Safer Care Victoria

2017 Summary Report

Safety systems assessment

COHUNA DISTRICT HOSPITAL
Maternity Service

Version 1.1

VICTORIA State Government

Contents

1 Summary of Safety System Assessment

Recent escalation of concerns from the Board at Cohuna District Health (CDH) to the Department of Health and Human Services (DHHS), seeking expert advice on the safety of their maternity services, triggered a safety systems assessment by Safer Care Victoria (SCV).

The safety system assessment (the assessment) aimed to:

(i) provide information to the CDH Board and the DHHS regarding the quality and safety of maternity services at CDH, and
(ii) support the CDH Board in its future planning of their maternity services at Cohuna.

Safer Care Victoria convened an assessment team comprised of professionals with expertise in rural General Practice/Obstetrics, rural midwifery care, health management and safety systems methodology. The team attended CDH over a two-day period where they worked closely with CDH staff members and pregnant women attending the service to understand the strengths, challenges and day-to-day workings of the CDH maternity service.

To conduct the assessment, the SCV team used a systematic approach that has been developed by SCV based on the Framework of Contributing Factors as described in the London Protocol. This involved the team reviewing clinical documentation, including policies and protocols, outcome data and clinical case management. The team also met with individuals for a series of interviews including clinicians (midwives, nurses, and medical staff) working at CDH, women who had or were due to give birth at CDH, managers, executive staff and staff of referral hospitals and services.

The assessment team made a number of observations and findings leading to 23 recommendations. The major finding was the fragility of the medical workforce with dependence on a single obstetric provider but opportunities for system improvement extended beyond that finding. Nonetheless, the following specific recommendations (numbers relate to summary table) were considered time critical, requiring immediate attention:

9. The General Practitioner-Obstetrician (GPO) should achieve a level 3 Fetal Surveillance Education Program (FSEP) score, as a matter of urgency, and by the end of the 2017-18 financial year at the latest
18. CDH to develop an on-call medical roster that they consider safe
19. CDH to develop and implement a formal policy regarding diversion of the CDH birthing service.

The assessment team considered a range of options for the future planning of maternity services at CDH and came to the considered view that maintaining birthing services but with purposeful recruitment of additional medical workforce, was the preferred option for CDH. Maintaining birthing services with the existing medical workforce, specifically a single-handed GPO was considered neither safe nor appropriate in 2018.

2 Recommendations

Summary of recommendation's

1. **Implement a process whereby all pregnant women who live locally, irrespective of planned place of birth, are registered in the CDH Birthing Outcomes System (BOS).**

2. **Develop and implement a community education program about CDH maternity and newborn capabilities, and associated safety concerns for mother, baby and staff of extending beyond this capability.**

   It will be important to ensure that the communication strategy is in plain accessible language and multimodal. The messaging should be clear and positive, with a focus on ensuring that babies are born safely and mothers are as healthy as they can be prior to conception, during pregnancy, while giving birth and postnatally.

   Women should also be provided with information about what maternity services (antenatal, labour, and postnatal) are available elsewhere in the region (e.g. Swan Hill, Echuca, Bendigo) and how the regions services integrate with each other.

   Given the small number of inpatient maternity services, there is an opportunity for the mid-Murray area to develop combined information as a shared resource, suitable for all local women irrespective of where they live and where they plan to give birth.

3. **Ensure access to patients' pregnancy care medical records is not dependent on handheld records.**

   The simplest, immediate approach to providing access to all pregnancy care records would be to provide the CDH midwives access to *Best Practice* on the ward, as is currently available to the GPs. However, such a solution may not best meet future needs because it would create a dependence on Ochre Medical Centre, a private company, for the maintenance of CDH pregnancy care records.

   An alternate solution worth considering would be to use BOS for entering pregnancy care information. The antenatal module of BOS is widely used by other Victorian maternity services. This would require installing BOS on the Ochre Medical Centre computer(s) and would likely require some additional BOS training for CDH midwives and training of medical staff on BOS. The longer term benefits of this approach would be that all women attending Ochre Medical Centre for pregnancy care, irrespective of their intended place of birth, would have medical records visible to CDH, thereby meeting recommendation one, and that maternity patient record access would not be dependent on a commercial third party (Ochre Medical Centre).

