Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Review of progress made at the Midland Regional Hospital, Portlaoise, in implementing recommendations following HIQA's investigation

December 2016

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent authority established to drive high-quality and safe care for people using our health and social care services in Ireland. HIQA's role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.

HIQA aims to safeguard people and improve the safety and quality of health and social care services across its full range of functions.

HIQA's mandate to date extends across a specified range of public, private and voluntary sector services. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, HIQA has statutory responsibility for:

- **Setting Standards for Health and Social Services —** Developing person-centred standards, based on evidence and best international practice, for health and social care services in Ireland.

- **Regulation —** Registering and inspecting designated centres.

- **Monitoring Children's Services —** Monitoring and inspecting children's social services.

- **Monitoring Healthcare Safety and Quality —** Monitoring the safety and quality of health services and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health Technology Assessment —** Providing advice that enables the best outcome for people who use our health service and the best use of resources by evaluating the clinical effectiveness and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion and protection activities.

- **Health Information —** Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Note of terms and abbreviations used in this report

A full range of terms and abbreviations used in this report is contained in a glossary at the end of this report.

Table of Contents

Executive Summary

Background to this Review

The Health Information and Quality Authority (HIQA) *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise* (referred to in this report as the HIQA Portlaoise Investigation Report) was published on 8 May 2015. This investigation was initiated as a result of the very negative experiences of a number of patients and their families in receipt of maternity services at the Midland Regional Hospital, Portlaoise (referred to in this report as Portlaoise Hospital).

The HIQA Portlaoise Investigation Report outlined a series of recommendations intended to reduce the likelihood of recurrence of the conditions that led to the poor experience of care provided to a number of patients and their families by the maternity services at Portlaoise Hospital. The recommendations were of relevance both to the hospital and to the Health Service Executive (HSE) at a regional and national level as well as the Department of Health and the State Claims Agency. Furthermore, learning of relevance to all health providers was contained throughout the report.

A key finding of the HIQA Portlaoise Investigation Report was the failure of the Irish health services to reflect on the findings of previous reports, reviews and investigations and apply system-wide learning for the benefit of all service users. The HIQA Portlaoise Investigation Report noted that HIQA had carried out six previous investigations into hospital care in Ireland between 2007 and 2013.

This Review, which began in April 2016, sought to evaluate the progress achieved at Portlaoise Hospital in implementing the HIQA Portlaoise Investigation Report's recommendations.

Review methodology

This Review was carried out by HIQA staff (referred to in this report as the HIQA Review Team), who are authorized to monitor compliance with standards in accordance with section 70(1) (a) of the Health Act 2007 (the Act). In accordance with section 8(1) (c) of the Act, HIQA issued formal documentation and data requests to relevant organizations. The HIQA Review Team also obtained information through interview with individuals, including staff working in Portlaoise Hospital and HSE staff at regional and national level whose role related to aspects of the governance and quality and safety of services at Portlaoise Hospital. In addition, the HIQA Review Team visited Portlaoise Hospital in June 2016 to interview staff and review the environment and physical facilities. On completion of evidence gathering, HIQA evaluated the findings.

The needs of patients affected by the Portlaoise investigation

When the HIQA Portlaoise investigation started in 2014, HIQA was contacted by or received information in relation to a large number of patients and their families, most of whom had used the maternity services at Portlaoise Hospital. The interactions that HIQA had with patients and their families raised significant concerns about the lack of a formal, integrated national response to address their ongoing needs. As a consequence, in June 2014, HIQA formally wrote to the then Minister for Health and raised these issues both as a concern and a risk. Subsequently, a single contact person was identified in the HSE to assist these patients and their families.

The HIQA Review Team sought to determine the HSE's ongoing response to addressing the needs of these patients and found that some of the complaints and concerns raised by families were still being addressed by the HSE. The HSE told the HIQA Review Team that it continues to work to ensure that these patients and their families are provided with any additional supports that are identified as part of the process.

Implementation of recommendations of national significance

The HIQA Portlaoise Investigation Report contained eight recommendations that needed to be implemented to both improve the quality and safety of services at Portlaoise Hospital and progress the safety of maternity and other clinical services across the public acute hospital system. Of these, six were of relevance at a national or regional level and two were of relevance at a hospital group level or locally at Portlaoise Hospital.

Recommendations 1 to 4 from the investigation were of relevance to the Department of Health – the reported level of progress achieved with the implementation of these recommendations, including details of the recently published National Maternity Strategy, can be found on the Department of Health's website. HIQA has also developed draft national standards that support the implementation of the National Maternity Strategy. These standards have undergone public consultation and have been endorsed by the Minister for Health. It is planned that they will be launched in late 2016.

Of the remaining two recommendations of national significance, Recommendation 5 called for the HSE to ensure the appointment of a director of midwifery before September 2015 in all statutory and voluntary maternity units and hospitals. At the time of writing, it was reported that seven permanent directors of midwifery were in post and one additional permanent post had an agreed start date in November 2016. Three units had temporary appointments, with plans in place to advertise and fill them on a permanent basis. Within eight units, permanent posts are currently being advertised or re-advertised but remained unfilled.

Recommendation 8 concerned the need for the HSE, the chief executive officer of each hospital group and the State Claims Agency to develop, agree and implement a memorandum of understanding between each party to ensure the timely sharing of actual and potential clinical risk information, analysis and trending data. The HIQA Review Team found that the HSE and the State Claims Agency have developed and agreed a Statement of Partnership between the two organisations and a Joint Governance Group had been established. The Joint Governance Group had met on two occasions at the time of this Review. The HIQA Review Team was informed that a suite of reports from analysis of claims and incident trends had been developed by the State Claims Agency and shared with the HSE.

Progress in implementing recommendations from the investigation of local and regional significance

Recommendation 6 and Recommendation 7 were of relevance to all hospital groups within the HSE. This HIQA Review examined the implementation of these recommendations within Portlaoise Hospital and the Dublin Midlands Hospital Group. This Review presents the findings in relation to these recommendations under the headings of governance, maternity services and general services.

Governance

The HIQA Portlaoise Investigation Report reviewed the arrangements in place for regional structures to maintain oversight of Portlaoise Hospital and the regional structures in place for the governance of quality and patient safety and risk management. The lack of an effective connection between local and regional risk management was identified.

In June 2016, the HIQA Review Team found there had been significant improvements in the corporate and clinical governance arrangements both locally at Portlaoise Hospital and regionally at hospital-group level.

Portlaoise Hospital is a member of the Dublin Midlands Hospital Group. The HIQA Review Team found that at the time of the review the hospital group had an established senior management team whose meetings had a clear focus on quality and safety issues relating to service provision. The hospital group was also conducting quality and safety walk-rounds at Portlaoise Hospital.

The senior management team at Portlaoise Hospital demonstrated that they were responsive to patient safety and quality concerns. There was evidence that the management team worked together in the management of complaints and in their response to patient safety incidents.

The HIQA Review Team noted that there was escalation to the Dublin Midlands Hospital Group of risks and serious incidents from the hospital and there was oversight of these risks to patient safety by the Dublin Midlands Hospital Group management team. The effectiveness of the working relationship between the hospital's and hospital group's management teams was much improved relative to that found during the HIQA Portlaoise Investigation.

The hospital has made significant progress in improving the evaluation and audit of the quality and safety of services provided. Although culture was not formally assessed by the HIQA Review Team, there was evidence of significant effort by the hospital's senior management team to provide leadership in order to support a better patient safety culture.

The Review Team also found that, in order to ensure safer treatment of patients at the hospital, hospital funding has been increased significantly compared to the funding provided before the HIQA Portlaoise Investigation. Relative to 2012, the hospital's budget for 2016 had been increased by €6.8m (a 15% increase) to a total of €51.7m. This increased funding largely pays for extra staff, many of whom work in the medical and emergency department services. Staffing levels were 18% higher, in terms of whole-time equivalent numbers, at the time of this Review compared to what was found during the investigation.

However, the continuing lack of certainty around services at the hospital has led to difficulty in recruiting and keeping staff and an ongoing reliance on expensive agency staff, which has significant financial implications for the hospital and the sustainability of services.

Notwithstanding the significant improvements in corporate and clinical governance, at the time of the Review, an agreed approach among the relevant decision makers on the expected range of clinical services that Portlaoise Hospital can safely deliver has yet to be agreed and published. This lack of an overall strategy for the direction of the hospital within the hospital group raised significant concerns in terms of the sustainability of current service arrangements.

The HIQA Review Team is aware that the Dublin Midlands Hospital Group has developed, in collaboration with an external advisory group, a Draft Action Plan for the hospital. It was explained to the HIQA Review Team that this plan intends to define a new model of service for Portlaoise Hospital within the Dublin Midlands Hospital Group; however, this Draft Action Plan has yet to be finalised, agreed by all relevant decision makers and published. Therefore, at the time of writing this Review, an ongoing absence of an agreed strategy for Portlaoise Hospital has resulted in a situation where the hospital, its staff, the community it serves and other relevant stakeholders remain in a state of uncertainty. This continued uncertainty threatens to undo much of the progress achieved by the hospital since the HIQA Portlaoise Investigation. As a matter of urgency, a clear strategic direction for the hospital that sets out a sustainable model of service must be agreed.

Maternity Services

Since the publication of the HIQA Portlaoise Investigation, the senior management team of Portlaoise Hospital has made significant progress in implementing improvements to enhance the quality and safety of services for patients using the maternity services. It was evident there was a system in place to respond to complaints in a timely manner. There was evidence of learning from incidents across the maternity service. Safety has also been significantly aided by a reduced number of births at Portlaoise Hospital and an improvement in the ratio of staff to births.

One of the key findings from HIQA's Portlaoise Investigation was the need to implement in full a clinical maternity network between Portlaoise Hospital and the Coombe Women and Infants University Hospital in Dublin. This was aimed at creating one single maternity unit over two sites which would facilitate:

- a common system of governance
- the capacity for medical, midwifery and other staff to be appointed to the network and to rotate between the two sites to facilitate training and service delivery
- training of junior doctors and midwives on both sites
- risk categorisation of patients to ensure that higher risk patients are managed at the Coombe Women and Infants University Hospital.

In March 2015, a Memorandum of Understanding was signed between the Coombe Women and Infants University Hospital and the HSE. A senior consultant obstetrician and gynaecologist from the Coombe Women and Infants University Hospital has been assigned as Clinical Director for Integration and attended Portlaoise Maternity unit two days a week. This role has been significant in terms of providing experienced senior clinical leadership and helping to progress the implementation of the clinical network.

There was a clear clinical audit plan for maternity services, and audits were conducted pertinent to key quality and patient safety concerns. Moreover, there was oversight of the training and education of staff in fetal monitoring and management of obstetric emergencies. The hospital was contributing to a number of national maternity databases to enable benchmarking against national rates, including the National Perinatal Epidemiology Centre's perinatal mortality and severe maternal morbidity reports and the HSE's Irish Maternity Indicator System. Data from these benchmarked quality and safety parameters indicated that Portlaoise Hospital was performing in line with nationally reported rates.

However, the maternity services at Portlaoise continue to struggle to recruit and retain non-consultant hospital doctors (NCHDs) and this remains a risk to patient safety. The recent appointment of two consultant obstetricians shared across both Portlaoise Hospital and the Coombe Women and Infants University Hospital was anticipated to enable the rotation of NCHDs between both sites, and this needs to be progressed urgently.

The recruitment and retention of midwifery staff and midwifery shift leaders also remained an ongoing issue for the management team in Portlaoise Hospital. The Review Team were informed that the hospital is funded to have 70 midwives in both clinical and non-clinical positions, while 54 midwives are needed for a hospital with 1,600 births according to HSE's midwifery workforce planning report. During the June 2016 on-site inspection, it was reported that there were 48 midwives employed at the hospital. However, 10 of these midwives were unavailable due to sick leave and maternity leave. The midwife staffing levels hindered the separation of the maternity ward from the labour ward. This needs to be progressed once adequate staffing to birth ratios are achieved to improve the governance of the maternity services.

There were improvements identified in maternity patient care pathways. However, there was little change to the infrastructure of the maternity ward. Furthermore, the Outpatients Department remained in need of refurbishment to maintain patient privacy and dignity.

Overall, the HIQA Review Team found that there was evidence of significant progress within Portlaoise Hospital's maternity services. However, the full integration of Portlaoise maternity services within the governance of the Coombe Women and Infants University Hospital needs to be facilitated through necessary capital investment and recruitment of agreed key personnel.

General Services

The HIQA Portlaoise Investigation Report concluded that Portlaoise Hospital was not adequately resourced or structured to provide the undifferentiated care that it was charged with providing. Although Portlaoise Hospital was regarded as a model 3 hospital, it was not resourced as such and was trying to deliver clinical services without the appropriate funding and staffing. This situation had led to the following circumstances:

- the Emergency Department's clinical governance arrangements were not in line with the HSE's National Clinical Programme for Emergency Medicine
- the Intensive Care Unit infrastructure was unfit for purpose, while low volumes of critical care activity in the hospital were likely to result in difficulties in maintaining ongoing clinical expertise and competence of staff
- general medical services at the hospital were not resourced or structured to effectively implement the HSE's Acute Medicine Programme
- there were insufficient acute and elective surgical presentations to ensure that surgeons maintained the necessary competencies and expertise
- The lack of adequate resources in the diagnostic imaging service constantly challenged the timely access for inpatient and outpatients to diagnostic services.

Many of these risks in relation to general clinical services had been previously identified in Portlaoise Hospital through multiple HSE reports. Despite this, remedial actions had not been comprehensively implemented by the HSE to safeguard patients' clinical care.

At the time of this HIQA Review, the most significant change that had taken place in the general services was the cessation of complex surgery* at the hospital since 4 August 2015. This meant that patients presenting to the Emergency Department who require complex surgery or inpatients at Portlaoise Hospital who develop complex surgery needs during their hospital stay need to be stabilised and transferred to one of three other hospitals in the Dublin Midlands Hospital Group (St James's Hospital, Tallaght Hospital, or the Midland Regional Hospital, Tullamore) for their surgery. However, there was no evidence to suggest that there were any formal documented policies, procedures, protocols or guidelines available to clinical

* Complex surgery in this context refers to any procedure involving the stomach, small bowel, colon or rectum, such as bowel resections and gastric or small bowel procedures that require a laparotomy. It does not apply to laparoscopy procedures, such as laparoscopic cholecystectomies, uncomplicated inguinal hernia repair or appendectomies.

staff to support them in implementing these processes on a day-to-day basis at the hospital. This shortfall is of particular importance given the hospital's reliance on locum NCHDs, especially in the Emergency Department.

This Review found that Portlaoise Hospital continues to provide a 24-hour, seven-days-a-week (24-seven) emergency service for undifferentiated[**] adult and paediatric patients who may arrive at the hospital with any degree of seriousness or complexity of illness or injury. This Review identified that the governance arrangements that existed in the Emergency Department at the time of the HIQA Portlaoise Investigation remained largely unchanged and continue not to be in line with the HSE's National Clinical Programme for Emergency Medicine. The Emergency Department continues to be staffed by a team of medical and surgical NCHDs as opposed to emergency medicine NCHDs. The emergency medicine consultants are clinically responsible for the care of all patients attending the Emergency Department during the hours they are onsite. Outside of these hours, responsibility for Emergency Department patients reverts to the respective on-call surgical and medical teams.

In June 2016, the hospital introduced the Irish Children's Triage System (ICTS) for children presenting in the Emergency Department and the paediatric ward. It was also reported that a paediatric triage nurse was available 24-seven to support this and that all children presenting at the Emergency Department or the paediatric ward are escorted by a nurse to the appropriate area for triage. The national Paediatric Early Warning System score has also been implemented.

There had been little change to the Intensive Care Unit at Portlaoise Hospital, and the HIQA Review Team found that it still did not meet the minimum requirements for critical care as set out by the Joint Faculty of Intensive Care Medicine of Ireland. Notwithstanding the fact that clinicians had adapted their practices to minimize risks to patients requiring critical care, the HIQA Portlaoise Investigation Team was not assured that critical care services were sustainable in Portlaoise hospital and this situation has remained unchanged at the time of this Review.

Since the HIQA Portlaoise Investigation Report, there have been improvements to the consultant medical and radiology staffing. In addition, the hospital has received funding for and has constructed a 10 bedded modern medical assessment unit on site. The Dublin Midlands Hospital Group identified the opening of this new Medical Assessment Unit as one of its priority actions for completion by the end of 2016.

[**] Undifferentiated patients include all types of patients with any degree of seriousness or severity of illness.

Conclusion

At the time of this Review, it was found that there had been significant improvements in the corporate and clinical governance arrangements at Portlaoise Hospital with a more effective management team at the hospital and better oversight provided by the Dublin Midlands Hospital Group senior management team.

In addition, in order to ensure safer treatment of patients at the hospital, hospital funding has been increased significantly compared to the funding provided to the hospital before the HIQA Portlaoise Investigation. This increased funding largely funds extra staff, many of whom work in the medical and emergency department services.

In particular, this Review has identified that maternity services at the hospital are now being provided in a much safer and sustainable way than during the period that prompted the HIQA Portlaoise Investigation, with benchmarked safety metrics within national norms. This improvement has been facilitated by improved leadership, governance and management within the service, increased investment, and an improvement in the staff to birth ratio, which has been largely driven by a reduced number of births. Efforts to begin the process of integration with the Coombe Women and Infants University Hospital have also seen service quality and safety of services enhanced at Portlaoise Hospital, but more remains to be done to progress this clinical network.

However, despite these improvements, the continuing lack of certainty around the provision of services at the hospital has led to difficulty in recruiting and keeping staff and an ongoing reliance on agency staff, which has significant financial implications for the hospital. The ongoing lack of certainty has a negative effect on staff recruitment, retention and morale, and this further affects the sustainability of services.

The HIQA Review Team was informed that the Dublin Midlands Hospital Group had advanced detailed proposed plans for the future of Portlaoise Hospital. It was outlined to the HIQA Review Team that this draft plan was unanimously agreed by the consultant leads of the HSE's national clinical care programmes who acted as an advisory group and with input from the HSE's National Ambulance Service. It was explained to HIQA that those who drafted this plan intended that it would determine a more appropriate potential model of service for the hospital based upon hospital capability and capacity, and the calculated needs of the patient population within the wider framework of services provided by the Dublin Midlands Hospital Group.

However at the time of this review, neither this, nor any other alternate strategic plan for the hospital had been agreed or advanced with a view to implementation.

It is acknowledged that an effective and informed action plan will take time to develop, and will require careful planning, to avoid unintended knock-on impacts on other hospitals in the hospital group, neighbouring hospital groups, the National Ambulance Service and community services. However, since the HIQA investigation report was published in 2015, the fundamental issue remains unresolved — to function as a model 3 hospital, Portlaoise Hospital must be both adequately and sustainably resourced and have the capability through the level of services it can safely provide to manage the full spectrum of patients that may present to the Emergency Department.

As things currently stand, and despite a 15% increase in funding and an 18% increase in staffing numbers, the hospital does not currently possess the inherent internal capability to manage all of the patients that may present to the Emergency Department. Moreover, services are currently being sustained through a reliance on agency staff, which is both costly and not good practice from a service sustainability and development perspective. While many of the issues identified during the HIQA investigation have been addressed, others remain. These remaining risks will only be fully addressed through the formulation and enactment of a clear strategic plan for the hospital, which is agreed by those with responsibility for the ultimate decision making on the hospital's future.

Chapter 1. Introduction

The Health Information and Quality Authority (HIQA) *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise* (referred to in this report as the HIQA Portlaoise Investigation Report) was published on 8 May 2015.[1] HIQA carried out the investigation at the request of the then Minister for Health following the Chief Medical Officer's report into perinatal deaths at Midland Regional Hospital, Portlaoise.[2]

HIQA's investigation examined the quality and safety of clinical services and the governance arrangements in place for the maternity and the general healthcare services at the Midland Regional Hospital, Portlaoise (referred to in this report as Portlaoise Hospital). The investigation also examined how these were governed at a more senior level within the the Health Service Executive (HSE).

The resulting HIQA Portlaoise Investigation Report identified significant scope for improving the arrangements for the governance and management of services at the hospital at a local, regional and national level. The report outlined eight recommendations that needed to be implemented to both improve the quality and safety of services at the Portlaoise Hospital and increase the safety of maternity and other clinical services across the public acute hospital system nationally.

Its recommendations required action from Portlaoise Hospital, the HSE, the Department of Health and the State Claims Agency in order to ensure local and national learning and service improvement.

This report presents the findings from a follow-up review conducted by HIQA to check the degree of progress achieved by Portlaoise Hospital, the HSE and the Department of Health on:

- support provided to patients who raised concerns before and at the time of the investigation
- implementing recommendations from the investigation report in the months following its publication.

One of the most notable characteristics of the HIQA Portlaoise Investigation Report was the number of patients and families who came forward to recount their negative experiences of services in Portlaoise Hospital and in some instances other hospitals and maternity services. Therefore, this report begins with an overview of HIQA's findings on the HSE's response to addressing the needs of patients who raised concerns during the HIQA Portlaoise Hospital Investigation in 2014 and 2015.

The report then briefly looks at findings and recommendations concerning the Department of Health and the HSE, which are of national significance. This report then considers in greater depth findings about progress at Portlaoise Hospital. Findings at a local hospital level extend to:

- changes to governance and management
- progress in developing maternity services within a clinical network
- progress in developing general services at the hospital when measured against findings outlined in the HIQA Portlaoise Investigation Report.

Finally, this Review concludes with an overall assessment of progress made both locally and nationally with implementing recommendations made in the HIQA Portlaoise Investigation Report.

This HIQA Review began in April 2016, and findings were informed by review of relevant documents and data, a two-day visit to Portlaoise Hospital, interviews with staff at the hospital and interviews with senior managers within the HSE. Full details of the review methodology are outlined in Appendix 1.

HIQA would like to acknowledge the co-operation of hospital management and staff during the onsite visit at Portlaoise Hospital.

Chapter 2. The HSE's response to addressing the needs of patients who raised concerns during the HIQA Portlaoise Hospital Investigation in 2014

Central to the initial HIQA Portlaoise investigation were those patients and families who had raised concerns about the care they received at Portlaoise Hospital. The HIQA Review Team involved in this 2016 Review was mindful of these concerns while conducting this review.

At the time of the initial HIQA Portlaoise investigation, HIQA received a large volume of telephone calls and correspondence from women who had attended the Portlaoise Maternity Unit and other maternity services in Ireland. The volume of calls, the details recounted and the evident upset and distress experienced by these women and their families highlighted the need for a formal, integrated national response.

