the CQHHS executive so it is now time for the successes to be consolidated and shared across CQHHS. It will be a challenging next phase for the Rockhampton Hospital maternity service to maintain the quality and pace of the change while splitting its focus to

support the other maternity services to reach the same benchmark. I am confident that the maternity service understands its challenges in continually refining the service and has the strategic and operational capability to continue on its journey. In recognition of the change efforts at Rockhampton Hospital, I do not consider it necessary to make any recommendations.

Gladstone Hospital maternity service



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Gladstone Hospital

13. Facility

13.1 Facility overview

Gladstone Hospital opened its doors in March 1890⁷², extending the main building in 1934.⁷³ It is the second largest facility in the Central Queensland catchment, with 79 overnight patient beds. It will undergo a major redevelopment throughout 2019 and 2020 when a new \$42 million emergency department is completed.

The Family Unit, which incorporates both maternity and paediatrics, has a total of 14 postnatal and gynaecological beds, nine paediatric beds, and four birth suites. A four-cot neonatal nursery was opened on 27 April 2019, and accommodates babies who are clinically stable but need additional support between 35 and 37 weeks gestation or are awaiting transfer to a higher level service. The nursery will also enable babies that need to be transferred to Rockhampton or Brisbane for care to be stepped down to Gladstone Hospital faster, limiting the amount of time that families have to spend away from home. In January 2019, works began on a \$1.25 million upgrade to the Family Unit, including the installation of ensuites for each birth suite. In 2018, there were 560 births at Gladstone Hospital.⁷⁴ This represents the largest number of births at a Level 3 public maternity service in Queensland.

The maternity and neonatal services at Gladstone Hospital have been assessed by CQHHS as a CSCF Level 3 service.⁷⁵ This is one of three Level 3 maternity services across CQHHS. According to the CSCF modules for maternity and neonatal care, a Level 3 service is expected to provide:

- planned birthing of babies at 37 weeks gestational age where there are no identified risk factors
- antenatal and intrapartum care for women with low risk pregnancies
- step-down service for physiologically stable postnatal mothers and babies from 35 weeks gestational age, or care of infants less than 35 weeks provided in consultation with a higher level service
- planned Caesarean sections from 39 weeks gestation or emergency Caesarean sections. A classification system must be used for determining service capability to perform Caesarean sections and outcomes should be audited against the classification system
- timely access 24 hours per day to at least two medical practitioners with credentials in either obstetrics or anaesthetics, an anaesthetic assistant, a registered midwife, and a clinician solely dedicated to neonatal resuscitation.⁷⁶

⁷² Gladstone Regional Art Gallery & Museum

⁷³ <http://gragm.qld.gov.au/media/1017/waves-of-settlement-1901-1939.pdf>

⁷⁴ <https://data.qld.gov.au/dataset/births-by-hospital/resource/7af8f98e-4f43-496b-b540-efa21bbe5e48>

⁷⁵ https://www.health.qld.gov.au/_data/assets/pdf_file/0028/444619/cscf-selfassess-sum-centralqld.pdf

⁷⁶ CSCF, Maternity Services, Module Overview, version 3.2 and CSCF, Neonatal Services, Module Overview, version 3.2.

13.2 Benchmarking Gladstone Hospital's performance

When benchmarked against its peer Level 3 maternity services, Gladstone Hospital consistently performed within the expected ranges for a variety of maternity indicators and in some cases exceeded the benchmarks for a Level 3 service, indicating its overall safety. The data from the WHA benchmarking report for 2016-17 shows:

- 39.2 per cent of women were giving birth for the first time
- 8.3 per cent of women were over the age of 35 when giving birth, compared to 17.64 per cent of women in the peer facilities (this same trend applied to women giving birth over 40 years of age)
- 2.5 per cent of women had a BMI in excess of 40 at 20 weeks gestation, compared with 3.37 per cent across Level 3 to 5 facilities
- 52.2 per cent of women had an unassisted vaginal birth after the spontaneous onset of labour versus 29.26 per cent of women in peer facilities
- 7.6 per cent of selected primipara women had an epidural, compared with 36.10 per cent of women in Level 3 to 5 peers hospitals
- 1.7 per cent of women who gave birth vaginally had a third or fourth degree tear, compared to 3.39 per cent in peer facilities
- 1.8 per cent of babies had an APGAR score of six or less at five minutes which is comparable with peer Level 3 to 5 hospitals where the rate is 1.87 per cent.

In addition to the above, Queensland Health provided CQHHS with a report outlining a '*high-level summary of patient safety and quality performance measures relating to maternal care at Gladstone Hospital*'. Some highlights of this report include:

- between September 2015 and March 2018, Gladstone Hospital had three VLAD flags at upper level 2 and 3, demonstrating that they had better outcomes than the state average
- between 1 January 2016 and 11 June 2018, Gladstone Hospital only had one extreme consumer complaint—this related to a neonatal death
- in 2017 there were no SAC 1 incidents in the maternity service at Gladstone Hospital.

13.3 Gladstone Hospital committee structure

Gladstone Hospital and the maternity service have two levels of safety and quality committees that are responsible for overseeing incident management, responses to complaints and trend analysis to support continuous improvement. Additionally, there is a leadership meeting that also considers complaints and clinical incidents. This meeting was implemented to ensure that leadership remained up-to-date and agile when managing complaints and incidents. Figure 5 shows the Gladstone Hospital committee structure and how it feeds into the overall safety and quality governance structure of CQHHS.

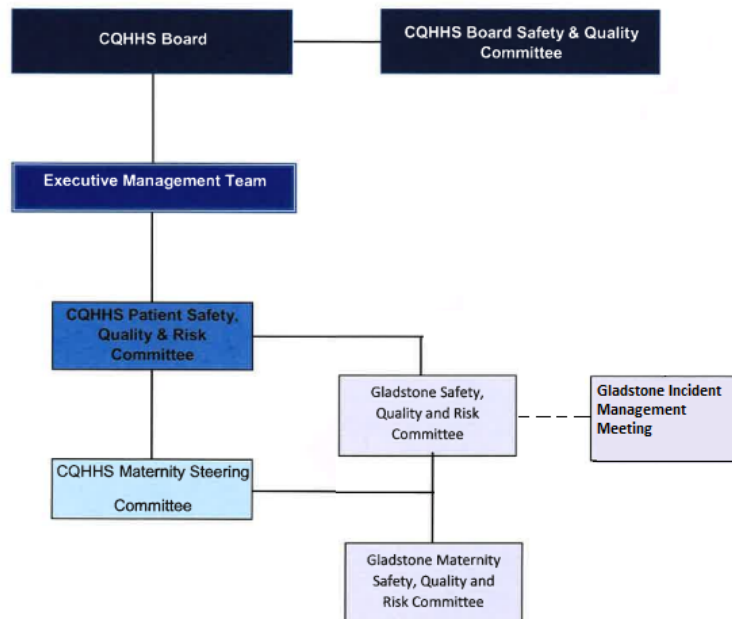


Figure 6 Gladstone Hospital maternity committee structure

A summary of each of these committees and meetings is as follows:

- Gladstone Safety, Quality and Risk Committee:** This committee meets monthly and is managed by the Gladstone and Banana Business Unit, who are responsible for the oversight of serious clinical incidents. The committee reviews safety and quality issues from service lines across the hospital. Two of the key responsibilities of the committee are: to monitor the progress and outcomes of corrective action plans, and monitor reports on safety and quality indicators.
- Gladstone Maternity Safety, Quality and Risk Committee:** This committee meets monthly and is chaired by the Midwifery Unit Manager. The committee discusses topics such as governance systems, risk register, audit outcomes, mandatory education tracking, and complaints and compliments. It is also the peak avenue for the maternity service to reflect on patient safety matters.
- Gladstone Incident Management Meeting (GIMM):** The GIMM meeting, modelled off the GOAT meeting in Rockhampton, is held weekly and attended by five members of the Gladstone Senior Leadership Team, including the Executive Director, Gladstone Hospital and directors from medical services, nursing and patient safety. The meeting was introduced to provide senior leadership with increased oversight of corrective actions and closure of recommendations. The purpose of the meeting is for the leadership team to review and monitor all complaints (both from consumers and third parties such as this office), monitor the progress of recommendations from implementation to closure, including endorsing the evidence provided to support recommendation closures, ensure that the open disclosure process is being completed, and escalate any relevant learnings to the Gladstone and Banana Safety, Quality and Risk Committee.

14. Maternity service reviews

14.1 Internal review

Between September 2017 and January 2018, the CQHHS undertook an internal review of the Gladstone Hospital maternity service. The review included executive interviews, midwifery and medical focus groups, consumer feedback, one-on-one interviews, a chart audit of 45 records (representing 8 per cent of births per year), and a review of clinical incident data. The review was undertaken as part of CQHHS' commitment to reviewing all of its maternity services to establish the baseline of the safety and quality of the services across the catchment facilities.

The review concluded that overall the standard of maternity care being provided at Gladstone Hospital was comprehensive and within the scope of a Level 3 service; however, there was significant room for refinement. The review identified three key areas for improvement:

- culture, workforce and team working
- governance
- clinical practice.

The review made 17 recommendations, which were approved by the CQHHS Board.

CQHHS advised that 16 of 17 recommendations were fully implemented, with the final recommendation due to be implemented by 30 September 2018. During the on-site stakeholder visit in October 2018, staff from the office were not satisfied that the implementation of the review recommendations was robust, with many recommendations only having been implemented two to four weeks before the visit. Concerns about the appropriateness of the maternity service's response to the internal review will be discussed in section 16.6.2 below.

14.2 Gap analysis

With the release of the office's report, *Gold Coast University Hospital's response to adverse maternity events*, in March 2018, CQHHS decided to proactively undertake a gap analysis between the Gladstone maternity service and the issues and recommendations made in the report. Gladstone Hospital reviewed its processes, policies and procedures, identifying that there were some gaps, particularly in relation to the safety and quality governance processes in place in the maternity service. There were measures to address the gaps but these were only in the planning or early phases of implementation and have not yet been embedded within the maternity service. The office was provided with a copy of the gap analysis and supporting evidence and considers that there is a need for ongoing improvement and refinement of the Gladstone maternity service's processes, which will be discussed in the context of the issues in section 16.6 below.

15. Complaints to the office

Between April 2016 and November 2017, the office commenced four investigations in relation to individual complaints about the Gladstone Hospital maternity service. Additionally, the office has received a further three complaints about the maternity service at Gladstone Hospital between June 2015 and December 2018.⁷⁷ These complaints have taken various pathways through the office's jurisdiction as outlined in Table 2 below. The main issue identified across the complaints was professional performance.

Table 2 Gladstone Hospital complaint outcomes

Outcome type	Number of outcomes ⁷⁸
No further action after assessment	1
Referral to another government entity	1
Complaint withdrawn	1

It should be noted that the total number of complaints about the maternity service is statistically insignificant when compared to the approximately 2,229 births occurring at Gladstone Hospital between 2015 and 2018.

16. Issues affecting maternity services at Gladstone Hospital

The following sections provide a detailed analysis of the issues investigated by the office. The sections include recommendations for change so that the quality, safety and reliability of, and public confidence in, maternity services at Gladstone Hospital can continuously build into the future.

16.1 Risk and escalation

Since 2016, there have been trends across clinical incidents of all SAC levels suggesting that risk is not managed and/or escalated well within the Gladstone Hospital maternity service in three key areas:

- assessment and reassessment using the initial midwifery assessment tool (IMA)
- clinical advice provided to women who contact the service by telephone, often when in labour
- management of the roles and responsibilities during an emergency.

⁷⁷ The total number of complaints does not include complaints which are still pending an outcome.

⁷⁸ There may be multiple outcomes for a complaint as it progresses through the office's jurisdiction.

16.1.1 Risk assessment and reassessment

Risk assessing and reassessing is a fluid task that needs to occur throughout a woman's pregnancy. Practitioners' cognitive biases⁷⁹ can lead them to confirm that a woman's pregnancy is low risk even when confronted with clinical information to the contrary.⁸⁰ Risk is made more difficult to assess when a patient's care is transferred to the hospital late in pregnancy or when the patient presents late. However, this makes fulsome and appropriate completion of the IMA more vital. The following case study demonstrates this situation:

Case study of Patient C

Patient C was a 31 year old woman with one previous confirmed pregnancy and live birth. Between September and December 2015 her care was provided by Gold Coast University Hospital. Patient C's early pregnancy was unremarkable.

In late December 2015, Patient C relocated to Gladstone and had her first appointment with the maternity service on 12 January 2016. She was 37 weeks gestation. Patient C's clinical records contain no evidence of an initial risk assessment being completed at this appointment nor was her risk category established and/or evaluated.

Patient C presented further on 9 February 2016, at 41 weeks gestation, and again there was no evaluation of her risk status. The following day Patient C presented in labour and subsequently gave birth to a live baby, who died a few hours later due to sepsis. Patient C's baby was the subject of a coronial inquest, the findings of which note that Patient C was not appropriate for a low risk model of care. The findings also noted that a more comprehensive assessment of Patient C's condition should have occurred on 9 February 2016, in response to her changing condition and risk status.

While the procedure requires the IMA to be completed at the first hospital visit, it is not explicit in relation to its application to patients whose care is transferred to the hospital during the pregnancy, particularly late stage transfers. This is an area where the procedure can be further refined to ensure that it captures the types of scenarios as occurred with Patient C.

Recommendation 1

I recommend that:

1. Within 30 days, the CQHHS *Maternity Risk Assessment Tool (Initial Midwife Assessment)* procedure be updated to explicitly require an initial midwifery assessment tool be completed for all women transferring into the service.

⁷⁹ 'Cognitive biases, also known as 'heuristics', are cognitive short cuts used to aid our decision-making. A heuristic can be thought of as a cognitive 'rule of thumb' or cognitive guideline that one subconsciously applies to a complex situation to make decision-making easier and more efficient.' Source: Sullivan et al, *Cognitive bias in clinical medicine*, Journal of the Royal College of Physicians of Edinburgh, September 2018.

⁸⁰ Sullivan et al, *Cognitive bias in clinical medicine*, Journal of the Royal College of Physicians of Edinburgh, September 2018.

16.1.2 Telephone advice

Too often across 2017 and 2018, women called the maternity service and were provided inappropriate clinical advice, which resulted in significant clinical outcomes and near misses. This is an issue that has been recurring since 2016. The following case study highlights the concerns.

Case study of Patient C

Patient C was scheduled to be induced on 11 February 2016, however, at the antenatal clinic appointment on 9 February 2016 it was clear from the CTG that she was in the early stages of labour with contractions occurring one in every 7.5 to 10 minutes. Patient C was assessed by an obstetrician and her management plan remained unchanged.

On 10 February 2016, at around 22:05, Patient C contacted the maternity service by telephone seeking advice about whether she should attend the hospital. The midwife advised her to *'stay @ home until unable to do so'*, despite Patient C living some 20 to 30 minutes away from the hospital and giving birth for the second time, which is generally quicker.

By approximately 22:15, Patient C woke her husband and asked him to take her to the hospital. She arrived at around 23:00, her waters broke on the way to the maternity unit and while in the elevator up to the unit she felt the urge to push; this was at approximately 23:15. By 23:20 Patient C was on the ward and Baby M was born at 23:31.

The coroner's findings note that Patient C should not have been sent home on 9 February 2016, particularly given the distance she lived from the hospital, and when she contacted on 10 February 2016 she should have been advised to attend the hospital immediately. Patient C's birth was rushed and precipitous, which potentially could have been avoided if appropriate telephone advice had been offered.

The above issue with Patient C's care has continued in the maternity service. Incident reporting provided by CQHHS showed that there were four clinical incidents occurring between March 2017 and October 2018, all of which had a common thread in relation to the provision of inappropriate clinical advice when telephone enquiries were made with the maternity service and/or a failure to complete telephone enquiry documentation. These incidents ranged from SAC 1 to SAC 4. It is important to note that this only captures cases where an incident was recorded in Riskman.⁸¹ However, during the internal review there were further incidences of inappropriate telephone advice being provided that were not categorised as incidents and as such are not captured in the reporting.

The following is brief outline of each of the four incidents identified in the internal review:

- In March 2017, a patient contacted the maternity service seeking to attend and travel to Rockhampton Hospital to give birth—this had been her management plan throughout the pregnancy. The patient's request to attend was ignored and by the time she attended Gladstone Hospital her labour was too established to enable a transfer.

⁸¹ Riskman is an electronic risk management system that is used by Queensland hospital and health services to record and manage all incidents, complaints and quality improvement.

- In August 2018, a patient was contacted by text message in relation to her concerns about reduced fetal movement. She contacted the maternity service again on the same day to discuss her concerns further, specifically that she had abdominal pain and nausea. The telephone enquiry form notes that the patient was advised '*possible ligament pain...apply heatpack [sic], analgesia and rest. Notify if persists*'. The patient presented the following day for a routine antenatal appointment and it was identified that there was an intrauterine fetal death.
- In September 2018, a patient contacted the maternity service seeking advice on whether she had a spontaneous rupture of membranes (SROM).⁸² The patient was offered the opportunity to attend the hospital but declined and it was agreed that she would attend in the morning for review. The telephone enquiry form was not appropriately completed as it only captured the plan for the patient to attend in '*the AM*'; there was no notation of her being offered the option of attending immediately. Further, there was no IMA available to assist with the clinical decision-making on what advice to provide the patient in relation to her attendance and/or potential urgency of her condition.
- In October 2018, a patient contacted the maternity service after a SROM and was advised to stay home until she had regular, painful contractions. Two hours after that advice the patient birthed in the Gladstone Hospital emergency department.

The potential significance of this trend was acknowledged by the senior leadership of the maternity service and rectification measures are being trialled to try to minimise the incidents recurring. These measures include:

- reviewing and refining the telephone enquiry form and procedure
- training staff in the maternity phone enquiry service and completion of the form in May 2017
- daily reviewing of the previous night's telephone enquiry forms by the midwifery unit manager and/or clinical midwifery consultant. Any identified concerns are addressed clinically with appropriate follow-up with the patient and through a performance discussion with the relevant staff member. This was implemented from 3 October 2018
- daily peer reviewing of the telephone enquiry forms from the previous day at the morning handover, which is attended by the midwifery unit manager and clinical midwifery consultant. This was endorsed by the Gladstone and Banana Safety, Quality and Risk Committee on 15 October 2018.

While the measures implemented to date are a positive step in addressing the issues with the appropriateness of the telephone advice, I remain concerned about the capacity for the maternity service to completely address the root cause of this issue, which appears to stem from the clinical ethos around risk. I consider that the above incidents were sufficiently far apart to enable the measures that were implemented to start to address clinical behaviours to limit the possible recurrence of the incidents. However, from the available evidence, it appears that no appreciable change in approach occurred. These incidents are indicative of problems with the safety culture of the Gladstone Hospital maternity

⁸² The spontaneous rupture of membranes occurs during a pregnancy when the amniotic sac is ruptured, spontaneously, at full term either at the beginning or during labour.

service in robustly responding to and modifying their approach to continuous and ongoing concerns. This will be explored in sections 16.5 and 16.6 below.

In relation to the specific issues with the telephone enquiry service, I am of the view that the measures recently implemented will require time to be embedded before they can be evaluated for their effectiveness.

Recommendation 2

To support the above embedding process I recommend that:

2. In relation to the telephone enquiry service the Gladstone Hospital maternity service must:
 - a. within 30 days make it mandatory to record in Riskman all instances where there has been some type of corrective action needed to be taken in response to telephone advice, including follow-up care needing to be provided to the woman, and/or discussions with individual staff members, whether formal or informal, about the appropriateness of the advice provided. This incident recording is to occur regardless of any other clinical outcomes.
 - b. within three months:
 - i. review all incidents of any SAC classification level for the period 1 January 2016 to 30 October 2018 where a telephone enquiry encounter was part of the care
 - ii. prepare a report to the CQHHS Safety and Quality Committee on the outcome of the review, including a summary of each incident and any deficiencies with the telephone enquiry advice provided
 - iii. develop a coordinated action plan, for endorsement by the CQHHS Safety and Quality Committee, to address the identified key issues and root causes for the repeated concerns with the telephone enquiry service. This action plan may include measures that have already been implemented.
 - c. provide the CQHHS Safety and Quality Committee with a quarterly report covering:
 - i. any incidents of any SAC classification level that involve the telephone enquiry service
 - ii. a status update from the midwifery unit manager on the number of occasions within the quarter on which she has had to either provide follow-up care after reviewing a telephone enquiry advice and/or have a formal or informal performance discussion with a midwife about the telephone enquiry advice provided.

The first quarter of reporting should commence within 30 days of endorsement of the action plan referred to in recommendation 2b. This reporting must continue for four quarters. Any ongoing issues with the telephone enquiry service should be addressed through the standard safety and quality escalation pathways.

16.1.3 Roles during an emergency

Clarity in roles and responsibilities during an emergency situation is important as it ensures that the emergency is managed appropriately and the opportunities for misunderstandings or missed communication are minimised. Evidence given by Gladstone Hospital maternity staff during the coronial inquest in August 2018 suggested that this has historically been an issue for the Gladstone Hospital maternity service, in part due to the limited number of emergencies encountered meaning that processes were not well established. The following case study provides an example of this issue:

Case study of Patient C

Following the birth of Patient C's baby on 10 February 2016, there was an emergency situation during which Baby M required resuscitation and management of sepsis. At or around 23:34, resuscitation was commenced on Baby M, present was a midwife and obstetric registrar. The midwife requested that the enrolled nurse on duty contact the paediatricians and ask them to attend the neonatal resuscitation. This was not in compliance with the Code Blue procedure in place at that time. The first paediatrician arrived at the hospital at 23:36. At 00:05 the nurse unit manager, clinical nurse consultant and second paediatrician attended on the maternity ward. The clinicians present were trying to manage Baby M's presenting condition.

Baby M went into cardiac arrest at 03:30 and a MET call was initiated. CPR was continued until 04:36, during this time a discussion was had with Patient C and her husband at 03:55 seeking their permission to cease the CPR. Baby M was declared deceased at 04:55.

During the course of the emergency no one assumed the role of team leader meaning that there was poor communication between clinicians, no overarching coordination of care, and limited, clear communication with the family. This was confirmed during the paediatricians' evidence at the coronial inquest, in which they both commented that there was no team leader or team coordination. This led to confusion around a number of key elements of Baby M's care, the most significant of which was a failed administration of antibiotics which was charted to be given at 01:25 but was not administered. The coronial inquest considered this issue in some detail and while it was concluded it may not have altered the outcome for Baby M, it remained unclear, even after oral evidence, whether the order for antibiotics was ever communicated to the midwifery and nursing staff and if so whose responsibility it was to ensure that the antibiotics were administered.

The lack of a team leader also impacted on the communication with Baby M's family. Specifically, during the coronial inquest Patient C commented in her evidence that at no time did staff make the gravity of the situation with Baby M clear to her. In fact, her husband left the hospital and had to be called back. He never would have left if either of them had understood how dire the situation was and that Baby M's condition was life threatening. Further, when they were discussing cessation of the CPR at around 03:55 neither Patient C nor her husband understood that Baby M would immediately die once CPR was stopped. The lack of clear and direct communication was troubling.

Without there being a coordination point and clear delineation in roles, the provision of care, while being of a satisfactory standard for a Level 3 facility, was hampered. Since this incident measures have been implemented to improve the coordination of emergency situations, including:

- revising the *Code Blue – Medical Emergency (Gladstone Hospital)* procedure, which establishes the team leader role and responsibilities

- the Recognition and Response to the Clinical Deterioration Committee, Banana and Gladstone, reviewing performance data relating to all code blues, ensuring that there is a minimum of one MET call drill in each ward area per month
- allocating a midwife as the team leader for obstetric emergencies and setting the roles for the first three midwives who enter the room as: medications, emergency buzzer, and register/scribe. This was initially utilised in response to post-partum haemorrhage emergencies but has now been broadened to apply across the maternity service since August 2018.

The incident with Patient C and Baby M was complex and would have represented a challenge for a tertiary facility. Nevertheless, the learnings resulting from the incident need to be embedded into the practices of the maternity service. Consequently, I would encourage the Gladstone Hospital maternity service to continue with the above efforts and ensure that neonatal emergencies are consistently drilled via mock scenarios and multidisciplinary training to promote a collaborative and cohesive response to emergencies when they arise.

