Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	National Maternity Hospital
Address of healthcare service:	Holles Street Dublin 2 D02 YH21
Type of inspection:	Announced
Date of inspection:	30 and 31 May 2023
Healthcare Service ID:	OSV-0001082
Fieldwork ID:	NS_0042

About the healthcare service

The following information describes the services the hospital provides.

1.0 Model of Hospital and Profile

The National Maternity Hospital (NMH) is one of the largest maternity hospitals in Ireland. It is a public voluntary hospital, managed by a Board of Governors (the Board). NMH is a member of the Ireland East Hospital Group (IEHG)[*] providing healthcare services on behalf of the Health Service Executive (HSE) as per Section 38 of the Health Act 2004, an arrangement that is underpinned by the principles set out in the HSE's national financial regulations.[†]

NMH is the tertiary maternity hospital in IEHG providing a range of maternity, gynaecology and neonatology services, which include community midwifery, anaesthetic services, fetal medicine, fertility treatment, pathology services, maternal medicine, perinatal mental health, urogynaecology and national neonatal transfer services. The hospital's colposcopy service is funded by the National Cancer Screening Service and is one of the largest services in Europe. NMH is also the designated regional hub for the development of assisted fertility services.

NMH provides maternity care pathways in line with the National Maternity Strategy[‡] – supportive care and community midwifery care pathway,[§] assisted care pathway[**]

[*] The Ireland East Hospital Group comprises twelve hospitals. These are the Mater Misericordiae University Hospital; St Vincent's University Hospital; Cappagh National Orthopaedic Hospital; the Royal Victoria Eye and Ear Hospital; the National Maternity Hospital; St Columcille's Hospital, Loughlinstown; St Michael's Hospital, Dún Laoghaire; the Midland Regional Hospital, Mullingar; St Luke's General Hospital, Kilkenny; Wexford General Hospital, Wexford; National Rehabilitation Hospital, Dún Laoghaire and Our Lady's Hospital, Navan. The hospital group's academic partner is University College Dublin (UCD).

[†] The national financial regulations apply to all staff in all divisions, community healthcare organisations and hospital groups where services are provided on behalf of the HSE. This includes permanent, temporary and agency staff. See: https://www.hse.ie/eng/about/who/finance/nfr/nfrb6.pdf.

[‡] *National Maternity Strategy-Creating a Better Future Together 2016-2026* sets out a plan for maternity and neonatal care in Ireland, to ensure its safe, standardised, of high quality and offer a better experience and more choice to women and their families.

[§] The supported care pathway is intended for normal-risk women and babies, with midwives leading and delivering care within a multidisciplinary framework. Responsibility for the co-ordination of a woman's care is assigned to a named Clinical Midwife Manager, and care will be delivered by the community midwifery team, with most antenatal and postnatal care being provided in the community and home settings. The woman, along with her healthcare professional, can choose where to give birth, in an alongside birth centre in the hospital, or at home.

[**] The assisted care pathway is intended for women and babies considered to be at medium risk, and for normal risk women who choose an obstetric service. Responsibility for the co-ordination of a woman's care is assigned to a named obstetrician, and care is provided by obstetricians and midwives, as part of a multidisciplinary team. Care is provided across both the hospital and community, and births take place within a hospital setting in a specialised birth centre.

and specialist care pathway.[††] In 2022 there were 6,815 births at NMH, which when compared to 2020 numbers (7,694), represented a 13% decrease in the number of births. The decrease is consistent with the decreasing birth rate experienced nationally. Nonetheless, NMH is one of the busiest maternity hospitals in the country.

The following information outlines some additional data on the hospital.

Model of Hospital	Maternity
Number of beds	200 inpatient and outpatient beds, including: – 29 antenatal beds – 14-bedded Labour and Birthing Unit – 66 postnatal beds – 18-bedded gynaecology ward – 35 baby cots in the Neonatal Unit.

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare. HIQA carried out a two-day announced inspection at NMH to assess compliance with 11 national standards from the *National Standards for Safer Better Healthcare*. The 11 national standards assessed during the course of the inspection were mapped to the national standards from the *National Standards for Safer Better Maternity Services* (see Appendix 1), which sit within the overarching framework of the *National Standards for Safer Better Healthcare.*

To prepare for this inspection, the inspectors[‡‡] reviewed information, which included previous inspection findings, information submitted by the provider, unsolicited information[§§] and other publically available information.

During the inspection, the inspectors:

- spoke with women who used the maternity services at NMH to ascertain their experiences of receiving care in the hospital

[††] The specialist care pathway for high-risk women and babies is led by a named obstetrician, and is provided by obstetricians and midwives, as part of a multidisciplinary team. Care is, in the main, provided within a hospital setting and births take place in the hospital, in a specialised birth centre.
[‡‡] Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with the *National Standards for Safer Better Healthcare*.
[§§] Unsolicited information is defined as information, which is not requested by HIQA, but is received from people including the public and or people who use healthcare services.

- spoke with staff and management to find out how they planned, delivered and monitored the service provided to women and babies who received maternity care and treatment in NMH
- observed care being delivered in the hospital, interactions with women who were receiving care in NMH and other activities to see if it reflected what women told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what women told inspectors during the inspection.

About the inspection report

A summary of the findings and a description of how NMH performed in relation to compliance with the 11 national standards assessed during inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors at a particular point in time — before, during and after the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that good quality and safe healthcare services are being sustainably provided in NMH. It outlines whether there is appropriate oversight and assurance arrangements in place at NMH and how people who work in NMH are managed and supported to ensure the safe delivery of high-quality care.

2. Quality and safety of the service

This section describes the experiences, care and support women using the healthcare services in NMH receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person centred and safe. It also includes information about the healthcare environment where women and babies receive care. A full list of the 11 national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
30 May 2023	09.00 - 17.00hrs	Denise Lawler	Lead
31 May 2023	09.00 - 15.30hrs	Patricia Hughes	Support
		Danielle Bracken	Support

Information about this inspection

This inspection focused on national standards from five of the eight themes of the *National Standards for Safer Better Healthcare*. These national standards were also mapped to comparative national standards from the *National Standards for Safer Better Maternity Services*.

The inspection focused on four key areas of known harm, these were:

- infection prevention and control
- medication safety
- the deteriorating patient[***] (including sepsis)[†††]
- transitions of care.[‡‡‡]

Over the course of the inspection, the inspection team visited the following clinical areas:

- Early Pregnancy Assessment Unit
- Emergency Room
- Unit 3 (antenatal ward) where pregnant women received care
- Labour and Birthing Unit where women were cared for during labour and birth
- Holles Wing (postnatal ward) where women and babies were cared for after birth
- Operating Theatre Department
- Neonatal Unit.

During the inspection, the inspection team spoke with the following staff at NMH:

- Representatives of the hospital's Executive Management Team:
  - Master
  - Director of Midwifery and Nursing
  - Clinical Director
  - Secretary/General Manager
- Consultant Lead for the Non-Consultant Hospital Doctors (NCHDs)
- A representative from the NCHDs
- Chief Medical Pharmacist
- Operational Assistant Director of Midwifery and Nursing
- Director of Quality, Risk and Patient Safety
- Quality manager

[***] The National Deteriorating Patient Improvement Programme (DPIP) is a priority patient safety programme for the Health Service Executive. Using Early Warning Systems in clinical practice improves recognition and response to signs of patient deterioration. A number of Early Warning Systems, designed to address individual patient needs, are in use in public acute hospitals across Ireland.

[†††] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.

[‡‡‡] Transitions of care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover. World Health Organization. *Transitions of Care. Technical Series on Safer Primary Care*. Geneva: World Health Organization. 2016. Available on line from https://apps.who.int/iris/bitstream/handle/10665/252272/9789241511599-eng.pdf

- Human resource manager
- A representative from each of the following hospital committees:
  - Infection Prevention and Control
  - Medication Safety
  - Antimicrobial Stewardship and Sepsis.

Acknowledgements

HIQA would like to acknowledge the cooperation of NMH's management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank the women who spoke with inspectors about their experiences of the care they received in NMH.

What people who use the healthcare services told inspectors and what inspectors observed in the clinical areas visited

During the inspection, inspectors visited six clinical areas — the emergency room, Early Pregnancy Assessment Unit (EPAU), Unit 3, Labour and Birthing Unit, Holles Wing, Operating Theatre Department and Neonatal Unit.

The emergency room was located on the ground floor of the hospital. It provided care for pregnant and postnatal women who presented to NMH with pregnancy and postnatal related illnesses 24/7. Attendees to the emergency room presented by ambulance, were referred directly by their general practitioner (GP) or self-referred. The emergency room had a total planned capacity of four bays comprising a triage room and three single self-contained cubicles.

NMH's Early Pregnancy Assessment Unit (EPAU) was located in a designated area and comprised nine rooms that supported the provision of specific care required by women experiencing complications in the first 12 weeks of pregnancy. The EPAU operated Monday to Friday from 8.00am to 4.00pm. The unit had a defined inclusion and exclusion criteria and accepted referrals from GPs, from NMH's antenatal booking clinics and NMH's emergency room. The Fetal Medicine Unit (FMU) was part of the EPAU, providing fetal ultrasound and fetal medicine services to women booked for maternity care at NMH. The FMU also provided care to women referred from other maternity hospitals in Ireland. Fetal ultrasound scans were offered to all pregnant women at intervals recommended in the national standards.

Unit 3 was a large 28-bedded ward comprising one 14-bedded multi-occupancy room ('nightingale ward'),[§§§] one three-bedded multi-occupancy room, one four-bedded multi-occupancy room, one five-bedded multi-occupancy room and two single rooms (both with

[§§§] Nightingale ward is of one large room without subdivisions, comprising a large number of beds arranged along the sides of the room.

en-suite bathroom facilities). Unit 3 accommodated women in early labour and or those categorised with a high-risk pregnancy requiring admission for inpatient assessment, monitoring and care. Unit 3 had adequate communal toilet and bathroom facilities for women to use. On the first day of inspection, 26 of the 28 beds were occupied.

The Labour and Birthing Unit had 14 single birthing rooms. Twelve of the 14 rooms had en-suite bathroom facilities. One room had a birthing pool for women opting for immersion in water as a method of pain management during labour. The unit had one positive-pressure ventilation room.[****]

Holles Wing was a large 35-bedded ward comprising five six-bedded multi-occupancy rooms, one three-bedded multi-occupancy room and two single rooms with en-suite bathroom facilities. On the first day of inspection, six of the 35 beds were closed. Holles Wing accommodated postnatal women and babies, and on occasion accommodated pregnant women requiring admission for inpatient assessment, monitoring and care. Holles Wing had adequate communal toilet and bathroom facilities for women to use.

The Neonatal Unit in NMH was a level 3[††††] tertiary unit where the full spectrum of specialised care was provided to critically ill pre-term and term newborn infants. The unit accepted newborns that required complex neonatal care from other maternity units within IEHG and across Ireland. The unit comprised 35 cots — 17 intensive care cots, 12 high dependency cots and six special care baby cots. The unit had negative pressure isolation facilities. The Neonatal Unit provided therapeutic cooling[‡‡‡‡] for infants born in NMH and for infants transferred to the unit from other maternity services across Ireland.

NMH's Operating Theatre Department had been reconfigured and refurbished to address the infrastructural deficiencies identified during previous HIQA inspections in 2015 and 2019, and to bring the department into compliance with relevant international best practice guidelines.[§§§§] The Operating Theatre Department comprised four operating theatres and a four-bedded recovery area. One of these recovery beds was repurposed as a High Dependency Unit bed. On the first day of inspection, three of the four operating theatres

[****] A positive-pressure ventilation room prevents the spread of airborne pathogens. The air pressure in the room is higher than in the patient's room and the adjoining corridors, which remain at neutral pressure ventilation. That prevents air from the corridors entering the isolation room and vice versa. The room functions as an isolation suite as it has ensuite bathroom facilities. The air pressure in the ensuite bathroom is negative in relation to the patient's room. That facilitates air being extracted from the patient's room and filtered in the bathroom before being released outside the hospital.