This interaction between families and the Investigation Team also informed a critically important recommendation from the investigation – that a patient advocacy service that was independent of both healthcare providers and government be established in Ireland so that, were a similar situation to arise in the future, patients and families would have an independent specialist advocacy service that they could contact to advocate on their behalf.

In immediate response to the large volume of telephone calls and correspondence that HIQA received at that time, HIQA wrote in June 2014 to the then Minister for Health and requested that a national alternative approach be created to provide:

- a trusted and single point of access
- a rigorous consideration of individual and families' experiences
- a review of the clinical outcomes, where appropriate
- relevant psychological support for patients and their families.

As a result, a single point of contact was identified in the HSE to address the needs of these women and their families. When permission was received by HIQA from these individuals, their details were transferred to the contact person.

At that time, the HSE informed HIQA that an incident management team, which included representatives from Portlaoise Hospital, the HSE and the patient advocacy group Patient Focus, had been established to manage concerns raised by these families about the care they received in the maternity unit. In addition, a clinical review team had been convened which included an external independent chairperson and a team of six external independent consultant obstetricians.

What has happened since HIQA's Portlaoise investigation?

The HSE informed the HIQA Review Team that the initial phase of this process involved a clinical chart review of 28 cases, 23 of whom had received maternity care at Portlaoise Hospital (referred to as the Phase I Clinical Review). The clinical review team was led by consultant obstetrician Dr Peter Boylan. This report, known as the Boylan Review, was published in May 2015.[3]

The HIQA Review Team was informed that all of these 28 women were offered meetings with either clinical staff from the hospital involved or with a team of independent experts recruited through the Post Graduate Forum of the Royal Colleges. Sixteen of these women had subsequent meetings with these independent external experts.

Thereafter, in March 2015, the Chief Executive Officer of the Dublin Midlands Hospital Group became the Commissioner responsible for managing the HSE review.

A second phase of the HSE review (referred to as the Phase II Clinical Review) was established to address the concerns raised by 102 other women who had contacted the HSE or HIQA. The reviewer(s) of the Phase II Clinical Review Team was required to:

- meet individual families along with a consultant obstetrician, a senior midwifery expert or a paediatrician or neonatologist to ensure that all concerns raised by these families had been fully addressed
- perform a clinical chart review of 17 additional cases where the initial screen had identified concerns about maternity services.

These 102 complaints went through a process similar to the Boylan Review, where the relevant hospital's lead obstetrician, senior midwife and quality and safety manager reviewed the healthcare record and conducted a clinical chart review. Subsequently, these patients were offered a meeting with an independent obstetrician, senior midwifery expert and, where required, a paediatrician or neonatologist. It was reported by the HSE that 89% of these complaints related to Portlaoise Hospital.

HIQA understand that the HSE intends to publish the findings from this process.

During the HIQA Portlaoise Investigation, HIQA asked the Minister for Health to provide these women and their families with access to relevant psychological and other support as needed. The Minister for Health responded that the matter had been referred to the HSE. The HSE told the HIQA Review Team that all women and families were offered counselling services and other services in the community, such as physiotherapy and occupational therapy service. A senior HSE community manager was assigned responsibility as a service liaison official to enable assessment of counselling or other service needs for the women concerned. The HSE told the HIQA Review Team that it continues to ensure the necessary access for some of these services.

The HSE needs to continue to work to ensure that these women and their families are provided with any additional supports that are identified as part of this process.[†]

[†] The HSE published *National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death* on the 10 August 2016.

Chapter 3. Evaluation of progress made in the implementation of nationally targeted recommendations following HIQA's Portlaoise investigation

The HIQA Portlaoise Investigation Report contained eight recommendations. Of these, six related to the national or regional HSE, while two related to Portlaoise Hospital and the hospital-group level within the HSE.

This chapter briefly outlines what has happened with the six national recommendations since the HIQA Portlaoise Investigation Report was published in 2015. Findings in relation to the further two recommendations, which are of greater direct relevance to services at Portlaoise Hospital, are outlined in more detail later in this report.

The recommendations

Recommendations 1 to 4

Recommendations 1 to 4 related to identified areas for action which fell under the responsibility of the Department of Health to implement. These recommendations called for:

- the establishment of an independent patient advocacy service
- oversight by the Department of Health to ensure implementation of the recommendations contained in the HIQA Portlaoise Investigation Report and previous HIQA investigations
- the development of a National Maternity Services Strategy for Ireland
- the necessary legal framework to enable the group boards of management and chief executive officers of each hospital group to comprehensively perform their governance and assurance functions.

Review of the implementation of these four recommendations was outside the scope of this HIQA Review. However, the Review Team note that the Minister for Health established an oversight group in June 2015 to oversee implementation of the recommendations in the HIQA Portlaoise Investigation Report.[4] Terms of reference and minutes for this oversight group along with implementation plans which outline the level of progress made with the implementation of these recommendations can be accessed on the Department of Health's website. HIQA note that, in particular, progress has been made with the publication of a National Maternity Services Strategy for Ireland, which is an important and welcome development.[5] Having published this strategy, efforts now need to be further extended to ensure its full implementation across all maternity services in Ireland.

HIQA has developed draft national standards that support the implementation of the National Maternity Strategy.[6] These standards have undergone public consultation and been endorsed by the Minister for Health. It is planned that they will be launched over the coming months. The National Maternity Strategy and the national standards, when implemented, represent necessary building blocks to providing a consistently safe, high-quality maternity service, which will in turn work towards restoring public confidence in the service.

Recommendation 5
The Health Service Executive (HSE) should ensure the appointment of a director of midwifery, before September 2015, in all statutory and voluntary maternity units and hospitals in Ireland that currently do not have such a post.

Why this recommendation was made

The HIQA Portlaoise Investigation Team found that the appointment of a director of midwifery with relevant current clinical and managerial experience and close ties to the Coombe Women and Infants University Hospital was a crucial factor in underpinning many of the improvements seen in Portlaoise Hospital's maternity service at the time of HIQA's Portlaoise Investigation. The Director of Midwifery was a member of the senior management team at the hospital. At that time, placing a director of midwifery in a maternity department located within a larger hospital was unique to Portlaoise Hospital in an Irish context and not reflected anywhere else in the country. The postholder represented the voice of maternity care at a senior level in the hospital and, therefore, was significant in effecting key changes in the maternity services. The HIQA Portlaoise Investigation Team recommended that this model of governance should be replicated nationwide.

What has changed since the HIQA Portlaoise investigation?

The HSE has agreed the model for the director of midwifery in hospitals and advertised these posts. It was reported by senior HSE management that they were actively trying to progress the filling of these posts but there had been challenges in doing so. The HSE confirmed its commitment to ensure a director of midwifery is appointed to all 19 units. At the time of writing, it was reported that seven permanent directors of midwifery were in post and one additional permanent post had an agreed start date in November 2016. Three units had temporary appointments, with plans in place to advertise and fill them on a permanent basis. Within eight units, permanent posts are currently being advertised or re-advertised but remained unfilled.

Recommendation 8
The Health Service Executive (HSE), the chief executive officer of each hospital group and the State Claims Agency must immediately develop, agree and implement a memorandum of understanding between each party to ensure the timely sharing of actual and potential clinical risk information, analysis and trending data. This information must be used to inform national and hospital-group patient safety strategies.

Why this recommendation was made

The State Claims Agency is the Irish state body responsible for claims and risk management functions under the National Treasury Management Agency (Amendment) Act 2000. The Clinical Indemnity Scheme is the main scheme under which the State Claims Agency manages clinical negligence claims taken against hospitals and clinical, nursing and allied healthcare practitioners covered under this scheme. One of its objectives is to advise State authorities, including the HSE, on risk management, with the aim of reducing the frequency, severity and repetition of adverse events. In so doing, it also aims to reduce subsequent claims and the cost of claims. The State Claims Agency does not have statutory powers by which it can compel healthcare institutions, including the HSE, to engage with it or to implement any recommendations which it may make.

As far back as 2007, the State Claims Agency had identified concerns about the quality of maternity services at Portlaoise Hospital. However, up to the time of the HIQA Portlaoise investigation, no formal engagement process was in place between the State Claims Agency and the HSE. As a result, the investigation identified that there was limited proactive and meaningful engagement between the State Claims Agency and the HSE in relation to reported adverse events at Portlaoise Hospital.

What has changed since the HIQA Portlaoise investigation?

The HSE and the State Claims Agency have agreed a Statement of Partnership. The Statement of Partnership, dated 14 December 2015, outlines the governance arrangements for the partnership, which include a Joint Governance Group that will meet twice a year. In addition, more formal escalation pathways have been established to better handle issues of concern that need to be raised at more senior levels of management within both the HSE and State Claims Agency. The statement also identified a reporting strategy between the two organisations with the aim of improving health and safety across the health service.

Minutes of the Joint Governance Group meetings held in November 2015 and February 2016 showed evidence of sharing of information between the organisations, and there was a plan to develop a suite of reports from analysis of claims and incident trends to consider actual and emerging clinical risks. The HIQA Review Team was informed that a suite of reports from analysis of claims and incident trends had been developed by the State Claims Agency and shared with the HSE. It was also noted that the State Claims Agency would contact the HSE's National Acute Office directly to raise any specific areas of potential risks arising from their contact with hospital clinicians.

Chapter 4. Progress in implementing recommendations from the investigation of local and regional significance

The following chapters focus on progress achieved to date in implementing two recommendations (Recommendations 6 and 7), which are relevant both locally at Portlaoise Hospital and regionally at hospital group level. These two recommendations were of relevance to all hospital groups within the HSE. However, for the purpose of this HIQA Review, progress with applying these recommendations was viewed in terms of what has happened within Portlaoise Hospital and the Dublin Midlands Hospital Group.

Recommendation 6
The Health Service Executive (HSE), along with the chief executive officers of each hospital group, must ensure that the new hospital groups prioritise the development of strong clinical networks underpinned by: a. a group-based system of clinical and corporate governance informed by the *National Standards for Safer Better Healthcare*. b. a clearly defined, agreed, resourced and published model of clinical service delivery for each hospital within the group. This must be supported by clearly defined, agreed and documented patient care pathways to ensure that patients are managed in or transferred to the most appropriate hospital. c. regular evaluation and audit of the quality and safety of services provided. d. systems to support a competent and appropriately resourced workforce e. a system to proactively evaluate the culture of patient safety in each hospital as a tool to drive improvement. f. systems in place to ensure patient feedback is welcomed and used to improve services and that patient partnership and person-centred care is promoted, as per the *National Standards for Safer Better Healthcare*. g. effective arrangements to ensure the timely completion of investigations and reviews of patient safety incidents and associated dissemination of learning. These arrangements must ensure that patients and service users are regularly updated and informed of findings and resultant actions.

Recommendation 7.
The Health Service Executive (HSE), in conjunction with the Chief Executive Officer of the Dublin Midlands Hospital Group should: A. review all of the findings of this investigation and address the patient safety concerns at the Midland Regional Hospital, Portlaoise B. immediately address the local clinical and corporate governance deficiencies in the maternity and general acute services in Portlaoise Hospital C. publish an action plan outlining the measures and timelines to address the safety concerns and risks at Portlaoise Hospital, to include both general and maternity services. This action plan should include a named person or persons with responsibility and accountability for implementation of recommendations and actions in internal and external reviews and investigation reports, and be continuously reviewed and updated in order to drive improvement and mitigate risk. The HSE and hospital group CEOs must now ensure that every hospital undertakes a self-assessment against the findings and recommendations of this investigation report, and develop, implement and publish an action plan to ensure the quality and safety of patient services.

The following chapters separate out the findings of this review in relation to these two recommendations under the chapter headings of governance, maternity services and general services.

Chapter 5. Governance

5.1 Introduction to governance of Portlaoise Hospital

The HIQA Portlaoise Investigation was the seventh investigation of its kind into the quality and safety of healthcare services in Ireland that HIQA had undertaken since 2007. [7,8,9,10,11,12] In each of these investigation reports, HIQA emphasised that the sustainable delivery of safe, effective and reliable person-centred care depends on service providers having competent capacity and capability in the areas of leadership, governance and management.

The *National Standards for Safer Better Healthcare*, published in 2012, set out the standards necessary to ensure effective systems of governance.[13] They state that a well-governed service is clear about what it does, how it does it, and is accountable to its stakeholders, including the people who use the services. These standards apply both to the Health Service Executive (HSE) as a provider and the HSE as a commissioner of services. Therefore, they cover local, regional and national HSE structures.

In the context of service delivery, governance systems must ensure patient services are only delivered within the scope of what can be done safely, effectively and sustainably. Therefore, management at a local, regional and national level must ensure that services are planned, controlled, organized and evaluated to ensure that a service can achieve its outcome in the short-, medium- and long-term.

This section of the report details the changes that have taken place in the national, regional (or Hospital Group) and local governance structures and the management tiers responsible for the planning, delivering and monitoring of the quality and safety of clinical services in Portlaoise Hospital.

5.2 HSE and Dublin Midlands Hospital Group

Background

The HSE is the organization charged with responsibility for providing all of Ireland's public healthcare services in hospitals and communities across the country. In 2014, the HIQA Portlaoise Investigation Team reviewed the regional structures in place to maintain oversight of Portlaoise Hospital, and the regional structures for the governance of quality and patient safety and risk management. HIQA identified a lack of effective connection between local and regional risk management and that regional HSE management did not respond appropriately to a deteriorating situation at Portlaoise Hospital.

A national initiative to establish hospital groups in Ireland had been outlined in the *Programme for Government 2011 – 2016*,[14] *Securing the Future of Smaller Hospitals: A Framework for Development*[15] and *Establishment of Hospital Groups as a transition to Independent Hospital Trusts*.[16] During the HIQA Portlaoise investigation, the HSE established hospital groups on an administrative basis and appointed a chief executive officer to each of the newly formed groups.

What has changed since the HIQA Portlaoise investigation?

The Dublin Midlands Hospital Group is one of seven hospital groups established under the Government's National Health Reform agenda. The Dublin Midlands Hospital Group includes Portlaoise Hospital along with the following hospitals:

- The Coombe Women and Infants University Hospital, Dublin
- St James's Hospital, Dublin
- Naas General Hospital, Co. Kildare
- The Midland Regional Hospital, Tullamore, Co. Offaly
- St Luke's Radiation Oncology Network, Dublin
- Tallaght Hospital, Dublin.

The hospital groups have a single management team with responsibility for overall performance within a clearly defined budget. In 2015, the HSE introduced its Accountability Framework outlining that hospital group chief executives are accountable to the National Director for Acute Hospitals for their planning and performance, including the quality and safety of services.[17]

The HIQA Review Team reviewed the governance arrangements in place to ensure the Dublin Midlands Hospital Group management team had good and reliable quality and performance assurance arrangements in place, along with effective working processes and clear communication pathways with the staff and management of Portlaoise Hospital.

5.2.1 Dublin Midlands Hospital Group Management Team

The Chief Executive Officer for the Dublin Midlands Hospital Group was appointed in November 2014 and the remaining members of the senior management team were appointed in 2015.

The senior management team includes the following positions:

- Group Clinical Director
- Group Chief Director of Nursing and Midwifery (Quality and Patient Safety Lead)

- Chief Operations Officer
- Chief Financial Officer
- Chief Director of Human Resources
- Group General Manager
- Group Quality and Patient Safety Manager
- Group ICT Manager
- Group Communications Manager.

The senior management team has clear terms of reference which outline its purpose, objectives, membership and roles and responsibilities. Each member of the senior management team also has a job description which clearly defines their reporting relationships, duties and responsibilities.

It was evident to the HIQA Review Team that the Dublin Midlands Hospital Group senior management team has formed a cohesive unit and that meetings were focused on the service's quality and safety. For example, key risks, such as nursing and midwifery shortages, infection control and service delivery issues, were discussed and actions put in place to address issues identified.

The HIQA Review Team was informed by both Portlaoise Hospital's and the hospital group's senior management that the Dublin Midlands Hospital Group, in line with the HSE's Accountability Framework and the HSE Service Plan 2016, hold monthly performance meetings with Portlaoise Hospital managers.

Minutes of the performance meetings between Portlaoise Hospital and the Dublin Midlands Hospital Group were reviewed by HIQA. They showed that these meetings were well attended, with senior managers from both Portlaoise Hospital and Dublin Midlands Hospital Group attending. Quality and patient safety is a standing item on the agenda of these hospital performance meetings. These meetings — as presented in the minutes — had evidence of a strong focus on risk management.

At interviews with members of the HIQA Review Team, members of the management team at both Portlaoise Hospital and Dublin Midlands Hospital Group reported that these meetings were effective. This was in contrast to HIQA Portlaoise investigation findings, which found that at that time the HSE Dublin Mid-Leinster Hospital Group performance meetings were poorly attended and there was minimal evidence of a strategic approach to identified concerns.

It was reported to the HIQA Review Team that the Dublin Midlands Hospital Group quality and patient safety function included a Quality and Patient Safety Governance Committee comprising the:

- Group Clinical Director
- Group Chief Director of Nursing and Midwifery
- Group Quality and Patient Safety Manager.

The Group Chief Director of Nursing and Midwifery is also the Group's overall lead in relation to Quality and Patient Safety. The HIQA Review Team was informed that the Group Quality and Patient Safety Manager works closely with the Lead for Quality and Patient Safety at hospital level. The Quality and Patient Safety Governance Committee meets fortnightly or more frequently if required. This Committee submits a monthly report to the Group Chief Executive Officer at the senior management team meetings.

A review of the minutes of these Quality and Patient Safety Governance Committee meetings and monthly Quality and Safety updates to the Group Chief Executive Officer found that reported serious incidents and escalated risks at Portlaoise Hospital were reviewed. It was also documented that serious incidents were raised by this Committee with the National HSE Acute Hospital Division.

The Quality and Safety Governance Committee started quality and safety walk-rounds in December 2015. Quality and safety walk-rounds are a safety initiative which involves structured visits by senior managers to clinical areas within their hospital to have conversations with front-line staff for the purpose of preventing, detecting and mitigating harm to patients and staff.[18] The Director of Nursing and the Interim Director of Midwifery at Portlaoise Hospital told the HIQA Review Team that they met regularly with the Group Chief Director of Nursing and Midwifery and they used this forum to raise concerns regarding staffing shortages. They reported that they found these meetings supportive. The Clinical Director for Portlaoise Hospital told the Review Team that he met with the Group Clinical Director once or twice a month and was supported in his role as Clinical Director through this mechanism. Overall, the HIQA Review Team found the management team at Portlaoise Hospital was supported through the current structures within the Dublin Midlands Hospital Group to swiftly and effectively address issues about quality and safety of services at the hospital.

5.3 Local management at Portlaoise Hospital

Background

In March 2014, the HSE had revised the governance of Portlaoise Hospital, which meant that at the time of the HIQA Portlaoise Investigation, a Senior Hospital Management Committee was responsible for providing safe effective services through leading and directing the performance of the general hospital services only. This Committee was chaired by an Assistant National Director and included the Hospital Manager, the Director of Nursing, the Clinical Director and a Quality and Patient Safety Risk Coordinator.

The maternity services were governed separately by an interim management team consisting of a General Manager, Director of Midwifery, Clinical Lead for Obstetrics, Quality and Patient Safety Manager.

What has changed since the HIQA Portlaoise investigation?

At the time of this HIQA Review, there has been significant changes to the management team of the hospital. The General Manager, who was initially appointed as part of the Interim management team for the maternity services, was appointed as General Manager for both general and maternity services in January 2015. The General Manager has responsibility for the day-to-day operational management of the general and maternity hospital and contributes to the strategic development of acute hospital services across the hospital group.

An interim Director of Midwifery, seconded from the Coombe Women and Infants University Hospital, was appointed to the maternity services in February 2016.

The hospital's Clinical Director is responsible for medical professional standards of practice and care in the hospital and for the ongoing delivery of high-quality safe services by the hospital's doctors and surgeons. In this context, since 2016, all the medical and surgical consultants working at Portlaoise Hospital, including those who have shared appointments between Portlaoise and other hospitals and the Clinical Lead for Obstetrics and Gynaecology, now report directly to the Clinical Director.

The senior management team has been further developed with the appointment of two new Operations Managers and a Quality and Safety Manager. As a consequence, the areas of patient services, domestic, maintenance and catering services, human resources, clinical engineering services, allied health professionals and clerical staff, patient advocacy, quality improvement and clinical audit have been included within defined line management functions and with clear lines of accountability.

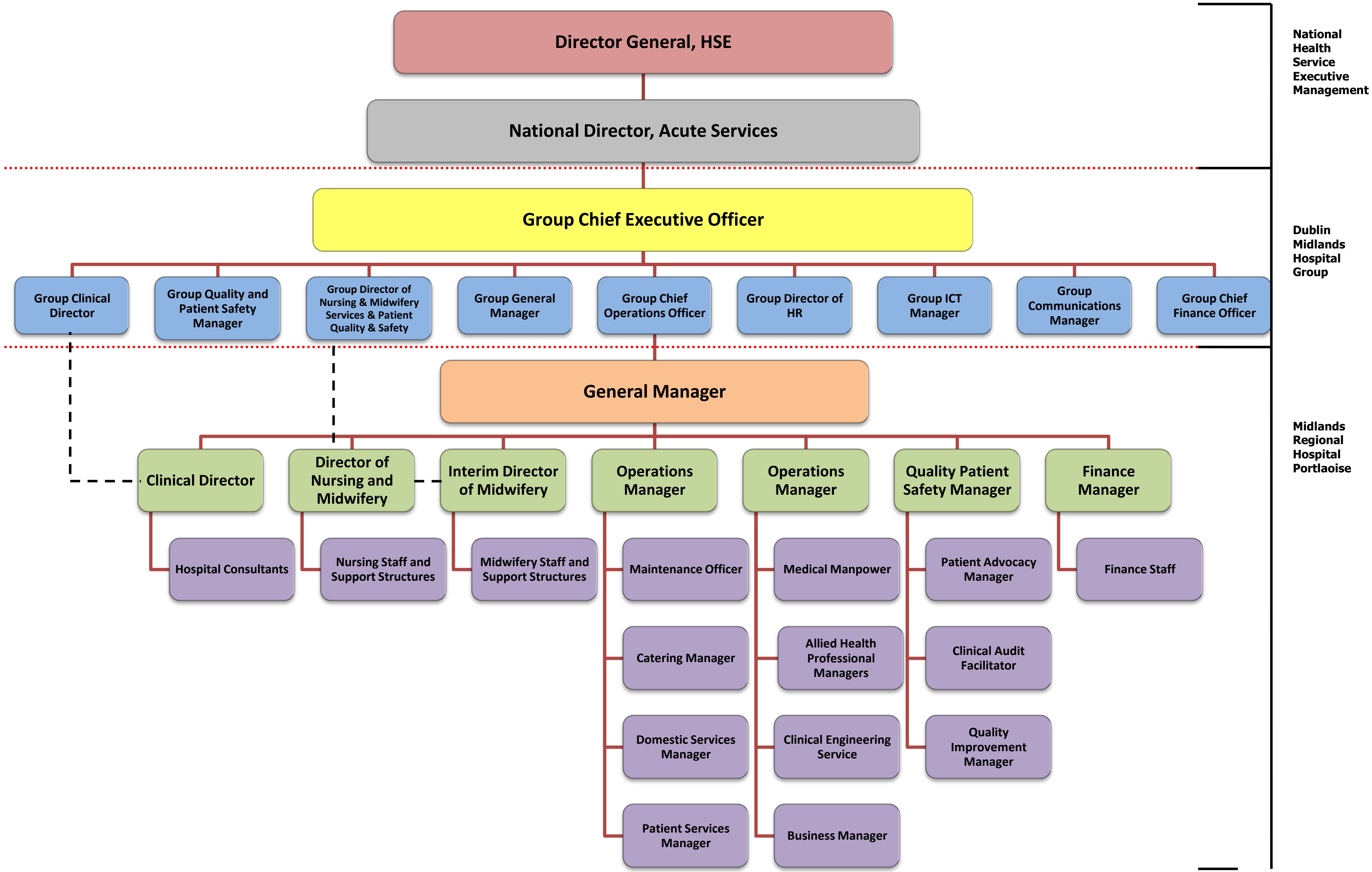
Portlaoise Hospital's Finance Manager reports directly to the General Manager and also has a functional reporting line to the Group's Chief Financial Officer. Figure 1 illustrates the organisational structure of Portlaoise Hospital within the Dublin Midlands Hospital Group and National HSE structures. The HIQA Review Team welcomes the significant improvements seen in the governance arrangements in place. For example, in day-to-day operational management of the hospital, the Clinical Director, the Director of Nursing and the Interim Director of Midwifery all report to the General Manager for all operational elements of services. The General Manager reports to the Dublin Midlands Hospital Group Chief Operating Officer.