16.2 Emergency and maternity liaison

The Gladstone Hospital emergency and maternity departments had a small, but consistent number of serious clinical incidents in 2017, which suggested that pregnant women were not being managed well between these departments. The following case study illustrates the concerns with the liaison and established processes between emergency and maternity:

Case study of Patient D

Patient D was a 28 year old woman with six previous confirmed pregnancies, three births and three terminations. She was 34 weeks pregnant. In May 2017 at around 10:00, Patient D was referred to the Gladstone Hospital emergency department by her GP due to consistent vomiting for the past two weeks, loss of appetite and painful urination.

Patient D was reviewed by a senior medical officer who prepared a treatment plan and recommended that Patient D be admitted for further tests. At around 13:50, Patient D discharged herself against medical advice. It is documented in the clinical records that Patient D and her carer were aware of the risks to herself and her baby on discharging before all clinical investigations were complete. Nowhere in the clinical records is it documented what specific risks were discussed with Patient D or whether the risks of pre-eclampsia were ever identified and discussed

Prior to leaving the hospital Patient D underwent an ultrasound. Even without the ultrasound results, Patient D's clinical presentation suggested that she had pre-eclampsia and should have been admitted immediately. The emergency nature of her presentation did not appear to be appreciated by the emergency department clinicians managing her care.

Patient D explained during the office's investigation that she was not in a position to be admitted as she was being supported by an OzCare worker who was only rostered on until 16:30. This meant she needed to leave the hospital to make appropriate care arrangements for her family after which she always intended on returning to the hospital. Patient D stated to the office that she overheard the senior medical officer advise the triage nurse that she was to be admitted when she re-presented to the emergency department; no note was made of this advice but the majority of clinical records in this case were input retrospectively by the emergency department clinician.

Case study of Patient D

At 16:00, Patient D attended the hospital to obtain her ultrasound results. Patient D expected to be admitted given her attendance only two hours earlier, but she was triaged as a category 5, requiring her to be seen within 120 minutes; in triaging Patient D no reference was made to her previous attendance or discharge against medical advice. After two hours of waiting Patient D chose to leave the hospital and return in the morning. This was a missed opportunity to manage Patient D's presenting condition and admit her as was the recommended course earlier in the day.

At no point during Patient D's attendance in the emergency department were any fetal assessments undertaken or documented nor was any member of the midwifery or obstetric team contacted to discuss her presenting condition and clinical history. Further, no contacts were made with more senior clinicians in Brisbane to assist with an appropriate management plan.

The following day a medical officer from the emergency department tried to contact Patient D on several occasions to discuss the abnormal ultrasound results. There is no evidence to suggest that these results were discussed with obstetric staff so as to flag to them that there may be a possible emergency situation. At 16:27, Patient D was brought by the Queensland Ambulance Service (QAS) to Gladstone Hospital and taken directly to the maternity unit. A category 1 Caesarean section was called and at 17:16 a male neonate was born with APGAR scores of 0 at 1, 5 and 10 minutes. The neonate was transported to Townsville Hospital for management; he died in June 2017.

The above case study is an example of missed opportunities throughout a patient's care; although the outcome may not have been preventable. Patient D's case did not appear to impact the clinical approach to pregnant women in the emergency department. Three months on from Patient D's case there was a further major failed obstetric management case, as the below case study demonstrates.

Case Study of Patient E

Patient E was a 22 year old Indigenous woman with a confirmed pregnancy at 6 weeks gestation. In August 2017, at around 18:20, QAS brought Patient E to the Gladstone Hospital emergency department for severe abdominal pain. Patient E was triaged as a category 3, requiring her to be seen within 30 minutes.

Patient E was reviewed by a medical officer. Patient E described generalised abdominal pain and extreme pressure in her vaginal area but there was no bleeding. She also had shoulder pain. Patient E admitted to cannabis use earlier in the day.

The medical officer considered whether Patient E may have an ectopic pregnancy⁸³ but ruled out this differential diagnosis largely due to a lack of vaginal bleeding, despite Patient E having a history of a week of vaginal bleeding for which she had blood tests three days prior to this presentation. The standard diagnostic management for an ectopic pregnancy would have been an ultrasound but as it was afterhours there was no ultrasound service available at Gladstone Hospital and her condition

⁸³ An ectopic pregnancy is a pregnancy that develops outside the uterus, usually in one of the fallopian tubes. In almost all cases, the embryo dies. In around 15 per cent of cases, the tube ruptures, causing pain, internal bleeding and shock, which is a medical emergency. Symptoms can include abdominal pain and vaginal bleeding but fewer than 50 per cent of women present with both symptoms; pain may also spread to the shoulder if bleeding into the abdomen has or is occurring. The main diagnostic methods for identifying an ectopic pregnancy include, pelvic examination, blood tests, ultrasound, or laparoscopic surgery.

Case Study of Patient E

was not considered serious enough to warrant calling the ultrasound technician for after-hours assistance.

The medical officer discussed Patient E's condition with a senior medical officer and it was agreed that she should be discharged home to sleep as she was likely suffering from cannabis intoxication. The plan was for Patient E to return in the morning for an ultrasound. At no point during Patient E's admission was any member of the midwifery or obstetric team contacted to discuss her presenting condition and clinical history nor were any contacts made with more senior clinicians in Brisbane to assist with refining the differential diagnoses in this case.

Patient E was discharged home at 22:15. The following day, Patient E's family members contacted Gladstone Hospital to advise that she had been found deceased. Patient E died due to a ruptured right fallopian tubal ectopic pregnancy. The Coroner relevantly commented that '*it is uncommon in this modern day and age for a ruptured ectopic pregnancy to prove fatal*'.

Patient E's death was likely preventable and is inexcusable in a major developed country, such as Australia, in 2017. It was apparent to staff during the visit in October 2018 that the incident had a significant impact on the emergency department and their approach to managing obstetric patients such that an incident like Patient E's should not occur again.

Some of the major improvements that have occurred in the emergency department and maternity service include:

- Introduction of the CQHHS *Triage of Maternity Patients in the Emergency Department* procedure (Obstetric Triage procedure). This procedure makes it explicit that when a woman is pregnant but the location of the pregnancy has not been established and she presents with any abdominal or pelvic symptoms then she is to have a pelvic ultrasound and full obstetric review prior to any discharge. This procedure also makes an obstetric review and management plan a standard part of emergency care, once the woman is clinically stable. Staff were advised during the visit that even if a pregnant woman was to attend the emergency department for a sprained ankle, once it is appropriately treated and managed, a nurse or midwife will perform a Doppler ultrasound scan to check fetal wellbeing and the woman will have a CTG.
- Engagement of part-time rotational fellows of the Australian College of Emergency Medicine from Brisbane. These staff are available onsite and via telehealth to provide advice and expertise to more junior officers in the emergency department. Over time the emergency department will move to a more specialist-led model of care rather than relying on senior medical officers and locums.
- Mock scenarios and multidisciplinary training between emergency and maternity. In a recent Practical Obstetric Multi-Professional Training (PROMPT) scenario, staff managed an imminent birth from the emergency department through to the maternity service. Obstetric topics also form part of the curriculum covered in weekly medical training in the emergency department.
- A midwifery review of the Emergency Department Information System (EDIS) report daily between Monday and Friday. Each day the midwifery unit manager, clinical midwifery consultant and/or antenatal clinic staff get a copy of the EDIS report, which includes any women who presented to the emergency department and were flagged as "preg/gest" or had a referral to the Early Pregnancy

Assessment Service (EPAS). The senior midwifery clinicians are looking to see whether there were any women who may be pregnant that are unknown to them or whether there are any clinical concerns that require follow-up. This review is a safety net and has proven a positive proactive step in managing pregnant women in Gladstone. For example, staff commented during the stakeholder visit that through this report they were able to identify a young Indigenous woman who was 31 weeks gestation and had attended no antenatal visits. The midwifery unit manager contacted the woman and connected her with the Gumma Gundoo health service, running out of the Woorabinda, to assist her with getting antenatal care.

In addition to the above, the Gladstone Hospital emergency department explored the possibility of a 24 hour radiology service. However, this service was unable to be staffed due to the limitations of their rural location, and may have jeopardised the current radiology services being provided. To address the afterhours gap, two obstetric and gynaecological staff are accredited to perform ultrasounds so if a scan is required then they will be contacted by the emergency department to perform the scan and will make the decision regarding discharging the patient.

During the site visit staff from this office observed the energy and passion that the emergency department clinicians had for securing safe and high quality care for their patients; the improvements implemented to date are an example of their commitment to quality improvement. While the implemented measures would address most of the issues identified in the cases of Patient's C and D there still appears to be one area for improvement: the triaging of patients who re-present after discharging against medical advice. I acknowledge that this is going to be a very small subset of the overall patient cohort being seen in the emergency department, and the Obstetric Triage procedure should address the type of situation that was encountered with Patient D, but given the possible severity of the outcomes further redundancies should be built into the system.

In Patient D's case she re-presented to the emergency department within two hours of discharging herself and while this appeared to be for a different purpose than her original presentation i.e. the collection of results versus referral from the GP for investigation of ongoing symptoms, the passage of two hours was unlikely sufficient to have changed the proposed plan to admit her. Patient D's triage category appears inappropriate given her earlier presentation and it should not be incumbent on a patient to be able to relay all of the necessary clinical history to a triage nurse to ensure that their previous attendances in a day are properly accounted for in the triage assessment. Patient D's clinical record or entry in EDIS should have had a flag or alert noting that if she re-presented to the hospital then her care should be escalated to a medical officer for discussion prior to assigning a triage category. The fact that Patient D re-presented to the emergency department was significant, as it was in line with what she advised medical staff she would do when she discharged herself, however, the system let her down by not properly flagging her when she returned to the hospital.

Recommendation 3

To address the above gap I recommend:

3. Within three months the Gladstone Hospital emergency department:

Recommendation 3

- a. establishes a mandatory process for placing an alert on a women's file where they are pregnant or potentially pregnant and have:
 - i. self-discharged against medical advice
 - ii. not waited to see a clinician
 - iii. left after treatment commenced.
- b. establishes a KPI benchmark for compliance, audit schedule and review process for the mandatory alert outlined in 3a above that reports quarterly to the Quality and Safety Committee in relation to:
 - i. all incidents relating to the care and management of pregnant or potentially pregnant women in the emergency department
 - ii. compliance rates with the policies and processes related to the care and management of pregnancy or potential pregnancy related presentations to the emergency department.

Any adverse issues or trends identified in relation to the care and management of pregnancy related presentations in the emergency department are to be escalated to the CQHHS Safety and Quality Committee and CQHHS Board in accordance with the existing governance framework.

16.3 Models of care

The Gladstone Hospital maternity service offers the following models of care:

- public hospital care and public hospital high-risk care
- MGP
- team midwifery
- shared care
- remote area maternity care for Aboriginal and Torres Strait Islanders.

The below discussion will focus on the MGP model.

16.3.1 Midwifery Group Practice

The all-risk caseload MGP model has been operating in Gladstone for two to three years. There are five midwives with a full-time midwife undertaking between 35 and 40 births per year.

As part of the on-site stakeholder visit in October 2018, staff met with members of the MGP and were advised that the model of care works as follows:

- the midwives work independently of each other, with a second midwife to provide back-up if required

- they are on-call Monday to Friday and two midwives are on-call on Saturdays and Sundays
- women must be referred by their GP to the MGP model
- all of the midwives work with the senior obstetrician in the maternity service
- there are weekly case conferences between the midwives and the obstetrician at which the woman's chart is reviewed and any issues are discussed; it may be decided at this meeting that women need to be removed from MGP if their risk status requires a different model of care
- they have monthly 'meet and greets' so that the MGP team can be introduced to as many women who are booked into the service as possible, which is beneficial if an MGP midwife has to deliver the baby in place of the primary carer.

The MGP representatives also advised that they have good relationships with the core midwives, sharing in education with core staff and contributing to service improvements. Staff from this office observed some disconnect between the MGP and broader maternity service but this was no greater than the disconnect observed between core staff and the service. These issues appear to stem from the culture of the service and will be discussed in more detail in sections 16.5 and 16.6 below.

Overall, the MGP service provided by the Gladstone Hospital maternity service is of a high quality and commensurate with the service being offered across Central Queensland. The main challenge facing this service in the future will be the growing demand and ability to keep pace with recruitment, particularly as many midwives do not apply for MGP roles due to the sporadic nature of the hours worked and requirement to be on-call. This issue is recognised by senior leadership and will be gradually addressed through the overarching CQHHS-wide initiatives targeting skilled recruitment.

16.4 Staffing and skills mix

The Gladstone Hospital maternity service is reasonably well staffed with a good mix of experienced and more junior nurses, midwives and medical staff. In the 2017–18 financial year the staffing hours consistently exceeded the hours required per patient day.

16.4.1 Midwifery staffing

At the time of Patient C's care in 2016 staff attributed the incident in part to insufficient staffing levels to meet the needs of the maternity service; however, neither the coronial findings nor the documentation provided to this office substantiates those claims. Regardless, since that time the midwifery staffing hours within the maternity service have increased with the introduction of a permanent clinical midwifery consultant and a midwifery educator. There has also been stability in the workforce with the appointment of a permanent midwifery unit manager in July 2017.

The Queensland Health BPF completed for the Gladstone Hospital maternity service for the 2017-18 financial year demonstrates the following safe staffing levels:

- staff ratios for the birth suite and maternity ward, where possible, are one-to-one care for a labouring woman, one-to-four care on the maternity ward during morning and afternoon shifts and one-to-seven care overnight

- 5.52 full time equivalent (FTE) staff for Birth Suite when rostering calculations only require a minimum of 3.52 FTE staff
- 8.86 staff per day for inpatient care, which is approximately three staff rostered on each shift
- 4.42 FTE paediatric nurses for the special care nursery

CQHHS advised that they will be recruiting 8.8 FTE midwives in the hospital and 2.8 midwives aligned with continuity of care models. This recruitment drive will be vital to the safety of the service due to the likely increase in demand following the closure of the private maternity service offered at the Mater Misericordiae, Gladstone on 1 October 2018.

As the numbers birthing in the service increase, the allocation of sufficient support staff will be important to ensure that the maternity service can meet both its clinical care, operational and reporting requirements, particularly the timely collection of perinatal data, which has previously been a challenge for the Gladstone Hospital maternity service. The 2017–18 BPF identified that there was only one FTE staff allocation to administrative support and this was split between maternity and paediatrics. This allocation could be considered going forward to ensure that the administrative support matches pace with the clinical workforce.

16.4.2 Medical staffing

There is still some reliance on the locum medical workforce in obstetrics and gynaecology to meet demand and the day-to-day operations of the maternity service e.g. covering planned leave. This will likely be inevitable while there remain challenges for rural locations to engage sufficient numbers of specialist clinicians. However, overall, the medical workforce is stable with allocation for:

- director, obstetrics and gynaecology who is also a consultant obstetrician
- two consultant obstetricians
- three principal house officers (four years plus postgraduate)
- one junior house officer (second year post graduate).

During the on-site stakeholder visit in October 2018, Gladstone Hospital representatives advised that they are still in the process of permanently securing a clinical director for obstetrics and gynaecology. The person undertaking this role will need to provide strong and consistent leadership across the maternity service to consolidate on Gladstone Hospital's successes and to continue the improvement journey. CQHHS should be making the bold decisions it has made in its other maternity services in relation to recruitment to ensure that recruitment is appropriate in the current context of the Gladstone Hospital maternity service.

16.5 Culture and communication

As discussed in the introduction to the issues, culture is something that an organisation has and based on discussions between the office's staff and clinicians from across the maternity service, during the on-site stakeholder visit in October 2018, it appeared that the Gladstone Hospital maternity service does not

have a cohesive culture. When compared to the on-site stakeholder visits at other CQHHS maternity services, it became apparent that the commonality of purpose was missing from the Gladstone Hospital maternity service. In saying that, staff from this office did observe a group of clinicians dedicated to, and passionate about, providing exceptional care to the women and babies of Gladstone and its surrounds.

Some work has been undertaken by the Gladstone Hospital maternity service to promote positive ways of working between clinicians, including:

- multidisciplinary team building workshops held on 18 and 19 July 2018
- provision of 'Communication and Patient Safety (CaPS)' training to all staff to assist with staff-to-patient and staff-to-staff communication
 - as at 27 September 2018, 69 per cent of staff across Gladstone Hospital had participated in the training
- providing clinical leaders with the opportunity to complete the 'Promoting Professional Accountability Programme', provided by the Cognitive Institute
 - the program is targeted at improving safety cultures
 - workshops and seminars forming part of the program were undertaken at Gladstone Hospital on 28 May 2018 and 4 September 2018.

While staff interactions are improving, the main areas where the culture appears to need development are: staff engagement with safety and quality processes and embracing change.

16.5.1 Safety and quality processes

Undertaking a structured audit program, accurately reporting on staffing through Trendcare, and participating in increased and consistent training is reasonably new for clinicians in the Gladstone Hospital maternity service. These requirements were previously ad hoc and there was less accountability if tasks were not completed. The shift in mindset required to see the value in these functions is significant, and based on this office's observations, staff are yet to fully adopt these functions as a part of standard clinical practice in a modern health system.

Several clinicians expressed their view during the on-site stakeholder visit in October 2018, that audits and reporting were onerous and took clinicians away from key clinical care duties. As noted above in section 16.4.1 in relation to staffing, the Gladstone Hospital maternity service is routinely adequately staffed, except during periods of surge activity. These functions should form part of the day-to-day activities of clinicians; this message needs to be reinforced by leadership to ensure that safety and quality processes are treated as business as usual.

16.5.2 Embracing change

This office spoke to clinicians who expressed frustration in relation to the recent implementation of some measures across the maternity service. In part, these frustrations appeared to stem from a lack of understanding as to why the measures were being implemented. They also appeared to result from staff not feeling listened to by leadership, particularly when concerns were raised about the capacity for a

Level 3 service to implement measures that had previously been implemented at a Level 4 or higher maternity service.

Leadership is inextricably linked to how well staff will embrace change as they need to participate fully in the journey. It will be important for leadership to manage expectations and engage staff given the amount of change that has occurred in the Gladstone Hospital maternity service over the last 12 months and will likely occur within the next 12 months.

I am concerned that the above issues may predominantly be a result of disconnect between leadership and staff. Therefore, I will not be making recommendations in relation to the culture of the maternity service as any issues within the culture can be appropriately addressed within the recommendation below regarding leadership.

16.6 Leadership

Since the beginning of 2016, Gladstone Hospital has been seeking to ensure that it has experienced staff in key leadership positions to stabilise the service, including the permanent appointment of the Director of Nursing and Director of Medical Services, and the introduction of a highly qualified Executive Director, Gladstone Hospital in late 2018. Furthermore, Gladstone Hospital had a full complement of permanent clinical directors across all of the services for the first time in September 2018.

I consider that the historic instability in the leadership significantly contributed to a situation where Gladstone Hospital's safety and quality processes and clinical incident management were in a state of disarray and not commensurate with the functioning of a safe and high quality health service. In relation to the maternity services, there was limited safety and quality oversight resulting in long periods where recommendations from serious incidents were not actioned. For example, in April 2018 when the Gladstone Hospital maternity service was preparing for the coronial inquest into Baby M, they reviewed all outstanding recommendations from within the maternity service arising from serious incidents. This review identified 55 SAC 1 recommendations and lessons learnt of which 29 were in various stages of implementation and 26 had not been progressed, despite years having passed since the incidents. While three of the highest level impact recommendations had been implemented in a timely manner, to have 55 recommendations outstanding from the most serious of incidents was unacceptable. Accordingly, the Gladstone Hospital executive, with substantial support from CQHHS, took on the task of ensuring that all recommendations still relevant were implemented. This was achieved by October 2018.

This was an encouraging turning point for the maternity service and the executive leadership's engagement with securing appropriate safety and quality systems, however, during the on-site stakeholder visit in October 2018 staff from this office were of the view that this task of implementing recommendations was somewhat perfunctory. While there was a voluminous body of work and effort that went into implementation of the various recommendations, the forward focus appeared unstructured in relation to how the service would safeguard against a similar situation through its safety and quality governance and what strategies it should utilise to embed the maturing safety and quality culture. This was evidenced by some inconsistencies between the safety and quality language used between the then Gladstone Hospital's executive leadership and the maternity staff.

The main concerns with the executive leadership are:

- limited role modelling of strategic direction and vision
- weak approach to safety and quality oversight.

16.6.1 Role modelling

The culture of a health service is only as good as its leadership and it is important for culture to be role modelled by all levels. During the on-site stakeholder visit in October 2018 staff from this office observed a lack of cohesion and role modelling of the safety and quality culture at Gladstone Hospital and in the maternity service. During the office's visits to other maternity sites within CQHHS, it was clear that from the executive leadership downwards there was a common safety and quality language being spoken amongst all staff; this approach was also connected with the overarching strategic vision for CQHHS. Of particular note is the consistent references to a golden thread running through safety and quality management and the triangulation of issues to inform continuous improvement. These same philosophies and approaches to safety and quality were not echoed by the leadership at Gladstone Hospital. Additionally, between the various levels of leadership there appeared to be some discordance, for example when questions were asked about how certain safety and quality committees operated or what type of approach was used to close recommendations leadership offered divergent opinions. This contributed to the overall impression that there was not a consistent approach to how the leaders interpreted and role modelled safety and quality for all staff. The impressions of the office's staff and some of the issues observed throughout the maternity service, discussed in this chapter, support the conclusion that the leadership at Gladstone Hospital and within the maternity service should focus on promoting a culture in which all staff have a broad understanding of the overarching safety and quality culture and how they contribute to it through their daily activities. While this office understands that many of these observations are known to the Gladstone Hospital maternity service, most recently having been gauged through a staff survey in June 2018, there have been significant changes that have occurred since that survey, including in the executive leadership. It would therefore be beneficial for the service to understand its current safety and quality landscape and staff perspectives. This would not only provide a baseline of the service but also an evaluative measure of the impact of the changes in the last six months.

Recommendation 4

To enable the Gladstone Hospital leadership to gauge its current safety and quality culture, leadership, and staff engagement in improvement projects, I recommend:

4. In relation to safety and quality leadership and culture that the Gladstone Hospital maternity service must:
 - a. within three months complete a staff survey seeking staff views on what they understand is the safety and quality culture and safety and quality leadership within the maternity service. The results of this survey should inform the kaizen workshop referred to in recommendation 4b.

Recommendation 4

- b. within six months run kaizen workshops and plan for evaluation of the outcomes of those workshops. At least one session should focus on leadership and the safety and quality culture.

16.6.2 Safety and quality oversight

To improve the executive leadership's safety and quality oversight they introduced the GIMM in May 2018. During the stakeholder visit representatives from Gladstone Hospital advised that there had been significant improvements with this meeting since September 2018, with more robust discussions occurring in relation to recommendations and complaints. Clinical directors and clinical reviewers are now invited to attend the meeting to provide status updates on the progress of corrective actions and clinical review outcomes.

While it is promising that the GIMM has improved, on reviewing agendas and minutes from the meetings between August 2018 and October 2018 it appears further improvements could be introduced, particularly in relation to the timely completion of actions and driving accountability through the establishment of deadlines for actions. Given this is the peak weekly meeting at which the executive leadership steers safety and quality improvement, it is essential that it is run effectively so that staff can receive feedback relating to safety and quality expectations.

Some specific issues identified on reviewing the meeting minutes were as follows:

- Limited or no timeframes captured for when actions were required to be completed, which may be captured in Riskman or different spreadsheet reporting. It is essential to appropriate safety and quality oversight that there are timeframes for the completion of actions as this creates accountability.
- Long delays with little substantive progress being made on actions, for example:
 - Between 2 August 2018 and 25 October 2018 there was an action to progress open disclosure with a family. From 2 August to 20 September 2018 no progress was made on this action and on this date it was identified that an autopsy report was required to enable open disclosure to proceed. The autopsy report was obtained in early October 2018 yet by 25 October 2018 the family had still not been contacted to arrange a time for the open disclosure meeting. While this was monitored by the GIMM there is no recording of expected timeframes for when this open disclosure should have occurred and why the lack of autopsy report was not identified until six weeks after open disclosure was entered as an action item.
 - On 2 August 2018, a SAC 1 recommendation was identified as ready for closure. Then on 24 August 2018 it was determined that the evidence for closure still had to be collated. By 8 October 2018, the recommendation and supporting evidence was ready to be presented to the Gladstone and Banana Safety, Quality and Risk Committee for closure. Although it is encouraging that the recommendation was not advanced for closure before the appropriate evidence had been collated, it is unclear why there was confusion over the recommendation's readiness for closure as at 2 August 2018. Nor is it clear why it took a subsequent two months to collate the evidence to ensure it was sufficient to support the recommendation.