   There are other bespoke maternity electronic medical records (eMR) solutions, such as K2 Systems, that would allow remote (Ochre Medical Centre) and hospital-based record entry, including routine reporting to DHHS. However, the required investment in such systems, both in capital and staff training, is probably not merited by the current birthing volume.

4. **Provide a computer in the birth suite.**

   This would allow (i) staff access to policies and procedures at point of care and (ii) for all intrapartum care notes to be entered electronically into the chosen eMR (e.g. BOS, Best Practice etc.).

5. **All policies/procedures should be updated to ensure that they support the maternity service at CDH.**

   Maintaining current and evidence-based policies and procedures is an important component of contemporary clinical governance. However, this can be a particularly burdensome task for a small workforce such as that at CDH. A sustainable and more practical solution would be to adopt state-wide material, where available (e.g.

eHandbooks), and/or adopt shared regional resources (e.g. Loddon-Mallee Clinical Council or equivalent). The co-development and maintenance of resources at a regional level would also support better integration of service provision to meets the needs of local women and facilitate staff working across services (e.g. midwives working at Echuca Regional Health (ERH) and CDH). Under Dr Howlett's leadership, we would encourage CDH to explore the further opportunities for the shared development and implementation of maternity policies and procedures in the mid-Murray region, if not at a whole of Loddon Mallee region.

We would also recommend some specific changes/updates to current policies and procedures, including decision tools and checklists:

- clarify the safe maternity care procedure regarding risk rating for hepatitis B information
- update the breech guideline to be aligned with the DHHS Maternity eHandbook.
- ensure that there is a local post-partum haemorrhage (PPH) procedure that includes use and administration of tranexamic acid. The use of a PPH documentation tool and algorithm should also be available in the birth room.
- consideration should be given to the development and adoption of a massive transfusion Protocol.
- develop/adopt decision making tools and checklists to support clinical care for key emergencies (e.g. PPH, shoulder dystocia, eclampsia, breech).

6. **Undertake an improvement project to ensure that all women have written consent for induction of labour (IOL).**

   Since the hospital has a policy requiring women to provide written consent for induction of labour it is incumbent on the hospital to ensure that this occurs. A small improvement project would likely assist in identifying the barriers to having written consent from all women and in planning solutions to these barriers.

7. **Introduce routine umbilical cord blood lactate testing for all births.**

   Assistance from health services (e.g. Monash Health) that have already established routine cord blood lactate testing would allow CDH to acquire and adopt existing clinical policies and protocols, including those relating to the care of a newborn baby with an unexpectedly high cord lactate. This will require the development and introduction of new care pathways for newborns and supporting training for medical and midwifery staff.

8. **Purchase basic simulation training equipment for maternity services.**

   When suitable funding is available, we would suggest CDH purchases a 'Limbs and Things PROMPT flex advanced model' (or similar) with a PPH and a cervical effacement and dilation module, to support on-site midwifery training in core clinical skills.

9. **The GPO should achieve a level 3 FSEP score, as a matter of urgency, and by the end of the 2017-18 financial year at the latest.**

   The GPO should be given an opportunity to attend a full day FSEP workshop as soon as possible, noting that his absence from CDH will require GPO cover. In preparation for the workshop, the GPO might consider completing one of the online RANZCOG resources, preferably OFSEPlus. Participation in the full FSEP should be an on-going requirement, ideally on an annual basis, and would be a component of the annual CPD plan (recommendation 10).

10. In agreement with the Director of Medical Services (DMS), on an annual basis the GPOs should undertake a range of obstetrics-focussed education and professional development opportunities to support their continuing professional development (CPD).

The on-going professional development needs of the GPO(s) will vary from year to year and will, of course, extend beyond obstetrics. Nonetheless, mitigation of the risks of professional isolation is particularly important in obstetrics. Strong consideration should be given to participating in short clinical attachments to larger maternity units such as Bendigo Health. This would strengthen relationships between CHD and Bendigo Health. Financial support for this would be available through the Rural Procedural Grants Program – see https://www.racgp.org.au/education/rural-programs/training-grants/rural-procedural-grants-program-(rpgp).