In addition, the Hospital's Clinical Director reports to the Group Clinical Director about issues of professional practice. The Group Clinical Director also works with the hospital's Clinical Director and General Manager in relation to human resource planning, scope of clinical services and clinical pathways across the hospital group and within Portlaoise Hospital, as well as quality and safety.

From a professional nursing and midwifery perspective, it was reported to the HIQA Review Team that the interim Director of Midwifery reports to the Director of Nursing at Portlaoise Hospital about professional practice issues. The interim Director of Midwifery is a member of the hospital management team at Portlaoise Hospital. The Director of Nursing and the interim Director of Midwifery are members of the Dublin Midlands Hospital Group's Nursing and Midwifery Executive Team. The Director of Nursing at Portlaoise Hospital reports to the Dublin Midland's Hospital Group Chief Director of Nursing and Midwifery in relation to:

- professional practice standards in nursing and midwifery
- human resource planning in nursing and midwifery
- interdisciplinary care
- the evolution of nursing roles and functions
- elements of quality and safety that relate to patient care and delivery of services.

Figure 1. The organisational structure of Portlaoise Hospital within the Dublin Midlands Hospital Group and National HSE structures.



5.3.1 Hospital funding

At the time of the HIQA Portlaoise investigation, the HSE stated that unlike other hospitals, Portlaoise Hospital's 2014 annual budget had not been reduced. This was explored further with the HSE, who explained that this was viewed as a positive and supportive signal to the hospital. The HIQA Portlaoise Investigation Team did not agree with this premise. Instead, the Investigation Team considered this position to be a misguided justification for the failure to address the substantive issue, that is, that the hospital was not adequately resourced (clinically or from the perspective of workforce or infrastructure) and not governed appropriately to be classified as a model 3 hospital.

What has changed since the HIQA Portlaoise investigation?

In order to ensure safer treatment of patients at the hospital, hospital funding has been increased significantly compared to the funding provided to the hospital before the HIQA Portlaoise Investigation. Portlaoise Hospital was allocated an annual budget of €44.9 million in 2012 and €45.2 million in 2013.[19] Its available budget for 2016, as outlined in the Dublin Midlands Hospital Group Operational Plan, is €51.7 million.[20] This is an increase of €6.8 million since 2012, a 15% increase relative to 2012.

This increased funding largely funds extra staff, many of whom work in the medical and emergency department services. At the time of the HIQA Portlaoise Investigation, the hospital employed 552 whole-time equivalent staff, equating to over 600 members of staff. At the time of this review, in May 2016, the hospital employed 650 whole-time equivalent staff, equating to over 740 members of staff. This was an 18% increase in whole-time equivalent positions filled since the HIQA Portlaoise Investigation.

5.3.2 Senior Management Team Meetings at Portlaoise Hospital

Portlaoise Hospital has now established a weekly operations management meeting, chaired by the hospital's General Manager. Evidence reviewed by HIQA confirmed that quality and patient safety was a priority area and issues raised were addressed in a timely fashion.

In addition, it was reported that the hospital's senior management team conduct frequent informal quality and safety walk-rounds as a component of quality and safety audits, including weekly environmental audits, daily bed-management meetings and hygiene audits.

5.4 Quality and patient safety governance structures at Portlaoise Hospital

Background

The 2014 HIQA Portlaoise Investigation Team reviewed the management systems around quality and patient safety at Portlaoise Hospital. It found that implementation of a pilot project for national quality and safety clinical governance at the hospital resulted in a hospital committee structure of over 20 different local committees organized under a Quality and Safety Executive Committee. Senior managers had expressed concern about the amount of time that was spent attending meetings and that, despite the time commitment involved, the minutes reviewed did not indicate effective management of issues that should have been of concern.

What has changed since the HIQA Portlaoise investigation?

The HIQA Review team considered the current governance arrangements for delivering safe, quality care at the hospital. The Review Team found that the Quality and Safety Executive Committee had been restructured in July 2015. The role of the committee has been refocused, with assurance arrangements in place to assess that services are safe, that patient safety is managed effectively and, when appropriate, risk is raised to a higher level. To this end, seven quality and safety committees representing all the clinical services in the hospital now report directly to the Quality and Safety Executive Committee.

Membership of these specialty committees include at least one member of senior management. At the time of this review, there was evidence that complaints and their management, reporting and investigating of adverse events, and management of risks to the service were monitored and being acted on at the Quality and Safety Executive Committee meetings. There was evidence of trend analysis and recommendations from such analysis. In addition, clinical audit findings, trends and other metrics (agreed standards of measurement for patient care) were also reviewed at the meetings. For example, analysis of reported medication incidents and recommendations from this analysis were considered. It was evident to the HIQA Review Team that these meetings were well organized and well attended. Additionally, decisions made were communicated appropriately, and actions were implemented within defined timelines.

5.5 Risk management and management of adverse incidents

Background

The HIQA Portlaoise Investigation Team had reviewed clinical risk management structures in place in the general services at Portlaoise Hospital. It had found no risk manager was in place and risks had not been comprehensively reviewed or addressed at a local and or senior level. As a result, there was little if any learning from adverse events taking place.

This was further complicated by patient-safety incident reports being administered off site, with no local hospital-wide system of collating data, trending or using information proactively to address risks. This same situation existed in the maternity services at Portlaoise Hospital until April 2014, when the HSE appointed a quality and safety manager for maternity services.

What has changed since the HIQA Portlaoise investigation?

5.5.1 Risk management

The hospital has addressed the identified absence of a qualified risk manager. The Quality and Safety Manager appointed in 2014 for the maternity services is responsible for risk management for both general and maternity services, has executive responsibilities and is a member of the senior management team.

In addition, administrative support to ensure that all incidents for general and maternity services are locally inputted in a timely manner into the National Incident Management System has also been put in place.[*] Operationally, line managers are now responsible for developing risk registers in their own clinical areas. There is now a clear pathway for raising risk issues. Documents recorded that escalated risks were being discussed at weekly operational team management meetings and were being effectively managed where appropriate.

It was reported that 15 risks, which could not be addressed at local level, were appropriately escalated to the Dublin Midlands Hospital Group in 2015. These related to infrastructural requirements concerning a lack of isolation facilities, outpatient department facilities and bereavement room, lack of information communications

[*] The National Incident Management System (NIMS) is a national web-based database for the reporting of adverse clinical incidents and 'near misses'.

technology (ICT) capacity, the reliance on agency and locum staff and the facilities in place for the Central Sterile Services Department*. There was evidence from review of the minutes and from interview with staff that these concerns were being actively addressed wherever possible. For example, a risk regarding the lack of fetal anomaly scanning in Portlaoise Hospital maternity services was escalated to the Dublin Midlands Hospital Group. As a result, anatomy scans are provided at the Coombe Women and Infants University Hospital for all women over 39 years of age who booked for maternity care in Portlaoise Hospital.

It was evident to the HIQA Review Team that the current risk register process in place at Portlaoise Hospital had improved since the HIQA Portlaoise investigation and there was clarity around the escalation and management of key risks.

5.5.2 Management of adverse events

There was evidence that incident reporting and management in Portlaoise Hospital had improved since the publication of the HIQA Portlaoise Report. There were clear processes in place to facilitate incident reporting. The hospital had been a pilot site for implementing the National Incident Management System (NIMS), and training had been provided to staff across the hospital to facilitate its roll out.

Monthly incident reports are issued to the lead clinicians in the various specialties for review in order to ensure that oversight of incidents is maintained. The hospital management team said they were assured that they maintained good oversight of incidents that occurred in the hospital.

The HIQA Review Team was informed by senior management that there was now a good patient safety incident 'reporting culture' across the hospital and that there were over 2,500 incidents reported for 2015. A good patient safety reporting culture within a healthcare service means that patient safety incidents are being reported frequently allowing for greater opportunities to learn and improve from patient safety incidents.[21] A good reporting culture, leading to higher reporting rates, has been found to be associated with a more positive safety culture.[22,23] Crucially, it ensures that staff feel safe to report incidents or near misses in the best interest of ongoing improvement in patient safety.

* The Central Sterile Services Department is an area in hospitals that performs sterilization and other actions on medical devices, equipment and consumables for subsequent use by health workers in the operating theatre of the hospital and also for other aseptic procedures.

A Serious Incident Management Team had been set up for the hospital. The HIQA Review Team was informed that whenever a serious reportable event[*24] or a serious incident happens, the hospital's General Manager, its Quality and Safety Manager, Clinical Director, Director of Midwifery and the Director of Nursing met to discuss how the incident would be investigated. Senior management at Portlaoise told the HIQA Review Team that the Serious Incident Management Team manages the incident in line with the HSE's Safety Incident Management Policy[25] to determine the level of escalation or investigation required. The decision is then communicated or escalated to the Chief Executive Officer of the hospital group by the General Manager for further consideration.

There was ongoing training provided to staff in systems-analysis investigation at Portlaoise Hospital to enable incidents to be investigated in a timely fashion in line with HSE guidelines. The challenge of sourcing external clinical expert input for serious incident management was reported to be an issue by the hospital's senior management team. The HIQA Review Team was told that this led to a delay in completing investigations. The hospital management team reported that systems-analysis investigations were not always the most appropriate method to examine an incident. Rather, they perceived the need for a variety of methods to enable effective and efficient investigations of incidents. The hospital management team reported that this had been raised to the HSE National Director of Quality Assurance and Verification.

In an interview with national HSE senior management, it was acknowledged that reasons for delays in HSE reviews and investigations included:

- inflexible investigation processes
- lack of availability of competent investigators with dedicated time
- complexity of cases
- public expectations regarding requirement for external investigators
- depending on the Forum of Irish Postgraduate Medical Training Bodies for sourcing clinical experts.

[*] HSE Serious Reportable Event (SRE) Implementation Guidance Document (2015) define SRE's as 'Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

To address this, HSE senior management reported that there were plans to review the HSE's Safety Incident Management Policy[25] by the end of 2016 and include additional methods for investigation and review. There were also plans to review the current approach to training and support for investigators.

There was evidence of learning and sharing of findings from previous investigations at the hospital. The HIQA Review Team was provided with an action plan that had been developed to monitor the implementation of recommendations from previous investigations into standards of care and reports that were relevant to the services at Portlaoise Hospital.

The action plan stated that the following had been implemented in response to recommendations from previous investigations:

- training and education for new staff at staff induction on the Irish Maternity Early Warning System IMEWS[*] and National Early Warning Score (NEWS)[**]
- development and implementation of the investigation and management of late fetal intrauterine death and stillbirth guidelines
- national guideline on oxytocin had been adapted for local use
- training on fetal monitoring for maternity staff
- roll out of the Caring Behaviour Assurance System — Ireland[***]
- staff had been provided with education on supportive bereavement care
- customer care training
- implementation of paediatric triage
- development of a guideline and information leaflet for pregnant women who present to the hospital with reduced fetal movements.

Incident trends were being reviewed and managed. For example, the hospital identified from a review of medication-related reported incidents that there was a trend in prescribing errors. As a result, a new prescription record had been

---

[*] The Irish Maternity Early Warning System (IMEWS) is an early warning scoring system designed to support the early detection of life-threatening illnesses.
[**] National Early Warning Score (NEWS) is a nationally agreed early warning score for the early recognition and management of acutely ill adult patients.
[***] The Caring Behaviours Assurance System — Ireland is described by the HSE as "an accountability system designed to engage individuals, teams and executive boards in achieving the national agenda for assuring the quality and safety of the care experience for patients, their families and for staff" and "a system for enabling and assuring the delivery of person-centred health and care from point of care to Executive Board".

introduced to mitigate this risk. This had been implemented in February 2016. There was also a plan to have a clinical pharmacist attend the medical ward rounds, as an additional means of monitoring prescribing, to help reduce the risk of prescribing errors.

There was evidence that the Dublin Midlands Hospital Group had oversight of the risk and incident management processes at the hospital and that incidents and risk escalated from Portlaoise Hospital were being reviewed by the Group Quality and Safety Team. Quality and safety was also a standing item on the monthly performance meetings between Portlaoise Hospital and Group Management teams.

Overall, the HIQA Review Team was assured that systems and processes for identifying and reporting clinical incidents were in place and that there was evidence of learning taking place from previous incidents at the hospital.

5.6 Complaints management

Background

The HIQA Portlaoise Investigation Team had found that Portlaoise Hospital had not developed a standardized way of managing complaints that was aligned to the HSE's national complaints management process and complaints policies and procedures manual, *Your Service Your Say*.[26] At the time, there were major non-compliances with national recommended timelines for completion of complaint reviews. There was also little evidence of learning, following investigations into specific complaints, being put into practice for the benefit of other patients.

What has changed since the HIQA Portlaoise investigation?

A new Patient Advocacy Manager has been appointed by the hospital and started on 22 June 2016. This post was vacant from December 2015 and, in the interim, the Quality and Patient Safety manager assumed responsibility for managing complaints. There was also dedicated administrative support at the hospital for managing complaints, while quarterly compilation reports outlining complaints was sent to the clinical ward managers and clinical departments. These reports categorised themes of complaints in line with the framework outlined in HSE guidelines.[27]

The hospital reported that 80% of complaints received were now closed within the expected 30-day time frame. This is in contrast to information reported at the time of the HIQA Portlaoise investigation, which showed that only 16% of complaints had been investigated and concluded within the prescribed 30-day time frame in 2013.

The HIQA Review Team was informed that staff are encouraged to address complaints at the point of occurrence. A verbal complaint form had been implemented in December 2015 and was reported to be working well, with 18 verbal complaints recorded in January 2016 and 20 verbal complaints recorded in February 2016.

The HIQA Review Team was informed that information and learning from complaints was relayed to staff through the specialty governance committees and to nursing and midwifery managers through their monthly senior nursing management meetings and clinical manager meetings.

The hospital senior management team reported that they found that meetings between patients and families, lead clinicians involved in their care, and the quality and patient safety manager soon after the complaint was received, was an effective means of responding to complaints. The management team reported that directly hearing families' experiences provided opportunities to managers and clinical staff for learning to promote service improvement.

The hospital also collated data on compliments it received. It was reported at interview that the ratio of compliments to complaints at the hospital was approximately seven compliments for every one complaint (118 complaints and 753 compliments received in 2015).

There were a number of initiatives ongoing at the hospital in response to feedback from complaints. Such initiatives included but were not limited to:

- The hospital management team had engaged with the HSE's Advocacy Unit to develop public and patient partnership initiatives, which started in December 2015. This programme involves patient and staff surveys and focus groups, and developing a hospital-wide action plan based on the findings.
- Training and education in open disclosure was ongoing across the hospital, with four members of staff receiving 'train-the-trainer' training, while 10 briefing sessions on open disclosure had been provided from November 2015–March 2016.
- The clinical departments had engaged with the Caring Behaviour Assurance System — Ireland and had developed action plans for maternity, paediatrics, surgery and theatre.

- A communications policy to promote clear communication between healthcare professionals had been developed and implemented for staff in the maternity services

It was evident to the HIQA Review Team that Portlaoise Hospital had improved the systems in place to effectively manage and learn from complaints.

5.7 Workforce planning

Background

The HIQA Portlaoise Investigation Team had found significant ongoing problems with workforce planning in Portlaoise Hospital, which was excessively relying on agency non-consultant hospital doctors (NCHDs), nurses and midwives. At the time of the HIQA Portlaoise Investigation, there was an absence of a clear vision for the hospital and a national imperative to reduce the staff headcount. These factors had reduced workforce planning to the level of counting staff rather than focusing on the type of service the hospital should be delivering and the workforce needed to deliver that service.

It was the opinion of the HIQA Portlaoise Investigation Team that incorporating Portlaoise Hospital into a clinical network within a hospital-group structure – with certain grades of staff, including hospital consultants, non-consultant doctors and speciality nurses, being obliged to rotate between sites as required – was necessary to assure the ongoing provision of a clinically competent and stable workforce at the hospital.

What has changed since the HIQA Portlaoise Investigation?

At the time of this HIQA Review, Portlaoise Hospital was still spending a significant amount of its budget on agency staff throughout the hospital. It was reported that between June 2015 and March 2016 (a period of 10 months), the hospital had spent €10.6 million on agency staff. This is a significant percentage of its annual funding given that its available budget, as outlined in the Dublin Midlands Hospital Group Operational Plan, is €51.7 million for 2016.[20]

Staff reported that relying on agency staff was primarily due to difficulties in attracting and retaining permanent staff, which was attributed both to a shortage of staff nationally and the uncertainty surrounding the future and range of clinical services to be provided in Portlaoise Hospital.

In the maternity service, two consultant obstetricians and gynaecologists had been appointed in August 2016 to work between the Coombe Women and Infants University Hospital and Portlaoise Hospital. These joint appointments require each consultant to work 25 hours on site in Portlaoise Hospital and the remainder of their time at the Coombe Women and Infants University Hospital. In addition, a midwife from Portlaoise Hospital was completing ultrasound training at Coombe Women and Infants University Hospital, and it was planned that additional midwives would also complete this training.

In general services, there had also been additional recruitment of consultants and other staffing. For example, a consultant radiologist, an additional medical consultant and an additional paediatric consultant had been recruited since the HIQA Portlaoise Investigation. However, no new arrangements had been established since the investigation to support rotation of doctors or nurses between hospitals within the Dublin Midlands Hospital Group.

5.8 Clinical audit and performance metrics

Background

Clinical audit is the review of current clinical practice in order to improve quality. It is an important means of understanding and assuring the service provider of the quality of care provided to patients.

The HIQA Portlaoise Investigation Team had found that while there was evidence of some clinical audits being carried out in different areas of the hospital, there was no strategic plan for clinical audit across the hospital. In addition, it did not have the information technology structures necessary to support an effective system of multidisciplinary audit.

What has changed since the HIQA Portlaoise Investigation?

The HIQA Review Team found that progress had been made in developing clinical audit structures at Portlaoise Hospital. There was a clinical audit facilitator on site who reported to the Quality and Patient Safety Manager. A hospital wide clinical audit committee was in the process of being set up, and a medical consultant had been nominated as the chairperson of the committee.

There was evidence that there were clinical audits in progress across the specialties and that recommendations from some of these audits had been implemented. For example, an audit of consent practices was undertaken for theatre services and, following implementation of recommendations, a re-audit identified that these practices had improved.

5.9 Clinical services at Portlaoise Hospital — national planning and oversight

Background

The HIQA Portlaoise Investigation Report had identified significant concerns in relation to the HSE's oversight of the safety and or appropriateness of services being provided at Portlaoise Hospital. The report had concluded that the HSE lacked a clear strategy or vision for the hospital. Portlaoise Hospital was regarded by the HSE as a model 3 hospital — a hospital which can provide acute services to patients presenting with all manner of injury and illness, including life support. However, the hospital was neither funded, equipped nor resourced to provide this range of services.

The HIQA Portlaoise Investigation Team recommended that, as a priority, the HSE had to determine, publish, and implement the range of clinical services that Portlaoise Hospital could safely deliver and that the hospital had to be fully integrated into a hospital-group structure with associated clinical networks.

What has changed since the HIQA Portlaoise Investigation?

At the time of this Review, the HSE had yet to finalise and publish a report which set out the expected range of clinical services that Portlaoise Hospital could safely deliver. HIQA is aware that the Dublin Midlands Hospital Group has developed a draft action plan for the hospital, which it was intended would define a new model of service for Portlaoise Hospital within the Hospital Group. However, at the time of this Review, this draft plan had yet to be fully agreed and published.

It was explained to the HIQA Review Team that the draft action plan was developed by senior managers in the hospital group in collaboration with an external advisory group made up of the national clinical leads for eight HSE national clinical programmes, including the clinical programmes for:

- Emergency Medicine
- Acute Medicine
- Obstetrics and Gynaecology
- Surgery

- Anaesthetics
- Critical care
- Paediatrics and Neonatology
- Transport Medicine.

HIQA has also been informed that the Dublin Midlands Hospital Group senior management team had worked with the Clinical Director of the National Ambulance Service, the Deputy Director of the Acute Hospitals Division, National Clinical Advisor to the Acute Hospitals Division, the Management and Clinical Staff at Portlaoise Hospital and the Master and Management Team of the Coombe Women and Infants University Hospital to develop this draft action plan.

HIQA understands that this draft plan sets out a proposed strategic direction for the Dublin Midlands Hospital Group and the clinical services that will be delivered in Portlaoise Hospital in the future. It was explained to the HIQA Review Team that this draft plan was unanimously agreed by the consultant leads of the national clinical care programmes, who acted as an advisory group. However, at the time of writing this report, it was explained to the Review Team that neither this nor any alternate plan had been finalised and agreed by those with responsibility for the ultimate decision making on the hospital's future. Consequently, in the absence of an agreed strategic plan being put in place, Portlaoise Hospital remains in a state of uncertainty.