[††††] The primary function of tertiary neonatal units is to provide specialised care to infants who are critically unwell. Most of the workload is concentrated on very preterm infants, unwell term infants and infants with major congenital malformations.

[‡‡‡‡] Whole body neonatal cooling or therapeutic cooling is 'active' (not passive) cooling administered during the current birth episode as a treatment for hypoxic ischemic encephalopathy. WBNC is only conducted in the four large tertiary hospitals in Dublin and Cork.

[§§§§] Department of Health, United Kingdom. Health Building Note 26: facilities for surgical procedures: Volume 1. [Online]. Available from: https://www.england.nhs.uk/publication/facilities-for-surgical-procedures-in-acute-general-hospitals-hbn-26/.

were operational and the fourth was available and appropriately resourced to manage emergency obstetric cases 24/7.

NMH's High Dependency Unit that was equipped to care for pregnant and postnatal women who required a higher level of observation and or invasive cardiac monitoring. The unit was usually staffed by midwives who have completed additional educational qualifications in high-dependency care. Pregnant and or postnatal women admitted to the High Dependency Unit were reviewed daily, or more frequently depending on their clinical needs by both the consultant obstetricians and consultant anaesthesiologists.

Inspectors spoke with women receiving care in NMH and observed staff interactions with women over the two days of inspection. Inspectors observed staff communicating effectively with women in all clinical areas visited. Staff were also observed actively engaging with women in a respectful and kind way, and taking the time to speak with and listen to women. Staff were focused on ensuring that a woman's individual needs were responded to promptly. This was confirmed by women who spoke with inspectors during the inspection.

Experiences of receiving care, as recounted to inspectors during this inspection, were consistent with the findings from the hospital's 2020 National Maternity Experience Survey,[*****] where the majority of women (84%) who completed the survey had a very good or good experience while attending NMH for maternity care. In general, women were satisfied with the care received and described midwifery, medical and support staff as being *'good, great and supportive', 'lovely and pleasant', 'so approachable and helpful'* and *'exceptional'.* Women felt *'well supported and cared for'* and told inspectors that midwives *'took the time to answer questions'*. Notwithstanding this, some of the women described how *'staff were very busy and under pressure'* and how staff *'had no time to answer patient call bells, especially at night'.* Women were very complimentary about the amount of health promotion information received during and after birth, especially information provided about domestic violence services. With regard to areas for improvement, one women suggested that the anxiety felt by expectant parents awaiting birth by a planned caesarean section could be alleviated somewhat by giving women and their partners an approximate time for the birth.

Women in all the clinical areas visited during inspection were aware of how to make a complaint about the care they received in NMH. They recounted how they and or family members would speak to a member of staff or go to NMH's website to make a complaint. Inspectors observed information on how to provide feedback on care received on display in

[*****] The National Care Experience Programme, is a joint initiative from the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE) and the Department of Health. It was established to ask women about their experiences of care in order to improve the quality of maternity services in Ireland. The National Maternity Experience Survey is a nationwide survey asking patients about their recent experiences in hospital. The purpose of the survey is to learn from women's feedback in order to improve maternity care. The findings of the survey are available at: https://yourexperience.ie/maternity/national-results/.

Holles Wing. However, information on the HSE's *'Your Service, Your Say'*[†††††] and independent advocacy services could be more clearly displayed across the other clinical and public areas in NMH. Inspectors were told that NMH's complaints process was displayed on digital patient screens throughout the hospital.

Overall, the women who spoke with inspectors during inspection were very complimentary about the staff they met, with the level of staff engagement and interaction and with the care received in all the clinical areas visited. Furthermore, there was consistency in what women told inspectors about their experiences of receiving care in NMH and what inspectors observed in the clinical areas visited during inspection.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under four national standards (5.2, 5.5, 5.8 and 6.1) from the two themes of leadership, governance and management and workforce. NMH was found to be compliant with two national standards (5.5, 5.8), substantially compliant with one national standard (5.2) and partially complaint with one national standard (6.1) assessed. Key inspection findings leading to the judgment of compliance with these four national standards are described in the following sections.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

Inspectors found that NMH had integrated corporate and clinical governance arrangements in place, with clearly defined responsibilities and accountability arrangements. These governance arrangements were effective and efficient, and there was appropriate oversight of the quality and safety of healthcare services provided at NMH. Organisational charts submitted to HIQA detailed the direct reporting arrangements of various governance and oversight committees to hospital management. They also outlined the hospital management's reporting arrangements to the Executive Committee of NMH's Board and the Chief Executive Officer (CEO) of IEHG. These corporate governance arrangements were consistent with what inspectors found during inspection.

Maternity Network

Since HIQA's last inspection in 2019, hospital management at NMH had progressed a collaborative and integrated approach to the delivery of maternity, gynaecology and

[†††††] Health Service Executive. *Your Service Your Say. The Management of Service User Feedback for Comment's, Compliments and Complaints*. Dublin: Health Service Executive. 2017. Available online from: https://www.hse.ie/eng/about/who/complaints/ysysguidance/ysys2017.pdf.

neonatal services with the other three co-located maternity units in IEHG — St Luke's General Hospital, Kilkenny, Wexford General Hospital and Regional Hospital Mullingar. However, this collaborative approach was not formalised within a clinical maternity network under a single governance structure, as per the National Maternity Strategy.

Inspectors were informed that NMH and IEHG were developing a clinical maternity network, using a hub and spoke model. The collaborative and integrative working arrangements between the maternity services in IEHG were functional and it was clear that there was progression in establishing the clinical maternity network since HIQA's previous inspection. However, the arrangements were not fully developed or aligned with the characteristics of a clinical maternity network as outlined in the National Maternity Strategy. The following collaborative arrangements had been established:

- network huddles every two weeks
- a dedicated IEHG Women and Neonates Serious Incident Management Forum (SIMF) that met every month
- quarterly educational meetings for the clinical maternity network with attendance by the HSE's National Women and Infants Health Programme (NWIHP)
- three joint consultant obstetrician appointments between NMH and the Regional Hospital Mullingar. There were several other consultant obstetrician collaborations, with a no refusal policy in the following areas:
  - maternal medicine
  - fetal medicine
  - genetics
  - in-utero transfer for prematurity
  - neonatal transfers for therapeutic hypothermia
  - placenta accreta
- NMH were in the process of appointing a third perinatal pathologist. When appointed, this will provide a comprehensive perinatal pathology service across IEHG's clinical maternity network.

At the time of inspection, others characteristics of a clinical maternity network, were not fully in place. There was no:

- joint appointments of consultant neonatologists working across the four maternity services in IEHG
- rotation of medical and midwifery and nursing staff between all four maternity services in IEHG. While this is recognised as good practice to assist health professionals maintain clinical skills and competence, there was no contractual arrangement to allow midwifery and medical staff to rotate from one hospital to another outside the training posts for medical students on basic and higher specialty training programmes
- formalised care pathways underpinning the transfer of women with complex high-risk pregnancies from the co-located maternity units in IEHG to NMH for more specialist care. Inspectors were told that women and infants from the three co-located

maternity units in IEHG were prioritised for admission to NMH. Notably, NMH was a national tertiary referral centre, therefore women and infants from all over Ireland were transferred to NMH for specialist care.

Inspectors found there were clear and defined lines of accountability with devolved autonomy and decision-making for maternity, gynaecology and neonatal services at NMH. There were also defined systems in place to hold staff in management to account for their area of responsibility. It was clear to inspectors that the Master was the accountable officer with overall responsibility and accountability for the governance of healthcare services provided in NMH. Inspectors found the Master, supported by the Executive Management Team (EMT), had appropriate oversight of the quality and safety of healthcare services provided at NMH and that the Master had defined reporting arrangements to NMH's Board and to the CEO of IEHG.

Executive Management Team

NMH's EMT was the senior executive decision-making team with responsibility for ensuring oversight of the clinical and corporate management arrangements, assuring the quality and safety of and implementing the strategic plans for healthcare services provided at NMH. Inspectors found the EMT functioned effectively and efficiently, in line with its terms of reference, and had appropriate oversight of the effectiveness of maternity, gynaecology and neonatal services provided in NMH. Documentation reviewed by inspectors and meetings with staff during inspection confirmed that the EMT met weekly and membership comprised the Master, the secretary general manager, the director of midwifery and nursing (DOMN). Other relevant senior managers attended and presented at meetings of the EMT as requested. The EMT reported on NMH's activity and performance against defined national performance indicators to the CEO of IEHG monthly and the relevant quality subcommittee of NMH's Board — Quality, Risk and Patient Safety Committee. Minutes of meetings of the EMT and performance meetings between NMH and IEHG reviewed by inspectors were comprehensive, action-orientated and it was evident that the implementation of agreed actions were monitored from meeting to meeting. It was also obvious from the minutes of these meetings that there was a proactive approach to supporting and resourcing the implementation of measures to enable the effective delivery of high-quality, safe healthcare services at NMH.

Clinical Governance Executive Committee

On the days of inspection, there was evidence of strong executive, clinical and midwifery and nursing leadership at NMH who had good operational grip. Clinical governance at the hospital was led by the Master, who was also the clinical lead for obstetrics and gynaecology. The delivery of maternity, gynaecology and neonatal care in NMH was facilitated and overseen by eight care groups, as set out below:

- antenatal, inpatient and outpatient/emergency room/FAU group
- labour/delivery group

- postnatal inpatient and outpatient group
- theatre/anaesthetic/adult resuscitation group
- gynaecology/inpatient and outpatient group
- gynae-oncology group
- neonatal/neonatal resuscitation group
- Maternal and Newborn Clinical Management System (MN-CMS) group.

All eight care groups had a defined reporting arrangement with the Clinical Governance Executive Committee (CGEC). The CGEC was responsible for driving and implementing the quality, risk and patient safety strategy in NMH. Inspectors found the CGEC functioned effectively and efficiently, in line with the committee's terms of reference. Minutes of meetings of the CGEC reviewed by inspectors were comprehensive and confirmed that the committee had appropriate oversight of the effectiveness of NMH's clinical governance structures, the management of corporate risks, auditing activity, feedback from women and their families, occurrence and management of patient-safety incidents and staff attendance at essential and mandatory education and training. Chaired by the Master, the CGEC met monthly and membership comprised senior executives with clinical representation from the different health professions and clinical departments in NMH. The CGEC reported and was operationally accountable to the hospital's EMT.

Quality, Risk, Health and Safety Committee

Inspectors found the NMH's Quality, Risk, Health and Safety Committee (QRHSC) functioned effectively and efficiently, in line with its terms of reference. The committee provided assurances on the quality and safety of services provided at NMH to the EMT. Chaired by NMH's secretary general manager, the QRHSC met monthly and membership comprised senior executives with clinical representation from the different health professions and clinical departments in NMH. The QRHSC delegated elements of its assigned responsibility and function in the areas of hygiene to a subcommittee. This subcommittee had a defined and formalised reporting arrangement to QRHSC monthly. Minutes of meetings of the QRHSC reviewed by inspectors were comprehensive and showed that the committee had appropriate oversight of the quality and safety of healthcare services, the management of clinical risks and infection prevention and control practices in NMH. Minutes of meetings also showed that the implementation of agreed actions were progressed from meeting to meeting. The QRHSC reported and was operationally accountable to the CGEC and EMT.