- No planned forward monitoring of an action plan implemented to address identified trends. Specifically, at a meeting on 7 September 2018 three trends were identified and held over for discussion at the next meeting where it was requested that the senior leadership team develop an action plan to address the trends. In the minutes from 13 September 2018, an action plan is recorded as having been developed by the leadership team and the action was closed. There was no minuting of the forward monitoring of the trend and the action plan to ensure its effectiveness in addressing the trends. This should be a key function of the GIMM and it is reasonable to expect that the effectiveness of a senior leadership team action plan would be evaluated at these meetings; being the most appropriate forum for this analysis and evaluation.

Despite some of the concerning features of the issues outlined above, my staff noticed an overall improvement in the quality of the minutes, likely indicating an improvement in the quality of the discussions, from the GIMM between August 2018 and October 2018, with a marked change in or around late-September 2018. I believe that even without recommendations from my office that the GIMM will continue to grow and improve of its own accord, refining and embedding their practices so as to have a more comprehensive grasp on the oversight of the safety and quality of the Gladstone Hospital maternity service and that some of the points outlined above may be useful to assist with this refining process.

17. Conclusion

Regardless of the issues outlined in this chapter, the public should have confidence in the safety and quality of the Gladstone Hospital maternity service. This service has the most births of any Level 3 public maternity service in Queensland and as such is under additional pressure to provide a high quality service within the funding limitations of a Level 3 facility. The external benchmarking results indicate that this maternity service has high quality outcomes compared with its peers, which is made more remarkable by the number of births occurring each year.

For a long time both the Gladstone Hospital and the maternity service had unstable senior leadership, difficulty in permanently recruiting sufficient staff and a lack of coordinated support across CQHHS. These issues are now being rectified, enabling the maternity service to refine and improve its clinical governance and safety and quality processes.

A major area of focus for the maternity service must be its staff, ensuring that they are engaged and prepared for the change that is likely to be implemented over the next 12 months. This change needs to occur in an environment where staff contribute to and understand what is occurring rather than having change imposed on them. Equally important will be how the leadership team will role model the safety and quality culture so that the maternity service becomes a cohesive unit.

The above changes will be challenging for both leadership and staff, requiring a shared vision of commitment and energy. I am confident that the Gladstone Hospital maternity service has the necessary focus to progress change and will be adequately supported by the CQHHS executive to meet the challenges head on.

Biloela Hospital maternity service



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Biloela Hospital

18. Facility

18.1 Facility overview

Biloela Hospital opened its doors in 1931, with extra wards added in 1974 and a new emergency department completed in 2015. It is the largest facility in the Banana Shire of Central Queensland, and is located 145 kilometres southwest of Rockhampton and 127 kilometres west of Gladstone. It supports smaller communities such as Baralba, Moura, and Theodore.

Biloela Hospital has 24 overnight patient beds. The maternity service operates 24-hours per day. It has a three-bed maternity ward and there is one birth suite. The maternity service is not a discretely staffed unit; rather staff at Biloela Hospital hold registration as both nurses and midwives. Antenatal clinics are offered two days per week and once per month there is a specialist obstetric clinic run by the gynaecological team from Rockhampton. In 2018, there were 67 births at Biloela Hospital.⁸⁴

The maternity and neonatal services at Biloela Hospital have been assessed by CQHHS as a CSCF Level 3 service.⁸⁵ This is one of three Level 3 maternity services across CQHHS. The CSCF capabilities of Biloela Hospital are the same as those described above for Gladstone Hospital because the CSCF sets the consistent requirements for the respective level of service.

18.2 Benchmarking Biloela Hospital's performance

Biloela Hospital is not included in the WHA benchmarking report due to the number and low complexity nature of births at the facility. However, CQHHS prepares monthly safety and quality scorecards, which track the maternity service's performance against key clinical indicators and outcomes. Some highlights from the October 2018 scorecard, which covers the April to June 2018 quarter, include:

- zero per cent of babies born with an APGAR score of less than 7 at 5 minutes
- 100 per cent of women having Caesarean sections received prophylactic antibiotics
- 90 per cent of CTGs had all features appropriately documented, including an appropriate classification and management plan
- the IMA was used in 100 per cent of occasions on the audited files.

18.3 Biloela Hospital committee structure

Biloela Hospital's committee structure is provided via the Gladstone and Banana Shire Business Unit. The structure appears to have two streams, which have responsibility for overseeing incident

⁸⁴ <https://data.qld.gov.au/dataset/births-by-hospital/resource/7af8f98e-4f43-496b-b540-efa21bbe5e48>

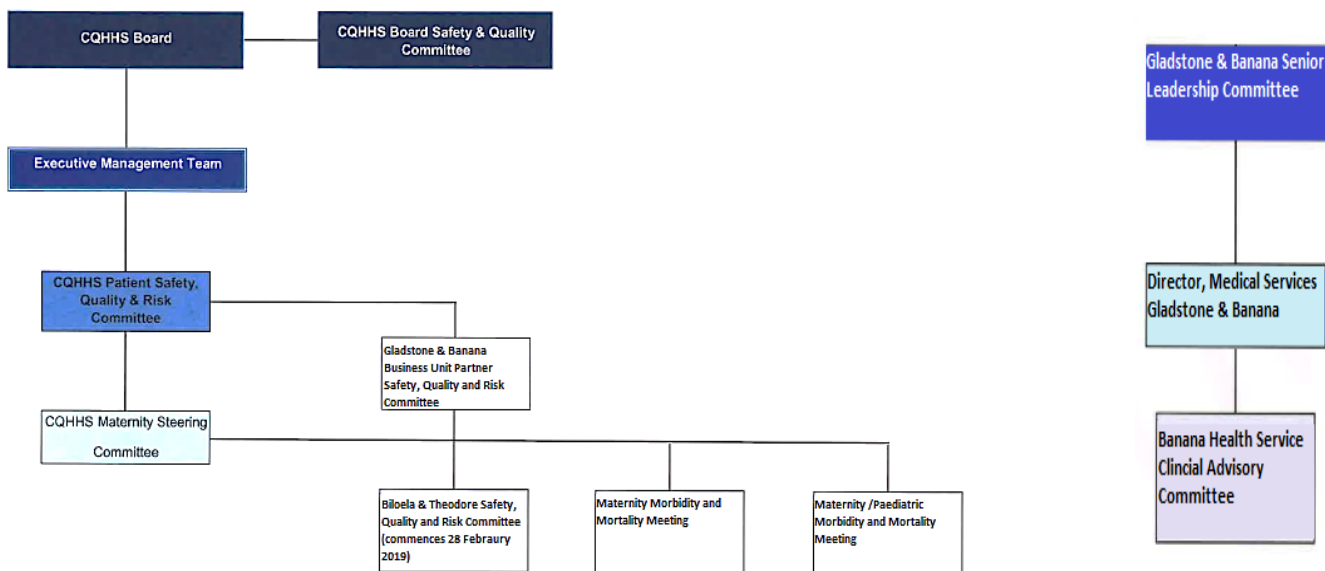
⁸⁵ https://www.health.qld.gov.au/_data/assets/pdf_file/0028/444619/cscf-selfassess-sum-centralqld.pdf

management, responses to complaints and trend analysis to support continuous improvement. These various committees also ensure that lessons learned from previous incidents are distributed to clinicians throughout the Banana Health Service. Figure 7 below illustrate the two committee streams.

Figure 7 Gladstone and Banana safety and quality committee structure

Stream 1

Stream 2



The appropriateness of this structure is discussed in section 21.1 below.

19. Maternity service review

Between August 2017 and January 2018, the CQHHS undertook an internal review of the Biloea Hospital maternity service. The review included visits to the service to audit processes and files, one-on-one interviews and the analysis of clinical data. The review was undertaken as part of CQHHS’ commitment to reviewing all of its maternity services to establish the baseline of the safety and quality of the services across the catchment facilities.

The review concluded that overall the standard of service being provided at Biloea Hospital was safe and of a high quality, however there were opportunities for improvement in relation to the clinical governance framework and incident management. The review made 9 recommendations, which were approved by the CQHHS Board in May 2018, with the review outcomes being released to staff in June 2018.

The recommendations are that Biloea Hospital:

1. explores the possibility of introducing a MGP

2. explores the possibility of establishing a Banana Shire Birthing Hub in conjunction with Theodore MPHS, which may be able to share midwifery resources across the two sites
3. introduces a monthly multidisciplinary safety and quality meeting
4. introduces a maternity mortality and morbidity meeting
5. forms a collaborative partnership with other Banana Shire facilities to support a joint approach to clinical governance and oversight of clinical outcomes
6. ensures that staff are educated on the types of incidents that should be entered into Riskman
7. ensures that the midwifery educator receives the individual results for staff undertaking the fetal surveillance training
8. promotes routine delayed cord clamping and restricts the collection of cord blood to limited situations
9. ensures that the birth register fields are updated to include a broader range of data.

Given the significant work involved with the implementation of some of the above recommendations, particularly in relation to exploring service redesign activities, an Assistant Director of Midwifery was appointed and commenced in November 2018. They will support the Gladstone and Banana Shire Business Unit to implement all of the recommendations, which have an expected completion date of 30 June 2019.

20. Complaints to the office

While this chapter draws primarily from the issues identified through the CQHHS internal review and by staff when analysing the investigative material in relation to Biloela Hospital, the office has received one complaint about the maternity service at Biloela Hospital between June 2015 and December 2018.⁸⁶ This complaint was referred to another government entity for management and the main issue was professional performance. This complaint is statistically insignificant when compared to the approximately 258 births occurring at Biloela Hospital between 2015 and 2018.

21. Issues affecting maternity services at Biloela Hospital

The following sections provide a detailed analysis of the issues investigated by the office. The sections include a recommendation for change so that quality and safety systems supporting the maternity service can continue to be refined at Biloela Hospital.

⁸⁶ The total number of complaints does not include complaints which are still pending an outcome.

21.1 Clinical governance

The clinical governance structure being utilised to support Biloela Hospital lacks clarity. Specifically, there are multiple committees with responsibility for clinical governance and/or safety and quality oversight of the maternity services but there are no clear reporting pathways between some of these committees. For example, the terms of reference for the Banana Health Service Clinical Advisory Committee (Advisory Committee) state that the committee will *'review and monitor quality and safety performance data and make recommendations for further audit, review and action...[and] escalate to the Gladstone & Banana Senior Leadership Team any matters requiring Executive-level decision-making [including] clinical issues.'* This escalation is to occur through the Director of Medical Services, Gladstone and Banana, who is also a member of the Advisory Committee. This is the stream 2 clinical governance structure and it is unclear how it loops back into the stream 1 structure, which is where the main safety and quality oversight activities occur. This opacity is evidenced by the Gladstone and Banana Business Unit Patient Safety, Quality and Risk Committee terms of reference which outline both indirect and direct reporting relationships into this committee, but do not include any reference to reporting to or from the Advisory Committee or the committees sitting above the Advisory Committee.

The separation of the Advisory Committee, and the stream 2 governance chain, is further demonstrated by the fact that it is supposed to have committees reporting through it that *'will obtain feedback from [the Advisory Committee] by receiving a copy of the relevant minutes'*; however, in the material provided by CQHHS, no reporting committees to the Advisory Committee could be identified. It appears that this committee stands alone. Given one of the key functions of this committee is to share patient safety learnings it would benefit from having clearly defined reporting relationships between it and the governance bodies that are supposed to receive and distribute the patient safety information. The two streams of the governance structure have not been mapped by either the Biloela Hospital or the Gladstone and Banana Business Unit.

In addition to the lack of clarity in reporting lines, the committees' memberships overlap. For example, all of the senior nursing and medical positions attend both the Advisory Committee and the Gladstone and Banana Business Unit Patient Safety, Quality and Risk Committee. While consistency of membership can be beneficial, particularly when the governance chain is unclear, a more streamlined committee structure can assist with limiting this type of overlap so as to ensure that committee members are not fatigued by participating in multiple monthly committees with similar functions.

Apart from rationalising the membership of committees, another way to address possible fatigue is through the marshalling of multidisciplinary resources thereby spreading the burden of clinical governance. Particularly in the Banana Shire there are several small facilities that would benefit from cross-facility safety and quality meetings. The Biloela Hospital maternity service review went some way to suggesting this approach through the recommendation that there be a Biloela Hospital and Theodore MPHS maternity safety and quality meeting. While this is a positive step, it is questionable whether cross-facility meetings should focus on specific subject matters given the limited numbers of maternity services provided and likely low numbers of safety and quality issues. It would be more advantageous for the Banana Shire to establish a series of cross-facility meetings on key general governance issues e.g. the Banana Shire safety and quality meeting (incorporating Biloela, Baralaba, Moura, and Theodore), and the Banana Shire mortality and morbidity meeting, which is already operating as a

general meeting due to the low numbers of incidents that require a mortality and morbidity review. This type of approach would limit the number of committees, promote sharing across the Banana Shire facilities and provide for a clearer governance chain.

Even with the above areas for improvement, I am satisfied that Biloela Hospital has sufficient oversight of safety and quality issues throughout its clinical governance. However, the structure currently in place appears convoluted and requires streamlining to ensure that resources are being used effectively and to limit the gaps in the governance chain where issues have the potential to fall through.

Recommendation 5

To assist the above process I recommend that:

5. Within 12 months the Gladstone and Banana Shire Business Unit:
 - a. maps out all of the clinical governance committees across Gladstone and Banana Shire, including their reporting lines upwards and downwards through the governance chain
 - b. reviews how the existing committee structure could be streamlined, including reviewing the terms of reference for each committee to ascertain overlap, and presents a paper to the Gladstone and Banana Senior Leadership Team on the review and any recommended changes
 - c. develops a diagram to demonstrate the final committee structure, including reporting relationships between the committees.

21.2 Risk and escalation

As a Level 3 service it is important that staff properly categorise a women's maternal risk status and have established pathways in place for escalating care to a higher level facility such as Rockhampton Hospital or Royal Brisbane and Women's Hospital. To date the office has not received any complaints suggesting that Biloela Hospital needs to improve its risk categorisation and escalation. Based on the material provided by CQHHS, it appears that there is a well-established escalation and referral pathway for women and babies who require higher level care—this is supported through the Queensland Ambulance Service and Retrieval Services Queensland. Additionally, Biloela Hospital are seeking to improve their management of higher risk patients by partnering with Rockhampton Hospital to introduce a weekly high risk antenatal clinic.

21.3 Models of care

Since 2011 there has been a steady decline in the number of births at Biloela Hospital, from around 100 per year down to 65 per year in 2017. This is due, in part, to an aging population. It is also a result of historical workforce issues which has meant that the maternity service was closed for long periods of time when staff were on leave or there was insufficient medical support to offer the maternity service at Biloela Hospital. This has not been an issue for a number of years and in 2016, staff from the hospital

launched a campaign to increase the awareness of the availability of planned birthing services at Biloela Hospital.⁸⁷

As a Level 3 maternity service, Biloela Hospital offers three models of care, namely:

- public hospital maternity care where care is provided in concert between the rural generalist medical practitioner and midwife for low risk women
- team midwifery care where antenatal, intrapartum and postnatal care are all provided by the hospital midwives for low risk women
- remote area maternity care where higher risk women are managed in conjunction with Rockhampton Hospital through telehealth and fly-in-fly-out specialist obstetric support.

In order to offer more choice to women, and as a by-product increase the birthing numbers, Biloela Hospital is exploring two additional models of care: shared care with local GPs and a MGP. Developing relationships with local GPs and supporting them with obstetric education is underway, with a maternity alignment training day having taken place in Biloela on 1 September 2018. This was held in collaboration with the Primary Health Network, which is an Australian Government initiative seeking to '*[increase] the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time*'.⁸⁸ The training day covered the stages of pregnancy from pre-conception to neonatal care. It was attended by all of the GPs in Biloela and signals a successful first step to implementing shared care.

In relation to the MGP this was a recommendation from the Biloela Hospital review and the viability of this model was explored by Biloela Hospital in or around March 2019. As a result, three FTE midwives have been allocated to Biloela Hospital to establish this model of care and recruitment was being finalised in June 2019.

For the size and location of Biloela Hospital it appears to be offering local women and those in the broader Banana Shire with a reasonable amount of choice in relation to models of care; with increased choice currently being planned. The models are also seeking to support women birthing as close to home as possible, although the limitations of the facility to only provide planned birthing to low risk women will necessitate travel. However, if travel can be limited through the provision of antenatal clinics and support from Rockhampton Hospital in Biloela throughout pregnancy then this is an appropriate and consumer-focused approach.

⁸⁷ <https://www.qt.com.au/news/antenatal-service-open-for-business-at-biloela/3024585/>

⁸⁸ Central Queensland is part of the Central Queensland, Wide Bay and Sunshine Coast Primary Health Network - <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home>

21.4 Staffing and skills mix

The Biloela Hospital does not have a dedicated staffed maternity service, due to the size of facility and number of births each year. Instead the service is supported by the nursing, midwifery and medical workforce from across the hospital.

21.4.1 Midwifery staffing

Given there is no dedicated maternity staff, all of the nursing staff engaged with the hospital are required to be registered as both a nurse and midwife so that they can respond to the clinical needs of the service as required. The staff work across three 8-hour shifts in a 24-hour day and there is a 'midwife' allocated to each shift. When women are birthing the service ensures that there is one-to-one care. Agency nurses (when needed they will be required to hold registration as both a nurse and midwife) are used for periods of staff leave as it is difficult for the hospital to recruit sufficient staff to create the necessary redundancies in the roster to cover staff absences.

Biloela Hospital has achieved some stability in its staffing over the last 12 months with permanent recruitment to the nurse unit manager and associate nurse unit manager positions. The hospital also created a new role for a part-time graduate nurse, who has since commenced, and received an allocation for three FTE midwives for a MGP. A major challenge for the maternity service is the ability to recruit trained midwives to the specific midwifery positions that are currently vacant. To date they have had no applicants for the advertised positions. This situation is a challenge facing most rural and remote health services across Australia.

21.4.2 Medical staffing

Medical staffing has been a challenge for Biloela Hospital for the past six years. The hospital has had three vacant medical officer positions that have had to be covered by locum medical practitioners with credentials in obstetrics and anaesthetics, which has increased operational expenses at the facility. Recently, the CQHHS Board approved a change in the medical staffing at Biloela Hospital, increasing to 6.5 FTE to accommodate a more 'family friendly' roster. The hospital was also accredited as a rural generalist training location, which should improve the ability to recruit medical officers with relevant procedural skills such as obstetrics and anaesthetics. Recruitment to the new medical model is underway and will be ongoing while positions are permanently recruited.

Another significant change in the medical staffing was the cessation of the flying obstetric and gynaecologist service (FOG). This service is operated out of the South West Hospital and Health Service (SWHHS), specifically Roma.⁸⁹ While this service was theoretically beneficial it posed challenges because the managerial and clinical arrangements sat outside of the health service in which care was being provided. It could also impact on continuity of care if a patient from Biloela Hospital had to be transferred to Rockhampton Hospital. Accordingly, with the increased capacity at Rockhampton Hospital,

⁸⁹ It provides routine and emergency obstetric and gynaecological support for rural and remote communities in Central and South West Queensland. It was established in 1988 and was adopted as a model of care by the Queensland Government.

and to further demonstrate the commitment to the hub and spoke model of care, CQHHS decided that obstetric and gynaecological support would be provided by the obstetric team at Rockhampton Hospital. This provides several benefits including provision of care closer to home for women in the Banana Shire, improved training links between specialist obstetricians and gynaecologists and the rural generalists at Biloela Hospital, and greater continuity of care if there is a patient transfer.

21.5 Culture and communication

The BPF for Biloela Hospital for 2018-19 notes that a strength of the service is the *'willingness of all levels of staff to work cohesively as part of the healthcare team to provide quality services to the community'*. This willingness is evidenced through Biloela Hospital's commitment to ensuring that its staff are supported in completing mandatory and ad hoc training. While this may not seem significant, particularly for mandatory training, the pressures of having staff taken away from their core clinical duties and covering those positions to ensure that the service can be maintained is not to be underestimated. In unhealthy safety and quality cultures, providing staff with opportunities to complete training is commonly one of the first things to fall away. In the case of Biloela Hospital, releasing staff for training can be made more challenging when they have to travel to Rockhampton. The training compliance rates are high at Biloela Hospital, for example, the records indicate that all relevant staff have completed the RANZCOG Fetal Surveillance Training and the PROMPT for 2018.

22. Conclusion

The maternity service at Biloela Hospital is small and facing the same challenges as most rural health services throughout Queensland: skilled clinical workforce recruitment and providing a service within the allocated resourcing. Despite these challenges it is clear that Biloela Hospital is committed to improving and refining its service, being innovative within the scope of its capability level and resourcing availability. Overall, I consider that the maternity service is safe and can be further supported by a clearer approach to clinical governance, which will enable learnings and practices from the broader CQHHS-wide maternity services network to be shared with Biloela Hospital and, where relevant, adopted. A clearer governance chain may also give Biloela Hospital a voice in the safety and quality governance structure, putting the challenges of a rural maternity service at the forefront of safety and quality planning.

Emerald Hospital maternity service



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Emerald Hospital

23. Facility

23.1 Facility overview

Emerald Hospital opened its doors in 1913, with a maternity block added in 1925.⁹⁰ It provides a range of services to Emerald and the Central Highlands, and is located approximately 270 kilometres west of Rockhampton. Its service area is well defined and includes Springsure, Blackwater, Tieri, Capella and the Gem Fields. Women from other HHS catchments and remote locations, such as Alpha, Blackall, Middlemount, Dysart and Clermont, also use the maternity service at the hospital.

Emerald Hospital has 32 overnight patient beds. The maternity service operates 24-hours per day. It has a six-bed maternity ward and there are two birth suites. The MGP is located in the Community Health building, which sits outside of the maternity service. Antenatal clinics, specialist clinics and telehealth clinics with tertiary facilities are offered to support women of varying risk categories. The specialist obstetric clinic is run by the gynaecological team from Rockhampton. In 2018, there were 322 births at Emerald Hospital.⁹¹

The maternity and neonatal services at Emerald Hospital have been assessed by CQHHS as a CSCF Level 3 service.⁹² This is one of three Level 3 maternity services across CQHHS. The CSCF capabilities of Emerald Hospital are the same as those described above for Gladstone Hospital because the CSCF sets the consistent requirements for the respective level of service.

23.2 Benchmarking Emerald Hospital's performance

When benchmarked against its peer Level 3 maternity services, who perform 500 or less births per year, Emerald Hospital consistently performed within the expected ranges for a variety of maternity indicators and in some cases exceeded the benchmarks for a Level 3 service, indicating its overall safety. The data from the WHA benchmarking report for 2016–17 shows:

- 40.3 per cent of women were giving birth for the first time
- 11.0 per cent of women were over the age of 35 when giving birth, compared to 13.37 per cent of women in the peer facilities (this same trend applied to women giving birth over 40 years of age)
- 0.4 per cent of women had a BMI in excess of 40 at 20 weeks gestation, compared with 0.90 per cent across Level 2 to 4 facilities
- 50.5 per cent of women had an unassisted vaginal birth after the spontaneous onset of labour versus 44.78 per cent of women in peer facilities

⁹⁰ <https://www.queenslandplaces.com.au/emerald>

⁹¹ <https://data.qld.gov.au/dataset/births-by-hospital/resource/7af8f98e-4f43-496b-b540-efa21bbe5e48>

⁹² https://www.health.qld.gov.au/_data/assets/pdf_file/0028/444619/cscf-selfassess-sum-centralqld.pdf

- 0.00 per cent of selected primipara women had an epidural, compared with 13.72 per cent of women in Level 2 to 4 peer hospitals. The epidural service was reinstated at Emerald Hospital in 2018
- 1.1 per cent of babies had an APGAR score of six or less at five minutes which is comparable with peer Level 2 to 4 facilities where the rate is 1.32 per cent.