Participation with midwifery colleagues in regular, less formal, on-site emergency simulation training would also enhance team building and response. At least annual PROMPT, or equivalent, simulation training should also be undertaken (and could be a component of the annual CPD plan).

11. CDH should continue to undertake regular multidisciplinary reviews of clinical care with external involvement.

Regular, objective review of clinical care and outcomes with the intent of continual improvement is a necessary component of any health service but is more difficult to do than generally thought. It is particularly difficult to do effectively in a small service such as CDH where almost everyone involved in the review process would have participated in the care provision or works very closely with those who did. There are also different "levels" of review from reviewing and reflecting on all recent patients – something that is typically easier to do well in a small service with low volumes – to reviewing rates of interventions and outcomes (e.g. inductions of labour, assisted births, PPH, blood transfusions etc.), to in-depth review of individual cases with a serious adverse outcome. CDH should be undertaking each and all of these activities and have involvement of external experts in all. Specifically, we suggest:

(i) a monthly multidisciplinary (GPO, GPA, midwifery) meeting to review the care and outcomes of **all** births in the previous month. Typically, this will involve the review of care of 4-6 women and provide an opportunity to reflect on all aspects of maternity care to ensure that the service is best meeting the needs of local women. It should also include a discussion of the care of local women who, for whatever reason, were transferred elsewhere for their birth. This meeting could be chaired by a senior midwife. Review of clinical guidelines, policies and procedures could also be appropriate agenda items for this meeting.

(ii) A quarterly multidisciplinary meeting to review complex cases, significant adverse outcomes and routine outcome measures.

CDH already have Professor Pettigrew visiting quarterly to provide external expert review for such a meeting. We were impressed by the processes in place to identify suitable cases for his review. The selection process – by the Quality Manager – does not need changing but the review and reporting processes do (see also recommendation 21). With regard to case review, we would suggest that the case material was sent to Professor Pettigrew ahead of the multidisciplinary (GPO, GPA, DMS, midwives) meeting and that the meeting is supported by minutes and documented outcomes of the cases reviewed, reflecting Professor Pettigrew's comments. It should be structured to provide clear findings and strong recommendations for care improvements, where necessary. (Such recommendations would generally not involve new policies and procedures or more staff education). The DMS should chair this meeting. If there was insufficient complex cases/ serious adverse outcome material to review then this meeting could be combined with a meeting to review key routine outcomes (e.g. rate of IOL, severe perineal tears, low Apgar scores, high cord lactates [if introduced], undetected fetal growth restriction etc.). Ideally, the list of routine measures to be reviewed, quarterly or bi-annually, would align

with the VMIA Perinatal Benchmarking measures. If ERH had, or introduced, a similar meeting then it would be an ideal meeting to undertake together.

(iii) CDH continues to participate in the Regional Perinatal Mortality & Morbidity Committee Meetings (RPMMC).

We understood that the attendance of CDH staff, including the GPO, at the RPMMC meetings has been good. This is to be applauded. We suggest that participation in these meetings is a necessary component of continued improvement. The challenge for a small service like CDH is that the case material discussed at the meetings will be largely from other services. However, as these meetings evolve, CDH should look to table discussions about policies and procedures and comparative discussions about regional benchmark indicators. All transfers from CDH to another service should be discussed at this meeting.

12. Develop a formal consultation and referral pathway with Bendigo Health.

All referrals from CDH, elective or urgent, should be by direct consultation between the GPO and the head of obstetrics at Bendigo Health, at least in the first instance. This includes antenatal referrals of women outside of CDH capability for transfer or shared care in early pregnancy, and emergency transfers. The outcomes of such consultations and referrals should be formally recorded in individual patient records and all transfers should be discussed and reviewed at the RPMMC meetings (see above)

13. Develop and run regular in-situ multi-disciplinary simulation training for medical and midwifery staff.

The provision of basic simulation equipment would allow CDH to develop and run short simulated emergency scenarios regularly and *ad hoc*, typically in double staff time. This will greatly enhance staff confidence and skills. In addition, CDH should run more formal simulated emergency training in collaboration with others (e.g. Maternity Services Education Program (MSEP), PROMPT). All staff, medical (GPO, GPA) and midwifery, should participate in the formal simulated training at least annually.