At operational level, HIQA was satisfied that there were clear lines of devolved responsibility and accountability for three of the four areas of known harm — infection prevention and control, medication safety and deteriorating patient. At the time of inspection, the following three committees were in place:

- Infection Prevention and Control Committee (IPCC)
- Drugs and Therapeutics Committee (DTC)

- Sepsis and Irish Maternity Early Warning System (IMEWS)[‡‡‡‡‡]/Irish National Early Warning System (INEWS)[§§§§§] Committee.

All three committees reported and were operationally accountable to the CGEC. NMH did not have a Bed Management and or Discharge Committee that oversaw the safe transitions of care for women and babies within and outside NMH. Data on scheduled and unscheduled care activity and inpatient bed capacity was discussed at monthly meetings of the CGEC and monthly performance meetings between NMH and IEHG.

Infection Prevention and Control Committee

Inspectors found NMH had a well-established multidisciplinary IPCC that functioned effectively and efficiently, in line with its terms of reference. The IPCC delegated elements of its assigned responsibility and function in the area of decontamination to a steering group. The steering group had a defined accountability and reporting arrangement to the IPCC. Comprehensive minutes of meetings of the IPCC reviewed by inspectors and meetings with staff during this inspection confirmed that the IPCC had appropriate oversight of NMH's compliance with defined infection prevention and control performance indicators and standards, the management of infection prevention and control risks and patient-safety incidents, audit activity and the implementation of quality improvement initiatives to improve infection prevention and control practices in NMH. Chaired by NMH's secretary general manager, the IPCC met four times a year. The IPCC reported and was operationally accountable to the CGEC and EMT.

Drugs and Therapeutics Committee

Inspectors found NMH had a well-established multidisciplinary DTC that functioned effectively and efficiently, in line with its terms of reference. The DTC delegated elements of its assigned responsibility and function in the areas of medical devices and medication safety to subcommittees, which had defined accountability and reporting arrangements to the DTC. Comprehensive minutes of meetings of the DTC reviewed by inspectors and meetings with staff during this inspection confirmed that the DTC had appropriate oversight of the implementation of NMH's medication safety strategy and related workplan, and antimicrobial stewardship programme.[******] Chaired by the Master, the DTC met four times a year. The DTC reported and was operationally accountable to the CGEC and EMT.

Medication Safety Committee

NMH's multidisciplinary Medication Safety Committee (MSC) was a subcommittee of the DTC. Comprehensive minutes of meetings of the MSC reviewed by inspectors and meetings with

[‡‡‡‡‡] Irish Maternity Early Warning System (IMEWS) is for use in all cases during pregnancy and during the first 42 days after the end of pregnancy irrespective of the gestation and irrespective of the presenting condition of the person.
[§§§§§] Irish National Early Warning System (INEWS) is an early warning system to assist staff to recognise and respond to clinical deterioration.
[******] An antimicrobial stewardship programme – refers to the structures, systems and processes that a service has in place for safe and effective antimicrobial use.

staff during this inspection confirmed that the MSC was functioning effectively, in line with its terms of reference. Inspectors found that the MSC was effective in ensuring safe medication practices at NMH through the implementation of the hospital's medication safety strategy and related workplan. The MSC reported on the progress in implementing the medication safety strategy to the DTC.

Sepsis and IMEWS/INEWS Committee

NMH had a multidisciplinary Sepsis and IMEWS/INEWS Committee. Minutes of meetings of the committee reviewed by inspectors and meetings with staff during this inspection confirmed that the committee was functioning effectively, in line with its terms of reference. It was evident that the committee had appropriate oversight of the implementation of national clinical guidance on sepsis management, IMEWS and INEWS at NMH. The committee reported to and was operationally accountable to the CGEC.

In summary, inspectors found effective and robust integrated corporate and clinical governance arrangements with clearly defined reporting structures, responsibilities and accountability arrangements were in place at NMH. Notwithstanding these arrangements, a formalised clinical maternity network, was not fully established and implemented as recommended in the National Maternity Strategy, but there was significant progress in advancing the clinical maternity network since HIQA's last inspection in 2019. Arrangements characteristic of a clinical maternity network, such as joint appointments in the specialties of anaesthesiology or neonatology or paediatrics across the maternity services in IEHG were not in place. IEHG, together with NMH senior management and the HSE's NWIHP, should continue to prioritise and progress the full implementation of the clinical maternity network.

Judgment: Substantially compliant

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services.

Inspectors found there were effective and efficient management arrangements in place to support the delivery of safe, high-quality and reliable healthcare services in NMH. The DOMN was responsible for the organisation and management of nursing and midwifery services at NMH. The DOMN was a member of the EMT, reporting to the Master. The DOMN also had a close working relationship with the chief director of nursing and midwifery for IEHG. In addition, in line with the national standards, NMH had designated clinical leads in the specialties of obstetrics, neonatology and anaesthesiology appointed on a rotational basis who provided clinical leadership and were responsible for the organisation and management of healthcare services within their specialty.

Findings relating to the emergency room

NMH's emergency room was the point of entry into the hospital for pregnant and postnatal women requiring unscheduled or emergency care during pregnancy and after birth. Inspectors found that NMH had appropriate systems and processes in place to support the effective functioning of the emergency room and to manage the demand for emergency care at NMH. Operational governance and oversight of the day-to-day workings of the emergency room during and outside core working hours was the responsibility of the on-call consultant obstetrician and gynaecologist. During this inspection, the emergency room was functioning well providing timely triage, medical review and assessment of women who presented for care. The emergency room had a reported average daily attendance rate of 35 to 45 women, representing an annual attendance rate of over 12,000 women.

At 11.00am on the first day of inspection, seven women were receiving care in the emergency room. Waiting times for triage and medical review were as follows:

- registration to triage waiting times ranged from 15 minutes to 1 hour 25 minutes
- triage to medical assessment waiting times averaged 60 minutes.

Findings relating to the wider hospital and clinical areas visited

Inspectors found effective management arrangements with defined lines of responsibility and accountability and devolved autonomy and decision-making were in place across NMH, which supported the effective and efficient management of healthcare services at the hospital.

Infection, prevention and control

The hospital's multidisciplinary infection prevention and control team were assigned with the responsibility for the day-to-day operational implementation of NMH's infection prevention and control plan.[††††††] The team comprised:

- 1 whole-time equivalent (WTE)[‡‡‡‡‡‡] consultant microbiologist who had a joint appointment between NMH and the Royal Victoria Eye and Ear Hospital. Clinical staff in NMH had access to a consultant microbiologist 24/7
- 1 WTE assistant director of midwifery (ADOM)
- 1 WTE Clinical Midwife Manager, grade 2 (CMM 2) in infection prevention and control
- 1 WTE antimicrobial pharmacist
- 1 WTE surveillance scientist
- 1 NCHD in microbiology at registrar grade

[††††††] An agreed infection prevention and control programme as outlined in the *National Standards for the Prevention and Control of Healthcare-Associated Infections in Acute Healthcare Services* (2017), sets out clear strategic direction for the delivery of the objectives of the programme in short-, medium- and long-term, as appropriate to the needs of the service.

[‡‡‡‡‡‡] Whole-time equivalent (WTE) is the number of hours worked part-time by a staff member or staff member(s) compared to the normal full time hours for that role.

- 0.5 WTE administrative support.

Implementation of NMH's infection prevention and control plan was appropriately monitored and overseen by the IPCC and the CGEC. The comprehensive infection prevention and control annual report for 2022 reviewed by inspectors detailed NMH's performance with infection prevention and control surveillance monitoring — *Clostridioides difficile* infection, *Carbapenemase-Producing Enterobacterales* (CPE) *Staphylococcus aureus* blood stream infections, *Vancomycin Resistant Enterococcus* (VRE), *Antibiotic Resistant Enterobacterales, Methicillin-resistant Staphylococcus aureus* (MRSA) — antimicrobial stewardship monitoring, audit activity, policy, procedures and guideline updates, staff education and training and quality improvement initiatives implemented in 2022 to improve infection prevention and control practices at NMH.

Medication safety

NMH did not have a comprehensive clinical pharmacy service for adults,[§§§§§§] but there was a comprehensive clinical pharmacy service for neonates. The clinical pharmacy service at NMH was primarily dispensary-based. Pharmacist-led medication reconciliation was carried out on women and babies categorised as high priority using clearly defined criteria with a focus on antimicrobial stewardship, women who attended the maternal medicines clinic, and women who met NMH's criteria for high priority. NMH was approved and funded for 7.4 WTE pharmacy staff. At the time of inspection, all of these positions were filled as follows:

- 4.8 WTE pharmacists, which included a chief pharmacist (1 WTE), 0.8 WTE senior grade pharmacist for medication safety and informatics, 1 WTE senior grade antimicrobial pharmacist, 1 WTE senior grade neonatal pharmacist and 1 WTE senior grade pharmacist for maternal medicine
- 2.6 WTE pharmacy technicians — all pharmacy technician positions were filled at the time of inspection.

Deteriorating patient

NMH had implemented the appropriate national early warning systems for the various cohorts of women — IMEWS (version 2) for pregnant and or postnatal women and INEWS (version 2) for non-pregnant patients receiving care in NMH. Clinical skills facilitators ensured that staff received training in the use of and escalation protocols for all the early warning systems used in NMH. The NMH had adopted the HSE's guidance for monitoring fetal heart rate during labour and birth. Compliance with this guideline was audited and recommendations made to ensure NMH came into full compliance with the national guidance.

[§§§§§§] A clinical pharmacy service is a service provided by a qualified pharmacist which promotes and supports rational, safe and appropriate medication usage in the clinical setting.

Transitions of care

Transitions of care incorporates internal transfers within NMH, shift and interdepartmental handovers, and the external transfer and discharge of women and babies from NMH. Internal transitions of care at NMH comprised the transfer of women and or babies to and from the:

- different care pathways based on a woman's risk categorisation — supported, assisted or specialist
- Labour and Birthing Unit
- High Dependency Unit
- Neonatal Unit
- Early Transfer Home (ETH)******* care pathway
- Domiciliary Care In and Out of Hospital (DOMINO)††††††† care pathway.

External transitions of care from NMH usually comprised the transfer of pregnant and or postnatal women to the Intensive Care Unit (ICU) in St Vincent's University Hospital (SVUH), when their clinical condition required it. As a tertiary referral hospital, NMH also received maternal and neonatal transfers from other maternity units within and outside IEHG. The number of transfers into and from NMH were reported monthly as part of the HSE's reporting requirements — Irish Maternity Indicator System‡‡‡‡‡‡‡ and Maternity Safety Statements,§§§§§§§ and these numbers were reviewed at monthly meetings of the CGEC. An ADOM, had oversight of the issues contributing to and impacting on the safe transfer of care for women and babies within and from NMH. However, the safe transfer of women and babies from and to NMH was not underpinned by a formally ratified inter-hospital transfer policy. This should be an area of focused improvement following this inspection.

Overall, inspectors found defined, responsive and reactive management arrangements were in place at NMH to manage, support and oversee the delivery of high-quality, safe and reliable healthcare services in NMH. It was clear that the executive management team had effective and efficient operational grip and there were defined lines of responsibility and accountability with devolved autonomy and decision-making for the governance and

******* Early Transfer Home care pathway comprises a team of midwives who provide postnatal care, support and advice in the woman's own home for women living in specific geographic areas within the population catchment for the National maternity Hospital. Women wishing to avail of this service may leave hospital 12-36 hours following the birth of their baby.

††††††† The Domiciliary Care In and Out of Hospital (Domino) care pathway allows the midwife and or GP to monitor the woman throughout her pregnancy, for the midwife to support the woman when attending the hospital for labour and birth, and for the midwife to provide care for the woman and baby after birth at home. The pathway supports continuity of care, facilitates a hospital-based birth and provides an early return home from hospital.