23.3 Emerald Hospital committee structure

Emerald Hospital and the maternity service have two levels of safety and quality committees that are responsible for overseeing incident management, responses to complaints and trend analysis to support continuous improvement. Additionally, a Central Highlands and Woorabinda leadership meeting was due to commence in late January 2019 to consider complaints and clinical incidents. The meeting was being implemented to ensure that leadership remained up-to-date and agile when managing complaints and incidents across facilities within the Central Highlands. Figure 8 shows the Emerald Hospital committee structure and how it feeds into the overall safety and quality governance structure of CQHHS.

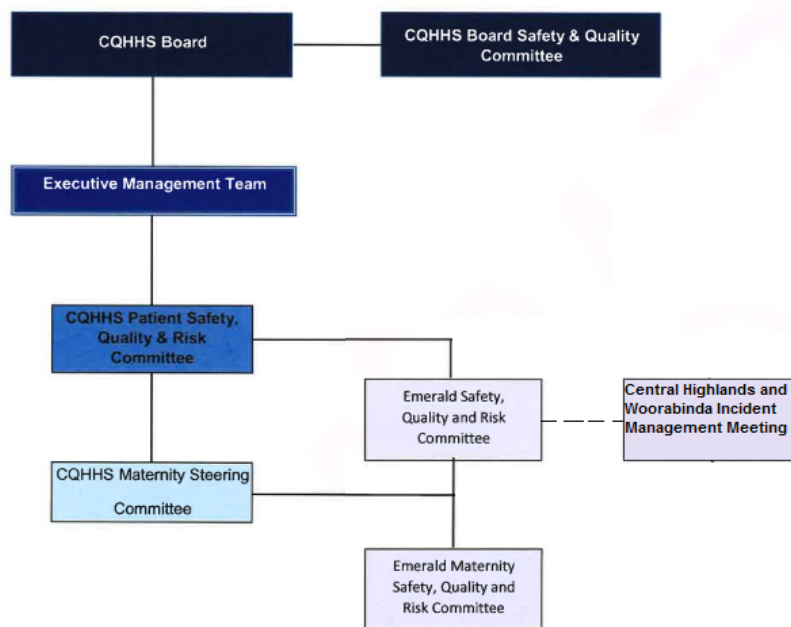


Figure 8 Emerald Hospital committee structure

24. Maternity service review

In February 2017, the CQHHS undertook an internal review of the Emerald Hospital maternity service. The review included executive, midwifery and medical focus groups, consumer feedback, one-on-one interviews, a chart audit of 35 records (representing 10 per cent of births per year), and a review of clinical incident data. The review was undertaken as part of CQHHS' commitment to reviewing all of its maternity services to establish the baseline of the safety and quality of the services across the catchment facilities.

The review concluded that overall the standard of maternity care being provided at Emerald Hospital was adequate, however, there was significant room for improvement to move to a contemporary maternity service. The review identified eight areas for improvement, many of which overlapped. For example, the issues identified with the culture, leadership, roles and responsibilities, and multidisciplinary team working all stemmed from discordance between the medical and midwifery staff and the lack of stable senior executive leadership during the preceding years. This impacted community engagement, whereby women were feeling unsupported in making informed birthing choices as midwifery and medical staff *'tried to stake a claim'* in a decision that was not theirs to own. Given the workforce issues, the safety and quality governance and clinical incident management processes in place in the maternity service were inappropriate for a modern healthcare setting. This resulted in several recommendations from previous incidents not being implemented and poor compliance with collating and tracking trend data. The review made 32 recommendations, which were approved by the CQHHS Board.

CQHHS advised that all of the recommendations were fully implemented as at December 2018. Some of the recommendations that are reliant on recruitment have been closed but not fully implemented due to the inability to recruit sufficient midwifery staff. These recommendations are being addressed through a broader workforce planning activity that is being undertaken by CQHHS. A special project team is also going to be convened to look at models of care across CQHHS, with a view to increasing the continuity models, which is largely dependent on recruitment. Emerald Hospital was initially unable to provide the office with evidence of the implementation of these recommendations as the documentation had not been appropriately maintained. This will be discussed in the context of clinical governance in section 26.1 below.

25. Complaints to the office

While this chapter draws primarily from the issues identified through the CQHHS internal review and observed by staff during the onsite stakeholder visit, the office has received one complaint about the maternity service at Emerald Hospital between June 2015 and December 2018.⁹³ This complaint was referred to another government entity for management and the main issue was communication. This complaint is statistically insignificant when compared to the approximately 1,199 births occurring at Emerald Hospital between 2015 and 2018.

26. Issues affecting maternity services at Emerald Hospital

The following sections provide a detailed analysis of the issues investigated by the office. The sections include a recommendation for change so that the quality, safety and reliability of, and public confidence in, maternity services at Emerald Hospital can continuously build into the future.

⁹³ The total number of complaints does not include complaints which are still pending an outcome.

26.1 Clinical governance

The Emerald Hospital maternity service's clinical governance framework requires development and embedding to become more contemporary and sophisticated in its approach to safety and quality oversight. Between 2015 and late 2017, the service was unable to achieve a strong approach to clinical governance. This was due to instability in executive leadership and resourcing issues that required sole focus on delivering care rather than achieving a balance between care and the supporting infrastructure. A constant series of reviews also meant that the service had to respond to frequent, and at times, destabilising change. Since the beginning of 2018 there has been an increased focus on clinical governance and new, experienced executive leadership that are supporting the service and Emerald Hospital to improve its governance arrangements.

Some of the key clinical governance processes introduced include:

- Development of the Central Highlands and Woorabinda Clinical Governance Operational Plan 2018-2019 (Operational Plan), which seeks to implement and support the health service wide programs that are aimed at improving the safety and quality of the care being delivered to Central Queenslanders.
- Introduction of the Central Highlands and Woorabinda Patient Safety, Quality and Risk Committee, which is responsible for providing strategic oversight and advice on safety and quality and clinical governance issues and, making any recommendations for changes to governance approaches. This committee also oversees the implementation of the Operational Plan.
- Developing a six-monthly safety and quality snapshot for the maternity service and seeking trended incident data from Riskman to start to proactively manage any safety and quality trends.

Despite the above advancements there remain challenges in maintaining the required elements of a contemporary approach to clinical governance. For example, during the stakeholder visit staff advised that it is often difficult to complete the monthly audit requirements for the maternity service due to staffing limitations, meaning that care must be prioritised over auditing. Resourcing equally has an impact on the available time for monthly maternity safety and quality meetings as when there is a surge in clinical activity the meetings need to be rescheduled. Finally, closing the loop on corrective actions, particularly in relation to evaluating the effectiveness of implemented recommendations, is difficult because there is often insufficient non-clinical hours built into the staffing numbers. These challenges are not unique to the Emerald Hospital maternity service but small adjustments may result in a more consistent approach to clinical governance. Approaches being trialled by the maternity service include:

- a bi-monthly safety and quality meeting rather than monthly to combat the rescheduling
- development of a monthly audit calendar showing what and how many audits are required for the month, rather than the yearly audit schedule. This enables staff to be clear on the audit expectations. The monthly calendar is posted on the main communication board for staff so that they can check-off when audits are completed, providing a visual prompt as to how they are tracking in completing audits for the month.

The maternity service is encouraged to focus on the refinement and embedding of its clinical governance processes, continuously improving the systems in response to any identified issues. For example, during

this office's investigation a number of documents were requested to demonstrate the implementation of the recommendations from the maternity service review. Initially these documents were unable to be located due to an uncoordinated approach to maintaining evidence of implementation. This situation had, in part, developed due to the lack of a Safety and Quality Business Unit Partner for some months because the person holding the position had been seconded and not replaced. This gap in the clinical governance system was not identified until the office's request for information. While the maintenance of evidence may seem trivial provided the recommendation is implemented, the inability to easily recall the evidence demonstrating implementation can have flow-on effects when seeking to evaluate the implemented recommendation some 6–12 months later. Simple gaps like this, once identified, can be time consuming to address. The Emerald Hospital maternity service, supported by CQHHS, responded quickly to this issue but going forward they need to ensure that there is a sufficiently robust clinical governance framework in place that facilitates the early identification of these types of issues. This is often best achieved through high level oversight via committees such as the Central Highlands and Woorabinda Patient Safety, Quality and Risk Committee.

26.2 Risk and escalation

As a relatively high volume Level 3 service it is important that staff properly categorise a woman's maternal risk status and have established pathways in place for escalating care to a higher level facility such as Rockhampton Hospital or Royal Brisbane and Women's Hospital. To date the office has not received any complaints suggesting that Emerald Hospital needs to improve its risk categorisation and escalation. Based on the material provided by CQHHS, it appears that there is a well-established escalation and referral pathway for women and babies who require higher level care—this is supported through the QAS and Retrieval Services Queensland.

The Emerald Hospital has consistently high audit results for key risk performance criteria, for example:

- The audit of the initial midwifery assessment tool demonstrated that of the 21 performance indicators, 15 were above 80 per cent compliant.
- In relation to responding to deterioration, the audit showed consistent performance with 20 out of 31 performance indicators achieving 100 per cent and 15 of those maintaining that score across two audit periods.
- The CTG audit showed sound improvement between the two audit cycles, July to December 2017 and January to November 2018, with the recognition and escalation of an abnormal CTG increasing from 66.6 per cent to 100 per cent.

While there remained some ongoing areas for improvement in the above audits, these are being consistently reviewed and managed by the maternity service to ensure that the strong results are maintained and lower results are improved.

The maternity service also participates in the Central Highlands Maternity Psychosocial Care Coordination meeting, which is a monthly multidisciplinary meeting that seeks to *'provide collaborative maternity care to promote active participation of different health disciplines in delivering quality care that*

is tailored to each individual woman's needs'.⁹⁴ This meeting brings together midwives, medical officers, child protection officer, social worker, nurse navigator and a number of other disciplines to provide a well-rounded client-centred care plan for high risk women. There is a clear referral pathway for newly identified women to be considered at the meeting and at each meeting agenda existing and newly referred clients are discussed. For each client a CQHHS care coordination review form is completed and updated whenever there is a change in the care plan. This form and its subsequent revisions are filed in the medical record within 24–48 hours of the meeting.

The above measures and audit results demonstrate that the Emerald Hospital maternity service understands the importance of assessment, response to, and escalation of risk during the antenatal and intrapartum period and has high quality procedures and processes in place to facilitate an appropriate and timely response to risk.

26.3 Models of care

The Emerald Hospital maternity service offers the following models of care:

- public hospital
- MGP
- team midwifery
- shared care

The below discussion will focus on public hospital care and the MGP as the main models of care where there is room for refinement in the maternity service.

26.3.1 Public hospital care

26.3.1.1 *Flying obstetric and gynaecologist service*

Public hospital maternity care is offered within the hospital environment and is provided in concert between the rural generalist medical practitioner and midwife, with specialist obstetric support provided by the consultant obstetricians in Rockhampton. Previously, the Emerald Hospital maternity service was utilising the FOG⁹⁵ to provide specialist support for higher risk women who needed an obstetrician involved with their care.

The FOG service provided obstetrics and gynaecology support to women in Emerald until March 2018, when the contract between Southwest HHS (who governed the service) and CQHHS expired. There were challenges identified in the governance of a service provided by an external clinical provider who sat outside the normal line management, escalation and referral pathways within CQHHS, particularly for patients who were at higher risk, who had an unexpected complication or who required escalation of care. The Rockhampton obstetrics and gynaecology team started to provide specialist clinical services in

⁹⁴ Terms of Reference for the Central Highlands Maternity Psychosocial Care Coordination meeting.

⁹⁵ The background to the FOG service is discussed in section 21.4.2 above.

a hub and spoke model with Emerald from March 2018, which was aimed at securing safer outcomes and an overall better obstetric and gynaecological service. This goal has been realised with Emerald Hospital reporting significantly improved clinical outcomes since the introduction of the model which continues to go from strength to strength.

26.3.1.2 *Telehealth*

In 2017, CQHHS commenced the Maternal and Antenatal Telehealth Service (MATES) project, which aimed at providing increased antenatal, obstetric and unscheduled maternal care to women in Emerald so that they did not have to travel considerable distances for care. The project was released in three stages, being:

- Stage one (implemented in October 2017) involved providing telehealth services from Rockhampton Hospital during routine antenatal and obstetric clinic appointment times.
- Stage two (implemented in February 2018) involved a multidisciplinary team telehealth approach for high risk women who needed more input into their care and management.
- Stage three (implemented in May 2018) involved providing access to the Telehealth Emergency Management Support Unit (TEMSU) for unscheduled antenatal and maternal care, including remote CTG monitoring and interpretation.

This was a successful project, which supported CQHHS' desired outcomes of improving the service for consumers and reducing the amount of unnecessary travel across the catchment. The major challenge was for the Emerald Hospital maternity service as it did not receive extra resources to facilitate the telehealth clinical appointments. In general, a midwife in Emerald would always attend a telehealth clinic appointment with a women as it facilitated better discussions. However, the telehealth clinic times were based on the Rockhampton schedule, which did not always align with Emerald's schedule placing pressure on the rostering of the service to facilitate the ad hoc appointments. During the visit in January 2019, the nurse unit manager advised that when there are insufficient staff to cover the appointments she would facilitate the telehealth appointment. This is not a sustainable solution. It is important that appropriate resourcing is provided to facilitate the function or clinic times are logically aligned to ensure a sustainable model moving forward.

26.3.1.3 *Water birthing*

Historically CQHHS required midwives to be credentialed to provide water birthing as an option. During the course of the maternity reviews it was identified that this was an out-dated approach as water birthing is a key part of a midwife's scope of clinical practice. Accordingly, CQHHS developed an online simulation training package for water birthing to enable midwives to reskill and provide this service. The Emerald Hospital maternity service is going to be the pilot site for the simulation training and reintroduction of the service. It is estimated that 45 per cent of all births will be water births, so this is a high demand service.

26.3.2 Midwifery Group Practice

Since 2012, Emerald has been offering a low risk MGP. There are six midwives with a full-time midwife undertaking between 35 and 40 births per year.

As part of the on-site stakeholder visit in January 2019, staff met with members of the MGP and were advised that the model of care works as follows:

- The midwives work independently of each other, with one midwife working out of Blackwater where there is a higher Indigenous population.
- There is a weekly case conference between the MGP midwives and medical staff to discuss new women referred to the service and any emerging issues that may require medical input or transfer of care to the core maternity service.
- Each new referral is taken to the first case conference and if a medical officer agrees that the woman is suitable for MGP then they sign-off on the model of care and make any necessary additions to the management plan.
- MGP can utilise the specialist obstetric clinics at Emerald Hospital for routine care or utilise the telehealth facilities if a more urgent consultation is required; MGP midwives can also escalate concerns to the medical officers who can liaise with Rockhampton Hospital.
- Postnatal home visiting is provided for up to four weeks

Also during the visit in January 2019, the office was advised that the MGP had lost four senior midwives in quick succession (over the course of a few months) due to staff moving away. This left a significant gap in the service and was in part filled by two midwives from the core maternity service. A staff shortage such as this has increased the pressure on the remaining and new MGP midwives and has also resulted in there being limited orientation and support for the new midwives joining the team. When discussing some of the approaches of the other MGPs across CQHHS, including buddying MGP midwives so that there is back-up for labouring women, facilitating meet-and-greets, and having a more collaborative and shared approach to the care, some staff commented that this type of approach would be beneficial as it would enable a midwife to feel less isolated when caring for her caseload of women. However, it was also noted that some of these approaches, such as meet-and-greets, may not be realistic for their patient cohort as many women have a challenging socioeconomic situation and are unable to travel to Emerald Hospital for routine antenatal visits let alone additional functions.

Staff noted that it would be beneficial if there was more shared care with the local general medical practitioners to ease the pressure on the MGP as it has a long waiting list of women wanting to access the service, who are then cared for through the public hospital model of care. The Emerald Medical Group has some 16 to 20 general practitioners who could offer shared care. Relationships are starting to form between these practitioners as the rural generalist medical practitioners from the hospital do rotational placements at the Emerald Medical Group. Further, in June 2018, a '*Central Queensland Maternity Alignment*' workshop was held to educate and inform general practitioners on how to provide obstetric care. This is a model of care that Emerald Hospital will continue to develop and is utilising the experience of the Mater Hospital in Brisbane to support improvements.

Overall the MGP at Emerald Hospital is safe and of high quality for its cohort of women however in some respects it is not as well developed as other MGPs across CQHHS, particularly in relation to how the MGP midwives work together. With the recent loss of a significant proportion of its staff the MGP is encouraged to revisit the service and its ways of working to ensure that the MGP midwives are supported and develop an excellent team culture with contemporary and innovative practices.

26.4 Staffing and skills mix

Even though the Emerald Hospital maternity service is reasonably well staffed with a good mix of experienced and more junior midwives and medical staff, it lacks the necessary staffing redundancy to allocate more hours to non-clinical functions, which are important for any maturing health service. To address the challenges in recruitment across CQHHS, they are developing a rural recruitment strategy as part of the strategy. This will apply to Biloela, Emerald and Gladstone.

26.4.1 Midwifery staffing

As with all regional locations in Queensland recruiting sufficient midwifery staff is difficult. The Emerald Hospital maternity service has consistently operated with an FTE midwifery vacancy of between two to five for the past two years. In January 2019, there was an FTE vacancy across the service of 5.20. A recruitment process was being undertaken to fill these positions, with the service now offering incentives to try to attract staff as applications for the positions had been limited. During the stakeholder visit in January 2019, staff reflected that recruitment accounts for a significant proportion of management's time in operating the service. This is challenging and undoubtedly has an impact on leaderships' capacity to be strategic and forward thinking.

The FTE vacancy sits against a backdrop of a service that is steadily increasing year-on-year in relation to total number of births. Further, there has been a recent change in demographics with a new mine opening in Blackwater, an increase in houses being sold with a corresponding increase in the population, and the good reputation of the service—this has resulted in 142 births being booked in between January and April 2019. Not only does the service need to address its current FTE vacancy but it also needs to start future proofing the service against the likely increase in demand from Emerald and the Central Highlands.

Even with this staffing profile, the Emerald Hospital maternity service has been able to achieve some important recruitment, including a 0.7 FTE midwifery educator, who commenced in January 2018, and two 0.4 FTE clinical facilitators who will commence in 2019. They are responsible for supporting and working with the new midwifery graduates. The ethos of recruitment across CQHHS, which is echoed at Emerald Hospital, is to grow their own. These supporting roles assist with that approach as they are ensuring that junior midwives will be encouraged to develop within the service. This has the potential to pay dividends for the maternity service in three to five years when the junior midwifery cohort become the more senior midwives and can share their learnings with the incoming junior staff. This is a sustainable model for CQHHS however it will take time to implement.

Another measure approved by Emerald Hospital in January 2019, is to commence recruitment for nursing staff in excess of the establishment numbers across the hospital so that any backfilling required

can be drawn from internal staffing rather than sourcing agency nurses. Once this recruitment is finalised it may also be used to support FTE vacancies in the maternity service for functions where nurses are able to be utilised in the place of midwives, such as caring for woman postnatally on the ward. The combination of the above approaches is evidence of a health service that is continually striving to address its recruitment challenges.

26.4.2 Medical staffing

Since 2014, the Emerald Hospital maternity service has been accredited to provide places to rural generalists and has developed a core group of 12.75 FTE rural generalists who cover various areas of medical practice across the hospital, including advanced skills in obstetrics, emergency, anaesthetics, surgery, and mental health. As a result of this program there has been limited use of locum medical practitioners to fill FTE vacancies. However, a lack of ability to recruit sufficient numbers of staff in peak periods and surges in activity still results in staff fatigue.

There is now a push for the maternity service to recruit more medical practitioners to ensure greater redundancies in staffing numbers, which contributes to safer outcomes. Some of the redundancy already built into the maternity service includes appropriate arrangements for overnight support with on-call rural generalists, nurses/midwives, and the director of nursing or nurse unit manager acting as the after-hours manager. Delivering care in this way is costly but this approach to rostering maintains access to an appropriate skill mix in the maternity service at all hours, which is often not well addressed by regional facilities.

In addition to having sufficient medical staff, the maternity service is also ensuring that its staff have adequate opportunities to improve their skills and experience. For example, there is a program where rural generalists can undertake a four-week placement in neonatal services in a tertiary level facility. The strong partnerships with Rockhampton Hospital also offer opportunities for medical staff to rotate through the maternity service, gaining experience with specialist obstetricians and being involved with higher risk cases. Overall, the effort of the Emerald Hospital in the last three years to consolidate its medical staffing is working, demonstrated by the improving stability across the maternity service.

26.5 Culture and communication

The internal review identified a '*clash*' in cultures between the midwifery and medical staff in early 2017; this was impacting on morale and team work. This cultural disconnect had been developing since around 2014, with the introduction of rural generalists, as midwives who had been working within the maternity service in excess of 20 years now had to share clinical responsibility for birthing women. Managing this transition was difficult for the maternity service due to a lack of stable leadership and limited focus on activities to build productive working relationships. The two main areas where there has been significant improvement and a corresponding impact on the culture are: the implementation of cultural initiatives, and increased staff training, including multidisciplinary training.

26.5.1 Cultural initiatives

These cultural issues resulted in a maternity service where staff felt blamed, mistrusted and disrespected. Significant remediation was required to turn around the culture. In a relatively short period of time the maternity service has dramatically improved staff morale and collaboration between medical and midwifery staff. During the stakeholder visit in January 2019, representatives from Emerald Hospital advised that the drivers for the cultural shift over the last 12–24 months have been multifactorial, including improved training, changes in staff, and stable leadership.

A number of cultural training programs and initiatives have been implemented across the maternity service in 2018, namely:

- structured team building and communication exercises through the CAPS program, focusing on crucial conversations and conflict management
 - in April/May 2018 there was a rural resilience retreat where a presentation was provided to medical officers about CAPS
- ensuring staff were held accountable for behaving in a manner consistent with the CQHHS values, and where there were identified issues offering individual counselling and coaching
- maternity staff developing their own ‘above the line and below the line’ behaviours to set the expectations for how staff within the service will work and interact with each other and consumers. This has empowered staff to raise concerns directly with each other as and when they observe the behaviour, reinforcing a positive and proactive culture
- several staff participated in the ALICE: Woman-Centred Care program—a leadership program being trialled by the Department of Health. It aims at supporting clinicians to be effective collaborative leaders within a multidisciplinary maternity service by giving them skills and tools to ensure that they *‘positively impact on authentically woman-centred care’*
- implementing the *‘Promoting Professional Accountability Programme’*⁹⁶, developed by the Cognitive Institute, across CQHHS, including workshops being held in Rockhampton for leaders with performance management responsibilities to provide them with *‘a model for graduated levels of intervention for addressing clinician behaviour that undermines a culture of safety and quality’*.

The maternity service also undertook a staff culture survey in 2018. The results were adequate but the three lowest scoring outcomes were:

- *‘there is a feeling of openness and trust in our unit*
- *we are able to communicate our points of view without fear of reprisal*
- *my opinion/input is regularly sought by Senior Leadership’.*

⁹⁶ The *Promoting Professional Accountability Programme* run by the Cognitive Institute seeks to address unprofessional behaviour in the work place and improve the safety and reliability of care. It is aimed at building on the existing professionalism of clinicians to provide safe and high quality care, while introducing accountability for staff who demonstrate repeated unprofessional behaviour.

These results indicate that while there has been an improvement in the culture within the service there is still work to be done to rebuild trust and safety between clinicians when speaking up—this inevitably takes time and is difficult to restore. There are no plans to repeat the survey. Instead, CQHHS is considering adding culture questions to the *Working for Queensland* survey. Given the lowest scores appear in important categories for a healthy culture, and came after some cultural improvements had been implemented, I would encourage the maternity service to conduct the survey again in 2019 to benchmark whether there has been an improvement in staff perceptions in relation to these lowest metrics.

26.5.2 Training

The increased focus on multidisciplinary training and debriefing to improve collegiality between clinicians and create safe environments in which they can have robust clinical discussions has contributed to an improvement in the trust between medical and midwifery staff across the service. For example, there are CTG review sessions, which have been incorporated into the morning handover and include both medical and midwifery staff.

Additionally, the 2018 activity report from the midwifery educator outlines a comprehensive education program throughout the year, with topics including:

- imminent birthing at Emerald and other smaller sites
- basic and advanced neonatal resuscitation
- Aboriginal and Torres Strait Islander cultural workshops
- fetal surveillance
- informed consent
- postpartum haemorrhage⁹⁷ knowledge assessment.