At the time of the Review, clinical and managerial staff from Portlaoise Hospital reported to the HIQA Review Team the effect that the continued lack of strategic direction was having on the staff morale, the ability to attract and retain staff and the ability to deliver safe services in the future. Staff reported their frustrations on hearing different stories each day in the media as to the future plans for the hospital.

This HIQA Review has identified that as things currently stand, the ongoing lack of clarity for the hospital with respect to its future direction is in fact having a negative effect on current service provision, primarily due to difficulty in recruiting and retaining staff. As the delay in progress becomes prolonged, the adverse impact of such a strategic vacuum for the hospital becomes ever greater. Publication and progression of a strategic plan for the hospital, which takes account of current and future population needs and the likely knock-on effect on other services is, therefore, required in the short term to avoid the undoing of much of the positive progress that has been made at the hospital since the HIQA Portlaoise Investigation.

5.10 Patient safety culture in Portlaoise Hospital

As part of the HIQA Portlaoise Investigation, HIQA had assessed the prevailing patient safety culture in Portlaoise Hospital using an assessment tool called the Safety Culture Index.[28] At the time of the HIQA Portlaoise Investigation, the results suggested that Portlaoise Hospital did not have a strong patient safety culture.

The completed 'Assessment of Safety Culture in Midland Regional Hospital Portlaoise using the Safety Culture Index' had suggested the immediate need for a management intervention. This would have included communicating a compelling vision of a new safety culture to all staff, which should have consisted of priority interventions such as:

- increasing management 'safety rounds'
- streamlining incident reporting procedures
- linking safety initiatives to actual incidents and issues
- providing incentives to empower staff about safety.

What has changed since the HIQA Portlaoise Investigation?

It was not within the scope of this HIQA Review to formally re-assess the patient safety culture in Portlaoise Hospital. Instead, the HIQA Review Team examined how Portlaoise Hospital and the Dublin Midlands Hospital Group had set about improving the patient safety culture at the hospital.

Patient safety culture is a complex phenomenon. A number of significant studies have shown that senior leadership accountability is crucial to an organisation-wide culture of safety.[29] In Ireland in 2008, *Building a Culture of Patient Safety – Report of the Commission on Patient Safety and Quality Assurance* identified leadership and accountability as fundamentally important criteria for safety.[30]

The HIQA Review Team found improved governance structures for quality and safety at Portlaoise Hospital, both locally and at Dublin Midlands Hospital Group level. Regular quality and patient safety meetings took place within the hospital for all specialities and at hospital-group level. Quality and patient safety were also standing agenda items at weekly management and operations meetings at Portlaoise Hospital.

The hospital had recently rolled out the Caring Behaviour Assurance System Ireland (the accountability system designed to improve patient safety, from the bedside to the boardroom) to a number of clinical departments and had developed action plans for maternity, paediatrics, surgery and theatre.

In addition, the National HSE Office of the Nursing and Midwifery Services Director has commissioned a programme from the Florence Nightingale Foundation[*] entitled 'Leaders for Compassionate Care'[**] programme which aims to assist managers to re-engage with core values such as effective communication. This programme was lead at hospital level by the Director of Nursing and Midwifery and the General Manager, while a number of Clinical Nurse Managers and Clinical Midwifery Managers from Portlaoise Hospital had attended this programme.

It was evident that there had been improvements to incident reporting and management in Portlaoise Hospital. Senior managers from the Dublin Midlands Hospital Group conducted formal quality and safety walk-rounds at Portlaoise Hospital, and the senior management team at Portlaoise Hospital conducted informal quality and safety walk-rounds to identify and discuss safety concerns.

The HIQA Review Team found that there was evidence of interventions by senior management to provide leadership at Portlaoise Hospital in order to support a safer patient culture.

5.11 Conclusions in relation to governance

The HIQA Review Team found there had been significant improvements in corporate and clinical governance at Portlaoise Hospital. The senior management team demonstrated that they were responsive to patient safety and quality concerns that were raised. There was evidence that the management team worked together to manage complaints and response to patient safety incidents.

The HIQA Review Team noted that risks and serious incidents from the hospital were being raised with the Dublin Midlands Hospital Group, and there was oversight

---

[*] The Florence Nightingale foundation is an organisation that supports nurses and midwives through scholarships, research, mentoring, leadership development and other academic activities.
[**] The Office of the Nursing and Midwifery Services Director commissioned a programme from the Florence Nightingale foundation entitled Leaders for Compassionate Care" - a three day development programme for leading nurses and midwives.

of these risks to patient safety at hospital-group level. The effectiveness of the working relationship between the hospital's and hospital group's management teams was much improved compared to that found during the HIQA Portlaoise Investigation.

The hospital also had made significant progress in improving how it monitored the quality and safety of services provided. There was also evidence of significant investment in the hospital to mitigate the risks associated with the difficulty in recruitment; however, this resulted in high agency staffing costs.

Despite significant improvements seen in corporate and clinical governance, the lack of an overall agreed and published strategy for the future direction of the hospital within the wider Dublin Midlands Hospital Group raised significant concerns in terms of the long-term sustainability of certain services at Portlaoise Hospital. The continuing sense of drift in the absence of a defined model of care and published action plan on the hospital's future was having a negative impact on the hospital in terms of staff morale and the hospital's ability to attract and retain staff.

Chapter 6. Maternity services at Portlaoise Hospital

6.1 Introduction

This section of the report reviews progress on the HIQA recommendations on maternity services at Portlaoise Hospital.

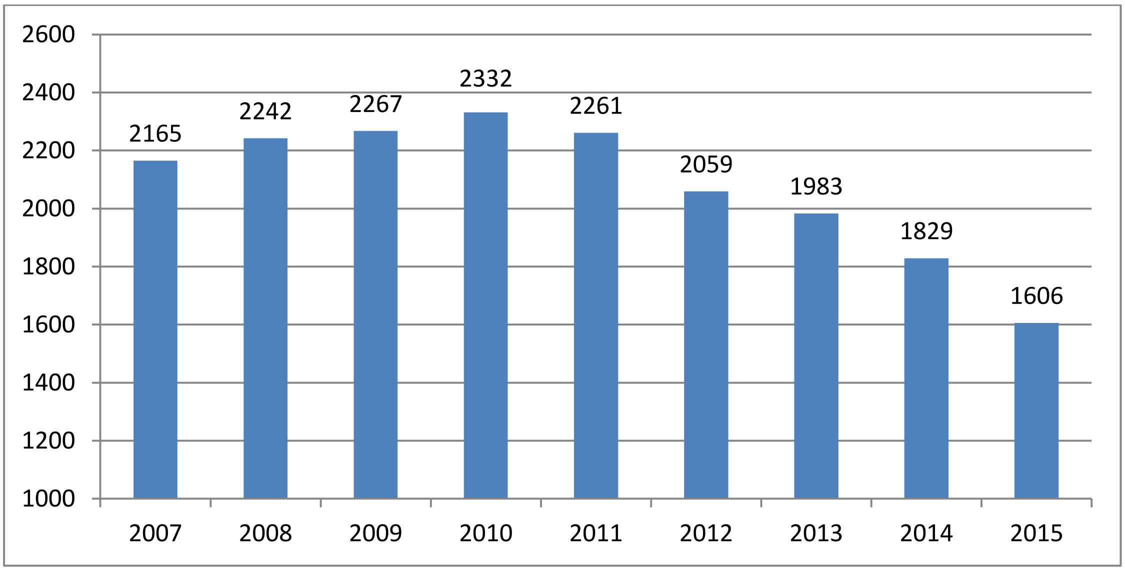
HIQA's Portlaoise investigation was prompted in response to concerns about the quality and safety of services at the hospital, in particular its maternity services. Chief among these concerns were consistent reports from many women and their families describing unacceptable standards of care. As part of this follow-up review, HIQA revisited the maternity department in June 2016 and observed current infrastructure for maternity services in the:

- Outpatient Department
- Early Pregnancy Assessment Unit (EPAU)
- Maternity ward
- Labour ward
- Special Care Baby Unit.

6.2 Profile of the maternity services at Portlaoise Hospital

Maternity services at Portlaoise Hospital are led by hospital consultants, with pregnant women and mothers attending the hospital for antenatal, delivery and postnatal care. The Maternity Department at Portlaoise Hospital primarily serves the population of Laois as well as parts of counties Offaly, Tipperary, Kildare and Carlow. The annual number of births at Portlaoise Hospital between 2007 and 2015 are set in out Figure 2.

Figure 2. Annual number of births at Portlaoise Hospital, 2007 to 2015



The HIQA Review Team were informed that there were 1,606 births to 1,588 mothers in 2015. This is a decline in births of 12% since 2014, and a decline of over 31% from the peak of 2,332 births in 2010. A review of birth rates for the first six months of 2016 noted a further decline in this number to a total of 677 births. This would give a projected estimate of the annual total of births in the hospital for 2016 of approximately 1,300–1,400 births.

It was reported to the HIQA Review Team that analysis of the number of births found that this was mainly due to a decline in new mothers booking for maternity care at the maternity unit, while women who had a previous birth in Portlaoise Hospital were more likely to return to the service. For example, in 2015 less than one in three births (31%) in the maternity unit were to first-time mothers.

The overall caesarean section rate for 2015 was 30.2 caesarean sections per 100 births. This rate had decreased from the rate of 32.7 caesarean sections per 100 births for 2014. This rate is similar to the national reported caesarean section rate for 2014 of 30.4 per 100 live births.[31] Data from 2014 from the National Perinatal Epidemiology Centre reported a corrected perinatal mortality rate of 5.5 per 1,000 births for Portlaoise Hospital, which was consistent with national rates that year.[32]

In 2014, the HSE Clinical Programme in Obstetrics and Gynaecology developed the Irish Maternity Indicator System (IMIS) as a way of measuring and interpreting activities in maternity services. This was developed in response to national recommendations made in the Chief Medical Officer's report and other HIQA investigations. Irish Maternity Indicator System data collated for Portlaoise Hospital in 2015 had no reported cases of neonatal encephalopathy for 2015 and perinatal mortality rates were consistent with nationally reported rates.[33]

6.3 Corporate and clinical governance

6.3.1. Introduction

The HIQA Review Team reviewed clinical and corporate governance of the maternity services at Portlaoise Hospital. In particular, this section of the report will focus on systems of management and leadership for the maternity services, workforce issues, clinical audit (ongoing review and evaluation of clinical practice), use of information and education and training.

6.3.2. Management team for the maternity services

Background

Following publication of the Chief Medical Officer's report in February 2014,[2] local corporate governance structures for the maternity services were reviewed and strengthened. An interim management team consisting of a General Manager, a Director of Midwifery, and a Quality and Patient Safety Manager were appointed by the HSE's Regional Director of Performance and Integration. In addition, one of the consultant obstetricians working in the maternity unit assumed the role of Clinical Lead and joined the interim management team.

What has changed since the HIQA Portlaoise Investigation?

The General Manager, who had been initially appointed as part of the interim management team for the maternity services, has since been appointed as General Manager for all general and maternity services in Portlaoise Hospital. The Director of Midwifery, who had been appointed to the interim management team for maternity services, has since been appointed as Director of Nursing for the General Hospital.

An Interim Director of Midwifery has been in position at the hospital since February 2016 and she reported directly to the General Manager. At the time of the review, the current postholder was on secondment from the Coombe Women and Infants University Hospital. The interim Director of Midwifery was a member of the senior management team at Portlaoise Hospital and attended weekly operations meetings to discuss issues relating to maternity services at these meetings.

The consultant who assumed the role of Clinical Lead for Obstetrics as a member of the interim management team was still in post and reported to the hospital's Clinical Director for clinical and professional issues and to the General Manager for operational responsibilities.

The maternity services held multidisciplinary team meetings weekly to fortnightly to review quality and patient safety. The Clinical Director for Integration (a senior consultant obstetrician and gynaecologist from the Coombe Women and Infants University Hospital) attended these meetings. The monthly Irish Maternity Indicator system reports, monthly maternity patient safety[*] statements, and policy and guidelines were some of the issues reviewed at these meetings.

It was evident to the HIQA Review Team that reporting relationships and levels of accountability were clearly outlined and understood by all members of the management team. Maternity services were a standing agenda item at the hospital's weekly operational meetings.

6.3.3. Clinical network

Background

Recommendations from the Institute of Obstetricians and Gynaecologists in 2006[34] and from the Chief Medical Officer's Report in 2014[2] had advised that clinical maternity networks should be established in Ireland. It was recommended that the Maternity Department in Portlaoise Hospital be linked to the Coombe Women and Infants University Hospital in Dublin. This was aimed at creating one single maternity unit over two sites which would support and enable:

- a common system of governance
- capacity for medical, midwifery and other staff to be appointed to the network and to rotate between the two sites to facilitate training and services

[*] In line with recommendations from the Chief Medical Officer's report, the HIQA Portlaoise Report and the HSE National Service Plan 2015, there is a requirement for all 19 maternity units to report and publish a maternity patient safety statement each month. The purpose of the statement is for each maternity unit to review their own data on a monthly basis. This data will inform management and assist them to carry out their role in quality and safety improvement (HSE 2015).

- training of junior doctors and midwives on both sites
- risk categorisation of patients to ensure that higher risk patients are managed at the Coombe Women and Infants University Hospital.

The HIQA Portlaoise Investigation Team had advised that developing such a clinical network was an essential step in ensuring the quality and safety of the maternity services at Portlaoise Hospital. In March 2015, a Memorandum of Understanding was signed between the Coombe Women and Infants University Hospital and the HSE.

What has changed since the HIQA Portlaoise Investigation?

At the time of this HIQA Review, a senior consultant obstetrician and gynaecologist from the Coombe Women and Infants University Hospital had been assigned as Clinical Director for Integration and was in position since April 2015. This role, which involved attending Portlaoise Maternity unit two days a week, had the remit to facilitate, with others, the development of a clinical network between both maternity units.

The HIQA Review Team was informed that the following changes have been overseen by the Clinical Director for Integration:

- A weekly multidisciplinary meeting is held to review all the caesarean sections from the previous week in order to identify any opportunities for learning and to increase confidence in clinical decision-making.
- A weekly consultant meeting has been set up with the purpose of reviewing any staffing or clinical issues arising from the previous week.
- The Clinical Director for Integration attends the ward-round meeting when in Portlaoise Hospital in order to offer clinical expertise and support to the obstetric team.
- The Clinical Director for Integration also attends the weekly multidisciplinary team meeting on quality and patient safety for maternity services in Portlaoise.
- Arrangements had been put in place to ensure that all women who book for maternity care in Portlaoise have a formal dating scan to determine their delivery due date.
- The Early Pregnancy Unit had been streamlined to ensure that antenatal patients are seen on an appointment-only basis in line with national guidelines.

- Anatomy scans are now provided at the Coombe Women and Infants University Hospital for all antenatal women over 39 years of age who book at Portlaoise Hospital.
- One of the midwives from Portlaoise Hospital had started practical training in ultrasound in the Coombe Women and Infants University Hospital with a view to providing scanning sessions in Portlaoise Hospital with support from the Coombe Women and Infants University Hospital.
- A business plan had been submitted for a computer system to allow ultrasound images from Portlaoise Hospital to be reviewed remotely in the Coombe Women and Infants University Hospital if a consultation is required.
- Two joint-appointment consultant obstetricians had been appointed to provide care between the Coombe Women and Infants University Hospital and Portlaoise Hospital, and they commenced these positions in August 2016.

The Memorandum of Understanding between the Coombe Women and Infants University Hospital and the HSE has an implementation plan which outlines the following five phases:

- Phase 1 — Signing of the Memorandum of Understanding
- Phase 2 — Pre-integration phase, which will involve outlining the need for in-depth project planning, research into information communications technology (ICT) options and agreement on a range of processes.
- Phase 3 — Foundation Building, which will involve the setting up of hospital integration teams across both sites and achieving agreement on reporting lines.
- Phase 4 — Cultural Integration, which will involve measures to standardise the organisational culture across both sites.
- Phase 5 — Assimilation, where, once all the milestones have been achieved, the Coombe Women and Infants University Hospital will assume governance of Portlaoise Maternity Services

An Integration Steering Group was set up in April 2015. This group is additionally supported by an external project management company. It meets monthly with senior members of both clinical and managerial staff from the Coombe Women and Infants University Hospital and Portlaoise Hospital and the CEO of the Dublin Midlands Hospital Group.

'Patient-pathway' workshops had been held with staff from both hospitals to examine current patient pathways in both hospitals. The information gathered in these workshops has been used to design a set of service blueprints for integrated-care pathways for maternity patients.

These draft service blueprints were displayed on both hospital sites for staff review, with feedback from staff being used to update them. Patient feedback sessions were held in Portlaoise, with the response being described as positive. These draft service blueprints were seen by the HIQA Review Team and provided a comprehensive overview of the care pathways for different types of maternity patients across both sites.

Joint perinatal mortality meetings between the Coombe Women and Infants University Hospital and Portlaoise Hospital were being planned; at the time of this Review, however, they had yet to take place as purchase of suitable ICT systems to support this measure was awaited. The Integration Steering Group had also submitted plans for a new modular building at Portlaoise Hospital, which would improve the outpatient services offered to maternity patients.

The Integration Steering Group recognized that the lack of an ICT solution for Portlaoise maternity services to link in with the Coombe Women and Infants University Hospital was a challenge and strategies were being reviewed to overcome this.

The Integration Steering Group also recognized the need for one dedicated obstetrics and gynaecology operating theatre for maternity services in Portlaoise Hospital, and it was reported that a service-level agreement was being developed to accommodate this.

HIQA was informed by senior management of Dublin Midlands Hospital Group that full integration of the Portlaoise maternity services within the governance structure of the Coombe Women and Infants University Hospital will only be fully enacted once the issues outlined in the Memorandum of Understanding are implemented. However, the HIQA Review Team was told that the biggest challenge to this was a need for investment, including capital funding for infrastructural and ICT development, and recruitment of personnel. The Memorandum of Understanding outlined the need for the appointment of additional personnel as well as infrastructural development across both sites.

Overall, there was evidence that the integration of services between the two maternity sites was making progress; however, a considerable body of work and investment is required to fully achieve this critically important development for maternity services at Portlaoise.

6.3.4. Clinical leadership

The assignment of the Clinical Director for Integration provided effective additional senior clinical leadership to the obstetricians at Portlaoise Hospital. Changes implemented since commencement of this role include reviewing and overseeing current practices and aligning the clinical quality and audit activities of the maternity department in Portlaoise Hospital with the Coombe Women and Infants University Hospital.

The HIQA Review Team were given examples of how the Clinical Director for Integration had enabled sharing of policies and practices from the Coombe Women and Infants University Hospital and provided support in implementing these at Portlaoise Hospital. The interim Director of Midwifery was adapting the partogram used in Portlaoise Hospital at the time of this HIQA Review to align it with the Coombe Women and Infants University Hospital Partogram.[*] The purpose of this was to reflect the recommendations of the clinical practice guideline for Oxytocin[**] issued by the National Clinical Programme in Obstetrics and Gynaecology.[35]

6.3.5. Clinical audit and performance metrics

Background

The HIQA Portlaoise Investigation into maternity services at Portlaoise Hospital identified a need for better audit arrangements to assure good practice and to identify areas of improvement.

What has changed since the HIQA Portlaoise Investigation?

The Maternity Services has established a multidisciplinary audit committee that meets monthly. There was evidence of a strong and effective audit agenda and that the recommendations arising from these audits were being implemented. The Clinical Audit Facilitator maintained a database of clinical audits completed in the maternity unit and progress on implementing recommendations of audits. Clinical

[*] The partogram is a graphical presentation of the progress of labour, and of fetal and maternal condition during labour.
[**] Oxytocin a medication used to induce or accelerate the process of giving birth.

audits were conducted by all members of the multidisciplinary team, and review of the minutes indicated that 33 staff members had been provided with training on clinical audit by the Clinical Audit Facilitator.

The maternity services had developed an annual audit plan for 2016 and some of the audits selected were based on recommendations from previous investigations and reports into services at the hospital. The HIQA Review Team found that the annual audit plan was strategic and focused on evaluating key risks in maternity care. For example, following audit of oxytocin and fetal monitoring, a plan was developed to standardize both oxytocin practices and the partogram used in Portlaoise Hospital to reflect the practices in the Coombe Women and Infants University Hospital.

The Irish Maternity Indicator System data collection tool, developed by the National Clinical Programme in Obstetrics and Gynaecology, was being collated in the Portlaoise Maternity Department by a consultant obstetrician and a clinical midwifery manager. The Clinical Director for Integration and Clinical Lead for Obstetrics both said this data was useful for reviewing trends in practice. For example, the number of obstetric anal sphincter injuries that occurred over a specific time frame indicated possible cause for concern. However, a chart review of all the cases involved found no practice issues or trends on further detailed examination. These results provided assurance to the clinical team of the care provided.

There was also evidence of monthly monitoring of the National Indicator Maternity System Metrics at the weekly Maternity Governance Committee.

The maternity services had implemented midwifery metrics for antenatal, intrapartum and postnatal care. These had been collated monthly by a clinical skills facilitator until December 2015. Midwifery metrics relevant to patient experience collated across the antenatal, labour ward and postnatal wards for 2015 scored between 94–100%. The HIQA Review Team was informed that no midwifery metrics had been collated to date in 2016 since the clinical skills facilitator had left the service.

Overall, there was evidence of an effective audit strategy in the maternity services.

6.3.6 The practice of transferring high-risk pregnant women and premature babies

Background

The HIQA Portlaoise Investigation had found that following on from the Chief Medical Officer's report in 2014, there was no evidence available that any formal arrangements had been introduced to assure the service that all transfers of pregnant women and babies were clinically appropriate and that all appropriate cases, including high-risk babies, were always transferred in a timely manner to an appropriate setting.

What has changed since the HIQA Portlaoise Investigation?

In May 2015, Portlaoise Maternity unit developed a comprehensive guideline on managing women requiring transfer to and from a high dependency unit and intensive care within or outside Portlaoise Hospital. The transfers of pregnant women to larger maternity units were being monitored as part of the data collected for the Irish Maternity Indicator System (IMIS). Clinical staff from the Maternity Department at Portlaoise Hospital told the HIQA Review Team that all patients requiring transfer out to another hospital were discussed as part of the daily ward rounds in the maternity ward.

The HIQA Review Team was also informed that if a baby needed to be transferred to another hospital, this was undertaken by the National Neonatal Transport Team and that the paediatric staff in Portlaoise Hospital had shared protocols and regular meetings with neonatal staff in the Coombe Women and Infants University Hospital.