‡‡‡‡‡‡‡ This Irish Maternity Indicator System encompasses a range of multidisciplinary metrics, including hospital management activities, deliveries, serious obstetric events, neonatal, and laboratory metrics. It provides within hospital tracking of both monthly and annual data. It also provides national comparisons across all maternity units, allowing hospitals to benchmark themselves against national average rates and over time.

§§§§§§§ The Maternity Safety Statement contains information on 17 metrics covering a range of clinical activities, major obstetric events, modes of delivery and clinical incidents.

management of healthcare services at NMH. Appropriate and effective arrangements were in place to address increases or decreases in demand for healthcare services and ensure the safety and quality of care provided to women and their babies in NMH 24/7.

Judgment: Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

Inspectors found NMH had systematic monitoring arrangements in place for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services provided at the hospital. Information on a range of different clinical data related to the quality and safety of healthcare services was collected, collated and published, in line with the HSE's reporting requirements — Maternity Safety Statements and Irish Maternity Indicator System. Performance data was also submitted to the National Perinatal Epidemiology Centre (NPEC)******** and Vermont Oxford Network.†††††††† Collated performance data was reviewed at monthly meetings of the CGEC and monthly performance meetings between the NMH and IEHG.

Risk management

Inspectors were satisfied that NMH had an overarching risk management framework with formalised structures and processes to proactively identify, analyse, manage and minimise risks to women and babies. Risks were identified and managed at local clinical area level and escalated to the EMT when required. Staff who spoke with inspectors and relevant documents reviewed by inspectors confirmed that CMMs were responsible for identifying and implementing controls to mitigate any potential and actual risks to patient safety. Risks identified at local clinical area level were recorded on local risk registers in NMH's electronic risk management system. More serious high-rated risks not managed at clinical area level were escalated to the EMT and recorded on NMH's corporate risk register. High-rated risks not managed at EMT level were escalated to NMH's Board and discussed at the monthly performance meetings between NMH and IEHG.

Audit activity

Inspectors were satisfied there was a strong culture of auditing in NMH and there was a coordinated and targeted approach when conducting clinical audits. A multidisciplinary audit steering group coordinated and oversaw all clinical audit activity and the implementation of

******** The National Perinatal Epidemiology Centre conducts ongoing national audits of perinatal mortality, maternal morbidity and home births in Ireland.

†††††††† The Vermont Oxford Network is a voluntary collaborative group of health professionals committed to improving the effectiveness and efficiency of medical care for newborn infants and their families through a coordinated programme of research, education, and quality improvement projects.

resulting quality improvement initiatives at NMH. The audit steering group reported and was operationally accountable to the CGEC. Relevant governance committees — the CGEC, IPCC, MSC and Sepsis and IMEWS/INEWS Committee — had oversight of the majority of clinical audits and corresponding findings, and initiatives implemented to address any identified shortfalls in care.

Oversight of serious reportable events and patient-safety incidents

Inspectors were satisfied there was effective and efficient oversight of the reporting and management of serious reportable events, serious incidents and patient-safety incidents that occurred in NMH. NMH reported nine serious reportable events in 2022. NMH's Women and Neonate Serious Incident Management Forum (WaN-SIMF) was responsible for ensuring that all serious reportable events, serious incidents and patient-safety incidents were managed in line with the HSE's Incident Management Framework and for the timely implementation of recommendations from reviews of serious reportable events, serious incidents and patient-safety incidents. Chaired by the Master, the WaN-SIMF met monthly and membership included appropriate clinical and executive management team representatives from NMH and IEHG. The WaN-SIMF reported and was operationally accountable through the CGEC to the EMT and the relevant quality subcommittee of NMH's Board — Quality, Risk and Patient Safety Committee. The WaN-SIMF submitted a report to the CGEC quarterly and a summary of the incidents and decisions from the WaN-SIMF was presented at monthly meetings of the IEHG's Women and Neonate's SIMF, which was chaired by IEHG's director for women and neonates' services. Learnings from serious reportable events, serious incidents and patient-safety incidents were shared with clinical staff in NMH at clinical handover and multidisciplinary safety huddles, and the HSE and other maternity services, as appropriate.

Perinatal morbidity and mortality multidisciplinary meetings

Inspectors were satisfied that multidisciplinary perinatal mortality and morbidity meetings were held every week in NMH with attendance from medical, midwifery and nursing staff. NMH's compliance with defined quality and safety indicators were reviewed, discussed and compared with similar data from other similar sized maternity services at these meetings. Learnings from perinatal mortality and morbidity meetings were shared with clinical staff in NMH at clinical handover, safety huddles and Grand Rounds.[‡‡‡‡‡‡‡‡] There was also evidence that other multidisciplinary meetings relating to maternal high-risk, oncology, fetal medicine, placenta accreta,[§§§§§§§§] birth and delivery, neonatal and radiology and colposcopy/pathology were held at NMH. Any learnings from these meetings were also shared with clinical staff at safety huddles and Grand Rounds.

[‡‡‡‡‡‡‡‡] A formal meeting where physicians discuss the clinical case of one or more patients.
[§§§§§§§§] Placenta accreta (and the more severe forms increta or percreta) is a serious pregnancy condition that occurs when the placenta grows too deeply into the uterus; also known as abnormally adherent placenta. The management of abnormally adherent placenta requires specialist multidisciplinary care.

Feedback from women using the maternity services

Inspectors found there were appropriate structures in place in NMH, underpinned by a formalised policy, to seek feedback from women who received care at the hospital. A secure patient feedback form was available on NMH's website for women and their families to provide feedback. The hospital also had an established forum — NMH's Patient Voice Group — that met every two months and provided feedback on the care received in NMH. Feedback from women and or families, and findings from the hospital's 2020 National Maternity Experience Survey were discussed at meetings of the CGEC. At the time of inspection, hospital management were working with the HSE to implement a number of time-bound quality improvement initiatives to improve the quality of care and services provided at NMH. These included, improving:

- access to antenatal educational classes
- women's involvement in decision-making during labour and birth
- opportunities for women to debrief after birth
- support and help with infant feeding
- emotional support for parents whose babies were in the Neonatal Unit.

Overall, inspectors found effective, robust and systematic monitoring arrangements were in place to identify and act on opportunities to continually drive improvements in the quality, safety and reliability of healthcare services at NMH. There were also effective and robust systems and processes in place to identify, manage and minimise risks to women and babies using the healthcare services at NMH. Hospital management were implementing a number of quality improvement initiatives to improve the quality of care and services provided at NMH.

Judgment: Compliant

Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare.

Inspectors found that NMH had appropriate arrangements in place to support and promote the delivery of high-quality, safe and reliable healthcare services. Notwithstanding this, there were a number of unfilled positions across a number of professions at NMH. Staffing shortfalls and the controls implemented to mitigate the effect of such shortfalls was a medium-rated risk recorded on NMH's corporate risk register. Workforce was also a standing agenda item for the monthly meeting between NMH and IEHG. While not a standing agenda item for meetings of NMH's EMT, it was evident from minutes of EMT meetings, reviewed by inspectors that human resource management was considered by the EMT.

Medical workforce

NMH was staffed with medical staff in the specialties of obstetrics, anaesthesiology and neonatology who were available onsite to provide care to women and newborns 24/7. The

hospital had an approved funding for a total of 52 WTE medical consultants across a range of specialties. Nine (17%) WTE of the approved and funded medical consultant positions across a range of specialties, were unfilled at the time of inspection. Inspectors were told that recruitment campaigns were being progressed to fill six of the nine unfilled consultant posts. Offers of employment had been made for two of the remaining three unfilled positions and funding was pending from the HSE for one medical consultant post. All permanent consultants were on the relevant specialist division of the register with the Irish Medical Council. Medical consultant staff were supported by 68 WTE NCHDs at registrar, Senior House Officer (SHO) and intern grades providing medical cover 24/7. Four (6%) WTE of the 68 WTE NCHD positions were unfilled at the time of inspection.

A consultant obstetrician provided clinical oversight of the care provided in the Labour and Birthing Unit 24/7. A consultant obstetrician was rostered to be in attendance in the Labour and Birthing Unit during core working hours Monday to Thursday and was free from other duties during these sessions. The consultant on call for the weekend provided consultant cover for Labour and Birthing Unit on Fridays and over the weekend. A rota of two NCHDs in obstetrics, one at registrar and one at SHO grade provided medical cover in the Labour and Birthing Unit and antenatal ward 24/7. In addition, two NCHDs in obstetrics at SHO grade were assigned to the emergency room 24/7. Two on call NCHDs in obstetrics at registrar grade provided medical advice and care for women who required review in the emergency room. A consultant obstetrician provided clinical oversight of the care provided in the emergency room 24/7.

The hospital were funded for a total of 93 WTE health and social care professionals (HSCPs) across a range of specialties. Fifteen (16%) WTE of the approved and funded HSCP positions were unfilled at the time of inspection. Inspectors were told that recruitment campaigns were underway to fill 14 of the 15 WTE unfilled HSCP positions.

Midwifery and nursing workforce

NMH was benchmarked for midwifery staffing in line with the HSE's Midwifery Workforce Planning Project. NMH were funded for a total of 450 WTE midwives and nurses (inclusive of management and other grades). Thirty-six (8%) WTE — 10 WTE permanent and 26 WTE temporary positions — of the funded midwifery and nursing staff positions were unfilled at the time of inspection. Hospital management were trying to fill the 36 WTE unfilled positions through continuous recruitment campaigns, agency staff and NMH's staff working additional time.

Shortfalls in the funded midwifery and nursing staff positions was evident in Unit 3 and the Labour and Birthing Unit (combined unfilled rate of 21%) and Holles Wing (6.6%). Notwithstanding this, priority was given to enabling the provision of midwifery one-to-one support********* for women in labour. The week before HIQA's inspection, NMH had

********* A woman in labour is cared for by a midwife who is assigned and looking after just her – this is called 'one-to-one care'. One-to-one care aims to ensure that the woman has a good experience of care and reduces the likelihood of problems for her and her baby. See:

introduced a tool in the Labour and Birthing Unit to assess and ensure the unit had the adequate and required level of staffing to safely meet the needs of women birthing their babies. This tool enabled the unit's staffing levels to be determined in real time, based on the assessment of women's needs during their episode of care. The true benefits of the tool were yet to be realised, but this will come when the tool is implemented across all clinical areas in NMH. Staff who spoke with inspectors confirmed that midwifery staff rotated through the antenatal ward and Labour and Birthing Unit, and postnatal ward and this facilitated midwifery staff to maintain clinical competence and skills. It was clear from staff who spoke with inspectors that, despite the shortfall in staffing levels, midwifery and nursing staff were not asked to work outside their scope of practice.

The Neonatal Unit had an approved funding for 72 WTE nursing positions (inclusive of management and other grades). At the time of inspection, 83 WTE (above funded complement) positions were filled. This enabled the care provided in the Neonatal Unit to align with the nurse:patient ratios recommended British Association of Perineal Medicine (BAPM) framework.[††††††††]

Midwifery and nursing staff in NMH were supported by maternity care assistants (MCAs). NMH had an approved funding for 52 WTE MCAs. During inspection, 13% of the approved and funded MCAs' positions were unfilled. It was difficult to quantify the specific impact that the staffing shortfalls had on care delivered in the inpatient clinical areas visited during inspection. The proportion of care delayed, unfinished or omitted as a consequence of the shortfall between the approved and funded, and actual filled midwifery and nursing, and MCA staff positions was not formally measured in NMH.