14. Formalise CTG training and accreditation processes, requiring all midwives to work towards a FSEP of level 3, in line with hospital policy.

In a maternity service the size of CDH, it is expected that all midwifery staff have achieved a level 3 FSEP. This is important in a service where the midwife will practice, at times, independently. The pathway for the implementation of this recommendation should be reflected in the local hospital policy. SCV acknowledges that while there is some urgency in this recommendation, it will take time to achieve. Other health services, such as, Monash Health, could provide assistance in sharing their policy and journey relating to this. All staff, medical and midwifery, should complete a full-day FSEP workshop annually.

We also recommend that one midwife, preferably one with FSEP level 3 currently, is given the role of leading CTG skills development for the service. This will entail a number of simple initiatives such as:

(i) developing a CTG training folder to collect CTGs as a local “library” to discuss and review

(ii) establishing a process for review of all CTGs, focussing on documentation and interpretation

(iii) assisting knowledge and skills development separate from FSEP workshops, including “intensive” support where a staff member doesn’t achieve FSEP level 3.

15. Develop strategies to support and enhance midwifery clinical skills experience and scope of practice.

Maintaining breadth and depth of midwifery skills will always be a challenge for small services such as CDH. It is likely that they will not be able to do this alone. Programs such as Maternity Connect may support this recommendation. CDH could also explore partnering with other services to 'swap midwives' to also allow metropolitan nurses to experience a rural maternity services, or by encouraging more midwives to work part time at Echuca or another health service.

16. Implement a patient safety graded assertiveness program.

Having a small workforce, particularly one that is so reliant on a single GPO, makes it inherently difficult for staff to question clinical decisions and / or practice. While far from unique to CDH, this presents very real risks to the service and needs to be specifically addressed. Having a workforce skilled in graded assertiveness, giving them the ability to speak up in challenging situations, is an essential element in any high reliability organisation.

There are several third party providers of excellent training. For example, the Cognitive Institute offers a "Speaking Up for Safety" program. CDH should explore such programs, perhaps in collaboration with other local services (e.g. Kerang or Echuca), to share costs.

17. Agree on a purposeful recruitment strategy for an additional GPO and GPA.

The near term sustainability of the CDH maternity is wholly dependent on sufficient GPO and GPA provision. With the departure of the GP Registrar mid-2017 the GPO provision is already insufficient. Indeed, the lack of progress with recruitment and the commitment from the GPO to the DMS in July 2017 to review the service viability by end 2017 was one of the trigger decisions to the SCV assessment.

In the first instance additional GPO cover is urgently required. We understood that a GPO at ERH had been credentialed for practice at CDH and so could provide cover (e.g. weekends, during leave etc.). This will hopefully meet short to medium term needs. CDH is encouraged to liaise with the Regional DHHS team and with DHHS workforce branch to explore potential funding incentives to specifically support successful recruitment and training of a rural GPO / GPA. Recruitment strategies such as providing an employee sign-on fee, educational opportunities and retention bonuses could be considered. We fear that if recruitment is left solely with Ochre Medical Centre then it will not be successful.

It was our understanding that the current GPA is keen to explore additional work locally. This would be an excellent immediate solution to GPA cover and, in consort with the current GPO who is also a GPA, would likely meet needs. With the retirement of the GPA from Kerang, CDH is encouraged to liaise with Kerang to explore whether the part-time GPA at CDH might also find sessions at Kerang, supporting her ability to work more locally.

There is an urgent need for a strategic approach to training and recruitment of procedural GPs (GPO/GPA). Advanced procedural GP training positions and consolidation of skills requires embedding in regional and rural hospitals in conjunction with the local GP training providers, Eastern Victoria General Practitioner Training (EVGPT) and Murray City Country Coast training (MCCC) in Victoria. The DHHS medical workforce branch could assist with strengthening the relationships between hospitals to formalise training opportunities for rural procedural GPs to access ongoing training opportunities.

In the longer term, CDH is encouraged to participate again in the training of future GPOs for CDH, in partnership with Bendigo Health and MCCC. A proposed pathway would be for a MCCC registrar to undertake their DRANZCOG Adv. training at Bendigo and then undertake a 'Consolidation of Skills' post, combining routine general practice and obstetric practice. Such a post can be funded by DHHS via Rural Workforce Agency

Victoria (RWAV) at Ochre Health and CDH with regular placements at Bendigo to supplement their CDH experience. The provision of a formal on-call roster with clear opportunities for time off is likely to be an important feature of the successful recruitment of younger GPs to such a role.