The HIQA Review Team found that there were 23 babies transferred to other hospitals in 2015 for neonatal care and the indications for these transfers were provided. There was no transfer of babies to other hospitals from January to March 2016 reported.

The HIQA Review Team found that there was improved monitoring of the transfer of high-risk women and babies. However, the service had yet to evaluate if all transfers are clinically appropriate and if these transfers occur in a timely manner to an appropriate setting.

6.3.7. Monitoring the incidence of postpartum haemorrhage

Background

The HIQA Investigation Team identified the level of clinical oversight of the calculated rate of postpartum haemorrhage* at Portlaoise Hospital as a potential area of concern.

What has changed since the HIQA Portlaoise Investigation?

In June 2016, the HIQA Review Team found that there was close monitoring of postpartum haemorrhage rates and outcomes in the Maternity Department. Guidelines for managing postpartum haemorrhage had been revised and updated in October 2015, and included a standard document outlining the clinical management to be completed whenever a postpartum haemorrhage occurred. The hospital had carried out an audit of postpartum haemorrhage from October to November 2015 and at the time of this review there was a further audit planned for 2016.

The National Perinatal Epidemiology Centre collates data from all maternity units on major obstetric haemorrhage* as part of the national audit of severe maternal morbidity.[36] Data from the Centre for 2014 found that Portlaoise Maternity Department had a major obstetric haemorrhage rate consistent with national rates. Blood usage in the Portlaoise maternity unit is also monitored as part of the Irish Maternity Indicator System (IMIS) as an additional safety surveillance measure, and information provided to the HIQA Review Team found that reported blood usage for Portlaoise Maternity patients in 2015 was in line with nationally reported rates for 2014.[33] Portlaoise Hospital had implemented multidisciplinary team training and education on obstetric emergencies in June 2014. This training included management of obstetric haemorrhage and was held every three months. A review of training records by the HIQA Review Team identified that it was well attended by members of the multidisciplinary team, including midwives, anaesthetists, obstetricians and theatre nursing staff.

---

* The HSE's Clinical Programme in Obstetrics and Gynaecology's guidelines on the prevention and management of postpartum haemorrhage define primary postpartum haemorrhage as the loss of 500 mls or more of blood from the genital tract within 24 hours of the birth of a baby. It further categorises a blood loss of 500 mls to 1,000 mls as minor, and more than 1,000 mls as major.

* Major obstetric haemorrhage (National Perinatal Epidemiology Centre definition for reporting severe maternal morbidity) estimated blood loss > [greater than] 2500mls or transfused five or more units of blood or received treatment for coagulopathy.

Overall, the HIQA Review Team was assured that the hospital closely monitored the rate of postpartum haemorrhage and regularly audited the effectiveness of its management.

6.4 Workforce

Background

The Chief Medical Officer's report had highlighted serious concerns in relation to staffing in the Portlaoise Maternity Department, including:

- an over-reliance on the use of agency and or locum clinical staff
- an absence of senior midwifery leadership
- an absence of effective workforce planning.

The staffing deficiencies in the maternity services were identified as an immediate key priority for the interim management team at the time of the HIQA Portlaoise Investigation.

The following section of the report will discuss the findings of the HIQA Review Team in respect of the following key staffing areas:

- midwifery services
- consultant obstetricians
- obstetric anaesthetic care
- non-consultant hospital doctor staffing.

What has changed since the HIQA Portlaoise Investigation?

6.4.1. Midwifery services

Since the HIQA Portlaoise investigation report was published in 2015, the HSE has completed a project to find out its workforce planning needs in relation to midwifery staffing in maternity hospitals within the current service delivery models.[37] This report identified a midwife to birth ratio for smaller hospitals such as the Portlaoise maternity unit as requiring one midwife for every 29 births.

At the time of the HIQA Portlaoise Investigation, significant progress had been made in increasing the midwifery numbers and introducing senior clinical midwifery managers, shift midwifery leaders, a bereavement specialist, a clinical skills coordinator and a clinical midwife specialist. However, at the time of this review, some of these staff had left the service, with vacancies for a clinical skills facilitator, midwifery shift leaders and staff midwives.

The Review Team were informed that Portlaoise Hospital is funded to have 70 midwives in both clinical and non-clinical positions. During the June 2016 on-site inspection, it was reported that there were 48 midwives employed at the hospital, comprising 44 midwives and four shift leaders. However, 10 of these midwives were unavailable due to sick leave and maternity leave. The HIQA Review Team was informed that in line with the HSE's midwifery workforce planning report,[37] 54 midwives are needed for a hospital with 1,600 births. HSE management informed HIQA that difficulties in midwifery recruitment was a national issue. The HSE's midwifery workforce planning report identified a shortage of midwives in most maternity units.

The HIQA Review Team was informed that keeping staff and shift leaders was challenging due to the uncertainty surrounding the future of the maternity service. The Interim Director of Midwifery informed the HIQA Review Team that with the current number of shift leaders, it was not possible to separate the maternity ward from the labour wards, a move which they felt would improve the governance of the unit.

6.4.2. Consultant obstetricians

At the time of the HIQA Portlaoise Investigation Report, there were three permanent and one locum consultant obstetrician in post in Portlaoise Hospital. During the onsite review, the HIQA Review Team was told by staff in the maternity unit that this situation remained unchanged. However, following the onsite review, two consultant obstetricians — who were recruited and appointed jointly between the Coombe Women and Infants University Hospital and Portlaoise Hospital — started work in August 2016.

6.4.3 Obstetric anaesthetic care

An obstetric anaesthetist is an anaesthetist who specialises in the care of pregnant women. There are three general anaesthetists who cover both pre-planned and emergency general and maternity services at Portlaoise Hospital. The HIQA Portlaoise Investigation Team in 2014 had been told there was no consultant obstetric anaesthetist at Portlaoise Hospital. This position had remained unchanged at the time of this review. However, the HIQA Review Team was informed by clinical staff at Portlaoise Hospital that more maternity patients are being referred to the anaesthetic pre-assessment services, which was an improvement from previous practices.

6.4.4 Non-consultant hospital doctor staffing

In Ireland, hospital doctors who have not yet reached consultant grade are referred to as non-consultant hospital doctors (NCHDs).

During the HIQA Portlaoise Investigation, Portlaoise Hospital was recognized by the Institute of Obstetricians and Gynaecologists[*] as a training location for certain grades of NCHDs. However, it did not recognize it as a training location for specialist registrars (senior trainee doctors) or year-three basic specialist training registrars in obstetrics and gynaecology. In addition, Portlaoise Hospital was not recognized by the College of Anaesthetists of Ireland[**] as a training location for non-consultant hospital anaesthetists. As a result, the HIQA Portlaoise Investigation report found both the obstetrics and gynaecology services and the anaesthetic services at Portlaoise Hospital struggled, and were likely to continue to struggle, to attract and retain NCHDs.

Experts on the HIQA Portlaoise Investigation Team considered it imperative that a system of rotation be designed between Portlaoise Hospital and a large maternity hospital such as the Coombe Women and Infants University Hospital. This would facilitate a system of NCHDs moving around on training schemes between both sites, thereby ensuring that the maternity services at Portlaoise Hospital improved and developed in tandem with their clinical network partners.

What has changed since the HIQA Portlaoise Investigation?

The 2016 HIQA Review Team found that there had been no improvement made with retaining and recruiting NCHDs for the maternity services at Portlaoise Hospital. The HIQA Review Team was told the maternity services relied heavily on agency and locum staff and continued to struggle to attract and retain NCHDs. The uncertainty of the future of the hospital was reported to add to this challenge.

With the appointment of two new consultant obstetricians, the HIQA Review Team was told by the Clinical Director for Integration that negotiations were ongoing

---

[*] The professional and training body for obstetricians and gynaecologists in Ireland
[**] the training body for doctors in anaesthesia, intensive care and pain medicine

between the HSE, the Coombe Women and Infants University Hospital and the Royal College of Physicians of Ireland to rotate the obstetric registrars appointed to the Coombe Women and Infants University Hospital to Portlaoise Maternity services as part of their appointment.

To mitigate this risk to patient safety, the HIQA Review Team was informed by clinical staff in the Maternity Unit that midwives and shift leaders had full autonomy to call the consultant obstetrician on call if they had any concerns about the decision-making of NCHDs. However, the HIQA Review Team believed the sustainability of maternity service in Portlaoise remains a concern due to the current NCHD staffing arrangements. Rotation of obstetric NCHDs between the Coombe Women and Infants University Hospital and Portlaoise Hospital should be urgently progressed.

6.4.6 Team working, supervision and communication

Background

The importance of close team work between midwives, NCHDs and consultants cannot be undervalued. Any breakdown in this team working puts women at increased risk by preventing the appropriate escalation and treatment when required. The HIQA Portlaoise Investigation Report identified key areas of concern reported by staff in relation to communication. These included:

- a reported reluctance on the part of midwives to raise concerns in relation to patient care issues with members of the medical team
- suggestions that some members of the midwifery staff undermined consultants in their dealings with patients
- both midwives and consultants reported a reluctance to rely on agency medical staff and locum NCHDs owing to concerns that some may not have the necessary competence or experience to manage all situations
- the practice of some consultants communicating with midwives rather than with their registrars created dissatisfaction among NCHDs and impacted negatively on their training
- handover for the labour ward is from consultant on-call to the next consultant on-call by telephone
- no formal handover from consultant obstetrician to consultant anaesthetist or anaesthetic registrar on a daily basis.

What has changed since the HIQA Portlaoise Investigation?

The HIQA Review Team identified that significant improvement had been made in all of these key areas of concern within the maternity services.

- The Review Team received a copy of the hospital's communication policy, which had been implemented in May 2016. This policy integrated the National Guideline on Clinical Handover developed by the National Clinical Effectiveness Committee[38] and outlined clear communication pathways for clinical staff in the maternity services.
- There was a daily handover at 9am that was attended by the obstetric team and midwife shift leader.
- The Review Team was informed that midwives had full autonomy to call the consultant obstetrician on call if they any concerns regarding the decision of a registrar and that this could be done by either the midwife or shift leader on duty. Any concerns that registrars may have about this practice were discussed at weekly multidisciplinary team meetings.
- Multidisciplinary training in obstetric emergencies (Practical Obstetric Multi-professional Training (PROMPT) skills and drills) was held quarterly and training records listed members of the obstetric, anaesthetic midwifery and nursing staff as being in attendance.
- It was reported by maternity staff that the midwifery shift leaders in the outpatient department identified women with at-risk pregnancies and communicated these patients' needs with the maternity ward where needed.
- There was strong incident-reporting culture in the maternity unit. Both clinical and non-clinical incidents were reported, with over 400 incidents reported for 2015. High incident-report rates are associated with a more positive safety culture.[29]
- Clinical midwifery managers were released to attend an Office of the Nursing and Midwifery Services Director (ONMD)[*] three-day programme on compassionate care[**] that was implemented to assist managers re-engage

[*] Office of the Nursing and Midwifery Services Director (ONMSD), established in 2006, has a primary focus in the strategic development of nursing and midwifery to provide optimum patient-centred care, leadership, supporting excellence and innovation and building capacity in nursing and midwifery to enhance patient care and service delivery

[**] The Office of the Nursing and Midwifery Services Director commissioned a programme from the Florence Nightingale Foundation entitled 'Leading Compassion in Practice'.

with core values such as effective communication. This programme was been promoted at hospital-level by the Director of Nursing and Midwifery and the General Manager.

- It was reported to the Review Team that there were no reported incidents related to interdisciplinary communication issues. Staff interviewed in the maternity services reported that there was good inter-professional communication.

6.4.7 Education and training

Background

HIQA Portlaoise Investigation Team reviewed the arrangements in place to ensure that midwifery and obstetric staff were competent in the recording and interpretation of cardiotocography* (CTGs). This was prompted by the findings of a number of local reviews since 2011, which had recommended that all midwifery and obstetric staff receive fetal monitoring cardiotocography training as poor CTG interpretation had been identified as a significant patient safety risk.

What has changed since the HIQA Portlaoise Investigation?

The HIQA Review Team was informed that the current system in place to ensure that midwifery and obstetric staff were competent in the recording and interpretation of fetal monitoring involved two methods of CTG training. One was an interactive online training programme called the K2 Fetal Monitoring Training System, which included four modules focused on fetal monitoring and five modules that provided education on the management of five obstetric conditions:

- pre-eclampsia
- shoulder dystocia
- breech presentation
- antepartum haemorrhage
- post partum haemorrhage.

* CTG an electronic means of recording the fetal heart beat and the uterine contractions during pregnancy. A cardiotocograph machine produces a trace known as a cardiotocograph which illustrates the fetal heart rate and uterine activity.

The second method required midwives from Portlaoise Hospital to attend a study day on fetal monitoring. This study day comprises a theoretical session for half of the day, with practical workshops for the second part of the programme. This is provided every two years by the Centre of Midwifery Education for the three Dublin Maternity Hospitals. Local guidelines outlined that the Divisional Midwifery Manager and the lead obstetrician have access to an online programme to monitor progress of all staff in completion of this mandatory training and provide feedback to the Quality and Patient Safety Committee on staff compliance with this training.

The HIQA Review Team was provided with the fetal monitoring evidence-of-training report that was issued to the maternity unit in April 2016. This was a comprehensive report outlining how many hours midwives and obstetric staff had participated in the online training programme in the previous 12 months and what modules were completed in the time frame. Training records for midwives were also provided, and this indicated that 98% of midwives currently employed in clinical practice in the maternity services were up to date in this aspect of their CTG training. Overall, it was evident to the HIQA Review Team that fetal monitoring training was well attended by obstetricians, NCHDs and Midwives.

6.5 Use of information

Background

The HIQA Portlaoise Investigation found that Portlaoise Hospital did not have the necessary information communications technology (ICT) system to support the required collection and timely analysis of data.

What has changed since the HIQA Portlaoise Investigation?

The HIQA Review Team found that the maternity services still did not have the necessary information technology system to support the collection and timely analysis of data.

An Integration Committee Project Group were looking at systems to mirror the current ICT systems used in the Coombe Women and Infants University Hospital to enable sharing of information between the two sites, but this system had yet to be implemented.

Furthermore, national implementation of quality assurance reports and patient safety statements were being collated by the Clinical Midwifery Manager 3 and one of the consultant obstetricians by manual review of various registers and notes. These reports were being reviewed monthly at the maternity governance meetings, and it was evident to the HIQA Review Team that this information was being used to monitor the quality and safety of care for patients.

There was also collation of Robson Classification[*] [39] on every mother who delivered in Portlaoise that was being compiled and sent to the National Perinatal Epidemiology Centre. At the time of the HIQA Portlaoise Investigation, the maternity services at Portlaoise Hospital did not compile an annual report in line with the recommendations from the report of the Lourdes Hospital Inquiry.[40] An annual report had been written in the interim. The HIQA Review Team reviewed this annual report for maternity services that was developed in 2015 and contained birth statistics and data for the years 2012–2014.

Senior managers from the Dublin Midlands Hospital Group noted that there was a need for an information technology system to enable and allow better data collection. It was reported that work was ongoing with the Office of the Chief Information Officer of the HSE to start implementing these systems.

6.6 Care environment

Background

The 2014 HIQA Portlaoise Investigation Team found that due to the existing infrastructure in the maternity services, staff were continuously challenged to deliver a person-centred service, particularly in the context of maintaining patient privacy and dignity.

What has changed since the HIQA Portlaoise Investigation?

The HIQA Review Team conducted an on-site visit to the maternity and outpatient areas in June 2016 and found many of the infrastructural challenges identified by the HIQA Portlaoise Investigation Team still remained.

The Early Pregnancy Assessment Unit remained separate from the maternity ward, and patients were seen here on an appointment basis only since 2015. There was access to an emergency call system if needed.

[*] The Ten Group Classification System developed by Professor Michael Robson, which is used for assessing, monitoring, and comparing caesarean delivery rates within and between healthcare facilities.

The Outpatient Department had not changed and staff reported that it remained overcrowded and continued to impact upon patients' privacy and dignity. The HIQA Review Team was told that plans had been developed and costed to develop a modular self-contained outpatient department for obstetrics and gynaecology services, but that this had yet to be provided.

During the initial HIQA Portlaoise Investigation, a risk to patient safety had been identified due to the three-roomed Maternity Assessment Unit being used to deliver a baby if all the labour rooms were occupied. The HIQA Review Team was told this no longer occurs unless a woman presented in an advanced state of labour and it was risk assessed as not safe to move her to the labour ward. It was also acknowledged that due to the decline in the number of births at the hospital, the likelihood of all four labour ward rooms being full had been reduced.

The 29-bed inpatient ward for antenatal, postnatal and gynaecological care was seen to need refurbishment, with insufficient bed spacing between some beds. For example, seven beds were in a room designed for six and the three bedded rooms looked cluttered. This was discussed with the hospital's management team at the time of the on-site visit to the maternity unit. It was reported that the seventh bed was removed from the six-bedded room in the maternity ward in June 2016, shortly after the HIQA Review Team visit.

The HIQA Review Team was shown plans for reconfiguring the maternity ward and labour wards that had been developed by the Integration Steering Group. These included a plan to have a high dependency unit in the labour ward area to avoid the need for women to be separated from their babies when they are critically ill. However, agreement for implementing these plans had yet to be decided at the time of the Review.

The HIQA Review Team was also informed that when the Emergency Department and the general hospital beds were at full capacity, female surgical patients were admitted to the maternity ward, which further compromised the care environment for maternity patients. Maternity staff completed incident forms to raise awareness of this concern, and these were escalated to the hospital management team.

This issue was raised with the hospital management team by the HIQA Review Team during the on-site inspection. The HIQA Review Team was informed that there were strict criteria for admitting general female patients to the maternity ward and a risk assessment had been undertaken to identify and put in place controls to address the risk. In addition, the Review Team was also told that with the opening of the day surgery ward, the use of maternity beds for surgical patients had been reduced and was being monitored by the senior management team at the hospital.

Overall, at the time of this review, despite the development of plans to change the infrastructure, there was little improvement to the maternity unit to support patients' privacy and dignity.

6.6.1 Patient pathways for initial assessment and admission

Background

In reviewing the patient pathway, the HIQA Portlaoise Investigation Team had identified specific areas or arrangements within the pathway which were considered a risk to the sustainable delivery of a safe, quality service to obstetric patents. The next section will explore these risks and the actions taken by the hospital to address these in the interim period.

What has changed since the HIQA Portlaoise Investigation?

There have been changes to these pathways since the initial HIQA Portlaoise Investigation. In 2016, during core hours, pregnant women under 22 weeks' gestation requiring an ultrasound scan attend the Early Pregnancy Assessment Unit, which is located in the Emergency Department, on an appointment basis only. GP referrals can be faxed or telephoned to the Early Pregnancy Assessment Unit. This is in line with the model of Early Pregnancy Assessment Unit recommended from the National Miscarriage Misdiagnosis Review.[41] Responsibility for governing the Early Pregnancy Assessment Unit service lies with the lead obstetrician.

All other pregnant women who require emergency assessment regardless of gestation present to the Maternity Assessment Unit. The Maternity Assessment Unit is staffed at all times by a midwife, who initially reviews the patient and refers to the obstetric team as necessary. Administrative support is also available during core hours (for the purpose of this report, historical core hours are defined as Monday to Friday between 9 am and 5 pm).

6.6.2 Obstetric ultrasound

Background

Pregnant women undergo ultrasound scanning as part of their antenatal care to assess the progress of their pregnancy and to aid their clinician's ability to evaluate, diagnose and treat obstetric conditions.

The HIQA Portlaoise Investigation Team had identified the following areas of concern relating to ultrasound services:

- capacity of the current ultrasound scanning service to deal with the volume and type of scans that should be undertaken
- inadequate skills and training of some of the healthcare professionals performing scanning
- not enough clinical oversight of the service.

What has changed since the HIQA Portlaoise Investigation?

The HIQA Review Team found that many of the risks identified in the initial HIQA Portlaoise Investigation had been addressed. The following improvements to the obstetric ultrasound service were identified:

- The Early Pregnancy Assessment Unit service had been reorganized so that every pregnant woman attended for a formal dating ultrasound scan (to help predict the delivery date) appointment around three weeks before her first visit with the consultant obstetrician.
- This dating ultrasound scan is provided either by a nurse who is competent and trained in ultrasound or a consultant obstetrician. The HIQA Review Team was informed by members of the obstetric and midwifery staff that this arrangement was working well for patients and staff.
- A consultant obstetrician was allocated to oversee the Early Pregnancy Assessment Unit to provide clinical oversight of the service.
- All pregnant women who were 39 years of age or over are offered an appointment at the Coombe Women and Infants University Hospital for a fetal anomaly ultrasound since January 2016.
- One of the midwives who had completed ultrasound training was attending the Coombe Women and Infants University Hospital two to three days a week to become competent in the practical aspect of ultrasound. It was reported to the HIQA Review Team that a second midwife would be released to attend for

training in the Coombe Women and Infants University Hospital once the first midwife was assessed as being sufficiently competent in this skill.
- There were plans in place to link the Portlaoise and Coombe Women and Infants University Hospitals' ultrasound services electronically so that expert review could be provided to Portlaoise clinicians as required from clinicians in the Coombe.

The HSE's Clinical Programme in Obstetrics and Gynaecology Clinical Practice Guideline on Fetal Growth Restriction[42] recommends that every woman should undergo a comprehensive evaluation of the fetal anatomy between 20–22 weeks' gestation. Furthermore, the National Maternity Strategy recommends that all women must have equal access to standardised ultrasound services in order to accurately date the pregnancy, assess the foetus for ultrasound diagnosable anomalies as part of a planned Prenatal Foetal Diagnostic Service, and for other indications if deemed necessary during the antenatal period.[5]

6.6.3 Bereavement services in the Maternity Department

Background

In 2014, members of the HIQA Portlaoise Investigation Team met with a number of parents whose babies had died while in the care of Portlaoise Hospital. Some of these parents told HIQA that the care they received was poor and the response they received from the hospital added to their trauma.

What has changed since the HIQA Portlaoise Investigation?

The HIQA Review Team considered the measures the maternity unit had introduced since the HIQA Portlaoise Investigation to improve the care and services offered to bereaved parents. Portlaoise Hospital initially appointed a midwife to the role of bereavement specialist, and three midwives had undertaken formal training in the care of bereaved parents. Subsequently, the bereavement specialist midwife left the service but was replaced by a bereavement and loss nurse for both the general and maternity services. The HIQA Review Team was informed that this nurse provided valuable support to women who experience pregnancy loss and perinatal death.

The maternity unit had more resources for bereaved parents, including a cuddle cot and mementoes boxes. In addition, the HIQA Review Team was informed that midwifery staff had engaged with a national pregnancy loss support group who had provided valuable feedback in order to improve the care provided to bereaved parents. There was evidence of audit of practices to evaluate supportive perinatal bereavement care, for example, an audit was undertaken to review compliance with provision of mementos to bereaved parents.