Staff training and education

NMH had a central mechanism to record staff uptake of essential and mandatory training across NMH. Attendance at essential and mandatory training by NCHDs was recorded on the National Employment Record (NER) system.[‡‡‡‡‡‡‡‡] Midwifery and nursing, medical and support staff who spoke with inspectors confirmed that they had received formal induction training on commencement of employment in NMH. Midwifery and nursing staff were required to complete essential and mandatory training in infection prevention and control, medication safety and the early warning systems on the HSE's online learning and training

https://www.nice.org.uk/guidance/qs105/chapter/quality-statement-2-one-to-one-care#:~:text=A%20woman%20in%20labour%20is,for%20her%20and%20her%20baby.

[††††††††] The British Association of Perineal Medicine (BAPM) framework provides guidance on the optimal size and activity levels of Neonatal Intensive Care Units (NICUs) in the UK and medical staffing. See: https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021#:~:text=This%20framework%20provides%20guidance%20on,the%20updated%20version%20in%202021.

[‡‡‡‡‡‡‡‡] The National Employment Record is a national system for recording non-consultant hospital doctor paperwork, including evidence of training. The system was designed to minimise repetitive paperwork requirements for non-consultant hospital doctors and eliminate duplication when rotating between employers.

portal (HSELanD). Midwifery and nursing staff attendance at essential and mandatory training was monitored at clinical area level by CMMs.

Training records reviewed by inspectors showed that the uptake of essential and mandatory training in fetal monitoring and early warning systems was satisfactory. However, training in relation to hand hygiene, obstetric emergencies including sepsis management (PROMPT),§§§§§§§§§ and neonatal resuscitation should be an area of focused improvement following this inspection. This was recognised by hospital management during inspection who confirmed to inspectors that there was a plan to improve staff attendance at mandatory training.

In 2022, the hospital's staff absenteeism rate was 4.78% (3.41% non-COVID-19 and 1.37% COVID-19), which was marginally higher that the HSE's target of ≤4%. The staff absenteeism rate in May 2023 was 5% (4.7% non-COVID-19 and 0.3% COVID-19). Occupational services, including an Employee Assistance Programme, were available for NMH staff and staff who spoke with inspectors were aware of these support services.

In summary, over the course of the inspection, there were staffing arrangements in place to provide baseline levels of healthcare services safely in NMH. However over time, running services with the staffing shortfalls identified in this inspection report will have an impact on service sustainability and staff retention. Hospital management need to be further supported by IEHG and national HSE in their efforts to address ongoing staffing shortfalls across professions in NMH. Hospital management should also ensure that all clinical staff undertake training appropriate to their scope of practice at the required frequency, in line with national standards.

Judgment: Partially compliant

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under seven national standards (1.6, 1.7, 1.8, 2.7, 2.8, 3.1 and 3.3) from the three themes of person-centred care and support, effective care and support, and safe care and support. NMH was found to be compliant with five national standards (1.7, 1.8, 2.8, 3.1, 3.3), substantially compliant with one national standard (1.6) and partially complaint with one national standard (2.7) assessed. Key inspection findings informing judgments on compliance with these seven national standards are described in the following sections.

§§§§§§§§§ The Practical Obstetric Multi-Professional Training (PROMPT) course is an evidence-based training package that teaches healthcare professionals how to respond to obstetric emergencies.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.
Inspectors observed staff in all the clinical areas visited promoting a person-centred approach to care. Staff promoted and protected the privacy and dignity of women when providing care. Staff were also observed actively engaging and communicating with women in an empathetic, compassionate, respectful and kind way. Women receiving care in the emergency room were accommodated in single cubicles, which facilitated and enabled the meaningful promotion of the woman's privacy, dignity and confidentiality, and was consistent with the human rights-based approach to care promoted by HIQA. In general, the physical environment in the inpatient clinical areas visited also promoted women's privacy, dignity and confidentiality. Privacy curtains were used when women were receiving care in multi-occupancy rooms. However, within the context of a shared environment, privacy curtains did not support the effective promotion of confidentiality and privacy when discussing individualised care and treatment with women. Inspectors observed staff in the clinical areas being responsive and attentive to the woman's individual needs in a respectful, cordial way, while taking account of a woman's preference and choices. Staff were observed assisting with baby care and infant feeding, and personal care when needed. Women who spoke with inspectors confirmed that they had received information on infant feeding including supports available when discharged home. Inspectors found evidence of a number of person-centred initiatives in place to support autonomous decision-making and choice for women accessing healthcare services in NMH. This included initiatives such as water immersion for pain management during birth, Labour Hopscotch********** birthing tool, different care pathways that align with those in the National Maternity Strategy and specialist and support clinics to support women after birth. The following clinics were available to women: ▪ a postnatal clinic for women who had complications during or after the birth of their babies. Women could be referred to this clinic by their GPs, public health nurses (PHNs) and or other hospitals ▪ a perineal clinic where women who sustained obstetric anal sphincter injuries†††††††††† were reviewed after birth

********** Labour Hopscotch is a visual birthing tool designed to aid women in active labour and birth. Providing structured guidance by outlining 20-minute rotating "steps" to perform during labour. These include keeping mobile by walking sideways on a stairs, or sitting on a stool while being massaged.

†††††††††† Many women experience tears to the vaginal and perineum during childbirth. Obstetric anal sphincter injuries are also known as third and fourth degree perineal tears. These types of tears usually occur unexpectedly during childbirth and it is not possible to predict these types of tears. These are tears that involve the muscle (the anal sphincter) that controls the anus, known as a third degree tear. If the tear extends into the lining of the anus or rectum, it is known as a fourth degree tear.

- a postnatal debriefing clinic for women who experienced a birth complicated by shoulder dystocia‡‡‡‡‡‡‡‡‡‡ and or any other traumatic birth
- consultant-led bereavement clinics provided follow-up care for couples who experienced pregnancy loss through miscarriage and stillbirth.

HIQA's findings were consistent with the overall findings from the 2020 National Maternity Experience Survey, where NMH scored above the national score in questions relating to women's involvement in decision-making and being treated with respect and dignity. Notwithstanding this, areas for improvement were identified during this inspection. The physical environment, in particular the use of multi-occupancy rooms did not always promote women's privacy and confidentiality. Notably, quality improvement initiatives were being implemented at the time of inspection, to further improve women's experiences of receiving care in NMH.

Judgment: Substantially compliant

Standard 1.7: Service providers promote a culture of kindness, consideration and respect.

Inspectors observed staff to be pleasant, respectful, kind and caring towards women in all the clinical areas visited during inspection. In general, staff were observed actively listening to and effectively communicating with women in an open and sensitive manner, in line with the woman's expressed needs and preferences. This was confirmed by women who spoke positively about their interactions with staff while receiving care in NMH. A culture of kindness, consideration and respect was promoted at NMH through the implementation of a number of practices, including:

- women were called by their preferred names
- women were provided with information about their care, health and wellbeing, and were encouraged to be actively involved in the decision-making about their plan of care
- a home away from home environment was encouraged for women requiring inpatient care
- staff wore name badges
- involvement of parents in the medical rounds in the Neonatal Unit.

Inspectors found there was evidence that hospital management and staff promoted a culture of kindness, consideration and respect for women receiving care at NMH.

Judgment: Compliant

‡‡‡‡‡‡‡‡‡‡ Shoulder dystocia is defined as a vaginal cephalic (head first) birth that requires additional obstetric manoeuvres to deliver the baby after the head has delivered and gentle traction has failed.

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.
Inspectors found there was a coordinated response to complaints and concerns received from women and or their families about the healthcare services and care received in NMH. Inspectors found NMH's complaints procedures were clear, transparent and accessible, although information about the process could be more clearly displayed in the clinical and public areas visited during inspection. All complaints were managed in a timely way and in line with the NMH's and HSE's complaints management policies. The complaints resolution process was audited and time-bound action plans were developed to address areas identified for improvement. Corporate governance and oversight of NMH's complaints management process including the timeliness of responses to complaints lay with the CGEC and EMT. NMH formally reported on the number and type of complaints received, and rate of resolution to the HSE annually. NMH's quality manager was the designated complaints officer and was the principal point of contact for women and or families wanting to make a complaint or raise a concern about the care received in NMH. The complaints officer was also assigned with responsibility for the implementation of recommendations arising from reviews of complaints. Staff who spoke with inspectors were knowledgeable about the NMH's complaints management processes. Two Patient Advocacy Officers helped women and or families to access support from independent advocacy services, when needed. Hospital management supported and encouraged point of contact complaint resolution in line with national guidance. Verbal complaints were managed at local clinical area level by CMMs and escalated to the CMM 3 if not resolved. Written complaints were manged by the CMM 3 for their area of responsibility, with input from CMMs and midwives, as appropriate. In 2022, hospital management received a total of 144 complaints. The majority (97%) of these complaints were resolved within the HSE's 30 working days timeframe. Complaints were tracked and trended at NMH. The majority of complaints received in 2021 related to communication and information (71%). Inspectors found sufficient evidence that time-bound quality improvement initiatives and or recommendations resulting from the complaints resolution process were implemented. These improvements included: ▪ a reconfigured and refurbished bereavement room in the Labour and Birthing Unit ▪ further staff training on how to communicate and interact with bereaved parents ▪ improving effective communication and teamwork skills for staff using Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS)§§§§§§§§§§ ▪ improved access to maternal mental health services

§§§§§§§§§§ Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is designed to help health care professionals improve patient safety and quality through effective communication and teamwork skills.

- training on complaints handling for the consultant medical staff
- adding information on NMH's complaints processes on all clinical letters issued
- refresher training on customer care for staff.

Staff who spoke with inspectors reported that feedback and learning from the tracking and trending of complaints was shared with them, which is important when trying to avoid reoccurrence of the same issues for women and babies using the healthcare services.

Overall, inspectors were satisfied there were effective, coordinated systems and processes in place at NMH to respond timely and efficiently to complaints and concerns raised by women who use the healthcare services and or their families. These systems and processes were effective in resolving complaints and concerns within national HSE timelines.

Judgment: Compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high-quality, safe, reliable care and protects the health and welfare of service users.

At the time of inspection, there was a long-term plan to relocate NMH to the campus of SVUH, but in the interim maternity, gynaecology and neonatal services will continue to be provided within the NMH's current footprint and infrastructure. HIQA acknowledges that the age and limited footprint of NMH's building presented many challenges and risks, which impacted on NMH's ability to conform to international best practice standards for the physical infrastructure. A number of refurbishment projects have been completed to a high standard at NMH since HIQA's previous inspection in 2019. These included the refurbishment of the Labour and Birthing Unit and emergency room, and the reconfiguration and extension of the Operating Theatre Department.

Inspectors found the physical environment in the clinical areas visited was generally bright, well maintained and clean with few exceptions. There was some general wear and tear of woodwork and floor surfaces, which did not facilitate effective cleaning and posed an infection prevention and control risk. CMMs who spoke with inspectors were satisfied with the level of cleaning resources in place during core and outside core working hours. Environmental cleaning was carried out by staff from NMH and an external contract cleaning company, with cleaning staff available 24/7. CMMs and cleaning supervisors had oversight of the standard of cleaning and cleaning schedules in their clinical areas of responsibility. Discharge and terminal cleaning********** was carried out by designated staff when required.

Cleaning of equipment was assigned to MCAs with oversight by the CMM. A tagging system was used to identify clean equipment. Inspectors observed equipment to be clean in all the clinical areas visited during inspection. Supplies and equipment were stored adequately and appropriately. Hazardous material and waste was stored safely and securely. There was

********** Terminal cleaning refers to the cleaning procedures used to control the spread of infectious diseases in a healthcare environment.

appropriate segregation of clean and used linen. Notwithstanding this, inspectors did observe an unclean floor brush being stored with clean linen in one of the clinical areas visited, this issue was raised with the CMM for immediate remedial action.

