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Health Ombudsman releases report into the safety and quality of maternity services provided by the Gladstone Hospital

Queensland's Health Ombudsman has today released a report into the safety and quality of maternity services provided at five facilities within the Central Queensland Hospital and Health Service (CQHHS) catchment, including the Gladstone Hospital, which is the busiest Level 3 public maternity service in Queensland. The report presents the findings of a systemic investigation that examined four clinical incidents that occurred within the maternity service between March 2017 and October 2018, all of which centred around the level of coordination and appropriateness of clinical care.

CQHHS conducted an independent review which was completed in 2018 and made 17 recommendations. By October 2018, all but one recommendation had been implemented by Gladstone Hospital.

The Office of the Health Ombudsman (the office) decided to investigate four individual complaints about the Gladstone Hospital maternity service, received between April 2016 and November 2017.

These investigations found that Gladstone Hospital had already begun to make improvements to its service, including significant work to improve collaboration between the emergency department and maternity service, and the announcement of the recruitment of 11.6 new midwives to the service. There remained some concern about the robustness of the recommendations implemented following the review and staff from the office observed some disconnect between leadership and staff.

Health Ombudsman Andrew Brown says the investigation revealed that the Gladstone maternity service is performing at a safe level and overall, 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 it still faces some challenges.

The investigation's main findings focused on the assessment of risk, collaboration between departments, staffing levels and leadership. As a result, Health Ombudsman Andrew Brown said he had made 4 recommendations along 3 themes: the assessment and management of risk, triaging pregnant patients in the emergency department, and benchmarking the safety and quality leadership to identify improvements.

"One of the major areas of focus for the maternity service needs to be on its staff, ensuring that they are engaged and prepared for changes that will need to be implemented in the coming year," Mr Brown said. "One of the challenges for the leadership is to role model the safety and quality culture to create a cohesive unit."

The investigation found that the maternity service had experienced a long period of unstable senior management, difficulty in recruiting permanent staff and a lack of coordinated support, which impacted upon their ability to improve safety and quality processes.

"I am confident that the Gladstone hospital maternity service has the necessary focus to progress this change," said Mr Brown. "In late 2018, a change in the executive leadership brought substantial

experience and triggered significant improvements in the maternity service. I'd like to acknowledge the work that has already commenced, enabling the maternity service to refine and improve, particularly in relation to clinical governance and safety and quality processes."

Mr Brown added that the necessary changes would be challenging for both leadership and staff, requiring a shared commitment and energy.

The full investigation report is available to download from the OHO website at www.oho.qld.gov.au.

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