The records demonstrate that across the year the training sessions were well attended with limited non-attendees; people who did not attend were unable to be released from their clinical duties. This same commitment to training is reflected in the CQ Learn training report, dated 5 January 2019, which shows a 97.40 and 82.25 per cent completion rate for mandatory and requisite training respectively. A focus on formal and ad hoc training is a positive signal of a culture that is improving as time is being dedicated to learning despite an environment where clinical pressures can be significant due to the staffing challenges. The maternity service should continue with its current approach to embed the safety and quality culture that is being perpetually refined and improved.

⁹⁷ Postpartum haemorrhage (PPH) is common in Australia and New Zealand, with an incidence rate of between 5 and 15 percent. A PPH occurs when there is more than 500ml of blood loss after a vaginal birth or 1,000ml after a caesarean section. There are two PPH classifications, namely: primary PPH which occurs within 24 hours of birth, and secondary PPH which occurs between 24 hours and six weeks postnatally. Guidelines for the management of PPH are developed by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Queensland Health.

26.6 Patient centred care

As noted above, the internal review identified that women were feeling disrespected and unsupported in making birthing choices due to the philosophical differences between medical and midwifery staff in or around early 2017. This had the potential to compromise patient safety or create the perception that safety was being negatively impacted upon because of individual staff ideology driving care choices rather than non-directive and clinically appropriate choices being discussed and followed, which had the woman at the centre of the care. Additionally, women reported concerns in relation to:

- there being no epidural service offered at Emerald Hospital, requiring women to travel to other facilities if they identified that they wanted an epidural as part of their birthing plan
- the choice of having a vaginal delivery after a Caesarean section (VBAC) being under threat.

26.6.1 Consumer partnering

The Emerald Hospital maternity service is committed to ensuring that consumers are at the centre of everything that they do so that their community has a maternity service in which they can have confidence and pride. The results of the internal review have clearly been taken on by the maternity service and are being comprehensively addressed. The beginnings of these efforts are demonstrated in the results of the Queensland Health's *Maternity Outpatient Clinic Patient Experience Survey 2017*, which is a biannual survey sent to women across Queensland to seek their views on the adequacy of the antenatal clinic experience. In 2017, the survey was sent to 110 women who attended clinics at Emerald Hospital between July and September 2017—there was a 53 per cent response rate. For most of the metrics where there were sufficient response numbers the Emerald Hospital maternity service ranked equal to or higher than its peer Level 3 facilities across Queensland. Some metrics were lower than the 2015 survey results and these are likely due to the difficulties in the service between 2015 and 2017. Positive results include:

- 82 per cent of women feeling listened to by midwives, and 75 per cent of women felt listened to by doctors, during clinic appointments
- 83 per cent of women felt comfortable asking questions or discussing their concerns with midwives
- 77 per cent of women felt that doctors explained the reasons for examinations, treatments and referrals in a way that women understood
- 76 per cent of women felt that their emotional health had been supported by staff
- 79 per cent of women considered that they had been included in decisions about their care as much as they desired to be.

The results of the survey were followed up by Emerald Hospital through its own patient experience survey conducted with mothers between January to June 2018 and June to December 2018. The results of the survey showed that 100 per cent of the women surveyed over the two periods, women felt that:

- staff showed care and compassion all of the time
- staff took the opportunity to learn about a woman's preferences before interacting with them

- they were listened to
- they were made to feel safe
- they were included in decisions about the care to the extent that they desired.

While the survey only canvassed the views of nine women over these two periods, which is approximately 3 per cent of births across a calendar year, it represents an improvement in how women are feeling about their engagement with the service during their pregnancy.

Other approaches taken by the maternity service include regular community forums. For example, in March 2017, the maternity service held a community forum to discuss the outcomes of the review. A further forum was held in April 2018 and the agenda included an outline of the strategy, maternity action plan, introduction of new services (epidural, VBAC, telehealth), what was planned for the service, and a brainstorming session to gather community ideas on how the service could continue to refine. This was well attended by past and present patients of the maternity service. A further forum was held in October 2018 which was not as well attended and it was recognised that these need to be more widely advertised, with further lead time to enable members of the community to attend.

On 31 October 2018, the maternity service held its inaugural Community Advisory Group meeting, which currently has 9–10 members of the community. The Chair of the CQHHS Board also attended. The purpose of the group is to have a structured environment through which the service can partner with community representatives to develop initiatives and materials for the maternity service. This may include community representatives providing feedback on new services or reviewing brochures and giving input into what they want to see included in the final document. The plan is for this meeting to occur quarterly. Also, any patients who complain are offered an opportunity to be a member of the group and be proactive in addressing their concerns. There are no plans yet to cap the membership of this group and it will be evaluated as it progresses.

During the office's stakeholder visit in January 2019, Emerald Hospital arranged a morning tea between staff from the office and a number of past and present patients of the maternity service. This was well attended by more than 10 mothers and babies, and midwifery staff. Overall, the consumers relayed positive experiences with the maternity service. One particular mother noted how supported she had felt during her recent birth, which followed from a previous birth in which there was an unpreventable adverse outcome. The consumers were open and actively engaged with the maternity service. This environment appeared to be in stark contrast to that described in the internal review and is undoubtedly due to the efforts by the maternity service to include consumers and address its cultural issues.

26.6.2 Epidural service

Under the CSCF a Level 2 maternity service or below is not able to offer an epidural service, however, there is no such limitation on Level 3 maternity services and above. Yet at Emerald Hospital the epidural service had declined over the years to the point where it was no longer being offered. If women identified that they wanted an epidural as part of their birthing plan, they were required to birth at either Rockhampton or Gladstone Hospital. There was no rationale for why the service had ceased at Emerald Hospital so the decision was made to reintroduce it—a complex and lengthy process as the epidural

service needed to be redesigned and staff trained prior to it commencing. Despite the community being vocal in their desire for this service, the maternity service did not want to reintroduce the function until it was safe.

On 1 and 13 February 2018, the maternity service held day-long workshops on the administration of epidurals during normal birth. The workshop was run by the midwifery educator. The workshops were well attended with 20 midwives receiving training across the two days. Midwives also had to complete a clinical assessment tool for '*Administration of Epidural in Labour (Emerald Maternity Services)*'. Part of this assessment required the midwife to be observed performing each step in undertaking an epidural, from providing the consumer with information, to preparing the epidural and pump, to monitoring vital signs, to managing adverse events.

To support understanding and communication with women about the epidural service, the maternity service developed the '*Epidural: Pain relief for your labour*' information brochure to advise women about what they can expect from an epidural, including how it is inserted, pain expectations, and risks. This was developed in consultation with the community.

In March 2018, the epidural service was reinstated and since that time in excess of 40 epidurals have been performed. Four months after introducing the service, Emerald Hospital completed an audit of all of the epidurals performed to ensure that the service was safe and of a high quality. The audit noted that the epidural rate was around 12.06 per cent, which is similar to peer Level 3 facilities. The audit identified that there were no concerns with the safety and quality of the epidural service. The major area for improvement highlighted by the audit was the completion of an anaesthetic review after an epidural and prior to discharge. This either did not occur or was not fully documented in nine of the 14 epidurals completed. There was a similar trend in relation to the completion of consent documentation.

While there is room for improvement in the processes being followed for the epidural service, as would be expected with the introduction of any new clinical program, the initial quality of the service is in part due to the measured path that Emerald Hospital took in reinstating the service, ensuring its safety from the outset. Despite being confident that the Emerald Hospital maternity service will continue to audit its epidural service, given some of the refinements that need to occur in relation to the governance processes and the lack of demonstrated action plan for addressing the results of the above audit, I am of the view that it is necessary for my office to continue to monitor Emerald Hospital's development of the service. Accordingly, I recommend that:

Recommendation 6

6. Within three months, the Emerald Hospital maternity service:
 - a. undertakes a chart audit of all epidurals performed since the previous audit. This process should include setting benchmarks for the expected completion of key areas of the epidural process e.g. 80 per cent of all charts audited have a fully documented post anaesthetic review process and provision of the information booklet
 - b. develops an action plan for any identified areas for improvement from the audit, if any. The action plan, if any, should include a process for evaluating the effectiveness of the measures once they are implemented

Recommendation 6

- c. presents the outcomes from the audit and any action plan to the Maternity Steering Committee.

26.6.3 Vaginal delivery after Caesarean section

The community raised concerns that the VBAC option was in jeopardy in the maternity service. During the office's visit to the service they advised that there had been poor governance around the VBAC service, with it being offered sporadically and largely dependent on the clinician reviewing the woman. The issue was exacerbated by the FOG service (discussed above) as the visiting obstetrician was making an assessment about a woman's suitability for VBAC without then being present during birth or to manage adverse complications.

In addressing the community's concerns the maternity service decided to improve the governance around the provision of VBAC. One of the key changes was the establishment of clear lines of communication between the rural generalists at Emerald Hospital and the specialist obstetricians at Rockhampton Hospital. There are several opportunities for consultation and escalation of VBAC issues through direct telephone contact, the High Risk Obstetric Meeting, and the visiting specialist obstetric clinics at Emerald Hospital. This change has increased the confidence of practitioners in the maternity service in offering women the choice of VBAC, provided they are clinically suitable. It also ensures specialist oversight of the birthing choice to make sure that the options being considered are safe and within the capability of the Level 3 maternity service.

The maternity service also developed the '*Emerald Hospital parent information sheet: Vaginal birth after caesarean (VBAC)*'. This was developed in consultation with the community; specifically the maternity service sought consumer feedback on the information sheet via the '*Consumer and carer information review form*'. The form sought feedback on the comprehension of the sheet in explaining VBAC, the design and layout of the sheet, and usefulness of the information being provided. Consumers were also given an opportunity to provide free text comments on how they considered the form could be improved. Ten of these feedback forms were completed and taken into consideration when the maternity service was finalising the VBAC information sheet. The final information sheet provides clear information about when it may not be suitable to have a VBAC and when a woman's clinical circumstances may require her to travel to Rockhampton for a VBAC, if that is the preferred mode of birth. The information sheet was scheduled to be published in December 2018 and is an excellent example of strong community partnerships to develop products relevant to community concerns.

27. Conclusion

The Emerald Hospital maternity service significantly changed between 2017 and 2018. The transformation of its relationships with consumers, brave decisions about models of care, and a shifting culture that is supporting safe and high quality outcomes in a multidisciplinary environment, all demonstrate a service that is committed to improving and meeting the demands of modern healthcare delivery. Some of the improvements are relatively recent, only having been implemented in late 2018, so

it will be important for leadership to maintain its energy and focus on embedding improvements and implementing new processes to address the ongoing challenges of delivering care in a rural maternity service. The recommendation I made in relation to the epidural service seeks to support the maternity service in its continuous improvement journey. Similarly the key observations in this chapter in relation to governance, staffing and culture should assist in guiding the maternity service on where to commit its energy so that it continues to build upon its successes in providing a safe and quality maternity service.

Theodore Multipurpose Health Service maternity service



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28. Facility

28.1 Facility overview

Theodore MPHS opened its doors in 1961; it was destroyed by fire and rebuilt in 1976.⁹⁸ In 2001, the hospital established itself as the Theodore Multipurpose Health Service (MPHS), in partnership with the Theodore Council on the Ageing Inc. The MPHS falls within the Banana Shire of Central Queensland, one of the outermost towns in the CQHHS catchment area. It is 84 kilometres south west of Biloela, 229 kilometres south west of Rockhampton and, 214 kilometres south west of Gladstone. It provides services to a number of local townships and surrounding areas including, Cracow, Camboon, Glenmoral, Isla and Lonesome Creek (approximately 1,200 people).

The MPHS has 10 overnight patient beds; five of these beds are allocated as aged care residential places, one of which is used for respite and palliative care or to support aged care patients awaiting a placement. The emergency department operates 24-hours per day. The Theodore Medical Clinic is co-located with the MPHS and works in partnership to provide a weekly antenatal clinic. The MPHS also offers postnatal services.

The maternity and neonatal services at Theodore MPHS have been assessed by CQHHS as a CSCF Level 1 service.⁹⁹ This is one of several Level 1 maternity services across CQHHS. According to the CSCF modules for maternity and neonatal care, a Level 1 service is expected to provide:

- no planned birthing services and appropriate training in imminent birth, basic life support and neonatal resuscitation
- antenatal and postnatal care provided by general practitioners or registered midwives—if there are maternal or fetal risk factors then antenatal care should be provided in partnership with a higher level maternity service
- care of healthy neonates with a gestational age of 37 weeks or greater—the care predominantly occurs in home or community settings
- appropriate access to a range of education and support services (located on-site or off-site) including, smoking cessation support, antenatal and postnatal psychosocial review, healthy hearing screening, parenting, bonding, feeding and lactation education.¹⁰⁰

⁹⁸ <https://hoteltheodore.com.au/town-of-theodore/>

⁹⁹ https://www.health.qld.gov.au/_data/assets/pdf_file/0028/444619/cscf-selfassess-sum-centralqld.pdf

¹⁰⁰ CSCF, Maternity Services, Module Overview, version 3.2 and CSCF, Neonatal Services, Module Overview, version 3.2.

28.2 Maintenance of Level 1 maternity service

Theodore was flooded in December 2010 and January 2011 causing considerable damage across the town including to the Theodore MPHS. The Theodore MPHS had to be repaired and parts of it rebuilt before full services could be restored, this included the operating theatre and birth suite. From 2011 onwards, the Theodore MPHS was unable to accommodate planned birthing services, operating as a Level 1 maternity service due the lack of appropriate facilities. Previously it was a Level 2 maternity service, the primary difference between the two capability levels being the provision of planned birthing services.

In October 2016, the flood repair work, including the availability of a birthing room, was completed. The community considered that access to the birthing room would result in planned birthing services being reinstated; however, in June 2018, the Chief Executive of CQHHS held a community meeting where it was announced that, due to safety concerns, the MPHS would remain a Level 1 maternity service. Expectant mothers would need to travel to Biloela, Gladstone or Rockhampton Hospitals to give birth, dependent on their risk status.

The Theodore community was dissatisfied with the decision, believing that it transfers the risk of birthing onto pregnant women, and lobbied the Queensland Government and CQHHS for a restoration of their Level 2 maternity service. There are no current plans for the reinstatement of planned birthing services at the Theodore MPHS but this will likely be reviewed in line with the Minister for Health and Minister for Ambulance Service's announcement on 19 June 2019 in relation to the Rural Maternity Taskforce, which requires each HHS to review its rural and remote maternity services over the next two years to ascertain whether services can be restored.

29. Maternity service review

Between August 2017 and January 2018, the CQHHS undertook an internal review of the Theodore maternity service. The review was undertaken as part of CQHHS' commitment to reviewing all of its maternity services to establish the baseline of the safety and quality of the services across the catchment facilities.

The review concluded that there was an overall positive culture within the service and across the Theodore MPHS. However, the maternity service had been developed in accordance with traditional medically-led principles and did not represent a contemporary maternity service. Also, the reduced activity within the service was resulting in significant gaps in the recency of practice for clinical staff. Specifically, the Nursing and Midwifery Board of Australia (the Board) outlines registration requirements for midwives, including that on initial registration and at each renewal a midwife must be able to satisfy the Board that they have undertaken a minimum of 450 hours of practice within the last five years.¹⁰¹ This practice requirement is difficult to achieve if there are insufficient births in rural and remote services to enable midwives to maintain their recency of practice. The birthing numbers in Theodore between

¹⁰¹ Nursing and Midwifery Board of Australia, *Registration Standard: Recency of Practice*, 1 June 2016.

2005 and 2011 (Table 3 below) would unlikely have been sufficient to enable midwives to maintain their registration.

Table 3 Theodore MPHS births 2005 to 2011¹⁰²

Year	No. of births
2005/2006	0
2006/2007	0
2007/2008	2
2008/2009	4
2009/2010	26
2010/2011	17

The review identified that the maternity service needed to be improved through the provision of contemporary, evidence-based practices that were in line with the service's capability level. One of the key areas of focus was on recognising deterioration and ensuring appropriate escalation to higher level facilities as required. It was also identified that communications with the community needed to be clear and consistent regarding the scope of maternity services available at the facility. The discussions with the community about the capability level of the service are discussed in section 31.4 below. The complete suite of recommendations were presented to staff at Theodore MPHS on 8 October 2018.

30. Complaints to the office

While this chapter draws primarily from the issues identified through the CQHHS internal review and by staff when analysing the investigative material in relation to the Theodore MPHS, the office received one enquiry about the maternity service at Theodore MPHS between June 2015 and December 2018.¹⁰³ This enquiry was not taken further as it related to matters outside of the office's jurisdiction.

31. Issues affecting maternity services at Theodore Multipurpose Health Service

The following sections provide a detailed analysis of the issues investigated by the office. The sections include a recommendation for change so that quality and safety systems supporting the maternity service can continue to be implemented and embedded at Theodore MPHS.

¹⁰² Figures provided by CQHHS during the adverse comment phase.

¹⁰³ The total number of complaints does not include complaints which are still pending an outcome.

31.1 Clinical governance

The CQHHS internal review, outlined above, made 16 recommendations for change to the Theodore MPHS maternity service. The recommendations focused on the need to redesign a contemporary and collaborative Level 1 maternity service that offers safe and high quality antenatal and postnatal care. The announcement of the continuation of the Level 1 maternity service in Theodore MPHS overshadowed other work in recent months meaning that implementation of the review recommendations has not been commenced. There is important work that needs to be completed through those recommendations to ensure that the maternity service meets its Level 1 capability requirements, including by securing clear referral pathways to higher level services and the development of the necessary models of antenatal and postnatal care (these are discussed further in sections 31.2 and 31.3 below).

Additionally, as part of the service redesign, the Theodore MPHS needs to develop sufficient safety and quality governance processes, such as policies, procedures and community information brochures, as a matter of priority. Clarity around the level of the service and its capability requirements also needs to be clearly articulated to the community so that they have an understanding of what the capability level entails, particularly as many of the services will be maintained e.g. antenatal clinics, telehealth with higher level services, and postnatal community visiting. This same messaging needs to be made clear by any medical practitioners who have previously provided shared care with the health service, as they need to be explicit about the limitations of the shared care in relation to the location of birth.

The action plan supporting the implementation of the recommendations categorises the redesign of the service as a high risk and was awaiting the recruitment of an Assistant Director of Nursing for Gladstone and Banana before the work could commence. Based on the length of time since the review recommendations were finalised, priority must be given to commencing implementation. As this will be a considerable body of work for a small health service, it will be important that it is introduced at a steady pace, with safety, and all that encompasses, as the main consideration. While the Theodore MPHS has the review recommendations to drive it to become a quality Level 1 maternity service, I am of the view that a recommendation is necessary to ensure the timely implementation of the recommendations.

Recommendation 7

I recommend that:

7. CQHHS provides six monthly status reports to the office on the implementation of the internal review recommendations until all recommendations are implemented and their fully implemented status is confirmed by the office.

31.2 Risk and escalation

As a Level 1 service it is important that staff properly categorise a woman's maternal risk status during the antenatal period, and where issues are identified, that there are established pathways in place for escalating care to a higher level facility such as Biloela, Gladstone or Rockhampton Hospitals. To date the office has not received any complaints suggesting that the Theodore MPHS needs to improve its risk categorisation and escalation and CQHHS has an established referral pathway for transferring between lower and higher level facilities. Accordingly, it will be important that these referral pathways continue to

be embedded and strengthened as the maternity service in Theodore is redesigned and becomes more settled.

To manage risk throughout the intrapartum period it would benefit the Theodore MPHS to build into its maternity redesign partnership and participation in some of the other CQHHS maternity services' antenatal clinics and case conferences. This will enable Theodore MPHS to discuss any high risk cases in appropriate forums, seeking advice and assistance from more senior and specialist clinicians throughout the CQHHS maternity network. These interactions also have an ancillary benefit of ensuring that the midwives at Theodore MPHS are aware of contemporary approaches to higher risk antenatal care and have increased exposure to more complex cases, which assists with identifying risk.

Given CQHHS has well established referral and communication pathways across its maternity services for managing and responding to risk, I am confident that the redesign of the Level 1 service for antenatal and postnatal care will appropriately capitalise on the experiences and resources across the catchment and will be addressed through the implementation of the review recommendations discussed above.

31.3 Models of care

The provision of contemporary antenatal and postnatal care is a key capability of a Level 1 maternity service, yet the care available at the Theodore MPHS does not appear to be meeting this requirement, leaving the women in the community with little or no care. In March 2019, during a community meeting between staff from the office and representatives from Theodore, community members commented that the antenatal and postnatal care provided via the Theodore MPHS was poor, with the perception being that postnatal care was completely absent because staff were not rostered on to provide such services and instead had to fit them around general nursing duties.

Rosters provided by CQHHS evidence that one staff member is rostered on for an antenatal clinical from 07:00 to 15:30 each Monday. This is confirmed by the BPF, which notes that the antenatal clinic is provided once a week in partnership with the general practice. There is no corresponding rostering for postnatal care, whether this is being provided in the hospital or via community visiting. This likely supports the community's view that this function is part of general nursing duties.

In relation to antenatal care, one clinic per week may be sufficient due to the lower numbers of birthing women being serviced by the Theodore MPHS, however, sufficient staffing hours also need to be made available for high risk telehealth appointments and ad hoc antenatal care. Antenatal care has one of the strongest correlations to various adverse outcomes. For example, Queensland Health identified that women with five or less antenatal appointments were found to be at 1.4 and 1.3 times the risk of a stillbirth or neonatal death, respectively, than women without the risk factor, based on data collected between 2007 and 2012.¹⁰⁴ Similarly, RANZCOG echoes the importance of antenatal care in detecting fetal abnormalities that may lead to perinatal deaths if they are not addressed.¹⁰⁵ By providing and

¹⁰⁴ https://www.health.qld.gov.au/data/assets/pdf_file/0032/355397/risk_chart.pdf

¹⁰⁵ https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Stillbirth_Research_and_Education/Stillbirth/Report

facilitating high quality antenatal care within the Theodore MPHS this will likely result in more women accessing the service, and by extension attending more antenatal visits, which may contribute to better outcomes for mothers and babies.

The Senate Select Committee on Stillbirth Research and Education's report (the report), released in December 2018, cited telehealth as an important mechanism for ensuring women receive antenatal care within their community from a suitably qualified and consistent practitioner, whether that is a midwife, GP obstetrician or specialist obstetrician.¹⁰⁶ This model is already being used across CQHHS, as discussed above in section 26.3 in relation to the use of telehealth for antenatal clinics and care in Emerald, and could be replicated to support the provision of antenatal and postnatal care in Theodore. This is an opportunity for CQHHS to redesign the antenatal and postnatal service in concert with the community and based on the experiences of the other maternity services across its network. During the community meeting, staff from the office were advised that the community provided a clear message that they wanted contemporary and fulsome antenatal and postnatal care designed to suit their needs.

One of the main recommendations from the internal review was the redesign of the service to meet the requirements of a Level 1 service. I am confident that through the implementation of this recommendation that the Theodore MPHS will introduce a high quality antenatal and postnatal service to support the Theodore and wider-Banana community. The observations made in this section should assist with the redesign of this service.

31.4 Patient centred care

Standard 2 of the National Standards '*...aims to ensure that consumers are partners in the design, delivery and evaluation of healthcare systems and services...this standard, together with the Clinical Governance Standard, underpins all other standards*'.¹⁰⁷ An expected outcome of this standard, when fully implemented, is that there will be systems in place to support consumers to partner with a health service in the evaluation of the healthcare system¹⁰⁸, this would extend to considerations around the provision of services. As part of the internal review conducted by CQHHS into the maternity service at Theodore MPHS there is no reference to the community being consulted, as there was with the other reviews, suggesting that no discussions were held with consumers about their maternity experiences.

Further, during the meeting between community representatives and staff from this office, community members advised that there was no consultation with the community about the decision to maintain a Level 1 maternity service. When the birthing suite was reopened during a ceremony in October 2016, the community thought that this signalled the return of planned birthing services. By June 2018, the community was advised that a Level 1 maternity service would be maintained, meaning that planned birthing would not be restored in Theodore. This was a major change for the community to digest and the feeling that their concerns had not been considered as part of the decision-making process compounded their dissatisfaction with the decision and the process by which the decision was reached.