Inspectors observed signage regarding hand hygiene clearly displayed, strategically located and readily available throughout NMH. Inspectors also observed infection prevention and control signage in relation to transmission-based precautions displayed in all clinical areas visited. Wall-mounted alcohol-based hand sanitiser dispensers and personal protective equipment (PPE) were also strategically located and readily available in all the clinical areas visited. Inspectors observed staff in the clinical areas wearing appropriate PPE in line with public health guidelines in place at the time of inspection. Not all hand hygiene sinks in the clinical areas visited conformed to requirements.[††††††††††] While physical distancing was observed to be maintained between beds in some of the smaller sized multi-occupancy rooms, this was not the case in the larger 'nightingale' multi-occupancy rooms.

While there were isolation facilities in all clinical areas visited, the number of isolation rooms with en-suite bathroom facilities in NMH was insufficient for the number of women who access care in the hospital. This was something hospital management had identified as a priority to be included in future capital development plans and projects. Notwithstanding this, inspectors found NMH had sufficient processes in place to prioritise and ensure appropriate placement and management of women with suspected or confirmed communicable disease. This process was overseen by NMH's infection prevention and control team. If there were no isolation facilities available, women requiring transmission-based precautions were cohorted in a multi-occupancy room, which was in keeping with national guidance. Emergency supplies and equipment including relevant medications to manage obstetric and neonatal emergencies were readily available and accessible in all clinical areas visited. There was documentary evidence that emergency equipment was checked daily and weekly, and serviced to ensure functionality as per hospital policy.

In summary, the physical environment and clinical equipment was observed to be generally bright, clean and well maintained at the time of inspection. However, the age and limited footprint of NMH's existing building presented many challenges and did not always support the delivery of high-quality, safe, reliable maternity care. Specifically, adequate physical distancing between beds in large multi-occupancy 'nightingale' wards was difficult to maintain. NMH had a shortfall in isolation facilities that will not be adequately addressed under current capital development plans for the existing building, but must be addressed when the hospital relocates to the campus of SVUH. Hospital management should continually look to address the shortfall in isolation facilities until such time as this can be addressed through the relocation of NMH to the campus of SVUH.

Judgment: Partially compliant

[††††††††††] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf.

Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved.

Inspectors found that there were efficient systems and processes in place at NMH to monitor, analyse, evaluate and respond to information from a variety of sources in order to inform continuous improvement of healthcare services. Sources included defined quality and safety performance metrics, findings from audit activity, risk assessments, patient-safety incident reviews, complaints and feedback from women and their families. Hospital management used this information and collated performance data to compare and benchmark the quality of services provided in NMH to other similar sized maternity services in Ireland.

Infection prevention and control monitoring

Inspectors were satisfied that the IPCC had oversight of and actively monitored the effectiveness of infection prevention and control practices at NMH. Hospital management monitored and regularly reviewed performance indicators in relation to the prevention and control of healthcare-acquired infection.[‡‡‡‡‡‡‡‡‡‡‡] In line with HSE's monthly reporting requirement, NMH monitored and publically reported on maternal and neonatal rates of:

- hospital-acquired *Staphylococcus aureus* blood stream infection
- *Clostridioides difficile* infection
- CPE
- *Group B Streptococcus* infections (GBS)
- COVID-19
- Congenital infection — *Toxoplasma gondii* and congenital *Cytomegalovirus* (CMV)
- maternal bacteraemia
- early onset neonatal bacteraemia
- maternal sepsis
- retained swabs.

Compliance with sepsis management, surgical site infection rate, peripheral vascular catheter and urinary catheter care bundles was also monitored at NMH. The comprehensive sepsis audit report reviewed by inspections, showed that the NMH's level of compliance with sepsis management was good, but areas for improvement were identified and prioritised. It was evident from meetings with infection prevention and control leads and staff who spoke with inspectors that monthly environmental, equipment and hand hygiene audits were undertaken at NMH using a consistent approach. Findings from environmental audits showed that all the clinical areas visited during inspection scored 90% or above in the months preceding HIQA's inspection. Clinical staff confirmed that findings from environmental hygiene audits were shared with them. Regular hand hygiene audits were conducted across a wide range of staff

[‡‡‡‡‡‡‡‡‡‡‡] Health Service Executive. *Performance Assurance Process for Key Performance Indicators for HCAI AMR in Acute Hospitals.* Dublin: Health Service Executive. 2018. Available on line from: https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/performance-assurance-process-for-kpis-for-hcai-amr-ahd.pdf.

in NMH with oversight by the infection prevention and control team. Findings from hand hygiene audits carried out in 2022 showed that the majority of clinical areas visited during the inspection were compliant with the HSE's target of 90%. Additional training was implemented in clinical areas where compliance with hand hygiene standards was less than 90%. Areas for improvement were identified from the auditing of infection and prevention and control practices. Inspectors found sufficient documentary evidence that time-bound action plans were developed to improve infection prevention and control practices and hygiene standards. The infection prevention control team, CMMs and household supervisor, with oversight by IPCC and CGEC, were responsible for ensuring the implementation of any time-bound action plans.

Medication safety monitoring

The DTC and MSC had oversight of the monitoring and evaluation of medication safety practices at NMH. Performance data relating to medication practices was collated monthly through the HSE's 'Test Your Care' nursing and midwifery metrics.§§§§§§§§§§ Documentation submitted to HIQA showed a high level of compliance with these metrics in all clinical areas visited in the months preceding HIQA's inspection. NMH submitted information on antimicrobial consumption to the Health Protection Surveillance Centre (HSPC) and carried out frequent antimicrobial pharmacist-led reviews of inpatient antimicrobial prescriptions. NMH also participated in the national HSE's multicentre emergency department antimicrobial stewardship audit and Point Prevalence Survey (PPS) of antimicrobial use. It was clearly evident from documentation reviewed by inspectors that time-bound quality improvement plans were developed when medication practices fell below expected standards. Information on medication alerts and findings from medication related audits and patient-safety incidents were shared with clinical staff via the medication safety shared desktop folder available on computers in clinical areas, medication safety memos, medication alerts and staff training and education sessions.

Deteriorating patient monitoring

NMH used the electronic healthcare record — MN-CMS. IMEWS, INEWS and the Identify, Situation, Background, Assessment, Recommendation (ISBAR) communication tool********** were integrated into the MN-CMS. Staff who spoke to inspectors confirmed that they were trained and inducted on how to use the MN-CMS. A designated coordinator supported staff using the MN-CMS. Performance data relating to the escalation process and response rate when a woman's early warning system triggered and or clinical condition deteriorated was collated monthly through 'Test Your Care' nursing and midwifery metrics. Documentation submitted to HIQA showed a high level of compliance with the IMEWS and INEWS escalation process in all clinical areas visited in the months preceding HIQA's inspection. Compliance

§§§§§§§§§§ Performance metrics that measure, monitor and track the fundamentals of nursing and midwifery clinical care processes.

********** Identify, Situation, Background, Assessment, Recommendation (ISBAR) is a communication tool used to facilitate the prompt and appropriate communication in relation to patient care and safety during clinical handover.

with national guidance on IMEWS, INEWS and ISBAR was audited at NMH using a standardised approach. Time-bound quality improvement plans were developed when improvements were needed.

Transitions of care monitoring

NMH did not have a formalised acceptance and retrieval policy to support the transfer of women and babies to NMH from other maternity services in IEHG. The numbers of in-utero transfers into and from NMH were reported monthly as part of the HSE's Irish Maternity Indicator System and Maternity Safety Statements. Clinical midwifery handover was audited and documentation submitted to HIQA showed high levels of compliance in all clinical areas audited in the months preceding HIQA's inspection.

Women's experience of using the maternity services

Staff in all clinical areas visited were aware of NMH's findings from National Maternity Experience Survey and there was evidence, as discussed in this inspection report, that quality improvement initiatives were implemented to improve women's experience.

Overall, NMH had robust systems in place to monitor and evaluate healthcare services provided at NMH and this information was used to improve healthcare services. Auditing of compliance with national guidance identified areas for improvement and provided hospital management and women receiving care in NMH with assurances on the quality and safety of the services and care provided. Time-bound quality improvement initiatives were implemented to ensure care provided in NMH aligned with national guidance and standards.

Judgment: Compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.

Inspectors found there were effective and robust arrangements in place in NMH to proactively identify, analyse, evaluate and manage immediate and potential risks to people availing of healthcare services in NMH. Documentation reviewed by inspectors and meetings with staff representatives over the course of the inspection confirmed that the management of identified risks was in line with the HSE's integrated risk management policy. Operationally, the clinical risk department had appropriate oversight of the management of identified risks and the effectiveness of the controls introduced to mitigate the potential and actual risks to patient safety.

Risks identified at local clinical area level were recorded on local risk registers. CMMs identified and applied controls to mitigate any potential and actual risk to the quality and safety of clinical services. CMMs, ADOMs and clinical risk managers were responsible for monitoring the effectiveness of the controls applied in their areas of responsibility. More

serious risks were escalated to the EMT and recorded on NMH's corporate risk register. At the time of inspection, seven high-rated risks related to the four areas of known harm were recorded on NMH's corporate risk register. These included risks associated with NMH's intensive care facilities, service demand, the increasing complexity of maternity and neonatal care, NMH's ageing infrastructure and physical environment and staffing levels. Inspectors were satisfied that the corporate risk register, along with the effectiveness of the controls applied to mitigate the risks, were reviewed and updated regularly by the clinical risk department, EMT and the relevant quality subcommittee of NMH's Board — Quality, Risk and Patient Safety Committee. NMH's compliance and conformance with national risk management policies and standards was audited by the clinical risk department with appropriate oversight by the EMT.

Infection outbreak preparation and management

Women receiving care at NMH were routinely screened for the following multi-drug resistant organisms (MDROs) — *Clostridioides difficile* infection, CPE, *Staphylococcus aureus* blood stream infections, VRE, MRSA and COVID-19 — at the first antenatal booking visit. Screening for CPE was as per national guidance. Compliance with MDRO screening processes was regularly audited with oversight by the infection prevention and control team. Where isolation facilities were available, women requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis, in line with national guidance. Alternatively, potential risks were mitigated by the cohorting of women requiring transmission-based precautions in multi-occupancy rooms. The practice of isolation on admission or diagnosis was audited annually. Audit documentation reviewed by inspectors showed that in 2022, 94% of women and 96% of newborns requiring transmission-based precautions were isolated within 24 hours of admission or diagnosis.

All babies in the Neonatal Unit were screened for:

- CPE weekly
- MRSA on admission and weekly thereafter
- VRE monthly
- gentamicin resistant *Enterobacterales* every two weeks
- extended spectrum *B-lactamase* (ESBL) monthly.

In 2022, NMH had a VRE outbreak in the Neonatal Unit. On review of relevant documentation, inspectors found the management of this infection outbreak was underpinned by a formalised up-to-date outbreak management policy and in line with national guidance. A multidisciplinary outbreak team was convened to advise and oversee the management of the infection outbreak. The summary report from the infection outbreak was comprehensive and it outlined control measures to mitigate the risk to patient safety in the short-term, potential contributing factors and recommendations to reduce the possibility of reoccurrence. NMH's infection prevention and control team and the IPCC had appropriate

oversight of the implementation of recommendations arising from the review of any infection outbreak.