The HIQA Review Team was provided with the local guideline on the Investigation and Management of Fetal Intrauterine Death and Stillbirth which had been developed to include aspects of the Coombe Women and Infants University Hospital's guideline. This guideline, which was implemented in February 2016, had a detailed checklist to assist staff to comply with the guideline.

The HIQA Review Team was told by maternity staff that all women who experienced perinatal loss were followed up by the bereavement and loss nurse and the obstetric consultant in charge of their care in the postnatal period. The midwives working in the Out Patient Department told the HIQA Review Team that they communicate closely with the bereavement and loss nurse to ensure that women returning for their postnatal visit are supported in a sensitive manner and are seen in a timely fashion.

However, the physical infrastructure remained unchanged since the HIQA Portlaoise Investigation and there is no dedicated separate area for bereaved parents to be cared for within the current maternity infrastructure. The HSE's *National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death*[*] recommend that women who have a perinatal death are cared for in a dedicated room with an en-suite toilet and shower and facilities to accommodate the woman's partner or companion to stay overnight during her stay in the hospital.[43]

The HIQA Review Team was informed that bereaved parents and women who were admitted to Portlaoise Hospital with perinatal death were always cared for in a single room (without en suite toilet or shower) on the maternity ward, but staff recognized that this was not in line with best practice.

The lack of a dedicated bereavement room in the maternity unit at Portlaoise Hospital had been raised as a risk to patients' experience of care by the hospital's management team to the Dublin Midlands Hospital Group Chief Operations Officer for review and management.

---

[*] The HSE published *National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death* on the 10 August 2016.

6.6.4 Access to the operating theatre

Maternity patients may require pre-planned or emergency caesarean sections or other surgical procedures as part of their pathway of care. There is no dedicated maternity operating theatre in or immediately adjacent to the Maternity Department at Portlaoise Hospital. Rather, the operating theatres in the main theatre suite are used, which are located one floor below the Maternity Unit.

In June 2016, there was no change noted to the theatre arrangements compared to the time of the HIQA Portlaoise Investigation. However, the transfer of patients requiring complex general surgery to other hospitals and the declining number of births at Portlaoise reduced the theatre activity overall for emergency procedures.

6.6.5 Management of healthcare records

Background

Healthcare professionals need access to all relevant information about the patient at the point of clinical decision-making in order to make informed decisions about the patient's clinical condition. Therefore, the effective completion and management of healthcare records[*] is essential.

The HIQA Portlaoise Investigation Report confirmed that the National Maternity Healthcare Record was in use at Portlaoise Hospital for public patients. However, some consultant obstetricians used a different healthcare record for health insurance or private patients. It was recommended the National Maternity Healthcare Record should be the only record in use.

What has changed since the HIQA Portlaoise Investigation?

In June 2016, the HIQA Review Team found that there was still a separate healthcare record in use by one consultant obstetrician for private patients. The HIQA Review Team recommend that this practice be discontinued.

The practice of maternity patients carrying their own obstetric chart had yet to be implemented at the time of the review. The HIQA Review Team recommends that in

[*] Healthcare records refer to all the information in both paper and electronic formats relating to the individual care of a patient or service user. This includes (but is not limited to) demographics (such as name, address, date of birth), medical history, social history, findings from physical examination, X-rays and specimens, the results of diagnostic tests, prescriptions, procedures and all communication relating to the care of the patients.

line with previous investigation recommendations[12] that maternity patients should as standard carry their own obstetric chart throughout their antenatal care. This would help and inform patient and staff communication and aid significantly with transfer of patients between hospitals. It also provides the opportunity for women to be partners in maternity care and to inform parents and share information.[44]

6.6.6 IMEWS and escalation of care

Background

The Irish Maternity Early Warning System (IMEWS) is an early warning scoring system designed to support the early detection of life-threatening illnesses. It should be used for the inpatient care of women who are pregnant or up to 42 days after they deliver their baby, irrespective of age, location or reason for admission.[45]

IMEWS was introduced for the monitoring of pregnant women at the Maternity Department at Portlaoise Hospital in 2013. However, the HIQA Portlaoise Investigation Team had reviewed evidence which highlighted that IMEWS had not been in use for pregnant and postnatal women that were cared for outside the Maternity Department, such as in the surgical ward of the hospital.

What has changed since the HIQA Portlaoise Investigation?

In June 2016, the HIQA Review Team was informed that IMEWS had been rolled out across the general hospital and was in use for maternity patients admitted to the general hospital services. There were education and training programme available at the hospital, and NCHDs were provided with NEWS (National Early Warning Score, which is a nationally agreed early warning score for the early recognition and management of acutely ill adult patients) and IMEWS training as part of their induction every six months.

The hospital audited compliance with IMEWS in June 2015. This audit demonstrated that the IMEWS was being successfully implemented as it found a high level of compliance with recording of observations and correctly repeating observations as appropriate.

All the obstetric consultants and consultant anaesthetists had attended both IMEWS and NEWS training. All midwives rostered at the time of the Review had attended IMEWS training. While IMEWS training was being rolled out across the hospital, only 57 nurses in the general hospital had received IMEWS training since April 2015.

6.7 Conclusions in relation to maternity services

Since the publication of the HIQA Portlaoise Investigation Report, the senior management team at Portlaoise Hospital have made major strides in significantly improving the quality and safety of services for patients using the maternity services. There was a system in place to respond to complaints in a timely manner, and there was evidence of learning from incidents across the maternity service.

Safety has also been significantly, if not inadvertently, aided by a reduced number of births and an improvement in the ratio of staff to births.

The appointment of the Clinical Director for Integration to provide experienced senior clinical leadership and to implement the clinical network has been a significant development.

There was a clear clinical audit plan for maternity services, and audits were conducted which were relevant to important quality and patient safety concerns. Additionally, there was oversight of the training and education of staff in fetal monitoring and management of obstetric emergencies.

There were improvements identified in maternity patient care pathways. However, there was little change to the physical infrastructure of the maternity ward and the Outpatients Department to support patient privacy and dignity.

Nonetheless, the maternity services at Portlaoise Hospital continue to struggle to recruit and retain NCHDs, this was identified as a potential risk to patient safety in the original HIQA Portlaoise Investigation. The recent appointment of two consultant obstetricians working between Portlaoise and the Coombe Women and Infants University Hospitals was anticipated to enable the rotation of non-consultant hospital doctors between both sites, and this rotation initiative needs to be progressed urgently.

Recruiting and retaining midwifery staff and midwifery shift leaders also remained an ongoing issue for the management team in Portlaoise Hospital at the time of this Review. Difficulties in this area hindered the separation of the maternity ward from the labour ward. To improve the governance of the maternity services, separating the two services needs to start once adequate staffing to birth ratios are achieved.

Not having a shared clinical information communications technology system between both hospital sites was identified as a barrier to integration of the maternity services, and this needs to be addressed.

Overall, the HIQA Review Team found that there was evidence of significant progress with acting on the recommendations and findings from the HIQA Portlaoise investigation. However, the full integration of Portlaoise maternity services within the governance of the Coombe Women and Infants University Hospital needs to be secured through necessary capital investment and recruitment of agreed key personnel.

Chapter 7. General hospital services at Portlaoise Hospital

7.1 Introduction

This section of the report presents the HIQA Review Team's findings in relation to the quality and safety of the non-maternity healthcare services provided at Portlaoise Hospital.

In 2014, the HIQA Portlaoise Investigation Team had concluded that Portlaoise Hospital was not adequately resourced or structured to provide the undifferentiated care (where patients may present themselves at the hospital with any degree, seriousness or complexity of illness or injury) that it was charged with providing at that time.

Although Portlaoise Hospital was regarded as a model-3 hospital, it was not resourced as such and was trying to deliver clinical services without the appropriate funding and staffing. This situation had led to the following circumstances:

- The Emergency Department's clinical governance arrangements were not in line with the HSE's National Clinical Programme.
- The Intensive Care Unit infrastructure was unfit for purpose, while low volumes of critical care activity in the hospital were likely to result in difficulties in maintaining ongoing clinical expertise and competency of staff.
- General medical services in the hospital were not resourced or structured to effectively implement the HSE's Acute Medicine Programme.
- There were insufficient acute and elective surgical presentations to ensure surgeons maintained the necessary competencies and expertise.
- The lack of adequate resources in the diagnostic imaging service constantly challenged timely access for inpatient and outpatients to diagnostic services.

Many of these risks in relation to general clinical services had been previously identified in Portlaoise Hospital through multiple HSE reports. Despite this, remedial actions had not been comprehensively implemented by the HSE to safeguard the patient's clinical care journey in the hospital.

This Review looked at developments since the HIQA Portlaoise Investigation Report was published in 2015 in a number of critically important clinical services in the hospital, with a particular emphasis on the surgical, emergency, paediatric, intensive care, medical services and diagnostic imaging.

7.2 Overview of general hospital services provided by Portlaoise Hospital

Portlaoise Hospital provides services to public patients and privately insured patients and is funded and operated by the HSE. At the time of this review, the hospital had 151 beds, which comprised 114 adult beds, 21 paediatric beds and 16 day beds. Allocated funding at the hospital for 2016 was 15% higher than in 2012. As of May 2016, the hospital employed 650 whole-time equivalent staff, equating to over 740 members of staff. This staffing level was 18% higher in terms of whole-time equivalent positions than at the time of the HIQA Portlaoise Investigation.

The general hospital services at Portlaoise Hospital include elective and emergency medical and surgical adult and children's services on an inpatient, day and outpatient basis.

7.3 Findings in relation to surgical services

Background

At the time of the HIQA Portlaoise Investigation, Portlaoise Hospital operated a 24-seven emergency surgical service, catering for all degrees of surgical illness or injury arriving at the hospital. The HIQA Portlaoise Investigation Team had found that low numbers of complex surgical procedures were being carried out at the hospital. As previously reported by HIQA, surgeons who do not have the opportunity to treat enough patients and or carry out a sufficient volume of procedures run the risk of becoming de-skilled.

Two separate HSE reviews* (conducted in 2013 and 2014) of the surgical services at Portlaoise Hospital had both concluded that Portlaoise Hospital on its own was not structured for safe, acute (emergency) and pre-planned surgical care. At that time, both reviews had advised that the risks associated with surgical care at Portlaoise Hospital could only be dealt within the context of providing a rationalised surgical service within a hospital-group setting.

What has changed since the HIQA Portlaoise Investigation?

It was reported that surgical services at Portlaoise Hospital were provided to adults and to children over the age of three years. In 2015, there were 1,807 adult surgical patient discharges, comprising:

- 1,455 (80%) emergency (non-elective or unscheduled) inpatient discharges
- 352 (20%) elective (pre-planned) inpatient discharges.

Pre-planned paediatric surgical activity was low. Out of 359 paediatric surgical inpatient discharges in 2015, 353 (98%) were emergency (non-elective or unscheduled) admissions and six (2%) were pre-planned admissions.

At the time of this follow-up HIQA Review, the surgical facilities at Portlaoise Hospital consisted of two main operating theatres and one smaller theatre which is suitable for local and minor procedures only. It also comprises an endoscopy unit, a 16-bed day unit and 30 inpatient beds. During the on-site inspection, clinical staff and senior management reported that most surgical inpatient beds were generally occupied with medical as opposed to surgical patients. At the time of the Review, only one of the two endoscopy suites was operational. The endoscopy unit had not yet gained accreditation by the Joint Advisory Group for Gastrointestinal Endoscopy.*

Ending complex surgery

At the time of this HIQA Review, surgery at Portlaoise Hospital operated on a 24-seven basis. However, complex surgery, whether pre-planned or urgent, had

* In 2013, the National Clinical Programme in Surgery (NCPS) Team visited Portlaoise Hospital for the purpose of reviewing the surgical services, while in 2014 a national HSE team reviewed the general services, including the surgical services, at Portlaoise Hospital.
* Under the auspices of the Royal College of Physicians in England, a Joint Advisory Group (JAG) on gastrointestinal endoscopy awards accreditation as a formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy global rating scale standards.

stopped in the hospital since 4 August 2015. Complex surgery in this context refers to any procedure involving the stomach, small bowel, colon or rectum such as:

- bowel resections
- gastric or small bowel procedures that require a laparotomy.

It does not apply to laparoscopy procedures such as:

- laparoscopic cholecystectomies
- uncomplicated inguinal hernia repair
- appendectomies.

While complex surgery is no longer conducted at the hospital, patients presenting to its Emergency Department who need complex surgery or inpatients at Portlaoise Hospital who develop complex surgical needs during their hospital stay need to be stabilized and transferred to one of three other hospitals in Dublin Midlands Hospital Group (St James's Hospital, Dublin; Tallaght Hospital, Dublin; or the Midlands Regional Hospital, Tullamore) for their surgery.

Because there was a weekly rota of such receiving hospitals in place, staff in Portlaoise Hospital were clear about which of these other hospitals they should contact to transfer such patients to each week. The Group Clinical Director is responsible for coordinating these complex surgical cases. It was reported to the HIQA Review Team by the Dublin Midlands Hospital Group senior management team that there is a 'no-refusal' policy in place for transferring these patients within the hospital group. However, if any problems do arise, the individual case would be raised with the Group Clinical Director for resolution.

It was reported that since complex surgery stopped at Portlaoise Hospital, 15 patients had been transferred between August 2015 and the end of December 2015, and 17 patients between January 2016 to the end of April 2016. The HIQA Review Team requested copies of any policies, procedures, protocols or guidelines supporting the transfer processes. In response, Portlaoise Hospital provided copies of letters from the Dublin Midlands Hospital Group CEO to senior management at Portlaoise Hospital and the receiving hospitals about complex surgery at Portlaoise stopping and a copy of the weekly rota for those receiving hospitals.

However, the HIQA Review Team did not receive evidence of formal documented policies, procedures, protocols or guidelines for clinical staff to support them to implement these processes on a day-to-day basis at the hospital.

This is of particular importance given the hospital's reliance on agency non-consultant hospital doctors (NCHDs), especially in the Emergency Department. This means that many NCHDs are not working permanently in Portlaoise Hospital and, therefore, there can be frequent changes in staffing. As a result, it is important that there are clearly documented procedures for all clinical staff as to the steps to be taken in identifying, immediately managing and transferring patients who require complex surgery.

The letter from the hospital group CEO outlined that any urgent transfer referral for complex surgery from the Portlaoise Emergency Department or for an inpatient at the hospital needed to be a consultant-to-consultant referral to the on-call general surgeon in the relevant receiving hospital.

However, the HIQA Review Team found that there was some ambiguity and confusion around how the referral was made by clinical staff. Senior management reported that surgical consultants at Portlaoise Hospital would speak directly to surgical consultants at the receiving hospital to arrange a patient transfer. However, some clinical staff said the surgical registrar in Portlaoise would contact the surgical house doctor in the receiving hospital, who would then in turn contact the receiving centre's surgical registrar to get a decision on the transfer.

Minutes from the hospital's Weekly Management/Operations Meetings in June 2016 indicate that senior management had agreed that such transfer decisions should be made between a consultant in Portlaoise and a consultant in the receiving hospital.

The Dublin Midlands Hospital Group with Portlaoise Hospital should now review and evaluate this transfer process and develop clear documentation (such as policies, procedures, protocols or guidelines accompanied by ongoing audit and rolling induction training for new staff) to support clinical staff in implementing these processes on a-day-to day basis at the hospital.

It was reported by senior managers that the system for transferring complex patients was working well but that the hospital had not carried out a formal evaluation of how efficiently complex surgery cases were identified and transferred to another hospital. Senior management said they were updated on a weekly basis at the hospital's Weekly Management/Operations Meetings about the numbers of patients transferred out from the hospital for complex surgery and their arrival and transfer times.

The HIQA Review Team reviewed minutes of these meetings from July 2015 to June 2016. There was evidence from these minutes that the weekly number of complex surgical cases had been discussed from the end of April 2016 but, prior to that, there was no reference that the numbers of cases being discussed at these meetings. Minutes from June 2016 show that the hospital plans to undertake an audit of complex surgery transfers at the hospital. The HIQA Review Team recommends that this audit is undertaken as a priority in the short term.

7.4 Findings in relation to the Emergency Department

Background

In 2014, the HIQA Portlaoise Investigation Team had found that the clinical governance arrangements in the hospital's Emergency Department were unsatisfactory and overcomplicated, with no single Emergency Department governance structure to ensure the quality and safety of patient care in that department.

The year before, the HSE's own Emergency Medicine Programme considered that the Emergency Department was not appropriately resourced to provide a 24-seven model of emergency care. In line with these findings, HIQA's Portlaoise Investigation Team had concluded that despite the Emergency Department cover provided by consultants, the existing clinical governance arrangements could not ensure a safe and sustainable service for patients using the service.

What has changed since the HIQA Portlaoise Investigation?

At the outset of the HIQA Portlaoise Investigation in 2014, there were two emergency medicine consultants — primarily based at the Midland Regional Hospital in Tullamore — who provided 30 hours of clinical services per week (including travel time) to the Emergency Department in Portlaoise Hospital. Under this arrangement, an emergency medicine consultant attended the Emergency Department weekdays Monday to Thursday, 8am to 2pm.

In July 2014, five months into the HIQA Portlaoise Investigation, a third emergency medicine consultant was appointed to Portlaoise Hospital. This consultant acts as Clinical Lead for the Emergency Department and works at the hospital during day time hours from Monday to Friday (excluding Wednesday) for 39 hours. At the time of this review, these consultant staffing arrangements remained the same.

Despite the fact that consultant numbers for the Emergency Department had increased from 0.7 to 1.7 whole-time equivalents, the roster of these consultants had not changed to match service demands. That is, emergency consultants' hours were largely rostered to work from Monday to Friday 9am to 5pm, rather than reorganizing their hours so there would be a consultant presence in the Emergency Department from 8am to 8pm each day.

The governance arrangements that existed at the time of the HIQA Portlaoise Investigation remained largely unchanged at the time of this Review. The emergency medicine consultants are clinically responsible for all patients attending the Emergency Department during the hours they are on site. Outside of these hours, the respective on-call surgical and medical teams are responsible. However, there is no formal consultant-to-consultant handover of patients in the Emergency Department when the emergency medicine consultants finish each day. The Emergency Department continues to be staffed by a team of medical and surgical NCHDs, as opposed to emergency medicine NCHDs. This arrangement had evolved in response to a lack of emergency medicine NCHDs nationally and is not unique to Portlaoise Hospital. These medical and surgical doctors are supervised by the emergency medicine consultants when they are on site in Portlaoise and revert to the supervision of the on-call surgical and medical consultants in Portlaoise after these core hours.

Accordingly, the HIQA Review Team found that there continued to be no single Emergency Department governance structure with responsibility for all patients accessing care in the department. The HIQA Review Team found that Portlaoise Hospital continues to provide a 24-hour, seven-days-a-week (24-seven) emergency service for undifferentiated[*] adult and paediatric patients who may present themselves at the hospital with any degree of seriousness or complexity of illness or injury. In 2015, a total of 24,979[**] adults and 11,265 children attended the Emergency Department at Portlaoise Hospital.

[*] Undifferentiated patients include all types of patients with any degree of seriousness or severity of illness.
[**] 24,979 adult presentations to the Emergency Department comprised 19,168 new adult presentations, 2,312 adult return presentations, 2,560 new maternity presentations and 939 return maternity presentations.

Following registration in the Emergency Department, patients are categorized by a nurse in the department using the Manchester triage system.[***] Data provided by the hospital indicated that most patients (87%) who presented to the Emergency Department in 2015 were assigned the less serious categories of 3, 4 and 5.

At the time of the review, HSE National Ambulance Service bypass protocols[****] continue to be in place, stipulating that patients travelling by ambulance with certain conditions should be taken by ambulance directly to other hospitals better equipped to treat these conditions. These include:

- ST segment elevation myocardial infarction (STEMI) (heart attack)
- a cerebrovascular accident (stroke)
- severe trauma (adult and paediatric patients)
- fractured neck of femur (broken hip).

However, most patients self-present directly to Portlaoise Hospital (rather than being transported by ambulance), and they may present with any of these conditions. In these instances, patients will be stabilized and transferred out to the most appropriate hospital. Clinical staff and senior management reported that in general these systems were working well.

However, there were no formal monitoring arrangements in place to assure the hospital that the ambulance bypass protocols were effective. The hospital should assure itself that the bypass protocols are effective, and, if it identifies any areas that may require improvement, it should work with the National Ambulance Service to address these areas.

The HSE's Emergency Medicine Programme outlines that registered advanced nurse practitioners play a vital role as members of emergency department and local injury unit multidisciplinary emergency care teams. It also states that developing this role will be crucial to delivering improvements in access and quality of care.[46,47] In June

[***] This is an assessment system to rapidly place patients into categories, according to the type of treatment they need and how quickly they need it.
[****] Ambulance bypass protocols divert patients with certain conditions to nominated facilities. For example, patients in the Portlaoise Hospital catchment area with fractured neck of femur are to be taken to the Midland Regional Hospital Tullamore, while patients in the hospital's catchment with signs of stroke are to be taken to Naas General Hospital. Paediatric patients with major trauma are to be transported to Our Lady's Children's Hospital, Dublin, or to Temple Street Children's University Hospital, Dublin.

2015, an advanced-nurse-practitioner service was established in the Emergency Department of Portlaoise Hospital. This is staffed by one advanced nurse practitioner in emergency nursing. While the hospital had received sanction to recruit two advanced nurse practitioners, it had not been able to recruit a second such nurse, despite recruitment campaigns.

The National Emergency Medicine Programme advises that patients should be triaged within 15 minutes of registration and recommends that 95% of patients should be triaged within this time. At the time of the review, a recent audit conducted over a two-week period in the Emergency Department at the Portlaoise Hospital had found that only 48% of patients were being triaged within 15 minutes. Clinical staff explained that if they are breaching the maximum 15-minute wait, then a secondary triage system is used which reduces the amount of documentation required. The HIQA Review Team recommends that the hospital should monitor the time taken for Emergency Department patients to be triaged on an ongoing basis and implement measures to address any delays in order to mitigate the risks involved in delayed patient triage.

Staff reported that the Emergency Department had a department risk register. Risks on it included the:

- lack of consultant cover in the Emergency Department at weekends and after 5pm each weekday
- the potential risk associated with the split between medical and surgical teams
- inadequate nursing skill-mix in Emergency Department due to redeployment of nursing staff.

In addition, the Dublin Midlands Hospital Group Quality and Safety Team conducted a safety walk-round in Portlaoise Hospital in December 2015. This team informed the HIQA Review Team that the greatest concern expressed by front-line staff concerned the transient nature of the agency NCHD workforce in the Emergency Department.

