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

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[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.

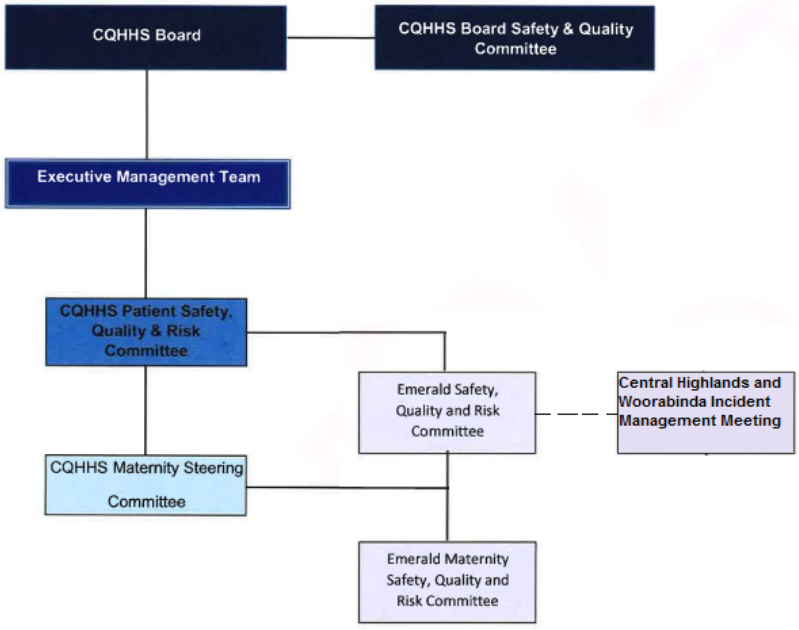

Figure 8 Emerald Hospital committee structure

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 FOG[95] 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 haemorrhage[97] 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.

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[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.