¹⁰⁶ Ibid

¹⁰⁷ <https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/Partnering-with-Consumers.pdf>

¹⁰⁸ Ibid

When staff from my office asked the community whether they may have been more accepting of the decision had they been consulted they confirmed that while they still would not have been happy they would have been more accepting of the final decision. This appears to have been a missed opportunity for CQHHS to consult with the community about the social risks associated with maintaining the Level 1 service and considering those risks in reaching its final decision. As it stands the community is of the view that CQHHS has simply transferred the risk of birthing from the Theodore MPHS to the community and did so without consultation or appreciation of the community's views.

CQHHS has confirmed that the community was not consulted in relation to the decision to maintain the Level 1 maternity service because it was one made for safety reasons (including recency of practice concerns and an inability to provide sufficient medical staffing for a Level 2 service) and directed by the CQHHS Board. However, safety in the provision of maternity services encompasses a range of factors, some of which would be from the perspective of the community and should have been included as part of the decision making process, namely:

- cultural risk for Indigenous women birthing 'off country' and needing to receive culturally competent care to ensure that they engage antenatally¹⁰⁹
- emotional risk related to the distress and isolation many women report in having to travel away from home to birth in an unfamiliar environment with unknown clinicians¹¹⁰
- financial risk related to travelling to give birth¹¹¹ as for a small proportion of women it is recommended that they relocate to be near a birthing facility from 37 weeks gestation, with term being 37 to 42 weeks gestation¹¹², which can result in a woman having to be away from home for up to five or six weeks; longer if there are birthing complications.

The lack of consultation between CQHHS and consumers in relation to the maintenance of the Level 1 maternity service in Theodore represents a missed opportunity for CQHHS to partner with its community in evaluating the healthcare system. Going forward there is work to be done to rebuild the relationship between CQHHS and the Theodore community and a central tenet of this rebuilding will be ensuring that whenever possible CQHHS partners with the community to design and develop the maternity service. CQHHS has some excellent modelling to draw upon, with the success of the community engagement in Emerald, and should ensure that it trials an equally open and engaging relationship with the Theodore community. The Chief Executive also committed in June 2019 to meet with representatives from the community to open a dialogue about how to approach the provision of maternity services in the town.

32. Conclusion

While the Theodore MPHS does not offer planned birthing services it was appropriate for the office to include it within this report given that it was one of the five services chosen by CQHHS for the internal

¹⁰⁹ Barclay, L et al, *Reconceptualising risk: Perception of risk in rural and remote maternity service planning*, *Midwifery* 38, 2016.

¹¹⁰ Ibid

¹¹¹ Ibid

¹¹² <https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Resources/Labour-and-Birth>

review discussed in section 29 above. The review identified major gaps in the capability of the Level 1 maternity service, recommending a complete redesign to ensure that it meets the requirements for a contemporary Level 1 service. These gaps were echoed by representatives from the community when they met with staff from this office in March 2019, noting that there was no antenatal or postnatal care.

Given that the Theodore MPHS has been operating a Level 1 maternity service since the 2011 floods, it is concerning that it does not have the expected supporting infrastructure currently in place to support this level of capability. Specifically, CQHHS and the Theodore MPHS need to focus on implementing the review recommendations to ensure that they have:

- adequate policies and procedures
- information materials targeted towards the community outlining the types of maternity services that will be offered at the Theodore MPHS
- strong antenatal and postnatal care pathways that are both midwifery and medically led.

Additionally, CQHHS needs to implement systems that will support strong community partnering in the evaluation and redesign of the maternity service at Theodore MPHS. Opportunities were missed to engage with the community and hear their views on the continuation of the Level 1 maternity service, which has created friction between the health service and the community. Effort now needs to be expended by CQHHS to start to rebuild the relationship and trust with the community to ensure that it is meeting the needs of the community, the requirements of the National Standards, and its staff in implementing a reinvigorated Level 1 maternity service.

Based on CQHHS' response in other maternity services to implementing recommendations and securing a high quality service, I am confident that CQHHS and Theodore MPHS will undertake the work required to reach a reliable, safe and high quality Level 1 maternity service. However, given the difficulties between CQHHS and the community, the significant body of work to be completed, and delayed progress to date, I will maintain routine oversight of implementation of the review recommendations to ensure that they are actioned fulsomely and in a timely manner.

CQHHS oversight of the maternity services



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33. CQHHS oversight of the maternity services

While responsibility for the provision of safe and high quality healthcare sits across all persons engaged within a health service, ultimate responsibility for ensuring that the health service meets this goal sits with the governing body, namely the CQHHS Board and board level committees. The Commission's National Model Clinical Governance Framework notes that there are two key components to board leadership: forward-looking leadership and retrospective accountability.¹¹³ These involve setting the strategic direction, testing the assumptions of health service management, and reviewing performance to ensure that it meets accepted standards.¹¹⁴ This role in leading strategic planning and ensuring accountability are recognised and reflected in the CQHHS *Clinical Governance Framework 2018–2020*.

During the office's investigation into the various CQHHS maternity services, it became clear that there were areas in which the CQHHS Board could refine its clinical governance leadership to provide a more robust and accountable system. Each of the following areas will be discussed in-turn below:

- transferring of patients in the MGP
- clinical incident management
- trending and benchmarking performance.

33.1 Transferring patients in the midwifery group practice

As discussed throughout this report, MGP is one of the key models for securing continuity of care for pregnant women. To that end there needs to be clear expectations regarding how a woman's care will be managed if her allocated midwife leaves MGP. This set of expectations should be driven by CQHHS to ensure that it implements a consistent policy across the health service catchment.

CQHHS has four MGP-specific policies and procedures, namely:

- *Midwifery Group Practice (MGP): Clinical Governance Requirements*
- *Midwifery Group Practice (MGP): Communication Pathways*
- *Midwifery Group Practice (MGP): Allocation to MGP*
- *Midwifery Group Practice (MGP): Transfer of Care.*

On reviewing the above procedures it became clear that none of them deal with the process and expectations for how a woman's care should be transferred when her allocated MGP midwife leaves the service or becomes unavailable for an extended period of time.

The above situation appears to be a gap in the MGP governance framework, which is particularly important to address as staff from the office, during the visits to Rockhampton, Gladstone and Emerald

¹¹³ Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, Sydney: ACSQHC; 2017

¹¹⁴ Ibid

maternity services, were advised that each of these services had experienced recent departures of MGP midwives, with the most extreme case being Emerald where three MGP midwives left within quick succession of one another. When asked about how a midwife's caseload was managed on their departure, staff from the office were given varying accounts of the process and expectations. In Rockhampton it was acknowledged that the transfer of patients and communication about the departure was not handled as well as expected. Without a benchmark or articulated set of expectations for approaching this scenario it is difficult to hold staff accountable for any deficiencies when transferring care.

Given continuity of care is at the centre of the MGP model, it is imperative that there be an established procedure to support the transfer of a woman's care when her allocated MGP midwife ceases with the service. The procedure should be aimed at limiting, as far as practicable, the disruption to the woman and making it clear how her care will be managed going forward. This may include a change in the model of care as in Emerald because there were insufficient MGP midwives to take over the departing midwives' caseloads.

Recommendation 8

To address the above gap in the governance framework I recommend that:

8. Within three months, CQHHS introduces a midwifery group practice procedure outlining the process for transferring a woman's care when her allocated MGP midwife ceases with the service. The procedure should include an outline of the roles and responsibilities of each person involved with the transfer of care and be focused on maintaining continuity of care, where possible.

33.2 Clinical incident management

Despite the issues across the various CQHHS maternity services between 2015 and 2017, the overarching clinical incident management framework at that time was relatively sound in ensuring that incidents were reported, categorised and investigated in line with their relevant SAC classification. The main areas for improvement in the framework are in relation to:

- developing recommendations
- escalating concerns when there are repeat recommendations
- ensuring appropriate oversight of recommendations.

33.2.1 Developing recommendations

33.2.1.1 Clinician engagement and consultation

The CQHHS *Clinical Incident Management Procedure* (CIM procedure) sets out the roles and expectations for managing SAC 1 to SAC 4 incidents from the CQHHS Board to the individual staff member reporting the incident. In relation to the development of recommendations the CIM procedure focuses on SAC 1 incidents, stating that prior to the final incident analysis report being handed over to

the Chief Executive for endorsement, the *'team facilitator and team lead clinician [for the review] may meet with the service area responsible lead to discuss recommendations developed by the team'*.

The CIM procedure is supported by the CQHHS *SAC 1 Recommendation Management Procedure* (SAC 1 procedure), which sets out the expected approach to developing recommendations for SAC 1 incident analysis. This procedure outlines that recommendations should be developed using the SMARTER¹¹⁵ principles. It also notes that *'seeking input/feedback on proposed recommendations may assist in ensuring that recommendations are appropriate, sufficiently address the risks and facilitate robust uptake by clinical teams.'* As with the CIM procedure, consultation between the incident analysis team and relevant clinicians is not mandatory.

Across all of the visits to the various CQHHS facilities, staff from this office routinely heard that clinicians feel separated from the development of recommendations during the incident analysis process. While the process should be independent from the clinicians involved with the incident, it should not be quarantined from clinician input into the recommendations. This should be occurring early in the process to ensure that the recommendations developed are meaningful, implementable, and supported by the clinicians who will ultimately be responsible for implementing, and working within, the recommendations. Rather than making this step voluntary in the CIM and SAC 1 procedures, consultation on the recommendations should be a mandatory step for all SAC 1 reviews where there will be recommendations. This type of approach is already captured in the SAC 2 incident analysis process where the CIM procedure requires that for a complex review there is *'[collaboration] with all relevant stakeholders and [a] review [of] proposed recommendations'*.

This position is also outlined in Queensland Health's *Best practice guide to clinical incident management* (the guide), which notes that consultation may be beneficial in *'order to ensure that the recommendations are appropriate, the identified risks have been addressed, and there is a high probability to reduce the reoccurrence of this or similar incidents.'* The guide notes that consumers and their families may also have relevant input into the development of recommendations, however, consultation with any party should clearly state that their suggestions and input may not be reflected in the final recommendations for a multitude of reasons.

33.2.1.2 *Strength of recommendations*

Strong recommendations are a key component of a mature and effective clinical incident management system as they secure the best outcomes in response to incidents that will have the greatest impact on preventing the future recurrence of similar issues. Specifically, the guide defines three strengths of recommendations: high impact or effort, moderate impact or effort, and low impact or effort. When developing recommendations in response to clinical incidents, the guide suggests that health services aim for high effect and low effort changes as these types of recommendations are most likely to succeed in addressing the reasons for the incident and prevent its recurrence. Low effect recommendations are less likely to have any impact on the root cause of the incident and will likely not prevent its recurrence.

¹¹⁵ SMARTER recommendations are specific, measurable, accountable, realistic, timely, effective and will be reviewed.

Figure 9, from the guide, provides examples of the types of recommendations falling within each category.

High Effect/ Effort	Architectural/physical plant changes
	Tangible involvement & action by leadership in support of patient safety
	Simplify the process and remove unnecessary steps
	Standardise equipment or process or care maps
	New device with usability testing before purchasing
Moderate Effect/Effort	Checklist/cognitive aid
	Increase in staffing/decrease in workload
	Read back process
	Enhanced documentation/communication
	Software enhancements/modifications
	Eliminate look and sound-a-likes
	Eliminate/reduce distractions (sterile medical environment)
Low Effect/ Effort	Redundancy/double checks
	Warnings and labels
	New procedure/memorandum/policy
	Training
	Additional study/analysis

Figure 9 Examples of types of recommendations and impact

The development of high quality recommendations is an area in which CQHHS could improve its processes. The office reviewed 14 RCA reports relating to SAC 1 maternity incidents from Rockhampton, Gladstone and Emerald for the period May 2015 to January 2018. This review only relates to RCA reports known to the office and excludes HEAPS or clinical reviews. The review analysed how many recommendations and lessons learnt had been made across all of the RCAs and what proportion of them were high, moderate or low quality recommendations. The office used CQHHS' categorisation of the recommendation and where there was none then the office assigned a category based on the guide's criteria. In some instances the office disagreed with CQHHS' assessment of the strength of a recommendation, for example, two recommendations from an Emerald RCA were the preparation of a memo and these were categorised as high control when they are low control in accordance with the guide. In these cases the office used the CQHHS categorisation in its review. The review identified 170 recommendations and lessons learnt across the 14 RCAs. Figure 10 illustrates the proportion of high, moderate and low recommendations made across the 170 total recommendations.

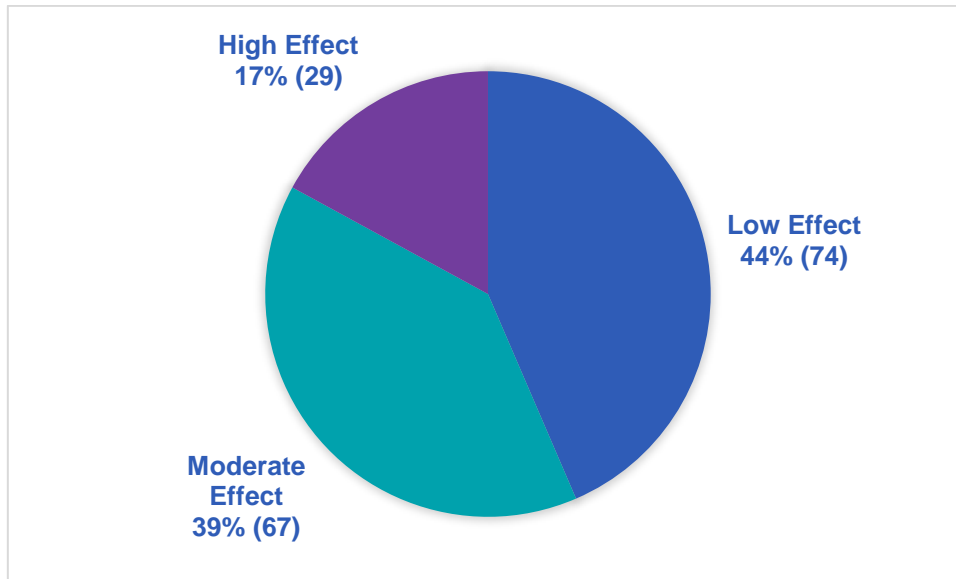


Figure 10 Review of strength of RCA recommendations

The figure above demonstrates that the highest proportion of recommendations of the sample group were low effect, focused on training or the preparation of memos to staff reminding them of their obligation to comply with clinical guidelines and internal processes. The proportion of high to low effect recommendations is not indicative of a strong approach to recommendations development. This is further highlighted by the fact that the 29 high effect recommendations came from only 6 of the 14 RCAs reviewed, with 10 high effect recommendations being from a single RCA. Effectively, a majority of the RCAs completed do not have any high effect recommendations.

The flow on effects of large amounts of moderate or low effect recommendations is that they have a limited potential for impacting on the reasons for the incident. Additionally, the implementation and evaluation cycle for recommendations is time consuming so it should be focused on high effect recommendations. This will ensure that the effort being expended to provide appropriate clinical governance oversight of the recommendation is commensurate with its impact. While there are important learnings in some of the low impact recommendations, CQHHS should consider whether there is scope to take a risk-based approach to the governance applied to a recommendation, so that low effect recommendations are not managed in the same way as high effect recommendations.

Overall, CQHHS must ensure that the recommendations being made across all of the maternity services are efficacious and worthy of the time and effort required to implement, monitor and evaluate them.

Recommendation 9

To secure greater involvement of clinicians in the development of SAC 1 incident recommendations and ensure increased strength in the recommendations being made, I recommend that:

9. CQHHS must:

Recommendation 9

- a. within 6 months, develop a clinician consultation process for all recommendations being proposed during a SAC 1 RCA or Human Error and Patient Safety (HEAPS) analysis. This should be a mandatory step in the clinical incident management process. Any relevant procedures, checklists or other policy documents should be amended to reflect the consultation process.
- b. within 12 months, introduce a benchmark that for all maternity SAC 1 and serious SAC 2 RCAs, where there are formal recommendations and lessons learnt, 70 per cent of all of the recommendations made must be moderate effect or higher in 80 per cent of all maternity incidents across each calendar year. This should be audited on an ongoing basis as part of the annual maternity audit program.
- c. within 12 months, develops as part of its clinical incident management process, a risk-based approach to implementation, evaluation and oversight of low, moderate and high effect recommendations.

33.2.2 Escalating repeat concerns

A strong clinical incident management framework should be capable of identifying repeating issues across incidents, provide for the escalation of repeat concerns to high level CQHHS Board level committees, and develop an appropriate action plan to secure a response to the issues that will, as far as practicable, prevent their recurrence. Historically this was done poorly by CQHHS as is demonstrated by the incidents at the Rockhampton Hospital maternity service between May 2015 and February 2016. Each of the five SAC 1 incidents had a contributory factor relating to the categorisation, identification and/or management of maternal risk. Nevertheless each incident appears to have been taken in isolation, without broader escalation of concerns to the CQHHS executive. Triangulating incidents that are recurring with the same themes is essential to a strong clinical incident management framework. However, at that time the Rockhampton Hospital maternity service and the CQHHS governance structures were immature and required further refinement to properly utilise clinical incident management to drive improvement and address trends holistically.

This escalation feature of a strong clinical incident management framework is particularly important when issues occur in quick succession (as they did in 2015 and 2016) because this does not allow sufficient time for measures to be implemented and evaluated. This timeframe also creates an immediate trend that needs to be addressed at a higher level as it should not wait for the 'implement and evaluate cycle' of individual recommendations in response to individual incidents.

Since 2016, the approach to escalating repeating recommendations has improved. The SAC 1 procedure notes that the CQHHS Maternity Steering Committee receives a quarterly report which includes '*SAC 1 contributory factors and recommendations to assist the committee to identify repeat recommendations and to ensure the escalation of risks occur...*' The SAC 1 procedure also outlines three points during the incident management process during which repeating and recurring recommendations can be escalated, they are during:

- the quality check of the SAC 1 investigation documentation undertaken by the CQHHS Quality and Safety Unit
- the handover meeting when the SAC 1 team presents their final report to the executive
- the recommendation review audit, which involves a thematic review of contributory factors and recommendations from a range of SAC classifications. The report is tabled every six months at the CQHHS Board Safety and Quality Committee and the Patient Safety, Quality and Risk Committee.

Finally, the SAC 1 procedure provides for the review of past recommendations over the preceding 24 months to ascertain whether the same or similar recommendations have been made in response to a similar clinical incident. If such repeating recommendations are identified, they can be escalated at any of the above three stages in the incident review process. At this stage these requirements only apply to SAC 1 recommendations and it would be beneficial for the framework to apply a similar, if not more streamlined, approach to SAC 2 to SAC 4 incidents.

While CQHHS is heading in the right direction with its clinical incident management approach, there is still room for further refinement in the identification and escalation of repeating issues as illustrated by the following case study:

Case study of Patient F

Patient F was a young first time mother who had been receiving shared care through a community service and Rockhampton Hospital. Over the course of two weeks in early January 2018, Patient F attended Rockhampton Hospital on several occasions for various routine and emergent pregnancy-related concerns. Patient F was 36 weeks gestation. During one of the visits, Patient F had an obstetric ultrasound to assess fetal growth. The ultrasound report recorded abnormal results but these were not immediately escalated to the obstetrics team at Rockhampton Hospital; this was a departure from the standard procedure.

Two days after the scan, Patient F's community service contacted the obstetric team at Rockhampton Hospital to escalate the abnormal scan result, which was identified during a routine case conference. Patient F was subsequently transferred to Rockhampton Hospital, where she underwent an intrauterine fetal death ultrasound scan, which confirmed the fetus' death. Patient F delivered the deceased fetus on this same date.

The incident analysis and open disclosure with Patient F's family identified that there was a missed opportunity to recognise Patient F's emerging clinical risk and develop an appropriate management plan in response, which is a theme that was identified during the incident analyses in 2015 and 2016 yet there was no discussion about the escalation of this as a repeating concern.

The case study of Patient F highlights that there are still gaps in the incident management system when responding to repeating themes from the preceding two years. The clinical incident management framework would benefit from taking a more holistic view of repeating concerns, ensuring that not only recommendations from the preceding 24 months are considered but also contributory factors and missed opportunities to ascertain whether there are areas of continuous improvement in the provision of maternity services.

Recommendation 10

To support the continued improvement of the CQHHS clinical incident management framework, I recommend that:

10. Within 12 months, CQHHS evaluates their approach to reviewing and escalating repeating concerns and recommendations for SAC 1 incident analyses. The new approach should include a requirement that for all SAC 1 incident analyses, past recommendations, lessons learnt, contributory factors and missed opportunities from the preceding 24 months are reviewed to ascertain any similarities or repeating issues. Where repeating issues, recommendations or other concerns are identified these should be escalated to the Maternity Steering Committee for action.

33.2.3 Oversight of recommendations

The CQHHS Board and CQHHS Safety and Quality Committee are the peak bodies within the safety and quality governance chain with responsibility for ensuring that recommendations arising from reviews and incidents are appropriately and fulsomely implemented. These two bodies are also responsible for testing the implementation status to ensure that the briefing from lower level safety and quality committees are fair and accurate. When reviewing maternity services across CQHHS, it appeared that this was an area that could be further refined.

Specifically, it was clear from when the CQHHS Board endorsed the recommendations from the internal review into the Gladstone Hospital maternity service that they had significant concerns about the safety of the service and required an assurance from February 2018 onwards. Consequently, at its February 2018 meeting, the CQHHS Board requested a number of additional reporting lines be put in place to closely oversee the recommendation implementation phase, namely:

- two members of the CQHHS Board Safety and Quality Committee receive a monthly update on the progress of the Gladstone Hospital maternity service
- a standing agenda item be added to the CQHHS Board Safety and Quality Committee providing an update on the Gladstone Hospital maternity service
- all recommendations relating to the Gladstone Hospital maternity service be implemented by February 2019.

These were sound measures by the CQHHS Board in securing appropriate oversight of the service, however, in June 2018, with a coronial inquest planned into a maternity incident, it was identified that the Gladstone Hospital maternity service was significantly behind in their implementation of recommendations. In response, the CQHHS Board directed that there be a weekly special meeting of the CQHHS Board Safety and Quality Committee to track the implementation of recommendations, particularly those that were outstanding from the incident, some two years earlier, which was the subject of the coronial inquest.

While the CQHHS Board implemented strong oversight systems in relation to the implementation of the Gladstone Hospital maternity service recommendations, when staff from the office visited the service in October 2018 it was clear that some recommendations were very recent; this issue was discussed

above in section 14.1. When concerns about the recency of some of the measures was discussed with CQHHS, there appeared to be a perception that the measures had been implemented for a longer period of time and were being embedded into practice. Arguably, the mechanisms implemented by the CQHHS Board and its committee should have safeguarded against any perception about the progress of the implementation of recommendations, however, such bodies are reliant on the information being briefed to them if they are not undertaking a sampling exercise to confirm the veracity of the information being provided and to test the timeline for when actions are occurring.

Recommendation 11

To support the CQHHS Board in testing the veracity of the information being presented throughout the safety and quality governance chain, I recommend that:

11. Within 12 months, CQHHS develops and implements an ongoing qualitative review process for the Maternity Steering Committee and the CQHHS Board Safety and Quality Committee in relation to the reporting of the recommendation status, including implementation and escalation of repeating recommendations. The review should be:
 - a. targeted at ensuring the accuracy of reporting from committees in the safety and quality governance chain in relation to: implemented recommendations, repeat recommendations, and reviewing the effectiveness of the evaluation of implemented recommendations
 - b. risk based¹¹⁶ in line with criteria developed by CQHHS to guide the identification of the sample of recommendations and repeat issues to be reviewed; where possible the audited recommendations should come from a range of SAC classifications.

33.3 Trending and benchmarking

The CQHHS *Clinical Governance Framework 2018–2020* sets clear expectations that CQHHS will *‘[promote a] culture of learning from adverse events (including near misses) and [seek] to strengthen safety [systems] and processes, in order to build a culture that fosters learning from mistakes and aims relentlessly to eliminate preventable harm.’* The clinical governance framework will also use incidents to identify trends and *‘problem sense’* to drive continuous improvement.

To achieve the above goal, CQHHS has a number of measures aimed at tracking, trending and benchmarking its maternity services, including:

- monthly reporting to the CQHHS Board and CQHHS Safety and Quality Committee on key performance indicators and performance measures for the maternity service, including individual scorecards for each maternity service. This is underpinned by the *Safety and Quality Performance*

¹¹⁶ The Institute of Internal of Internal Auditors explains that a risk based internal audit *‘aims to deliver increased value through effective and relevant internal auditing. It does this through a combination of aspects, approaches and techniques into a single audit while focussing on areas of highest risk to customers, stakeholders, organisation, community and the environment.’* The Institute of Internal Auditors, *White Paper – Integrated Risk-Based Internal Auditing*, July 2016.