7.5 Paediatric emergency care

Background

In 2014, the HIQA Portlaoise Investigation Team reviewed the care pathways for paediatric patients who present to the Emergency Department in Portlaoise Hospital.

They found that emergency paediatric patients were managed in two separate areas of the hospital by two different clinical teams. There was no formal system of triage in use for medical or surgical paediatric patients presenting to the Emergency Department. This meant that children attending the Emergency Department on the ground floor were redirected, without being formally triaged to assess the severity of their condition, to the paediatric ward, which is located on the first floor of the hospital.

What has changed since the HIQA Portlaoise Investigation?

At the time of this HIQA Review, the two separate pathways for medical and surgical paediatric patients remained in place, a situation seen in a number of hospitals nationally.[47,48] The HSE's Emergency Medicine Programme recommends that all 24-seven emergency departments in which children are treated should appoint a paediatric emergency medicine consultant or a consultant with subspecialty training in paediatric emergency medicine.[47]

In 2015, the National Clinical Programme for Paediatrics and Neonatology identified Portlaoise Hospital as one of several hospitals in Ireland that do see enough children to justify the appointment of a full-time consultant paediatric emergency medicine specialist.[49] The Clinical Programme recommended that emergency care settings treating more than 10,000 children per year should have:

- a paediatric trained nurse on duty within the department at all times
- a designated paediatric emergency medicine consultant responsible for training and delivery of care
- medical and nursing staff with experience in paediatric care.

In June 2016, the hospital introduced the Irish Children's Triage System[50] for children presenting in the Emergency Department and the paediatric ward. It was also reported that a paediatric triage nurse was available 24-seven at Portlaoise Hospital to support this.

In addition, during the HIQA Review Team's on-site visit, it was reported that there were plans to install better signage (floor line markings) from the Emergency Department to the paediatric unit in order to guide children and their families to the unit. Weekly operational management team minutes after the HIQA Review Team's on-site visit indicate that floor line markings had been put in place and that all children presenting at the Emergency Department or the paediatric ward will be escorted by a nurse to the appropriate area for triage.

The National Paediatric Early Warning score was also implemented at Portlaoise Hospital on 26 June 2016, and it was reported to HIQA that an audit of its effectiveness would take place before the end of the year.

The HIQA Review Team welcomes the introduction of the Irish Children's Triage System and the Paediatric Early Warning Score, and it recommends that the hospital continues to monitor the effectiveness of their implementation.

7.6 Intensive and critical care

Background

The HIQA Portlaoise Investigation Team had found that the overall volume of critical care activity within the Intensive Care Unit (ICU) of Portlaoise Hospital was low, hindering the ability of staff to maintain their clinical skills. The ICU as reviewed by the HIQA Portlaoise Investigation Team did not meet the minimum requirements for critical care and had been deemed as being not fit for purpose. The HIQA Portlaoise Investigation Team was not assured that critical care services were sustainable in Portlaoise Hospital.

What has changed since the HIQA Portlaoise Investigation?

Overall, the HIQA Review Team found that the ICU at Portlaoise Hospital still did not meet the minimum requirements for critical care as set out by the Joint Faculty of Intensive Care Medicine of Ireland and adopted by the National Clinical Programme for Critical Care.[51]

As at the time of the Investigation in 2014 and 2015, the HIQA Review Team found that the ICU at Portlaoise Hospital did not meet the minimum requirements for critical care as set out by the Joint Faculty of Intensive Care Medicine of Ireland (JFICMI) as the unit did not have:

- on-site ICU NCHDs with critical care skills (including airway skills) at all times
- daily ICU consultant sessions committed to ICU alone
- a minimum of two consultants with ICU training and qualifications

- availability of direct access to continuous veno-venous haemofiltration* (CVVH).

Since the HIQA Portlaoise Investigation, a room in the ICU had been converted into an isolation room, but other than this alteration, no other changes to the infrastructure had taken place, and the ICU remains unfit for purpose.

The ICU can still accommodate four non-ventilated patients or two ventilated patients.** The hospital reported that 184 patients had been admitted to the ICU in 2015, of which 55 patients required mechanical ventilation. Staff reported that patients requiring mechanical ventilation often required mechanical ventilation for a number of days, rather than being stabilized and transferred out of Portlaoise Hospital. Staff reported that one patient had recently been ventilated for 16 consecutive days. Therefore, the ICU does not only stabilize patients and transfer them to other larger ICUs; rather in some instances it provides prolonged ventilatory support for patients.

In total, 19 patients in 2015 had required transfer to another hospital for intensive care, either due to the patient's clinical condition or diagnosis (15 patients) or because there was no ICU bed available in Portlaoise Hospital (4 patients).

It was reported that any paediatric patient requiring critical care is stabilized and immediately transferred to a Dublin paediatric hospital, with around 15 such children being transferred each year from Portlaoise Hospital. Patients admitted to the ICU are admitted under the care of their admitting medical or surgical consultant.

In the absence of intensive care specialists (intensivists), the anaesthetic consultant staff continue to assume responsibility or provided advice for patients requiring intensive care.***

Notwithstanding the fact that clinicians had adapted their practices to minimize risks to patients requiring critical care, the HIQA Portlaoise Investigation Team was not

---

* Continuous veno-venous haemofiltration is a short-term treatment used in ICU patients with acute or chronic kidney failure to facilitate the removal of waste products from the bloodstream.
** Every ventilated patient accommodated in the Intensive Care Unit required temporary closure of a bed space in the Intensive Care Unit.
*** If the patient is mechanically ventilated, the anaesthetist assumes responsibility for patient care. If the patient is not mechanically ventilated, the patient remains under the care of the admitting doctor and the anaesthetist provides advice.

assured that critical care services were sustainable in Portlaoise Hospital. This situation has remained unchanged at the time of this Review.

7.7 Medical services

Background

The HIQA Portlaoise Investigation Team had concluded that medical services at Portlaoise Hospital required significant restructuring and resourcing in order to deliver a service aligned to the HSE's Acute Medicine Programme. Consultant staffing for the medical division consisted of three full-time and one temporary consultant physician. The HIQA Portlaoise Investigation Team found that the medical team was under-resourced in light of the fact that consultant physicians were responsible for managing all adult emergency medical attendances in the Emergency Department as well as hospital medical inpatients.

In addition, one of the consultant physicians was the Clinical Director for the hospital and a member of the senior hospital management team in addition to being the specialty lead for medicine. Nonetheless, the HIQA Portlaoise Investigation Team had been reassured to note that the hospital was recruiting two medical consultants. The hospital had said these pending appointments would at last facilitate the release of the hospital's Clinical Director from general medical duties for 25 hours each week in order to increase time spent on carrying out the functions of the clinical director role.

What has changed since the HIQA Portlaoise Investigation?

Since the HIQA Portlaoise Investigation, there have been improvements to the consultant medical staffing with a fourth full-time medical consultant being appointed on a permanent basis and a fifth consultant appointed on a locum basis. This meant that medical consultants now worked a one-in-five on-call rota. These appointments have helped to release the hospital's Clinical Director from general medical duties for a period of time each week in order to increase time for the functions of the clinical director role.

7.8 Medical Assessment Unit

Background

The HIQA Portlaoise Investigation Team had found that despite the recommendations of the HSE's Acute Medicine Programme, the hospital did not have a medical assessment unit.* The HIQA Portlaoise Investigation Team was concerned that the medical services at Portlaoise Hospital would continue to struggle to implement the Acute Medicine Programme in the ongoing absence of a Medical Assessment Unit or Acute Medical Assessment Unit.

What has changed since the HIQA Portlaoise Investigation?

The hospital had received funding for, and substantially constructed, a 10-bed modern Medical Assessment Unit on site. The HIQA Review Team visited the Medical Assessment Unit, which was nearing completion. The 2016 Dublin Midlands Hospital Group Operational Plan identifies the opening of the new Medical Assessment Unit at the Portlaoise Hospital as one of its priority actions for completion by the end of 2016.[20]

Senior management of the Dublin Midlands Hospital Group informed the HIQA Review Team at interview that this was still a priority for the Hospital Group management team, and that they planned to open the Medical Assessment Unit by late 2016.

7.9 Diagnostic imaging services

Background

The 2015 HIQA Portlaoise Investigation had concluded that the diagnostic imaging service at Portlaoise Hospital was significantly under-resourced and was under pressure to efficiently respond to the demand from unscheduled, scheduled, outpatient and community care services. It was reported to the HIQA Portlaoise Investigation Team that some patients had been waiting long periods (up to six months) for imaging tests, particularly ultrasound scanning. Despite these constraints, there was evidence of regular clinical audit within the diagnostic imaging services.

What has changed since the HIQA Portlaoise Investigation?

---

* The National Emergency Medicine Programme defines a medical assessment unit (MAU) as a unit in a model 2 (local) hospital which will see general practitioner- (GP-) referred differentiated medical patients who have a low risk of requiring full resuscitation. It will have assessment beds in a defined area and serve a clinical decision support function. Admissions will be to inpatient beds in a model 2 hospital.

During the HIQA Portlaoise Investigation, the service had 2.5 whole-time equivalent consultant radiologists. The HIQA Review Team found that consultant radiologist staffing had improved, with the service now being provided by a total of 3.5 whole-time equivalent consultants (2.5 permanent consultants and one long-term locum consultant).

It was reported by clinical staff at the hospital that the service was still under pressure to meet service demands and the waiting lists for ultrasound scans had increased. They reported that in March 2016, there were 992 patients waiting for an ultrasound, with the longest wait for a patient being nine months.

The HIQA Review Team found that the Radiology Department had a proactive programme of quality assurance and improvement in place, including clinical audit and peer review. It was benchmarking its results from these activities with national benchmarks.

7.10 Conclusion for general services

With exception of complex surgery stopping at Portlaoise Hospital, only limited changes to general services at the hospital had taken place since the HIQA Portlaoise Investigation Report was published. As a consequence, many of the risks to patients attending general services at the hospital, which had been identified during the original investigation, remain.

Among the critical findings from the HIQA Portlaoise Investigation was that Portlaoise Hospital lacked a clear strategic direction. As a result, the hospital did not have a clear vision of what type of service it provided. This led to a situation where some of the services provided were poorly planned and funded and were not set up in a sustainable way.

At the time of writing this report, no decision on the strategic future of Portlaoise Hospital had been taken. For the time being, the hospital continues to accept undifferentiated patients through its Emergency Department, in the knowledge that it cannot safely and effectively treat some of them and that these sicker patients will require transfer to a more appropriate hospital.

Measures have been put in place to streamline the transfer of the small number of patients who present to the hospital's Emergency Department and who need complex surgery. However, it is acknowledged by the hospital group management team that such a situation is not a satisfactory long-term arrangement.

While safeguards have been put in place in an attempt to try to mitigate the risks associated with the current model of medical care provided at the hospital, risks to patient safety remain. More substantive decision making is required in order to provide a safer long-term arrangement for undifferentiated patients who currently present to the hospital.

Elsewhere in this report, the HIQA Review Team has cited significant progress in relation to improved leadership, governance and management at the hospital, better clinical governance structures and improvements in the quality and safety of maternity services.

However, the HIQA Review Team believes that Portlaoise Hospital has now reached a critical juncture.

Current arrangements around accepting and treating undifferentiated patients who present to the Emergency Department, some of whom may need to go on to receive critical care in a different hospital, are unsustainable within the current service.

The status quo is not an acceptable long-term situation from a patient safety point of view, and the ongoing uncertainty that results from the lack of a long-term plan is damaging for the hospital and impacts on current service sustainability. A decision on what general medical and surgical services the hospital can, or might safely and sustainably provide with service redesign, needs to be urgently made in the best interest of patients. In particular, management of existing risks that are present at the hospital under its current configuration with respect to critical care services and the ongoing receipt of undifferentiated patients to the Emergency Department should be prioritized in the short term.

Chapter 8. Conclusions

8.1 Introduction to conclusions

The HIQA Portlaoise Investigation Report was published on 8 May 2015 and became the seventh such investigation report published by the Authority in seven years. The report identified a basic and worrying deficit in the Irish health services: the health service's apparent inability to effectively reflect on the findings of all reports, reviews and investigations and apply system-wide learning from these findings for the benefit of all service users. The report called for the HSE to respond in a clear and measurable way to the publication of the findings of the investigation and to ensure that these findings did not constitute yet another lost opportunity for service improvement across the wider healthcare system. Therefore, this Review was undertaken by HIQA in line with its 2016 business plan to assess the progress on the implementation of the recommendations from the investigation report at a local, regional and national level.

At the time of this review, it must be acknowledged that just over a year had passed since the report's publication and, therefore, implementation must be assessed in this context. The following sections outline the key conclusions of this review.

8.2 HSE's response to addressing the needs of patients who raised concerns during the HIQA Portlaoise Hospital Investigation in 2014

During the HIQA Portlaoise Investigation, it was requested that the women that raised concerns during the investigation and their families would be provided with access to relevant psychological and other support as needed. The HIQA Review Team was informed that all of these women were offered counselling services and other services in the community, such as physiotherapy and occupational therapy service. However, work to ensure the necessary access for some of these services was still in progress. The HSE also needs to continue to work to ensure that these women and their families are provided with any additional supports that are identified as part of this process.

8.3 Evaluation of progress made in the implementation of nationally targeted recommendations following HIQA's Portlaoise investigation

The HIQA Portlaoise Investigation Report contained eight recommendations. Of these, six related to the national or regional HSE, while two related to Portlaoise Hospital and hospital-group level within the HSE.

In terms of progress with these national recommendations, the following had been achieved at the time of this Review:

- the Minister for Health had established an oversight committee in the Department of Health to ensure the implementation of the recommendations from the Portlaoise Investigation Report
- the Department of Health had developed and published a 10 year strategy for the maternity services
- the HSE and the State Claims Agency had developed and agreed a Statement of Partnership between the two organizations to facilitate sharing of information between the two organizations regarding patient safety risks.

However, a significant number of director of midwifery posts had not yet been filled, although advertising for recruitment was taking place.

Progress made in relation to services at the Midland Regional Hospital Portlaoise

Recommendation 6 and Recommendation 7 were of relevance to all hospital groups within the HSE. However, for the purpose of this review, progress with applying these recommendations was viewed in terms of what has happened within Portlaoise Hospital and the Dublin Midlands Hospital Group.

8.4. Governance

The HIQA Review Team found there had been significant improvements in the corporate and clinical governance arrangements at Portlaoise Hospital. The senior management team demonstrated that they were responsive to patient safety and quality concerns that were raised. There was evidence that the management team worked together in the management of complaints and in their response to patient safety incidents.

The HIQA Review Team noted that there was escalation to the Dublin Midlands Hospital Group of risks and serious incidents from the hospital and there was oversight of these risks to patient safety at group Level. The effectiveness of the working relationship between the hospitals and hospital group management team was much improved relative to that found during the HIQA Portlaoise Investigation.

Among the critical findings from the HIQA Portlaoise Investigation Report was that Portlaoise Hospital lacked a clear strategic direction. This led to a situation where some of the services provided were poorly planned and funded and were not set up in a sustainable way.

At the time of this Review, HIQA identified that the Dublin Midlands Hospital Group had advanced detailed proposed plans, with the input and agreement of relevant national clinical care programmes and the National Ambulance Service, to determine an alternate model of service for the hospital based upon hospital capability and capacity, and the calculated needs of the patient population within the wider framework of services provided by the Dublin Midlands Hospital Group. However, at the time of this Review, this plan had yet to be fully agreed by all relevant decision makers and published.

In addition, in order to ensure safer treatment of patients at the hospital, hospital funding has been increased significantly compared to before the HIQA Portlaoise Investigation. This increased funding largely pays for additional staff, many of whom work in the medical and emergency department services described. The lack of certainty around services at the hospital has led to difficulty in recruitment and retention of staff and an ongoing reliance on agency staff, which has significant financial implications for the hospital. The ongoing lack of certainty has a negative effect on staff recruitment, retention and morale, and this further affects the sustainability of services.

The HIQA Review Team again reiterates that as a priority, there is a requirement for all relevant decision makers to determine the range of clinical services that Portlaoise Hospital can safely deliver within the Dublin Midlands Hospital Group. Once this has been determined this information should be published and an implementation plan put in place. The HIQA Review Team found that as it stands this failure to make a decision as to the future of service delivery at the hospital is having an adverse effect on the hospital.

8.4 Maternity services

Since the publication of the HIQA Portlaoise Investigation Report, the Senior Management team of Portlaoise Hospital have made significant progress in implementing improvements to enhance the quality and safety of services for patients using the maternity services. It was evident there was a system in place to respond to complaints in a timely manner. There was evidence of learning from incidents across the maternity service. Safety has also been significantly aided by a reduced number of births and an improvement in the ratio of staff to births. There was a clear clinical audit plan for maternity services, and audits were conducted pertinent to key quality and patient safety concerns. Moreover, there was oversight of the training and education of staff in fetal monitoring and management of obstetric emergencies.

One of the key findings from HIQA's Portlaoise Investigation was the need to implement in full a clinical maternity network between Portlaoise Hospital and the Coombe Women and Infants University Hospital in Dublin. In March 2015, a Memorandum of Understanding was signed between the Coombe Women and Infants University Hospital and the HSE. At the time of this HIQA Review, a senior consultant obstetrician and gynaecologist from the Coombe Women and Infants University Hospital had been assigned as Clinical Director for Integration and attended Portlaoise Maternity unit two days a week. This role had been significant in terms of providing experienced senior clinical leadership at Portlaoise Maternity unit and helping to progress with the implementation of the clinical network.

While there had been significant steps towards integration, the HIQA Review Team were informed that full integration of the Portlaoise Maternity services within the governance structure of the Coombe Women and Infants University Hospital will only be fully enacted once the issues — such as appointment of additional personnel and infrastructural development across both sites — outlined in the Memorandum of Understanding are implemented and that the biggest challenge to this was investment.

The maternity services at Portlaoise continue to struggle to recruit and retain NCHDs, and this remains a risk to patient safety. The appointment and recruitment of two consultant obstetricians shared across both Portlaoise Maternity and the Coombe Women and Infants University Hospital was anticipated to enable the rotation of non-consultant hospital doctors between both sites, and this needs to be progressed urgently.

Overall, the HIQA Review Team found that there was evidence of significant progress with implementation of the recommendations and findings from the HIQA Portlaoise Investigation. However the full integration of Portlaoise maternity services within the governance of the Coombe Women and Infants University Hospital needs to be facilitated through necessary capital investment and further recruitment of agreed key personnel.

8.5 General services

The most significant change in the general services provided at the hospital since the investigation has been the cessation of complex surgery. Otherwise, however, with the exception of cessation of complex surgery only limited change to the provision of general services at the Portlaoise Hospital has occurred. As a consequence, many of the risks identified during the original investigation remain.

Current arrangements around the receipt of undifferentiated patients, particularly those who may need to go on to receive critical care, are unsustainable within the current construct. The status quo is not an acceptable situation from a patient safety perspective, and ongoing uncertainty is additionally damaging for the hospital. More substantive decision making needs to occur the best interest of patients around the future direction of general services in the hospital.

The HIQA Portlaoise Investigation Report recommended that that Portlaoise Hospital should be incorporated into a clinical network within a hospital-group structure — with certain grades of staff including hospital consultant, non-consultant doctors and speciality nurses being obliged to rotate between sites as required — to assure the ongoing provision of a clinically competent and stable workforce at the hospital. However, at the time of this Review, the general services had not implemented any new arrangements since the investigation to support rotation of doctors or nurses between hospitals within the Dublin Midlands Hospital Group.

8.6 Concluding remarks

Overall, at the time of this Review, it was found that there had been significant improvements in the corporate and clinical governance arrangements at Portlaoise Hospital, with a more effective management team at the hospital and better oversight provided by the Dublin Midlands Hospital Group senior management team.

In addition, in order to ensure safer treatment of patients at the hospital, hospital funding has been increased significantly compared to the funding provided to the hospital before the HIQA Portlaoise Investigation. This increased funding largely funds extra staff, many of whom work in the medical and emergency department services.

In particular, this Review has identified that maternity services at the hospital are now being provided in a much safer and sustainable way than during the period that prompted the HIQA Portlaoise Investigation, with benchmarked safety metrics within national norms. This improvement has been facilitated by improved leadership, governance and management within the service, increased investment, and an improvement in the staff to birth ratio which has been largely driven by a reduced number of births. Efforts to begin the process of integration with the Coombe Women and Infants University Hospital have also seen service quality and safety of services enhanced at Portlaoise Hospital, but more remains to be done to progress this clinical network.

However, despite these improvements, the continuing lack of certainty around the provision of services at the hospital has led to difficulty in recruiting and keeping staff and an ongoing reliance on agency staff, which has significant financial implications for the hospital. The ongoing lack of certainty therefore has a negative effect on staff recruitment, retention and morale, and this further effects the sustainability of services.

The HIQA Review Team were informed that the Dublin Midlands Hospital Group had advanced detailed proposed plans for the future of Portlaoise Hospital. It was outlined to the HIQA Review Team that this draft plan was unanimously agreed by the consultant leads of the HSE's national clinical care programmes who acted as an advisory group and with input from the HSE's National Ambulance Service. It was explained to HIQA that it was intended that this plan would determine a more appropriate potential model of service for the hospital based upon hospital capability and capacity and the calculated needs of the patient population within the wider framework of services provided by the Dublin Midlands Hospital Group.

It is acknowledged that an effective and informed action plan will take time to develop and will require careful planning to avoid unintended knock-on impacts on other hospitals in the hospital group, neighbouring hospital groups, the National Ambulance Service and community services. However, since the HIQA investigation report was published in 2015, the fundamental issue remains unresolved — to function as a model 3 hospital, Portlaoise Hospital must be both adequately and sustainably resourced and have the capability through the level of services it can safely provide to manage the full spectrum of patients that may present to the Emergency Department.

As things currently stand, and despite a 15% increase in funding and an 18% increase in staffing numbers, the hospital does not currently possess the inherent internal capability to manage all of the patients that may present to the Emergency Department. Moreover services are currently being sustained through a reliance on agency staff, which is both costly and not good practice from a service sustainability and development perspective. While many of the issues identified during the HIQA investigation have been addressed, others remain. These remaining risks will only be fully addressed through the formulation and enactment of a clear strategic plan for the hospital, which is agreed by those with responsibility for the ultimate decision making on the hospital's future.

Appendix 1 – Methodology

This section outlines the methodology used by HIQA to review progress with the implementation of the recommendations of the *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise*. It describes the HIQA Review Team and the phases of the review.