Medication safety

NMH did not have a comprehensive clinical pharmacy service. Pharmacist-led medication reconciliation was carried out on women and babies categorised as high priority using clearly defined criteria. Medication stock control was carried out by pharmacy technicians in all clinical areas visited. HIQA was satisfied that risk-reduction strategies for high-risk medicines were used in NMH. The hospital had a list of high-risk medications aligned with the acronym 'A PINCHO'.[††††††††††††] NMH had a list of sound-alike look-alike medications (SALADs). NMH's medication formulary, prescribing guidelines, including antimicrobial guidelines and medication information were readily available and accessible to staff at the point of prescribing.

Deteriorating patient

Staff in the clinical areas visited were knowledgeable about the IMEWS and INEWS escalation process. Inspectors were satisfied that NMH had effective systems in place to review and manage women with a triggering early warning system. Staff confirmed that the ISBAR communication tool was used when requesting medical review for a woman with a triggered early warning system.

NMH's Labour and Birthing Unit was not adjacent to the operating theatre department, but inspectors were satisfied that NMH had robust procedures in place to ensure the rapid transfer of pregnant and or postnatal women to the operating theatre department, when needed. NMH did not have a Level 3[‡‡‡‡‡‡‡‡‡‡‡‡] ICU onsite. Critically ill pregnant and or postnatal women requiring intensive care were transferred to SVUH, when required. Inspectors were satisfied that NHM had formal arrangements in place with SVUH to accept pregnant and or postnatal women requiring critical care.

Clinical staff in NMH had 24-hour access to clinical advice from consultants in the specialties of haematology and microbiology. A number of consultant anaesthesiologists and consultant obstetricians and gynaecologists had joint appointments between the NMH and SVUH, which enabled a close working relationship between the two hospitals. NMH and SVUH had agreed pathways in place for the management of pregnant and postnatal women with complex medical conditions. Multidisciplinary meetings were held monthly with clinical staff representatives attended from SVUH and NMH to discuss and prospectively develop a plan of care for these women. Medical consultants in NMH also consulted and collaborated with

[††††††††††††] Medications represented by the acronym 'A PINCH' include anti-infective agents, anti-psychotics, potassium, insulin, narcotics and sedative agents, chemotherapy and heparin and other anticoagulants. The National Maternity Hospital used 'A PINCHO' with O representing other medicines.
[‡‡‡‡‡‡‡‡‡‡‡‡] Level 3 critical care is the level of care required for patients who need advanced respiratory support (mechanical ventilation) alone or basic respiratory support along with support of at least one additional organ.

paediatric consultants and clinical specialists from Children's Health Ireland at Crumlin Hospital and Children's Health Ireland at Temple Street Hospital when required.

Safe transitions of care

NMH had a system in place to reduce the risk of harm associated with the process of maternal and neonatal transfer from other maternity services in IEHG. However, this process was not underpinned by a formalised policy.

Policies, procedures and guidelines

NMH had a group of up-to-date infection prevention and control policies, procedures, protocols and guidelines, which included policies on standard and transmission-based precautions and infection outbreak management. NMH also had a group of up-to-date medication policies, procedures, protocols and guidelines based on National Clinical Effectiveness Committee (NCEC) guidelines including sepsis management, clinical handover, IMEWS and INEWS. All were available to staff and accessible via a computerised document management system.

Pregnant women, wishing to have a homebirth, could register for the homebirth service if they met the defined eligibility criteria. This service was provided by self-employed community midwives (SECM) on behalf of the HSE under the National Homebirth Service. At the time of inspection, the HSE were in the process of developing and defining an overarching clinical governance framework for the homebirth services. In the interim, hospital management at NMH were proactive and responsive in ensuring there was effective governance and oversight arrangements, with contingencies in place for women choosing the SECM homebirth pathway. Contingencies included the development and ratification of a group of policies, procedures, protocols and guidelines that underpin care provided within the SECM homebirth pathway and ensured midwives worked within their scope of practice.

In summary, there were effective systems in place at NMH to identify and manage the potential risk of harm for women and babies receiving care in NMH. While national HSE progress the development of an overarching clinical governance framework for the SECM's homebirth service, in the interim, hospital management at NMH had implemented governance arrangements and contingencies to ensure the safety and quality of care for women choosing to have a homebirth with SECMs.

Judgment: Compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.
Inspectors found there were effective management systems in place at NMH to identify, report, manage and respond to patient-safety incidents in line with national guidance. Inspectors were satisfied patient-safety incidents related to the four areas of known harm were reported in line with the HSE's Incident Management Framework to the National Incident Management System (NIMS).§§§§§§§§§§§ Inspectors reviewed a copy of the clinical risk and legal department's summary report for 2022, which detailed the hospital's rate of reporting of clinical incidents to NIMS and provided a breakdown of incidents that occurred at NMH in 2022. NMH's reported number of patient-safety incidents indicated that there was a good reporting culture at the hospital. In 2022, 1,384 clinical incidents were reported to NIMS, equating to an average reporting of 115 patient-safety incidents per month, which is comparable to other similar sized maternity hospitals in Ireland. Staff who spoke with HIQA were knowledgeable about what to report and how to manage and respond to a patient-safety incident. Staff also confirmed that debriefing and After Action Reviews********** were carried out to identify learning and service improvements after a patient-safety incident. Patient-safety incidents in relation to the four key areas of known harm were tracked and trended by the clinical risk and legal departments and collated data on the number, type, location and categories of reported patient-safety incidents was reviewed at meetings of the Clinical Incident Review Group, NMH's WaN-SIMF, EMT and relevant quality subcommittee of NMH's Board — Quality, Risk and Patient Safety Committee. The majority (1,185) of reported patient-safety incidents in 2022 related to care, with bleeding after birth and unexpected deterioration of clinical condition being the two most commonly occurring clinical incidents reported that year. The review of any serious reportable events, serious incidents and patient-safety incidents at NMH was supported by the newly established HSE's Obstetric Emergency Support Team. Inspectors found the quality and clinical risk departments, Clinical Incident Review Group and EMT had appropriate oversight of the implementation of recommendations arising from reviews of patient-safety incidents. Staff confirmed that information relating to feedback on and learning from patient-safety incidents was shared with clinical staff by CMMs at clinical handover and multidisciplinary safety huddles. There was evidence that learning from clinical incidents was also shared nationally with other maternity services and NWIHP, where appropriate.

§§§§§§§§§§§ The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

********** After Action Review is a structured facilitated discussion of an event, the outcome of which enables the individuals involved in the event to understand why the outcome differed from that which was expected and what learning can be identified to assist improvement.

Infection prevention and control patient-safety incidents

NMH's infection prevention and control team reviewed all infection prevention and control related patient-safety incidents and made recommendations for corrective measures to reduce reoccurrence of the incident. The IPCC had oversight of the effectiveness of any control measures implemented to mitigate patient safety risks arising from infection prevention and control patient-safety incidents.

Medication patient-safety incidents

Fifty-four medication patient-safety incidents were reported at NMH in 2022. Medication patient-safety incidents were categorised according to the severity of outcome as per the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) medication error categorisation. The DTC and MSC had oversight of the effectiveness of any control measures implemented to mitigate patient safety risks arising from medication patient-safety incidents.

Overall, inspectors found there was a robust system in place at NMH to identify, report, manage and respond to patient-safety incidents. Patient-safety incidents, were tracked and trended, and recommendations from patient-safety reviews were implemented to improve healthcare services for women and babies. Learning was shared with clinical staff in NMH and other maternity services, which is important for the continual improvement of maternity services.

Judgment: Compliant

Conclusion

HIQA carried out a two-day announced inspection of NMH to assess compliance with national standards from the *National Standards for Safer Better Health*. The 11 national standards assessed during the course of the inspection were mapped to the national standards from the *National Standards for Safer Better Maternity Services*, which sit within the overarching framework of the *National Standards for Safer Better Healthcare.*

The inspection focused on four areas of known harm — infection prevention and control, medication safety, deteriorating patient and transitions of care. Overall, NMH was found to be;

- compliant with seven national standards assessed (5.5, 5.8, 1.7, 1.8, 2.8, 3.1, 3.3)
- substantially compliant with two national standards assessed (5.2, 1.6)
- partially compliant with two national standards assessed (6.1, 2.7).

Capacity and Capability

Inspectors found formalised corporate and clinical governance arrangements were in place at NMH, with effective governance and appropriate oversight by the NMH's Board of Governors and IEHG to assure the delivery of high-quality, safe and reliable healthcare services provided at NMH. At operational level, inspectors also found clear lines of accountability with devolved autonomy and decision-making were in place. These arrangements were focused on ensuring and improving the quality and safety of maternity, gynaecology and neonatal services across NMH.

There was evidence that hospital management and IEHG had progressed and supported collaborative working arrangements among all four maternity services in IEHG. Notwithstanding this, the collaborative approach was not formalised within a clinical maternity network under a single governance structure, as detailed in the National Maternity Strategy. HIQA acknowledges that in the IEHG there are details that need to be considered when establishing a clinical maternity network. The clinical maternity network in IEHG comprised three HSE funded statutory maternity units — St Luke's General Hospital, Kilkenny, Wexford General Hospital and Regional Hospital Mullingar and one voluntary hospital — NMH. As a voluntary hospital, NMH was not responsible for the governance of the other three maternity units. Clinical responsibility and governance of these three units lay with the HSE Board. So, establishing a clinical maternity network under a single governance structure will require some consideration and accommodation at NMH, IEHG and national HSE levels. Nonetheless, the progression and implementation of a clinical maternity network incorporating all four maternity services in IEHG should continue to be progressed by IEHG, NMH and national HSE.

Inspectors found effective and efficient management arrangements were in place to manage and oversee the delivery of high-quality, safe and reliable healthcare services in the areas of infection prevention and control, medication safety and deteriorating patient at NMH.

Inspectors were also found effective and responsive arrangements were in place to address increases or decreases in service demand and ensure the safety and quality of healthcare for women and their babies receiving care in NMH. HIQA acknowledges hospital management's efforts to actively recruit medical, midwifery and nursing staff. Nevertheless, as detailed in this report, NMH were carrying a staffing shortfall across all professions, but in particular midwifery and nursing, which needs to be addressed. Notwithstanding the fall in the number of births at NMH, the cumulative 21% shortfall in midwifery and nursing staff in Unit 3 and the Labour and Birthing Unit and 6.6% in Holles Wing posed a risk to safe staffing. Staff recruitment and retention is a system-wide issue, but hospital management at NMH and the executive management of IEHG should continue in their efforts to recruit and retain staff to ensure the safety and quality of care provided to women and babies. Hospital management had oversight of staff attendance at and uptake of essential and mandatory training. Levels of staff attendance and uptake of training in obstetric and neonatal emergencies, sepsis management, hand hygiene, basic life support should be areas of focused improvement following this inspection. Inspectors found effective and systematic monitoring arrangements were in place to identify and act on opportunities to continually improve the quality, safety and reliability of the healthcare services provided at NMH.

Quality and Safety

Inspectors found staff in NMH promoted a person-centred approach to care and staff were observed being cordial, kind, caring and respectful towards women receiving care in NMH. Staff were aware of the need to respect and promote the dignity, privacy and autonomy of women, which is consistent with the human rights-based approach to care promoted by HIQA. Hospital management used feedback from women who received care in NMH to prioritise and identify areas for service improvement. Inspectors were satisfied that the systems and processes in place to respond to complaints and concerns raised by women and or their families were effective and robust in resolving complaints and concerns promptly and the effectiveness of the complaints resolution process was audited.

Inspectors found the physical environment in the clinical areas visited did not always support the delivery of high-quality, safe, reliable maternity care. HIQA acknowledges that hospital management were progressing with the repurposing and refurbishing of some clinical areas to support the delivery of high-quality, safe care and that in the long-term NMH will relocate to a purpose built facility on the site of SVUH. Notwithstanding this, the number of isolation facilities at NMH were insufficient, some of the multi-occupancy rooms were challenged for space and hand hygiene sinks in the clinical areas visited did not always confirm to requirements. The challenges due to NMH's ageing infrastructure was recognised by hospital management and solutions to address the challenges were being prioritised in infrastructural projects and plans currently underway or planned in NMH.