Reporting and Monitoring procedure, which sets out clear expectations for performance reporting across CQHHS

- quarterly reporting to the Maternity Steering Committee on all SAC 1 contributory factors and recommendations to assist with the identification of trends
- morbidity and mortality meetings across the network, which examine data and explore themes to drive system improvements
- *Patient on Our Shoulder*, which is a quality and safety newsletter disseminated to staff that highlights key themes or areas of improvement and new safety and quality initiatives
- patient safety notices, which are disseminated across CQHHS after serious incidents to ensure any broader learnings are shared outside of the facility in which the incident occurred.

The above are just some of the measures implemented by CQHHS to routinely track the performance of the maternity service and identify trends or issues as they emerge, enabling a more agile response to preventing serious clinical incidents. When reviewing the myriad of measures CQHHS has in place to monitor performance, it was clear that this has been an area of focus for the health service, with some measures demonstrating sophistication and maturity beyond the expected capability of a health service of its size. One particularly impressive example was from Rockhampton Hospital and is outlined in the case study below.

Case study of control charts

In response to the incidents in the Rockhampton Hospital maternity service in 2015 and 2016, the service wanted to be able to generate real-time data in relation to a series of key performance measures. Previously the service had been relying on the Queensland Health state-wide perinatal data collection, which occurs quarterly and has a six to eight week lag time between the end of the quarter and release of the data, which results in a consistently historical safety and quality snapshot. To obtain a more current picture of the performance data a midwife would manually collate and generate monthly data, taking on average 16 hours to complete the data capture.

To streamline the process staff in the maternity service undertook a project to develop control charts¹¹⁷ for key performance measures across the maternity service. Initially they developed a list of key performance measures that were aligned with the perinatal data indicators and the Women's Healthcare Australasia clinical indicators. The list was distributed to staff for consultation and as a result of the consultation further performance measures were added.

With a settled list of indicators, staff developed 34 control charts relating to various key performances measures. Each chart has a central line, which is the baseline expectation for performance, and upper and lower control limits setting the acceptable deviations from the central

¹¹⁷ 'The control chart is a graph used to study how a process changes over time. Data are plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).' – <https://asq.org/quality-resources/control-chart>

Case study of control charts

line. Figure 11 below is an example of a control chart, which was used by CQHHS in a poster submission for a health conference.

During the stakeholder visit in October 2018, staff from the office were also advised that where there is three consistent quarters of improvement in key performance measures, the control line and upper and lower control limits are adjusted to meet the improved performance; resulting in a continuously improving benchmark for the key performance measure. Further, if performance is exceeding upper or lower control limits then this can be investigated promptly to ascertain whether corrective measures are required, or to determine what improvements have resulted in consistently higher performance.

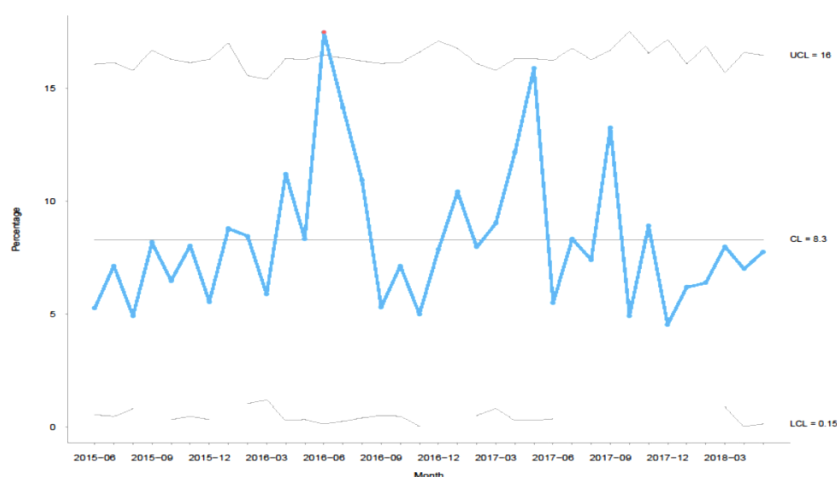


Figure 11 Example control chart from CQHHS

Due to the work done setting up the control charts, and the alignment with existing data capturing processes, the preparation of the monthly data now takes on average 20 minutes. This makes the preparation of data more manageable within the busy clinical environment and provides the CQHHS Board and CQHHS Board Safety and Quality Committee with a monthly up-to-date snapshot of how the maternity service is tracking against key performance measures.

After a three month trial at Rockhampton Hospital the control charts were rolled out to all maternity services across CQHHS. To provide more meaningful data for smaller maternity services, the control charts are prepared quarterly.

Now that CQHHS has embedded its tracking and trending of key performance measures and SAC 1 and, to a lesser extent, SAC 2 incidents, it is important for focussed trending to occur in relation to SAC 3 and 4 incidents. These generally make up the largest bulk of incidents in a health service and are the greatest resource for landscape scanning to identify where the next major adverse incident may occur. Given CQHHS' demonstrated understanding of and commitment to trend analysis and performance reporting I do not consider it necessary to make a recommendation in relation to SAC 3 and 4 trend analysis as I am confident that this will start to occur as the performance reporting processes continue to mature.

34. Adverse comment submission

CQHHS' adverse comment submission made 36 comments in relation to this report. The office accepted a majority of these comments and welcomed CQHHS' input into the accuracy of the information being reported and the appropriateness of the recommendations being made. Accepted comments have been incorporated into the report and are not separately identifiable.

Commentary was provided in relation to three recommendations (outlined below) and on considering CQHHS' submission I have decided to retain the recommendations for the following reasons:

- In relation to the recommendation requiring a staff survey be completed at Gladstone Hospital (recommendation 4a), CQHHS are of the view that this recommendation is unnecessary because they completed a similar staff survey in June 2018 and have a baseline of staff views. However, given that this survey was completed a year ago; the significant changes in the executive leadership at the hospital; and new processes that have been implemented within the maternity service to start to address some of the concerns highlighted by this report, it seems appropriate that a new baseline is ascertained to inform both an evaluation of the last 12 months and what is required moving forward. Accordingly, I am continuing to make this recommendation to support Gladstone Hospital's understanding of its current safety and quality landscape.
- CQHHS consider that the technical recommendation proposed for Emerald Hospital (recommendation 6) in relation to their epidural service is not necessary as they have completed a follow-up audit and confirmed that the service is safe. This report does not contend that the epidural service is unsafe, rather I am recommending a follow-up audit and action plan to address the considerable deficiencies identified with the recordkeeping when the first audit of the service was completed. No evidence has been provided to demonstrate that the gaps in recordkeeping have improved or are otherwise being addressed. It is therefore appropriate for this recommendation to be retained.
- Regarding this office's oversight of the implementation of the review recommendations in Theodore MPHS, CQHHS has queried the need for this recommendation given the work that has been done to improve and embed recommendation management across the Gladstone and Banana region. While I acknowledge the work undertaken by CQHHS to improve its oversight of recommendation implementation, I consider recommendation 7 is still necessary given the protracted period during which the review recommendations were not progressed, despite this coinciding with the improvements to the management of recommendations. I note that CQHHS has not disputed this office's conclusion that no progress had been made towards implementing the recommendations in Theodore to date. This suggests that this is an area that requires independent oversight to ensure the recommendations are fulsomely implemented.

In addition to the above, CQHHS flagged that some of the patients may be identifiable from the case studies due to the small communities within which they live. While I appreciate CQHHS' concern for the privacy of its patients, the case studies are derived from complaints to this office and all complainants have agreed for their stories to be shared as de-identified case studies in an effort to improve healthcare for mothers and babies across CQHHS. As such, I am satisfied that the privacy of all individuals referenced within the patient stories has been appropriately managed.

35. Conclusion and recommendations

After two years of difficulty between 2015 and 2017, marked by external reviews, leadership instability, safety concerns, and outmoded maternity services, CQHHS is clearly rebuilding itself stronger, with a more coordinated and focused strategic vision that aims to provide great care to all Central Queenslanders. There are undoubtedly still challenges to overcome within the maternity service, as has been highlighted throughout this report, but CQHHS has demonstrated the innovation, energy and commitment to keep driving the health service forward to meet and exceed those challenges.

The Rockhampton Hospital maternity service was a significant focus for CQHHS for a number of years due to the safety concerns in 2015, but now that it is a safe and high quality service providing leadership across the CQHHS maternity services, it is time for equal attention to be paid to Gladstone, Emerald and Biloela. The Gladstone Hospital maternity service is facing significant difficulties as the busiest Level 3 maternity service in Queensland. It will require excellent leadership to improve the safety and quality culture and grow the service over the short to medium term. The Emerald and Biloela Hospital maternity services are facing the same problems as most rural maternity services across Queensland in relation to recruitment and retention of suitably qualified and senior clinicians. It will be vital for CQHHS to develop and drive a robust recruitment strategy. In Theodore there is work to be done to rebuild the relationship with the community and design a Level 1 maternity service that suits the community's needs and meets the CSCF requirements. This is no small body of work and will require renewed energy by the CQHHS executive to deliver high quality services across its catchment.

The recommendations made throughout this report are aimed at supporting CQHHS and the individual maternity services in their refinement and improvement journey. While there were some tragic incidents that led to my office's investigation, the impacts of which cannot be forgotten, the opportunity for my office to partner with CQHHS to continuously improve the maternity service is a valuable outcome. I am of the view that overall, the advancements made across the planned birthing services in CQHHS would prevent, as far as practicable, the recurrence of the issues highlighted through the incidents. In any instances where there are still safety improvements to be made, my recommendations should assist CQHHS and its individual maternity services to address these gaps going forward.

The strong stakeholder collaboration undertaken during the investigation and adverse comment process of this report will be maintained throughout the recommendations monitoring phase and has been built into the recommendations monitoring plan (see **Appendix 4**). Through these recommendations and CQHHS' own initiatives, I am confident that the provision of maternity services across CQHHS, at any level of service, will continue to improve to meet the community's needs.

35.1 Full list of recommendations

No.	Recommendation
1	Within 30 days, the CQHHS <i>Maternity Risk Assessment Tool (Initial Midwife Assessment)</i> procedure be updated to explicitly require an initial midwifery assessment tool be completed for all women transferring into the service.
2	In relation to the telephone enquiry service the Gladstone Hospital maternity service must:

No.	Recommendation
	<ul style="list-style-type: none"> a. within 30 days make it mandatory to record in Riskman all instances where there has been some type of corrective action needed to be taken in response to telephone advice, including follow-up care needing to be provided to the woman, and/or discussions with individual staff members, whether formal or informal, about the appropriateness of the advice provided. This incident recording is to occur regardless of any other clinical outcomes. b. within three months: <ul style="list-style-type: none"> i. review all incidents of any SAC classification level for the period 1 January 2016 to 30 October 2018 where a telephone enquiry encounter was part of the care ii. prepare a report to the CQHHS Safety and Quality Committee on the outcome of the review, including a summary of each incident and any deficiencies with the telephone enquiry advice provided iii. develop a coordinated action plan, for endorsement by the CQHHS Safety and Quality Committee, to address the identified key issues and root causes for the repeated concerns with the telephone enquiry service. This action plan may include measures that have already been implemented. c. provide the CQHHS Safety and Quality Committee with a quarterly report covering: <ul style="list-style-type: none"> i. any incidents of any SAC classification level that involve the telephone enquiry service ii. a status update from the midwifery unit manager on the number of occasions within the quarter on which she has had to either provide follow-up care after reviewing a telephone enquiry advice and/or have a formal or informal performance discussion with a midwife about the telephone enquiry advice provided. <p>The first quarter of reporting should commence within 30 days of endorsement of the action plan referred to in recommendation 2b. This reporting must continue for four quarters. Any ongoing issues with the telephone enquiry service should be addressed through the standard safety and quality escalation pathways.</p>
3	<p>Within three months the Gladstone Hospital emergency department:</p> <ul style="list-style-type: none"> a. establishes a mandatory process for placing an alert on a women's file where they are pregnant or potentially pregnant and have: <ul style="list-style-type: none"> i. self-discharged against medical advice ii. not waited to see a clinician iii. left after treatment commenced.

No.	Recommendation
	<ul style="list-style-type: none"> b. establishes a KPI benchmark for compliance, audit schedule and review process for the mandatory alert outlined in 3a above that reports quarterly to the Quality and Safety Committee in relation to: <ul style="list-style-type: none"> i. all incidents relating to the care and management of pregnant or potentially pregnant women in the emergency department ii. compliance rates with the policies and processes related to the care and management of pregnancy or potential pregnancy related presentations to the emergency department. <p>Any adverse issues or trends identified in relation to the care and management of pregnancy related presentations in the emergency department are to be escalated to the CQHHS Safety and Quality Committee and CQHHS Board in accordance with the existing governance framework.</p>
4	<p>In relation to safety and quality leadership and culture that the Gladstone Hospital maternity service must:</p> <ul style="list-style-type: none"> a. within three months complete a staff survey seeking staff views on what they understand is the safety and quality culture and safety and quality leadership within the maternity service. The results of this survey should inform the kaizen workshop referred to in recommendation 4b. b. within six months run kaizen workshops and plan for evaluation of the outcomes of those workshops. At least one session should focus on leadership and the safety and quality culture.
5	<p>Within 12 months the Gladstone and Banana Shire Business Unit:</p> <ul style="list-style-type: none"> a. maps out all of the clinical governance committees across Gladstone and Banana Shire, including their reporting lines upwards and downwards through the governance chain b. reviews how the existing committee structure could be streamlined, including reviewing the terms of reference for each committee to ascertain overlap, and presents a paper to the Gladstone and Banana Senior Leadership Team on the review and any recommended changes c. develops a diagram to demonstrate the final committee structure, including reporting relationships between the committees.
6	<p>Within three months, the Emerald Hospital maternity service:</p> <ul style="list-style-type: none"> a. undertakes a chart audit of all epidurals performed since the previous audit. This process should include setting benchmarks for the expected completion of key areas of the epidural process e.g. 80 per cent of all charts audited have a fully documented post anaesthetic review process and provision of the information booklet

No.	Recommendation
	<ul style="list-style-type: none"> b. develops an action plan for any identified areas for improvement from the audit, if any. The action plan, if any, should include a process for evaluating the effectiveness of the measures once they are implemented c. presents the outcomes from the audit and any action plan to the Maternity Steering Committee.
7	CQHHS provides six monthly status reports to the office on the implementation of the internal review recommendations until all recommendations are implemented and their fully implemented status is confirmed by the office.
8	Within three months, CQHHS introduces a midwifery group practice procedure outlining the process for transferring a woman's care when her allocated MGP midwife ceases with the service. The procedure should include an outline of the roles and responsibilities of each person involved with the transfer of care and be focused on maintaining continuity of care, where possible.
9	<p>CQHHS must:</p> <ul style="list-style-type: none"> a. within 6 months, develop a clinician consultation process for all recommendations being proposed during a SAC 1 RCA or Human Error and Patient Safety (HEAPS) analysis. This should be a mandatory step in the clinical incident management process. Any relevant procedures, checklists or other policy documents should be amended to reflect the consultation process. b. within 12 months, introduce a benchmark that for all maternity SAC 1 and serious SAC 2 RCAs, where there are formal recommendations and lessons learnt, 70 per cent of all of the recommendations made must be moderate effect or higher in 80 per cent of all maternity incidents across each calendar year. This should be audited on an ongoing basis as part of the annual maternity audit program. c. within 12 months, develops as part of its clinical incident management process, a risk-based approach to implementation, evaluation and oversight of low, moderate and high effect recommendations.
10	Within 12 months, CQHHS evaluates their approach to reviewing and escalating repeating concerns and recommendations for SAC 1 incident analyses. The new approach should include a requirement that for all SAC 1 incident analyses, past recommendations, lessons learnt, contributory factors and missed opportunities from the preceding 24 months are reviewed to ascertain any similarities or repeating issues. Where repeating issues, recommendations or other concerns are identified these should be escalated to the Maternity Steering Committee for action.
11	<p>Within 12 months, CQHHS develops and implements an ongoing qualitative review process for the Maternity Steering Committee and the CQHHS Board Safety and Quality Committee in relation to the reporting of the recommendation status, including implementation and escalation of repeating recommendations. The review should be:</p> <ul style="list-style-type: none"> a. targeted at ensuring the accuracy of reporting from committees in the safety and quality governance chain in relation to: implemented recommendations, repeat

No.	Recommendation
	<p>recommendations, and reviewing the effectiveness of the evaluation of implemented recommendations</p> <p>b. risk based¹¹⁸ in line with criteria developed by CQHHS to guide the identification of the sample of recommendations and repeat issues to be reviewed; where possible the audited recommendations should come from a range of SAC classifications.</p>

¹¹⁸ The Institute of Internal of Internal Auditors explains that a risk based internal audit '*aims to deliver increased value through effective and relevant internal auditing. It does this through a combination of aspects, approaches and techniques into a single audit while focussing on areas of highest risk to customers, stakeholders, organisation, community and the environment.*' The Institute of Internal Auditors, *White Paper – Integrated Risk-Based Internal Auditing*, July 2016.

Acronyms

ACM	Australian College of Midwives
Advisory Committee	Banana Health Service Clinical Advisory Committee
AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
APH	Antepartum Haemorrhage
BMI	Body Mass Index
Board	Nursing and Midwifery Board of Australia
BPF	Business Planning Framework
CaPS	Communication and Patient Safety training
CIM procedure	CQHHS Clinical Incident Management Procedure
COAG	Council of Australian Governments
Commission	Australian Commission on Safety and Quality in Healthcare
Council	Queensland Maternal and Perinatal Quality Council
CPAP	Continuous positive airway pressure
CPR	Cardiopulmonary resuscitation
CQHHS	Central Queensland Hospital and Health Service
CSCF	Clinical Services Capability Framework
CTG	Cardiotocography
DMS	Director of Medical Services
EDIS	Emergency Department Information System
EPAS	Early Pregnancy Assessment Service
FOG	Flying obstetric and gynaecologist service
FTE	Full time equivalent
GIMM	Gladstone Incident Management Meeting
GOAT	Rockhampton Hospital Get Our Act Together meeting
GP	General Practitioner
Guide	Queensland Health's Best practice guide to clinical incident management
HEAPS	Human Error and Patient Safety
HHB Act	<i>Hospital and Health Boards Act 2011</i>
HHS	Hospital and Health Service
HIE	Hypoxic-ischemic encephalopathy
IMA	Initial Midwife Assessment
MATES	Maternal and Antenatal Telehealth Service
MDAU	Maternity Day Assessment Unit
MET	Medical Emergency Team

MGP	Midwifery Group Practice
MPHS	Theodore Multipurpose Health Service
MRAT	Maternity Risk Assessment Tool
National Standards	National Safety and Quality Health Service Standards
Network	State-wide Maternity and Neonatal Clinical Network
NHS	National Health Service, United Kingdom
NICE	National Institute for Health and Care Excellence, United Kingdom
NSAMS	National Strategic Approach to Maternity Services
Obstetric Triage procedure	CQHHS Triage of Maternity Patients in the Emergency Department procedure
Office	Office of the Health Ombudsman
Operational Plan	Central Highlands and Woorabinda Clinical Governance Operational Plan 2018–2019
Procedure	CQHHS Maternity Risk Assessment Tool (Initial Midwife Assessment) procedure
PROMPT	Practical Obstetric Multi-Professional Training
PTSS	Patient Travel Subsidy Scheme
QAS	Queensland Ambulance Service
QNMU	Queensland Nurses and Midwifery Union
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCA	Root Cause Analysis
Record	Patient's handheld pregnancy health record
Referral Guidelines	National Midwifery Guidelines for Consultation and Referral
Report	Senate Select Committee on Stillbirth Research and Education's report
SAC	Severity Assessment Code
SAC 1 procedure	CQHHS SAC 1 Recommendation Management Procedure
SCN	Special Care Nursery
SROM	Spontaneous rupture of membranes
Strategy	Destination 2030: Great Care for Central Queenslanders
SWHHS	South West Hospital and Health Service
TEMSU	Telehealth Emergency Management Support Unit
VBAC	Vaginal birth after Caesarean section
VLAD	Variable Life Adjustment Display
WHA	Women's Healthcare Australasia
WHO	World Health Organization

Appendix 1—State-wide and national maternity services frameworks

State and national maternity standards, guidelines and benchmarks

Clinical services capability framework

In 1994, the first iteration of the *Clinical Services Capability Framework for public and licensed private health facilities* (CSCF) was introduced in Queensland—it originally only applied to public hospitals but from 2004 it was extended to apply to private hospitals. The CSCF sets out the clinical and support services that a hospital can safely provide within their capability level.

There are six CSCF levels for facilities. These cover a range of acute and sub-acute care, including maternity and neonatal services. The maternity service CSCF module aims to achieve the safe provision of care to the mother and baby as close as possible to home; recognising that some women and babies need to travel outside of their local community to access appropriate levels of care. The models of care are dependent on the woman's maternity risk¹¹⁹, which may be low, moderate or high. The maternity services module must be read and applied in conjunction with the neonatal services module as maternal care requirements cannot occur in isolation of the neonate.

All existing and new CSCF module development is managed via the CSCF Governance Committee, which is overseen by the Chief Health Officer, Department of Health, and Director General, Department of Health.

Queensland Health clinical guidelines

Queensland Health has developed a set of clinical guidelines, covering a variety of topics relevant to maternity, neonatal care and operational frameworks. There are clinical guidelines, flowcharts, educational tools and consumer information available in connection with the various subject matters. These guidelines are available on the internet, accessible by anyone. The guidelines are reviewed by Queensland Health every five years unless a change in practice necessitates an earlier review.

Subject matters covered by the guidelines include early pregnancy loss, gestational diabetes mellitus, induction of labour, intrapartum fetal surveillance, normal birth, trauma in pregnancy, vaginal birth after caesarean section, assessment – routine newborn, hypoxic-ischaemic encephalopathy, and resuscitation of a neonate.

¹¹⁹ The model of care is dependent on the woman's maternity risk category. The CSCF sets out three categories of care, namely: low risk requiring primary care from a midwife or general practitioner; moderate risk requiring secondary care from a general practitioner or registered medical specialist in obstetrics; and high risk requiring tertiary care from a multidisciplinary team in a specialised service (level 6 facility).

Variable Life Adjustment Display

Queensland Health developed a variable life adjustment display (VLAD) in response to serious adverse events that occurred in and around 2005. The VLADs are a tool for identifying extraordinary trends in certain clinical cases (defined by clinical indicators). There are three groups of VLAD indicators with three flagging levels.¹²⁰ VLADs are generated on a monthly basis, responsive to the clinical environment, utilising data from various sources. They are a critical tool for a broad picture of patient outcomes against set clinical indicators. VLADs also enable hospitals to plot their progress against the set clinical indicators in comparison to state averages and identify trends that could indicate an issue with, or improvement in, clinical outcomes.

When a VLAD flags at a particular point it suggests that over time there has been more (or less) patients experiencing the set benchmark outcome than expected.¹²¹ This may suggest that a hospital has improved clinical outcomes and could share learnings to enable other services to achieve similar results. Conversely, it could indicate poorer clinical outcomes that need to be reviewed to ascertain the cause.

HHSs are required to mandatorily report on some VLAD flags.¹²² If a HHS is notified about a VLAD flag, then they have 30 days to complete a review of the variation and prepare a report, including identifying any issues and outlining an action plan to correct poor results or maintain positive results. These reports are uploaded onto the VLAD clinical monitoring system.¹²³

The VLAD Committee will clinically review responses to VLAD flags to ensure they are adequate and have an appropriate action plan.¹²⁴ The committee may request further information from a HHS if concerns are raised regarding the adequacy of the response and/or proposed plan. The committee may also escalate issues if HHSs fail to comply with their VLAD obligations. The committee meets monthly.

