Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services by Professor Euan M Wallace

Executive Summary

Findings

1.1 Inpatient and outpatient maternity services are major components of the clinical services provided by Djerriwarrh Health Service.

1.2 Djerriwarrh Health Service has experienced almost a doubling in the number of births at Bacchus Marsh 2006-2013.

1.3 Overall, the perinatal mortality rate, expressed as a gestation standardised perinatal mortality ratio, at Bacchus Marsh is significantly higher than the State average and much higher than would be expected for a "low risk" unit.

1.4 Misuse and/or misinterpretation of fetal surveillance by cardiotocography (CTG) is a recurrent feature of the perinatal deaths reviewed. This suggests that the workforce is inadequately skilled in fetal surveillance.

1.5 Overall, staffing levels are appropriate for the size and capability of the maternity service, but there is inadequate staffing infrastructure supporting midwifery education.

1.6 The lack of out-of-hours/emergency paediatric cover for neonatal resuscitation and care is a likely contributor to poorer than expected outcomes.

1.7 There is a lack of formal expert multidisciplinary perinatal mortality and morbidity review.

1.8 There has been a lack of high quality staff education.

1.9 The clinical governance framework has not enabled the health service to monitor and respond to adverse clinical outcomes in a timely manner.

Recommendations

1.10 All staff, medical and midwifery, should be required to complete formal fetal surveillance education, preferably by the RANZCOG Fetal Surveillance Education Program (FSEP), on an annual basis and be able to demonstrate a Skill Level commensurate with their role.

1.11 DjHS considers purchasing a centralised electronic fetal surveillance system, such as K2, to provide additional oversight of intrapartum fetal surveillance and an alert system.

1.12 DjHS reviews the lack of on-call specialist paediatrics for the maternity service.

1.13 DjHS introduces a regular (eg quarterly), multidisciplinary perinatal mortality and morbidity review meeting involving obstetrics, paediatrics, midwifery, anaesthetics, and clinical quality teams. All perinatal mortality cases should be reviewed and classified. DjHS considers inviting an external expert to be a member of this review meeting.

1.14 DjHS maternity service establishes a regular (weekly or fortnightly) CTG review meeting to underpin and sustain staff training in CTG interpretation.

1.15 DjHS maternity service establishes a regular (weekly) meeting involving midwifery and obstetric staff to discuss and reflect on the clinical activity and outcomes for the week.

1.16 DjHS develops a limited suite of in-house maternity performance indicators to be reported to the Board at a regular interval (eg rate of low Apgar scores, severe perineal trauma rate, PPH rate).

1.17 DjHS introduces a midwifery educator position and reviews midwifery shift handover scheduling to facilitate and support staff education.

1.18 DjHS introduced regular (eg quarterly) multidisciplinary emergency obstetric training, such as either MSEP or PROMPT.

1.19 DjHS further develops its relationships with Western Health (Sunshine Hospital) to provide training grade staff in obstetrics and gynaecology, and paediatrics and senior support for clinical review.

1.20 The Department of Health and Human Services reports the GSPMR on ALL maternity services, irrespective of size.