18. CDH to develop an on-call medical roster that they consider safe.

We suggest that the medical roster should be based on the following broad principles:

- maintain a formal on call roster with at least two GPs to fill the following three medical roles required to maintain a safe level of cover: GPAs, GPOs, and hospital cover. The nominated GPO cover may also be on-call for GP services. The GPO cannot be on call for maternity services and anaesthetic services at the same time, i.e. the GPO cannot cover the GPA role
- all GPs (including GPO) must have at least four days off each month, with no on-call duties. This is inclusive of private and public patients
- if the on call GPO is based in a surrounding town (e.g. Echuca) they should be contacted by the hospital as soon as a woman presents in labour or calls the hospital to say she is presenting, and should stay locally (e.g. Cohuna) until the baby is born and the woman is stable
- the GPO on call at CDH cannot be on call for another health service (e.g. ERH) at the same time. They need to be exclusively on-call for CDH.

19. CDH to develop and implement a formal policy regarding when diversion of the CDH birthing service is required.

It is likely, particularly in the near term, that even with additional staffing resources, there will be times when there are shortcomings in the provision of sufficient staffing, whether medical or midwifery. In such events, such as the GPO not being in town and no cover available, or lack of sufficient midwives to staff the roster, CDH should have a formal diversion policy and procedure. These should include a clear communication strategy for the community, impacted health services (e.g. ERH, Swan Hill, Bendigo) and the Regional DHHS office.

20. CDH should consider approaches to rebuilding trust and confidence in the workforce.

The midwifery workforce is committed to the provision of safe and high quality care. The senior management and executive are similarly committed. This shared vision will only be achievable if there is trust and confidence in each other. Providing team building workshops and regular staff forums will allow clear communication pathways and assist in creating a cohesive culture. This may include communicating the clinical governance process to staff and providing a forum for staff to ask questions.

21. Develop a review tool and reporting process for serious events (ISR 1 and 2).

Ensure that the relevant staff attend RCA training in 2018. (There is a session booked for the Loddon Mallee area to be held in Bendigo in April 2018). Develop and implement a review tool and formal reporting process for all ISR 1 and 2 events. Review and reporting of women whose care needs exceed those of the CDH capability framework should be included in this process. The DMS should have visibility of these.

22. Consider introducing a maternity outcome dashboard for reporting to Board.

The Victorian Managed Insurance Authority (VMIA) are currently piloting the implementation of benchmark dashboards for maternity services. The dashboard is automatically generated on-site by the health service from

its own BOS. (In essence, a service can generate an output as often as they wish with the press of a button). Using BOS for the entry and reporting of pregnancy and birth outcomes would provide CDH with this facility without any infrastructure investment. Such reporting can be used by the clinical workforce, executive, and the Board and assist in ensuring clear visibility of maternity outcomes and performance.

23. AV to be invited to participate in PROMPT training once commenced.

3 List of abbreviations

BOS	Birthing Outcome System	**GPA**	General Practitioner Anaesthetist
CDH	Cohuna District Hospital	**IOL**	Induction of labour
CPD	Continuing Professional Development	**ISR**	Incident Severity Rating
CTG	Cardiotocography	**MCCC**	Murray City Country Coast Training
DHHS	Department of Health and Human Services	**PPH**	Post-Partum Haemorrhage
DMS	Director of Medical Services	**PROMPT**	Practical Obstetric Multidisciplinary Professional Training
eMR	Electronic medical record	**RANZCOG**	Royal Australian and New Zealand college of Obstetricians and Gynaecologists
ERH	Echuca Regional Health	**RPMMC**	Regional Perinatal Morbidity & Mortality Committee
EVGPT	Eastern Victoria General Practitioner Training	**RWAV**	Rural Workforce Agency Victoria
FSEP	Fetal Surveillance Education Program	**SCV**	Safer Care Victoria
GP	General Practitioner	**VMIA**	Victorian Managed Insurance Authority
GPO	General Practitioner Obstetrician		