National Safety and Quality Health Service Standards

The Australian Commission on Safety and Quality in Healthcare (the Commission) was established in 2006 by the Australian, state and territory governments to lead and coordinate national improvements in

¹²⁰ There are three groups of VLAD indicators, Group A, Group B and Group C. There are then three levels that vary dependent on the group. A lower level rate indicates that the outcome rate is higher than the state outcome rate, whereas, the upper level rate indicates that the outcome rate is lower than the state average. For Group A, levels 1 to 3 are 30%, 50% and 75% respectively. For group B, levels 1 to 3 are 50%, 75% and 100% respectively. For Group C, levels 1 to 3 are 125%, 150% and 175% respectively.

¹²¹ *Guideline for Variable Life Adjustment Displays and other National Patient Safety Indicators*, Health Service Directive, version 1.1, 9 January 2017, Queensland Health.

¹²² Level 1 flags are not required to be reviewed. Whereas, lower level 2 and lower level 3 VLAD flags require review.

¹²³ The VLAD clinical monitoring system is an electronic information system that disseminates VLAD graphs, notification reports and captures responses to flags. The system is maintained by the Patient Safety and Quality Improvement Service within the Department of Health.

¹²⁴ All responses to lower level 3 flags are reviewed by the VLAD Committee.

safety and quality in health care.¹²⁵ One of the commission's key outputs was the introduction of the National Safety and Quality Health Service Standards (the National Standards), which were introduced in September 2011. All health service organisations were required to be accredited to the National Standards from January 2013.

A second edition of the National Standards was released in November 2017. All health service organisations will commence being accredited against these new standards from January 2019. The second edition was developed in consultation with a wide variety of stakeholders with a view to *'address[ing] gaps identified in the first edition, including mental health and cognitive impairment, health literacy, end-of-life care, and Aboriginal and Torres Strait Islander health. [The second edition] also updates the evidence for actions, consolidates and streamlines standards and actions to make them clearer and easier to implement, and reduces duplication'*.¹²⁶

Under the second edition the 'Clinical Governance' and 'Partnering with Consumers' standards create the *'overarching system requirements for the effective implementation of the remaining six standards, which deal with specific high-risk clinical areas of patient care'*.¹²⁷ This overarching system is further supported by the National Model Clinical Governance Framework, which *'provides a consistent national framework for clinical governance that is based on the [standards and]...supports a shared understanding of clinical governance among everyone working in health service organisations, including clinicians, managers and members of the governing body. This will ensure that clinical governance systems are implemented effectively, and support safer and better care for patients and consumers'*.¹²⁸

The eight National Standards are:

1. clinical governance
2. partnering with consumers
3. preventing and controlling healthcare associated infections
4. medication safety
5. comprehensive care
6. communicating for safety
7. blood management

¹²⁵ Australian Commission on Safety and Quality in Health Care, 'About Us', <https://www.safetyandquality.gov.au/about-us/governance/>.

¹²⁶ *National Safety and Quality Health Standards Second Edition Overview*, <https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/Overview-of-the-NSQHS-Standards-second-edition.pdf>

¹²⁷ Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards guide for hospitals*, Sydney: ACSQHC; 2017.

¹²⁸ Australian Commission on Safety and Quality in Health Care, *National Model Clinical Governance Framework*, Sydney: ACSQHC; 2017

8. recognising and responding to acute deterioration.¹²⁹

Under the second edition all health service organisations will be required to be accredited against the eight National Standards every three years, with no mid-cycle review. This is a change from the first edition where accreditation happened every three or four years with a mid-cycle review of some specific standards. There will be transitional arrangements for health service organisations on the four year cycle, which will cease on 31 December 2019.¹³⁰ Health service organisations will also now have to achieve re-accreditation before their accreditation award expires; this is likely to be some four months before the end of the three year accreditation period.¹³¹

To achieve accreditation a health service organisation is assessed against each standard, which has four specific criteria and a number of associated actions relevant to each criteria. Assessors will be evaluating whether the health service organisation has met the actions required in the standard. Accreditation can now be undertaken via two pathways: announced or short notice assessments.¹³² The short notice assessments are a new approach and involve three or four standards being assessed during each visit, for which 48 hours' notice is given to the health service organisation.¹³³ During an accreditation cycle there will be three short form assessments, with no more than two per year. Some standards may be assessed more than once in the accreditation cycle so that a health service organisation is not aware of what standard is being assessed.¹³⁴

A health service organisation can achieve accreditation where the actions are either met or met with recommendations, provided that it is the first occasion on which an action is being met with recommendations.¹³⁵ If a hospital does not meet some of the actions then they are given 60 business days to rectify the issue/s before a decision is made regarding accreditation.¹³⁶ If the final assessment still determines that there are criteria not met, then the hospital may be reassessed in six months.¹³⁷ After a reassessment if a health service organisation still has actions that are not met then their accreditation will be rescinded and they will have to work with the Commission to achieve future accreditation.¹³⁸

The Commission has approved accrediting agencies to accredit hospitals in accordance with the National Standards. The oversight of the assessors will be strengthened and enhanced under the

¹²⁹ Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards, 2nd ed*, Sydney: ACSQHC; 2017.

¹³⁰ <http://nationalstandards.safetyandquality.gov.au/accreditation-scheme>

¹³¹ Ibid

¹³² Ibid

¹³³ Ibid

¹³⁴ Ibid

¹³⁵ Ibid

¹³⁶ Ibid

¹³⁷ Ibid

¹³⁸ Ibid

processes for the second edition, including post-assessment surveys, observation visits, data analysis and information from regulators.¹³⁹

The second edition of the National Standards have some considerable changes and seek to ensure a more dynamic and comprehensive approach to accreditation to protect the public from harm and improve the quality of health service provision across Australia.

National Maternity Services Plan 2010 to 2016

The National Maternity Services Plan, developed by the Australian Health Ministers' Advisory Council (AHMAC) and its Health Policy Priorities Principal Committee, set out a five year vision for maternity services in Australia from 2010 to 2015. The plan was extended by a further year to 30 June 2016. The purpose of the plan was to provide a strategic national framework to guide maternity services' policy and program development across Australia.

The plan had four priority areas being:

1. access
2. service delivery
3. workforce
4. infrastructure.

The plan was underpinned by 10 principles for maternity services in Australia. These principles varied from ensuring that maternity services were woman-centric, to delivering equity of access in both rural and remote and city locations, to securing maternity services within a national system for monitoring performance and outcomes, and guiding quality improvement.

Implementation, reporting and evaluation of the plan were the responsibilities of AHMAC who reported to COAG. The plan was to be superseded by the National Framework for Maternity Services, which was being developed and is discussed below.

Draft National Framework for Maternity Services

In April 2016, the COAG Health Council agreed that the National Framework for Maternity Services will focus on two key components:

- evaluation of the processes that occurred in developing and implementing the National Maternity Services Plan 2010–2015
- development of an enduring National Framework for Maternity Services.

¹³⁹ Ibid

The purpose of the framework, once developed, was to provide a vision and principles for the delivery of maternity services in Australia, which could provide a structure for states and territories to develop jurisdictional plans relevant to their local circumstances.

In March 2017, a draft National Framework for Maternity Services was released for consultation, with the consultation period closing on 18 April 2017. This was the second phase of consultation. At a final consultation meeting on 23 June 2017, the decision was made to cease progressing the framework.¹⁴⁰

National Strategic Approach to Maternity Services

On 22 September 2017, the AHMAC agreed to commence a new process to develop a National Strategic Approach to Maternity Services (NSAMS). This was a follow-on from the ceased National Framework for Maternity Services. The work is being led by the Australian Government in consultation with a broad range of stakeholders. The project is supported by a time-limited Project Reference Group and Advisory Group.¹⁴¹

On 2 May 2018, a draft consultation paper was released on the NSAMS. Consultation closed on 18 June 2018 and on the basis of that extensive consultation, a second round of consultation commenced in October 2018. This round *'will involve face to face workshops, an online survey and opportunity to submit online responses. In addition there will also be a series of webinars to enable greater access for those in rural and remote areas'*.¹⁴² The consultation workshops occurred in various locations across Australia from 9 October to 16 November 2018, with over 480 people attending.¹⁴³

It is anticipated that the final NSAMS will be developed by July 2019.

National Core Maternity Indicators 2016

The National Core Maternity Indicators were developed by the AIHW out of indicators that were developed in or around 2002 resulting from a review recommending that Australia *'establish an enquiry process with annual benchmarking and/or reporting of performance indicators for obstetric and gynaecological practice and outcomes'*.¹⁴⁴ The purpose of the indicators is to *'assist in improving the quality of maternity services in Australia by establishing baseline data for monitoring and evaluating practice change'*.¹⁴⁵

¹⁴⁰ <https://ama.com.au/media/national-framework-maternity-services-scrapped>

¹⁴¹ <http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-pdb-maternity>

¹⁴² Ibid

¹⁴³ Ibid

¹⁴⁴ <https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/background-and-indicator-development>

¹⁴⁵ <https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/summary>

The most recent AIHW report focused on 12 indicators, relating to data available between 2004 and 2016 (being the most recent perinatal data¹⁴⁶ available). The indicators cover the antenatal period, labour and birth, and birth outcomes. The indicators are continuously being reviewed by the AIHW in response to data and trends across Australia's maternity services. The report highlights that nationally, there has been an increase in the number of assisted vaginal births, caesarean sections and induction of labour.¹⁴⁷ There is also a noticeable difference between women in public environments receiving less antenatal care in the first trimester than those in private environments. The data suggests a correlation between antenatal care and socioeconomic status, age of the woman, and size of the facility by births per year.¹⁴⁸

The indicators are an important measure to enable maternity service providers and the community to be informed about the performance of the maternity service system across Australia and prompt improvements to the system in a meaningful, evidence-based way in response to key clinical datasets.

Women's Healthcare Australasia benchmarking

Women's Healthcare Australasia (WHA) is the peak not-for-profit body for hospitals and healthcare services providing healthcare to women and babies across Australia.¹⁴⁹ Membership is not compulsory but a significant number of public and private health services throughout Australia, including CQHHS, have current membership with WHA.

One of the key outcomes from WHA is a benchmarking report released for each financial year. This report benchmarks clinical care outcomes against a set of agreed clinical indicators. It enables peer health services to gauge their overall performance against the clinical indicators in comparison to other equivalent health services; health services being grouped according to their level from the CSCF. It is a useful tool for enabling health services to identify areas where they are doing well or where there is room for quality improvement.

¹⁴⁶ The Australian Institute of Health and Welfare (AIHW) is responsible for the National Perinatal Data Collection, which is a national data collection for pregnancy and childbirth. The data is collected by state and territory health departments and each year an extract is provided to AIHW for compilation into a national dataset.

¹⁴⁷ <https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/summary>

¹⁴⁸ <https://www.aihw.gov.au/reports/mothers-babies/ncmi-data-visualisations/contents/antenatal-period-indicators/a2>

¹⁴⁹ <https://women.wcha.asn.au/>

Appendix 2—State-wide and national maternity services frameworks

State and national networks

Queensland Maternal and Perinatal Quality Council

The Queensland Maternal and Perinatal Quality Council (the Council), established in 2009, reports to the Minister for Health and Ambulance Services and is gazetted under the HHB Act as a quality committee. The council's purpose is to:

- collect and analyse clinical information regarding maternal and perinatal mortality and morbidity in Queensland to identify state-wide and facility-specific trends.
- make recommendations to the Minister for Health and Ambulance Services on standards and quality indicators of maternal and perinatal clinical care to enable health providers in Queensland to improve safety and quality
- assist with the adoption of such standards in both public and private sectors¹⁵⁰
- work collaboratively with various state and national government agencies, including the State-wide Maternity and Neonatal Clinical Network, to advance its goals of improving the quality of maternity services across Queensland.

The council consists of no more than 25 members and comprises representatives from a number of fields, including neonatology, obstetrics, midwifery, neonatal nursing, maternal fetal medicine, general practice obstetrics, Indigenous health, data collection and statistical analysis, and consumers.¹⁵¹ The current chair of the council is the Dean of Medicine, Griffith University and a Professor of Obstetrics and Gynaecology at Gold Coast University Hospital.¹⁵² The council has four sub-committees dedicated to key subject matter areas e.g. Maternal Mortality and Aboriginal and Torres Strait Islander Perinatal.¹⁵³

The council may seek information and data from a variety of sources, including this office, to inform its work. Reporting is an important function of the council, with it preparing biennial or triennial, and ad hoc reports for the Minister for Health and Minister for Ambulance Services. These reports identify trends and issues in maternity and neonatal care relating to maternal and perinatal mortality and morbidity; making recommendations for quality improvement activities and methodologies for their implementation to improve the safety and quality of health services.

¹⁵⁰ Queensland Maternal and Perinatal Quality Council, Terms of Reference July 2016.

¹⁵¹ Ibid

¹⁵² <https://clinicalexcellence.qld.gov.au/priority-areas/safety-and-quality/queensland-maternal-and-perinatal-quality-council/membership>

¹⁵³ Ibid

State-wide Maternity and Neonatal Clinical Network

The State-wide Maternity and Neonatal Clinical Network (the network) was established in 2007 and its remit is to:

- ensure consumers and/or carers are supported to actively participate in open, honest shared decision-making to improve the patient experience and patient health outcomes
- provide expertise, direction and advice to all Queensland healthcare providers and the Department of Health in relation to maternity and neonatal care
- provide strategic oversight of state-wide maternity and neonatal clinical documents
- provide expertise, direction and advice to healthcare administrators.¹⁵⁴

The network comprises multidisciplinary representation from various fields, including obstetrics, midwifery, neonatology, allied health, public health and Indigenous Australians from around the state. The network also works in collaboration with a variety of stakeholders, including the Queensland Maternal and Perinatal Quality Council, Rural and Remote Clinical Network, Child and Youth Clinical Network, Patient Safety and Quality Improvement Service, and the Office of the Chief Nursing and Midwifery Officer.¹⁵⁵

The network's priorities as at November 2018 include providing strategic oversight and/or expertise to the:

- Perinatal Mental Health and Wellness Project
- State-wide Neonatal Planning Project/High Complex Services Planning Framework
- Queensland Clinical Guidelines Program
- Midwifery Leadership Advisory Group.¹⁵⁶

Maternity Services Forum

In November 2016, the Maternity Services Forum was convened at the request of the Minister for Health and Ambulance Services, to respond to broad concerns about the quality of public maternity services in Queensland, some of which had been raised by the office directly with Queensland Health.¹⁵⁷ The forum was attended by 119 key stakeholders from each of the 15 HHS, with representatives from obstetrics, midwifery, safety, quality and clinical governance and consumers.¹⁵⁸

¹⁵⁴ <https://clinicalexcellence.qld.gov.au/priority-areas/clinician-engagement/statewide-clinical-networks/maternity-and-neonatal>

¹⁵⁵ Ibid

¹⁵⁶ Ibid

¹⁵⁷ <https://clinicalexcellence.qld.gov.au/sites/default/files/docs/improvement/maternity-services/communique-maternity-forum-2016.pdf>

¹⁵⁸ Ibid

Prior to the forum, a survey was conducted with HHS staff (not limited to those attending the forum), key stakeholders and consumers working in maternity services about what was and was not working well, why had the issues arisen and what were the impacts in maternity services.¹⁵⁹ The survey identified three main areas for discussion at the forum, namely:

1. improving leadership and management of public maternity services with a focus on joint professional collaboration to deliver consumer centric care
2. improving the reliability and timely response to changing risk to mother and baby, especially during labour
3. improving the reliability and sustainability of staffing, skill mix and care models.¹⁶⁰

At the conclusion of the forum it was agreed that three working groups would be established and they would work closely with the State-wide Maternity and Neonatal Clinical Network to continue developing an action plan in response to the issues identified at the forum. The working groups are:

- Group 1: Collaborative Leadership Culture
- Group 2: Identification and management of risk in pregnancy
- Group 3: Models of Care and Workforce.¹⁶¹

The completed action plans from each group were endorsed by the Queensland Health System Leadership Team in May 2017, with work commencing to support delivery of the actions in the 2017/18 year. This work has been overseen by the Maternity Services Forum Steering Committee at quarterly meetings.¹⁶² In Queensland Health's September 2017 communique it identified that there were seven key actions for each working group and a majority of these were between 0 and 30 per cent complete. Specifically, there were five actions with zero progress, seven had 10 per cent completion, one was 20 per cent complete, one was 25 per cent complete, four were 30 per cent complete, two were 70 per cent complete, and one was 100 per cent complete.¹⁶³

In addition to the working groups, the Maternity Services Forum identified a number of challenges facing Aboriginal and Torres Strait Islander mothers, babies and their families. It was agreed that these issues should be addressed via a specific, focused discussion, which occurred on 3 August 2017 via the *Growing Deadly Families, a healthy start for mums and bubs* forum, which was attended by 98 key Aboriginal and Torres Strait Islander stakeholders from around Queensland.¹⁶⁴ The forum identified three key issues:

¹⁵⁹ Ibid

¹⁶⁰ Ibid

¹⁶¹ Ibid

¹⁶² Clinical Excellence Division, Maternity Services Forum, Communique, July 2017.

¹⁶³ Clinical Excellence Division, Maternity Services Forum, Communique, September 2017.

¹⁶⁴ https://clinicalexcellence.qld.gov.au/sites/default/files/2017-12/Communique_ATSI%20Maternity%20Forum_3%20Aug%202017.pdf

1. 'continuity of care
2. *partnerships for governance and leadership*
3. *embedding Indigenous workforce and support into health services*'.¹⁶⁵

The plan was for the organising committee of the forum to develop an action plan with strategies to address the identified areas for improvement and have the Maternity Services Forum Steering Committee provide oversight of implementation.¹⁶⁶

Rural Maternity Taskforce

On 12 August 2018, the Hon. Steven Miles, Minister for Health and Minister for Ambulance Services, requested that the Department of Health convene a summit to consider the issues in relation to rural birthing.¹⁶⁷ In response the Department of Health has established the Rural Maternity Taskforce, which is 'a panel of rural consumers, maternity experts, clinicians and health service decision-makers'.¹⁶⁸

The taskforce's outcomes will include:

- 'a report on current maternity services, which will include an analysis of the factors that affect access to and safety of services, and outcomes for mothers and babies
- a decision-support guide for Hospital and Health Services to assist with planning, developing and delivering rural and remote maternity services'.¹⁶⁹

The taskforce completed a series of events to inform its outcomes, these include:

- a public call for submissions, which closed on 18 February 2019
- focus groups, that were held in five rural and remote locations, in February and March 2019
- a Queensland Rural and Remote Maternity Summit, held on 19 June 2019.

Staff from this office attended the Summit on 19 June 2019, at which the Minister confirmed that the six recommendations made in the report would be adopted and implemented and he committed to a number of measures to start to address the issues identified in the report.^{170 171}

¹⁶⁵ Ibid

¹⁶⁶ Ibid

¹⁶⁷ <http://statements.qld.gov.au/Statement/2018/8/12/rural-maternity-services-in-queensland>

¹⁶⁸ <https://clinicalexcellence.qld.gov.au/priority-areas/patient-experience/rural-maternity-taskforce>

¹⁶⁹ Ibid

¹⁷⁰ <https://clinicalexcellence.qld.gov.au/sites/default/files/docs/maternity/rural-maternity-taskforce-report.pdf>

¹⁷¹ <http://statements.qld.gov.au/Statement/2019/6/19/maternity-report-proposes-changes-for-rural-mums>

Council of Australian Governments Health Council

The Council of Australia Governments (COAG) is the peak intergovernmental forum in Australia. Its members are the Prime Minister, state and territory first ministers and president of the Australian Local Government Association. COAG has eight councils that support it to fulfil its national functions.

The COAG Health Council and its advisory body, the Australian Health Ministers' Advisory Council, provide a mechanism for the Australian Government, New Zealand Government and state and territory governments to discuss matters of mutual interest concerning health policy, services and programs.

One of the key projects currently underway by the council is the National Strategic Approach to Maternity Services (discussed in detail above).

Appendix 3—List of investigation documents

A copy of the full list of documents obtained and relied upon to inform this investigation can be found on the office's website.

Appendix 4—Recommendations Monitoring Program

This office intends to monitor the recommendations through a collaborative approach with CQHHS, which will enable this office to be more responsive to the changing nature of the health environment while still retaining an oversight role to ensure that the recommendations are fully and effectively implemented.

As many of the recommendations made in this report have a 12 month timeframe, the recommendations monitoring program is aimed at tracking CQHHS' progress against the implementation of the recommendations through regular stakeholder engagement. This may include meetings, whether face-to-face or remotely, site visits, seeking documentary evidence, progress reports¹⁷² or a combination of measures. While the stakeholder meetings have been set at three monthly intervals, these timeframes may be adjusted in response to CQHHS' progress in implementing the recommendations.

The following schedule sets out the framework for the recommendations monitoring program.

Program approach	Timeframe	Topics for meetings	Rec No. ¹⁷³
Correspondence and documentary evidence	Within 30 days of the final report	▪ CQHHS <i>Maternity Risk Assessment Tool</i> procedure	1
		▪ Recording of telephone advice incidents in Riskman	2a
Stakeholder meeting with evidence provided	Within three (3) months of the final report	▪ Telephone advice incident review and action plan	2b
		▪ Flags for patients for discharge against medical advice	3
		▪ Triaging patients who re-present after discharging against medical advice	3
		▪ Gladstone Hospital maternity service staff survey	4a
		▪ Emerald Hospital epidural audit	6
		▪ CQHHS midwifery group practice procedure for transferring patients	8
		▪ Telephone advice incident reporting to CQHHS Safety and Quality Committee	2c
	Within six (6) months of the final report		

¹⁷² Pursuant to section 89(2) of the Act, a further request may be made by the Health Ombudsman for a progress report about the implementation of recommendations made in the investigation report.

¹⁷³ The recommendation numbers correspond with the recommendations made in this report.

Program approach	Timeframe	Topics for meetings	Rec No. ¹⁷³
		▪ Gladstone Hospital maternity service kaizen workshops	4b
		▪ Gladstone and Banana Shire Business Unit clinical governance	5
		▪ Theodore MPHS review implementation status report	7
		▪ CQHHS clinician consultation process for all major incident reviews	9a
		▪ Serious incident recommendation benchmarking	9b
		▪ Risk-based recommendation implementation, evaluation and oversight	9c
		▪ Reviewing and escalating repeating recommendations	10
		▪ CQHHS qualitative review process	11
	Within 12 months of the final report	▪ Topics covered in the 6 month meeting that have 12 month deadlines	2c, 5, 7, and 9b-11

Appendix 5—CQHHS response to report



File reference: J:HSCE-LETTERS:2019:044-19:SW/m

Central Queensland
Hospital and Health Service

25 June 2019

Mr Andrew Brown
Health Ombudsman
400 George Street
Brisbane Qld 4000

BY EMAIL: Executive@OHO.qld.gov.au

Dear Mr. Brown *Andrew*

Central Queensland Hospital and Health Service (CQ Health) would like to sincerely thank the team from the Office of the Health Ombudsman (OHO) for its time and diligence in compiling this report. CQ Health's focus on improving health care in our maternity service has delivered great results and it is reassuring when an external and independent review by OHO identifies that our services deliver safe, high quality maternity services.

Proactive maternity service reviews and the progressive implementation of service and cultural improvements began at Rockhampton Hospital and have now been progressed at all Central Queensland public birthing facilities.

The improvements highlighted for the Rockhampton Hospital maternity service will be reflected across CQ Health's birthing hubs as improvements and process changes are embedded as business-as-usual.

The recommendations for ongoing improvement in the report are welcomed and reaffirm the actions CQ Health had put in place prior to the OHO review and in the months since OHO's last visit to Central Queensland. There has been a particular focus of service improvement and clinical governance at the Gladstone Hospital maternity unit and CQ Health is determined to deliver improvements that match those achieved at Rockhampton Hospital.

CQ Health is committed to delivering further and ongoing improvements in our maternity services and in all the health services we deliver. The OHO recommendations will support our ongoing work.

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CQ Health is committed to delivering great care closer to home – care our staff are proud of and care the community trusts.

The findings and recommendations in the report and the work undertaken since the OHO visit are very-much supported by our recent accreditation process undertaken by the Australian Council on Healthcare Standards in which CQ Health met all health care standards.

To achieve such supportive assessments by two independent organisations held within months of each other highlight the effectiveness of our approach to improving services and improving the health of Central Queenslanders.

Thank you again for the report and CQ Health welcomes the findings that our services deliver safe, high quality maternity services, and we welcome the recommendations.

Yours sincerely



Steve Williamson
Health Service Chief Executive
Central Queensland Hospital and Health Service
Adjunct Professor CQ University