Inspectors found robust systems were in place to monitor and evaluate healthcare services provided at NMH and there was a responsive and reactive approach to continual improve healthcare services. Inspectors also found there were effective and robust systems in place at NMH to proactively identify, manage and minimise the potential risk of harm to women

and babies. There was appropriate oversight of the management of reported patient-safety incidents. There was evidence that recommendations from patient-safety incidents were implemented and learning from incident reviews was shared with clinical staff in NMH, across IEHG and nationally with other maternity services, which is important when ensuring the quality and safety of maternity, gynaecology and neonatal services.

Overall, HIQA found a good level of compliance with the 11 national standards assessed during the inspection, but as outlined in this inspection report, opportunities for improvement were identified. Following this inspection, HIQA will, through the compliance plan submitted by hospital management, as part of the monitoring activity, continue to monitor the progress in implementing the short-, medium- and long-term actions identified and being employed to bring NMH into full compliance with the *National Standards for Safer Better Healthcare*.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance classifications

An assessment of compliance with selected national standards assessed during this inspection of NMH was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the standards is identified, a compliance plan was issued by HIQA to hospital management. In the compliance plan, hospital management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the hospital's progress in implementing the action(s) set out in any compliance plan submitted.

HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Capacity and Capability Dimension	
National standard from *National Standards for Safer Better Healthcare* (NSSBH) mapped to national standard from the *National Standards for Safer Better Maternity Services* (NSSBMS)	**Judgment**
Theme 5: Leadership, Governance and Management	
NSSBH Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high-quality, safe and reliable healthcare. NSSBMS Standard 5.2: Maternity service providers have formalised governance arrangements for assuring the delivery of safe, high-quality maternity care.	Substantially compliant
NSSBH Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high-quality, safe and reliable healthcare services. NSSBMS Standard 5.5: Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.	Compliant
NSSBH Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services. NSSBMS Standard 5.8: Maternity service providers systematic monitor, identify and act on opportunities to improve the safety and quality of their maternity services.	Compliant
Theme 6: Workforce	
NSSBH Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare. NSSBMS Standard 6.1: Maternity service providers plan, organise and manage their workforce to achieve the service objectives for safe, high-quality maternity care.	Partially compliant

Quality and Safety Dimension	
National standard from *National Standards for Safer Better Healthcare* (NSSBH) mapped to national standard from the *National Standards for Safer Better Maternity Services* (NSSBMS)	**Judgment**
Theme 1: Person-Centred Care and Support	
NSSBH Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted. NSSBMS Standard 1.6: The dignity, privacy and autonomy of each woman and baby is respected and promoted.	Substantially compliant
NSSBH Standard 1.7: Service providers promote a culture of kindness, consideration and respect. NSSBMS Standard 1.7: Maternity service providers promote a culture of caring, kindness, compassion, consideration and respect.	Compliant
NSSBH Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process. NSSBMS Standard 1.9: Complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Compliant
Theme 2: Effective Care and Support	
NSSBH Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. NSSBMS Standard 2.7: Maternity care is provided in a physical environment which supports the delivery of safe, high-quality care and protects the health and welfare of women and their babies.	Partially compliant
NSSBH Standard 2.8: The effectiveness of healthcare is systematically monitored, evaluated and continuously improved. NSSBMS Standard 2.8: The safety and quality of maternity care is systematically monitored, evaluated and continuously improved.	Compliant

Quality and Safety Dimension	
National standard from *National Standards for Safer Better Healthcare* (NSSBH) mapped to national standard from the *National Standards for Safer Better Maternity Services* (NSSBMS)	**Judgment**
Theme 3: Safe Care and Support	
NSSBH Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services. NSSBMS Standard 3.2: Maternity service providers protect women and their babies from the risk of avoidable harm through the appropriate design and delivery of maternity services.	Compliant
NSSBH Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents. NSSBMS Standard 3.5: Maternity service providers effectively identify, manage respond to and report on patient safety incidents.	Compliant

Appendix 2 – Compliance Plan as submitted to HIQA for National Maternity Hospital

Compliance Plan Service Provider's Response

National Standard	Judgment
NSSBH Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high-quality, safe and reliable healthcare. NSSBMS Standard 6.1: Maternity service providers plan, organise and manage their workforce to achieve the service objectives for safe, high-quality maternity care.	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard.

Draft Workforce Action Plan

1. Continue to attend all relevant recruitment exhibitions both within Ireland and Abroad either as part of the wider Ireland East Group or solely, to represent the National Maternity Hospital.
Timescale staff app, this is in addition to traditional job vacancy websites.
Timescale – 6 months

2. Widen our usage of social media platforms, such as better utilisation of linked in and the IEHG – ongoing

3. Develop the recruitment hub within the National Maternity Hospitals own website which is currently under a review more broadly and this will be an action once the current site has been redeveloped.
Timescale – 12 months due to interdependence with internal comms and broader website reconstruction project.

4. Better promotion of the staff benefits associated with working within the NMH, a staff benefit statement was created in early 2023 alongside a digital staff handbook, further consideration now needed on how to promote these as a means of attracting talent.
Timescale – 6 months

5. At a departmental level, utilise the information received through the introduction of performance achievement to establish talent pipelines and development opportunities which in turn will support in the retention of staff.

Timescale -12 months to align with performance achievement timelines.
6. Working with the People and Organisation Committee of the Hospital Board to have an overall Recruitment Strategy and Workforce plan. New NMH Strategy commencing in January 2024.
Timescale - 6 to 12 months.

7. Setting up the Alumni Office – staff member due to start in September 2023 and this is part of their job description.
Timescale - 6 to 12 months.

8. Linking with different 3rd level colleges both in Ireland and abroad to recruit Graduates and employ staff on Gradlink programmes – ongoing.

Draft Staff Training and Education Action Plan

Further development of the NMH's online platform (Totara) as the central mechanism for recording staff training. This platform was upgraded in 2022 and training sessions where given in terms of its key features, particularly in terms of its reporting capabilities. Timescale - 6 months
Sepsis training: Utilise the IEHG Sepsis Campaign (launched 31.07.2023) to increase awareness and compliance with this training requirement. Part of this includes a fortnightly return to IEHG in terms of compliance.
Timescale – 3 months

Obstetric Emergencies: Since the HIQA visit a PROMPT Train the Trainer day was run to increase the number of trainers for PROMPT. There are 3 PROMPT sessions planned for the remainder of year and staff will be encouraged to attend.
Specific to NCHD's from 2024 an MDT PROMPT session to include the NCHDs will be held during their induction week in January and July.
Timescale 6 – 12 months

Neonatal Resuscitation Programme: The American Academy of Paediatrics (AAP) and American Heart Association (AHA) released the 8th Edition of the Neonatal Resuscitation Program (NRP) in late 2021. Trainers had to update and only the 8th edition of NRP had to be taught in 2022.
There are 2 -3 NRP training dates each month until the end of year.
Timescale - 6 – 12 months

BLS: Additional BLS programmes were run to accommodate the new NNCHD's commencing 1 July (x 6).
2 BLS training sessions running per month with additional BLS training being added.
Timescale - 6 – 12 months

Hand hygiene: Mandatory training for all staff. Face to face Mandatory training resumed in late 2022 and is run every 2 months. Hand hygiene training also available on HSELanD.
Timescale - 6 – 12 months

Timescale: As above

National Standard	Judgment
NSSBH Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users. NSSBMS Standard 2.7: Maternity care is provided in a physical environment which supports the delivery of safe, high-quality care and protects the health and welfare of women and their babies.	Partially compliant

Outline how you are going to improve compliance with this standard. This should clearly outline:

(a) details of interim actions and measures to mitigate risks associated with non-compliance with standards.

(b) where applicable, long-term plans requiring investment to come into compliance with the standard.

The EMT agrees with the assessment the hospital is partially compliant with Standard 2.7 relating to the physical environment.
The Hospital was aware of this prior to the approval of the Co-Location Project in May 2013 when the Minister for Health at the time confirmed "An estimated €25m in capital funding would be required for the NMH, in the short-term, if it were to remain in situ."

To date, despite numerous submissions for funding of clinically necessary projects to HSE Estates, only partial funding has been provided for these projects. The hospital was obliged to unilaterally undertake the essential upgrades to the Labour and Birthing Unit and Operating Theatres required subsequent to the October 2015 HIQA inspection.
It should be noted the Minister's original 2013 estimate of €25m has now increased to €35.98m (Elm Park project definitive Business Case (2020)).

(a) Over the last number of years, working alongside IEHG, a number of interim infrastructure project have been proposed to HSE Estates – a new 4-storey lift (completion 2024), ambulatory gynae procedure rooms (H1 2024), electrical upgrade works (Q1 2024), refurb of PN1 sanitary facilities (Q2 2024), Post Mortem/ Bereavement/ Lab facilities (H1 2025), Refurbishment/extension of CSSD (H1 2024) and OPD relocation/refurb (2025)– however project funding has yet to be approved.
The move to Elm Park is 8-10 years away so the Hospital believes it is imperative these works are completed as soon as possible to ensure optimal value is obtained from the investment.
In addition to the larger projects, there are smaller, equally essential projects to remedy the dilapidation of an aging campus that need to be addressed. Again the sooner these can be addressed the greater value can be obtained. All of the following have been raised with HSE Estates/ IEHG for remediation pre-move:

- Downpipes repairs 2024 – subject to funding.
- Repairs to Stairs 2023/2024 – subject to funding.
- Roof Repairs 2024-2025 – subject to funding.

- Flooring Repairs 2024/2025 – subject to funding.
- Boiler repairs/replacements 2024/2025 – subject to funding.
- Fire Doors 2024/2025 – subject to funding.
- UPS/IPS (Recovery Room) 2024/2025 – subject to funding.
- Access Control 2024/2025 – subject to funding.
- Nurse Call/Paging 2024/2025 – subject to funding.
- Building Management Systems 2024 – subject to funding.

There are also other items under consideration, but still to be raised with stakeholders

- Antenatal Ward Bathrooms extension END 2024/2025
- SPC Refurb
- Gynae rooms reconfiguration
- Merrion Wing refurbishment

Projects underway

1	New lift to accommodate patient transfers	PROJECT WITH HSE ESTATES - 2024
2	Ambulatory Gynae procedure rooms	PROJECT WITH HSE ESTATES 1ST HALF 2024
3	Electrical Upgrade Works	EARLY 2024
4	Refurbishment of PN 1 sanitary facilities	COMPLETE MID 2024

Projects in process with IEHG

1	Post Mortem/ Bereavement/ Lab facilities	FIRST HALF 2025
2	Refurbishment/extension of CSSD	FIRST HALF 2024
3	OPD relocation/refurb	2025

(b) The Hospital's response today remains the same as that to the 2015 HIQA Inspection: the agreed and accepted solution to all of the physical environment issues is the move to a new purpose built modern facility. Without a new modern build on another site the infrastructure issues cannot be resolved up to modern standards and expectations but we hope these proposed works will be sufficient improvements from the current situation in the interim.

Funding approval is still awaited on the current proposed infrastructure projects - new lift, ambulatory gynae procedure rooms, electrical upgrade works, Post Mortem/ Bereavement/ Lab facilities, Refurbishment/extension of CSSD and OPD relocation/refurb - the hospital will continue to engage with all stakeholders to ensure Maternity care is provided in a physical environment which supports the delivery of safe, high-quality care and protects the health and welfare of women and their babies.

Timescale: As above