OFFICE OF THE HEALTH OMBUDSMAN

Health service investigation—snapshot report

Investigation focus: Review into a hospital's maternity care provided between April 2021 and July 2022 (October 2024).

Wider learnings and recommendations for service improvements

The investigation identified opportunities for improvement and proposed recommendations relating to:

- Clinical staff compliance with Maternity guidelines, pathways and policies related to clinical observations, management of pregnant women with diabetes and recognition of and responding to clinical concerns.
- Implementation and compliance with a decision/referral matrix related to women with diabetes.
- Medication safety, focusing on missed medications and on-time medications.
- Timeliness of discharge summaries and auditing discharge summary content against information in clinical records.
- Auditing written handover processes to measure compliance with the clinical handover framework.
- Improving staff access to clinical safety and quality data.
- Timeliness of clinical incident reporting, identifying and actioning opportunities for improvement.
- Trends in clinical incidents related to issues identified as part of the Maternity Services Quality Improvement Plan 2023/2024 and OHO investigation as a measure of the impacts of actions implemented on patient outcomes.

Background

The Office of the Health Ombudsman (OHO) initiated an investigation after receiving written notification from a Hospital and Health Service (HHS) about concerns raised in an internal complaint regarding the maternity services at one of their hospitals.

The main concerns identified were related to:

- Peripartum clinical care, including incomplete/inadequate recording of observations, inadequate management of women with diabetes and failure to escalate concerns related to patients' conditions.
- Medication administration, including lack of timely administration of medication or missed medication doses.
- Clinical documentation, including missed or inaccurate recording of clinical information in patient records and discharge summaries.
- Clinical governance processes, specifically the management of clinical incidents.

The HHS appropriately recognised the potential systemic concerns raised by the complainant and notified the OHO to independently assess these issues. Concurrently the HHS undertook an independent assessment of maternity services by an external health care manager and leader with experience in midwifery and maternity service delivery. This review resulted in a number of recommendations for improving service delivery which informed the development of a Maternity Services Quality Improvement Plan 2023/2024. This proactive approach reflects the organisation's commitment to improving patient safety and care quality.

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Issues investigated

During the investigation, the OHO held meetings with key representatives of the HHS and the hospital and obtained relevant information including complaint information, clinical records, clinical incident reports, patient feedback and audit data, guidelines, policies and procedures, staff training records, governance documents and written submissions. The OHO investigation also referred to national and state standards, frameworks and guidelines that apply to and influence the provision of maternity services provided by Public Hospital in Queensland. The information obtained identified the issues, informed the scope and findings of the investigation.

The scope of the investigation, after review of the notification to the OHO and information obtained during the OHO's investigation, was refined and the following issues were highlighted and analysed in detail.

Whether the hospital maternity services:

1. Has and follows appropriate policies, procedures, guidelines and management pathways for delivery of peripartum care to obstetric patients, relating to:
    a. observations during the peripartum period
    b. management of patients with diabetes during the peripartum period
    c. recognising patient deterioration and escalation.
2. Has and follows appropriate policies and procedures for medication management and administration.
3. Has and follows appropriate policies and procedures for clinical communication.
4. Has and follows appropriate governance processes for clinical incident management.

Key findings

The OHO investigation findings revealed concerns with the hospital maternity services related to the following:

- Peripartum care: The investigation highlighted areas where peripartum management of women could be improved to align more closely with best practice. Specific concerns identified were missed or inadequate recording of observations, mismanagement of patients with diabetes and inadequate staff recognition and response to patient deterioration.
- Medication safety: Issues identified with missed medications and timeliness of medication administration.
- Completeness of clinical documentation: Gaps identified in the consistency and completeness of clinical records, raising concerns about effective communication, continuity of care and escalating clinical concerns.
- Governance of clinical incident management: The investigation found that while the hospital's clinical incident governance processes for management and oversight of clinical incidents were in place, there were the need to improve the timeliness of logging clinical incidents, acting on staff feedback and other quality and safety measures.

Over the course of the investigation, the hospital made progress on recommendations resulting from the maternity services review, outlined in the Maternity Services Quality Improvement Plan 2023/2024. Some of these recommendations addressed the concerns raised during the OHO investigation. Where concerns had not been addressed the OHO have made recommendations for service improvement. The OHO will continue to engage with the HHS to monitor the implementation of the recommendations.