HIQA Review Team

This review was developed and carried out by HIQA staff who are authorized to monitor compliance with standards, in accordance with section 70(1) (a) of the Health Act 2007 (the Act).

Lines of enquiry

Lines of enquiry were developed by HIQA to guide the review approach and to provide the Review Team with a framework for the selection and gathering of information.

The lines of enquiry were aligned to the:

- the *National Standards for Safer Better Healthcare*
- findings and recommendations of *Report of the investigation into the quality and safety of care provided by the Health Service Executive in the Midland Regional Hospital, Portlaoise*

Documentation and data

In accordance with section 8(1) (c), HIQA issued formal documentation and data requirements to relevant parties.

The Review Team obtained documentation and data which covered areas such as the:

- corporate and clinical governance structure and management arrangements
- patient activity and patient-outcome data
- risk management systems including reported adverse incidents
- arrangements for the dissemination and implementation of policies, procedures, guidelines and best available evidence
- workforce planning and staffing arrangements.

HIQA provided a time frame of 10 working days for the return of documentation and data from the date that the information requests were issued.

Interviews

HIQA obtained information through interview with individuals including:

- staff working in Portlaoise Hospital at local level
- HSE staff at national level whose role related to aspects of the governance and quality and safety of services at Portlaoise Hospital

All individuals who were interviewed were provided with a minimum of 10 working days' notification of interview.

HIQA interviewed selected individuals using a framework of areas of exploration related to the lines of enquiry. The interviews were used to:

- clarify issues that may have been identified during the Review Team's review of documentation and data
- gather information generally
- consider any further information that was provided
- inform the Review findings.

Observation

In order to obtain information about the environment and physical facilities for the delivery of safe, high-quality care to patients at Portlaoise Hospital, members of the Review Team observed a number of the areas in the hospital during the course of a two day visit in June 2016. This observation included the:

- Emergency Department
- Maternity Department, including the delivery unit
- Intensive Care Unit
- Coronary Care Unit
- Outpatients Department
- Special Care Baby Unit
- General Medical Ward
- General Surgical Ward
- Operating Theatre
- Endoscopy Unit

- Paediatrics Unit
- The Theatre Department
- The Medical Assessment Unit, which was under construction and in the process of being fitted out at the time of this review.

Due process feedback

HIQA provided a copy of the relevant excerpt(s) of the confidential draft report of the Review findings, on an individual basis or in a representative role, to relevant healthcare professionals and senior managers in the HSE and interviewed by the Review Team during the Review. Those who received a copy of the relevant excerpt(s) were invited to offer their feedback and commentary generally on any matters in the draft report excerpt. HIQA provided a time frame of 10 working days for the return of any feedback and comments from the date of issue of the draft excerpt of the report. Every comment received was carefully considered by HIQA prior to the publication of this report.

Glossary of terms used in this report

Accountability: being answerable to another person or organisation for decisions, behaviour and any consequences.
Adverse event: an incident that results in harm to a patient.
Advocacy: the practice of an individual acting independently of the service provider on behalf of and in the interests of a patient, who may feel unable to represent themselves.
Allied health practitioners: encompasses clinical support specialties such as physiotherapy, occupational therapy, social work, speech and language therapy and clinical nutrition.
Ambulance bypass protocol: patients with specified conditions are taken by ambulance directly to larger nominated facilities better equipped to provide the healthcare intervention required, rather than to smaller local hospitals.
Anaesthetic: a substance that produces partial or complete loss of sensation.
Anaesthetist: a medical specialist who administers an anaesthetic to a patient before a medical procedure or surgery.
Antenatal care: care provided to a pregnant woman during her pregnancy.
Benchmarking: a process of measuring and comparing care and services with similar service providers.
Best available evidence: the consistent and systematic identification, analysis and selection of data and information to evaluate options and make decisions in relation to a specific question.
Caesarean section: a surgical procedure used to deliver a baby through incisions created in the mother's abdomen and uterus.
Cardiotocography: an electronic means of recording the fetal heart beat and the uterine contractions during pregnancy. A cardiotocograph machine produces a trace known as a cardiotocograph which illustrates the fetal heart rate and uterine activity.

Care pathway: a multidisciplinary care plan that outlines the main clinical interventions undertaken by different healthcare professionals in the care of patients with a specific condition or set of symptoms.
Clinical audit: a quality improvement process that seeks to improve patients' care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical director: the primary role of a clinical director is to manage and plan how services are delivered and contribute to the process of strategic planning, influencing and responding to organisational priorities. This will involve responsibility for agreeing an annual directorate service plan, identifying service development priorities and working to aligning directorate service plans with hospital or network plans.
Clinical directorate: a team of healthcare professionals within a specialty, or group of specialties.
Clinical governance: a system through which service providers are accountable for continuously improving the quality of their clinical practice and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This includes mechanisms for monitoring clinical quality and safety through structured programmes, for example, clinical audit. See **Clinical audit**.
Clinical guidelines: systematically developed statements to assist healthcare professionals and patients' decisions about appropriate healthcare for specific circumstances.
Clinical Indemnity Scheme: The Clinical Indemnity Scheme was established in 2002 to rationalise medical indemnity arrangements by transferring responsibility for managing clinical negligence claims and associated risks to the State, via the Health Service Executive (HSE), hospitals and other health agencies.
Clinical nurse manager (CNM): refers to nurses who undertake first-line nursing management posts with responsibility for professional leadership, staffing and staff development, resource management and facilitating communication. There are three grades of first-line nurse management: CNM 1, CNM 2 and CNM 3. A CNM 1 reports to a CNM 2; a CNM 2 is in charge of a ward or unit of care and reports to a CNM 3; a CNM 3 is in charge of a department and reports to an assistant director of nursing.

Clinical midwife manager (CMM): refers to midwives who undertake first-line midwife management posts with responsibility for professional leadership, staffing and staff development, resource management and facilitating communication. There are three grades of first-line midwife management: CMM 1, CMM 2 and CMM 3. A CMM 1 reports to a CMM 2; a CMM 2 is in charge of a ward or unit of care and reports to a CMM 3; a CMM 3 is in charge of a department and reports to an assistant director of midwifery.
Competence: the knowledge, skills, abilities, behaviours and expertise sufficient to be able to perform a particular task and activity.
Complaint: an expression of dissatisfaction with any aspect of service provision.
Concern: a safety or quality issue regarding any aspect of service provision raised by a patient, service provider, member of the workforce or general public.
Consultant: a hospital consultant is a registered medical practitioner in hospital practice who, by reason of his or her training, skill and experience in a designated specialty, is consulted by other registered medical practitioners and assumes full clinical responsibility for patients in his or her care, or that aspect of care on which he or she has been consulted, without supervision in professional matters by any other person. Consultants include surgeons, physicians, anaesthetists, pathologists, radiologists, oncologists and others.
Continuous veno-venous haemofiltration: a short-term treatment used in an intensive care unit (see **ICU**) for patients with acute or chronic kidney failure, to facilitate the removal of waste products from the bloodstream.
Core hours: core working hours refer to the hours when a department or area is fully functional and historically was classified as the working hours of 9am to 5pm, Monday to Friday.
Corporate governance: the system by which services direct and control their functions in order to achieve organisational objectives, manage their business processes, meet required standards of accountability, integrity and propriety and relate to external stakeholders.
Critical care services: service for the provision of medical care for a critically ill or critically injured patient.

CT: computed tomography is a computerised X-ray imaging technique which is used to generate cross-sectional and three-dimensional images of internal organs and structures of the body.
Culture: the shared attitudes, beliefs and values that define a group or groups of people and shape and influence perceptions and behaviours.
Dublin Midlands Hospital Group: this hospital group was previously called the Health Dublin Midlands Group. It will comprise: St James's Hospital, Dublin; Tallaght Hospital, Dublin; Midland Regional Hospital Tullamore; Naas General Hospital; Midland Regional Hospital, Portlaoise; and the Coombe Women and Infants University Hospital, Dublin. Its primary academic partner will be Trinity College Dublin (TCD).
Effective: a measure of the extent to which a specific intervention, procedure, treatment, or service, when delivered, does what it is intended to do for a specified population.
Elective: an elective procedure is one that is planned by the patient and the surgeon or a physician at a time that is advantageous to the patient. It is not usually urgent.
Emergency care: the branch of medicine that deals with evaluation and initial treatment of medical conditions caused by trauma or sudden illness.
Evaluation: a formal process to determine the extent to which the planned or desired outcomes of an intervention are achieved.
Evidence: data and information used to make decisions. Evidence can be derived from research, experiential learning, indicator data and evaluations.
Gastrointestinal endoscopy: an examination of the inside lining of the digestive tract including the oesophagus, stomach, and upper small intestine using an endoscope, which is a flexible fibre optic tube with a tiny camera at the end.
Governance: in healthcare, an integration of corporate and clinical governance; the systems, processes and behaviours by which services lead, direct and control their functions in order to achieve their objectives, including the quality and safety of services for patients. See also '**Clinical governance**' and '**Corporate governance**' above.

Gynaecology: the branch of medicine particularly concerned with the health of the female organs of reproduction and diseases of these organs.
Healthcare professional: a person who exercises skill or judgment in diagnosing, treating or caring for service users, or preserving or improving the health of service users.
Healthcare record: all information in both paper and electronic formats relating to the individual care of a patient or service user. This includes (but is not limited to) demographics (such as name, address, date of birth), medical history, social history, findings from physical examination, X-rays and specimens, the results of diagnostic tests, prescriptions, procedures and all communication relating to the care of the patients.
High dependency unit (HDU): a unit in a hospital that offers specialist nursing care and monitoring to ill patients. It provides greater care than is available on general wards but less than is given to patients in intensive care.
HSE: The Health Service Executive, established under the Health Act 2004, is the statutory body responsible for providing health and social care services to everyone living in Ireland.
Infection control: the discipline and practice of preventing and controlling Healthcare Associated Infections and infectious diseases in a healthcare organisation.
Inpatient: a patient who remains in hospital while receiving medical or surgical treatment.
Intensive care unit (ICU): a unit in a hospital providing complex support for multi-organ failure and or advanced respiratory support.
Irish Maternal Early Warning System (IMEWS): a system for the early detection of illness during pregnancy and after a woman has had a baby. Previously referred to as I-MEWS in national guidelines.
Key performance indicator (KPI): specific and measurable elements of practice that can be used to assess quality and safety of care.
Locum: a healthcare professional, with the required competencies, who is employed to temporarily cover the duties of another healthcare professional who is on leave.

Manchester triage system: this is an assessment system used in emergency departments to rapidly place patients into categories, according to the type of treatment they need and how quickly they need it.
Master of a maternity hospital: master is a term from the 19th Century when the Rotunda, the Coombe and National Maternity hospitals in Dublin were each granted the power to appoint a lead doctor to take control of all aspects of the hospitals' clinical and administrative areas.
Methodology: a system of methods, rules and procedures used for the delivery of a project.
Model of service: the way a health service is delivered. It can be applied to a single service unit, to an organisation or a national service.
Model 1, 2, 3 and 4 hospitals: in 2010, the HSE's National Acute Medicine Programme described four generic acute hospital models (model 1, 2, 3 and 4). Their purpose was to define the level of service that can be safely provided at acute hospitals within the constraints of available facilities, staff, resources and local factors. **Model-1 hospitals** are community and or district hospitals and do not have surgery, emergency care, acute medicine (other than a select group of low-risk patients) or critical care. **Model-2 hospitals** can provide the majority of hospital activity including extended day surgery, selected acute medicine, local injuries, a large range of diagnostic services, including endoscopy, laboratory medicine, point-of-care testing, and radiology – computed tomography (CT), ultrasound and plain-film X-ray – specialist rehabilitation medicine and palliative care. **Model-3 hospitals** admit undifferentiated acute medical patients; provide 24-seven acute surgery, acute medicine, and critical care. **Model-4 hospitals** are tertiary hospitals and are similar to model-3 hospitals but also provide tertiary care and, in certain locations, supra-regional care.
Monitoring: systematic process of gathering information and tracking change over time. Monitoring provides a verification of progress towards achievement of objectives and goals.

Morbidity rate: refers to the incidence or the prevalence of a disease or medical condition in a given population.
Mortality rate: refers to the measure of the number of deaths in a given population.
Multidisciplinary: an approach to the planning of treatment and the delivery of care for a patient by a team of healthcare professionals who work together to provide integrated care.
National Integrated Medical Imaging System: a new, central computer-based system for storing and examining X-rays and scans, managed and controlled by the Health Service Executive (HSE).
NEWS: National Early Warning Score. This is a nationally agreed early warning score for the early recognition and management of acutely ill adult patients.
Non-consultant hospital doctor (NCHD): terminology used in Ireland to describe doctors that have not yet reached hospital consultant grade. NCHDs include specialist registrars, registrars, senior house officers and interns.
Non-elective or unscheduled cases: people who require or who perceive the need for advice, care, treatment or diagnosis that is not planned or pre-booked. Non-elective or unscheduled care is available every day and should receive a prompt response depending on the urgency of the clinical need of the patient.
Obstetrics: the branch of medicine concerned with pregnancy and childbirth.
Obstetrician: a doctor who has specialised in the area of obstetrics.
On call: the provision or availability of clinical advice in addition to or outside of core working hours.
Open disclosure: a comprehensive and clear discussion of an incident that resulted or may have resulted in harm to a service user while receiving healthcare. Open disclosure is an ongoing communication process with service users and their families or carers following an adverse event.
Out of hours: outside the core working hours of 9am to 5pm, Monday to Friday. See **Core hours**.

Outpatient department (OPD): a hospital department which is primarily designed to enable hospital consultants and members of their teams to see patients at clinics for scheduled care. Patients attending the outpatient department may be a new patient referral or patients who are attending for review following discharge from hospital or who had previously attended the OPD.
Outpatient: a patient who receives treatment at a hospital (at an emergency department or a clinic) but is not hospitalised.
Paediatrics: the branch of medicine concerned with the treatment of infants and children.
Paediatrician: a specialist in paediatrics.
Patient safety incident or event: an event or circumstance which could have resulted, or did result, in unnecessary harm to a patient. Patient safety incidents include an incident which reached the patient and caused harm (adverse event); an incident which did not reach the patient (near miss); and an incident which reached the patient, but resulted in no discernible harm to the patient (no harm event).
Pathology: a branch of medical science primarily concerning the examination of organs, tissues, and bodily fluids in order to make a diagnosis of disease.
Pathologist: a specialist in the area of pathology.
Perinatal death: the death of a baby in the weeks before or after birth.
Person-centred care: the behaviours, practices and protocols which ensure that the patient is at the centre of the delivery of coordinated and integrated care which, in turn, should ensure the best possible outcomes for the patient in terms of health and welfare.
Performance management and or **performance monitoring:** process which includes activities that ensure that goals are consistently being met in an effective and efficient manner. Performance management can, for example, focus on the performance of an organisation, a department, service, or the processes to deliver a service.

Policies, procedures, protocols and guidelines: a set of statements or commitments to pursue courses of action aimed at achieving defined goals.
Policy: a written operational statement of intent which helps staff make appropriate decisions and take actions, consistent with the aims of the service provider, and in the best interests of service users.
Postnatal care: care delivered during the period from giving birth to the first six weeks after birth.
Primary care: an approach to care that includes a range of services designed to keep people well. These services range from promotion of health and screening for disease, to assessment, diagnosis, treatment and rehabilitation as well as personal social services.
PROMPT: Practical Obstetric Multi-Professional Training (PROMPT) is an evidence-based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.
Protocol: in healthcare, a detailed plan of a medical treatment or procedure.
Quality assurance: the systematic process of checking to see whether a product or service is consistently meeting a desired level of quality.
Radiologist: a doctor who has specialised in the area of radiology.
Radiology: is a medical specialty that uses imaging (such as X-rays and scans) to diagnose and treat disease seen within the body.
RDO: a regional director of operations, HSE. From 2009, RDOs were the senior managers on regional HSE management teams. Regional directors of performance and integration (RDPIs) replaced the RDOs in 2013 as managers of performance and integration across hospital and community services.
RDPI: a regional director for performance and integration, HSE.
Risk management: the systematic identification, evaluation and management of risk. It is a continuous process with the aim of reducing risk to an organisation and individuals.

Risk register: a risk register is a risk management tool. It acts as a central repository for all risks identified by an organisation and, for each risk, includes information such as risk probability, impact, controls and risk owner.
Risk: in healthcare, the likelihood of an adverse event or outcome.
Scheduled care: describes the care which patients receive on a planned basis.
Safety walk-rounds: a safety initiative which involves structured visits by senior managers to clinical areas within their hospital to have conversations with front-line staff for the purpose of preventing, detecting and mitigating harm to patients and staff.
Service: anywhere health or social care is provided. Examples include, but are not limited to, acute hospitals, community hospitals, district hospitals, health centres, dental clinics, general practitioner (GP) surgeries, homecare, and so on.
Service level agreement (SLA): a framework for the provision of services, including details of quality and governance requirements.
Service provider: any person, organisation, or part of an organisation delivering healthcare services [as described in the Health Act 2007 Section 8(1)(b)(i)–(ii)] on behalf of the Health Service Executive (HSE).
Skill mix: the combination of competencies including skills needed in the workforce to accomplish the specific tasks or perform the given functions required for safe high-quality care.
Stakeholder: a person, group or organisation that affects or can be affected by the actions of, or has an interest in, the services provided.
Stroke: occurs when a blood vessel, carrying oxygen and nutrients to the brain, bursts or is blocked by a clot, causing an interruption of the blood supply to part of the brain.
Surgery: medical treatment in which a doctor cuts into someone's body in order to repair or remove damaged or diseased parts.
Surgeon: a specialist doctor in surgery.
Terms of reference: a set of terms that describe the purpose and structure of a project, committee or meeting.

The Authority: the Health Information and Quality Authority, or HIQA.
Triage: the process in which patients are sorted according to their need for care. The process is governed by the kind of illness or injury, the severity of the problem, and the facilities available.
Ultrasound: a procedure in which high-energy sound waves are bounced off internal tissues or organs and make echoes. The echo patterns are shown on the screen of an ultrasound machine, forming a picture of body tissues called a sonogram.
Undifferentiated patients: all types of patients with any degree of seriousness or severity of illness or injury.
Whole-time equivalent (WTE): one whole-time equivalent employee is an employee who works the total number of hours possible for their grade. WTEs are not the same as staff numbers as many staff work reduced hours, for example, two nurses working 19 hours per week each would be 1 WTE as full-time hours for nursing staff are 39 hours per week.
Workforce: the people who work in, for, or with the service provider. This includes individuals that are employed, self-employed, temporary, volunteers, contracted or anyone who is responsible or accountable to the organisation when providing a service to the service user or patient.

References

(1) Health Information and Quality Authority. *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise*. Dublin: Health Information and Quality Authority; 2015. Available online from: https://www.hiqa.ie/publications/report-investigation-safety-quality-and-standards-services-provided-health-service-exec

(2) Holohan T. *HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date*). Department of Health; 2014. Available online from: http://health.gov.ie/wp-content/uploads/2014/03/portlaoise_perinatal_deaths.pdf

(3) Boylan, P. A Review of 28 Maternity Case Notes by a Clinical Review Team Undertaken at the Request of the Health Service Executive. Dublin: Health Service Executive; 2015.

(4) Department of Health. *Oversight Group for the Implementation of the Recommendations contained in the HIQA Report on Portlaoise Hospital (2015)* [online] Available from: http://health.gov.ie/patient-safety/oversight-group/

(5) Department of Health. *Creating a Better future together. National Maternity Strategy 2016-2026.* Dublin: Department of Health; 2016. Available online from: http://health.gov.ie/wp-content/uploads/2016/01/Final-version-27.01.16.pdf

(6) Health Information and Quality Authority. *Draft National Standards for Safer Better Maternity Services.* Dublin: 2016. Available online from: https://www.hiqa.ie/publications/draft-national-standards-safer-better-maternity-services

(7) Health Information and Quality Authority. Report of the investigation into the quality, safety and governance of the care provided by the Adelaide and Meath Hospital, Dublin incorporating the National Children's Hospital (AMNCH) for patients who require acute admission. Dublin: 2012. Available online from:

http://www.hiqa.ie/publications/report-investigation-quality-safety-and-governance-care-provided-adelaide-and-meath-hos.

(8) Health Information and Quality Authority. *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at Mallow General Hospital.* Dublin: 2011. Available online from: http://www.hiqa.ie/publications/report-investigation-quality-and-safety-services-and-supporting-arrangements-provided-h.

(9) Health Information and Quality Authority. *Report of the investigation into the quality and safety of services and supporting arrangements provided by the Health Service Executive at the Mid-Western Regional Hospital Ennis.* Dublin: 2009. Available online from: http://www.hiqa.ie/publication/report-investigation-quality-and-safety-services-and-supporting-arrangements-provided-hs

(10) Health Information and Quality Authority. *Report of the investigation into the circumstances surrounding the provision of care to Rebecca O'Malley, in relation to her symptomatic breast disease, the Pathology Services at Cork University Hospital and Symptomatic Breast Disease Services at the Mid Western Regional Hospital, Limerick.* Dublin: 2008. Available online from: http://www.hiqa.ie/publication/investigation-circumstances-surrounding-provision-care-rebecca-omalley-relation-her-symp.

(11) Health Information and Quality Authority. *Report of the investigation into the provision of services to Ms A by the Health Service Executive at University Hospital Galway in relation to her symptomatic breast disease, and the provision of Pathology and Symptomatic Breast Disease Services by the Executive at the Hospital.* Dublin: Health Information and Quality Authority; 2008. Available online from: https://www.hiqa.ie/press-release/2008-07-15-health-information-and-quality-authority-publish-investigation-report-patho

(12) Health Information and Quality Authority. *Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive (HSE) to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway (UHG), and as reflected in the care and treatment provided to Savita Halappanavar.* Dublin: Health Information and Quality Authority; 2013. Available online from:

http://www.hiqa.ie/publications/patient-safety-investigation-report-services-university-hospital-galway-uhg-and-reflect.

(13) Health Information and Quality Authority. *The National Standards for Safer Better Healthcare*. Dublin: Health Information and Quality Authority; 2012. Available online from: https://www.hiqa.ie/standards/health/safer-better-healthcare

(14) Department of the Taoiseach. *Programme for Government 2011 - 2016.* Department of the Taoiseach; 2011. Available online from: http://www.taoiseach.gov.ie/eng/Work_Of_The_Department/Programme_for_Government/Programme_for_Government_2011-2016.pdf

(15) Health Service Executive, Department of Health. *The Framework for Development - Securing the Future of Smaller Hospitals.* Dublin: Department of Health; 2013. Available online from: http://health.gov.ie/wp-content/uploads/2014/03/SecuringSmallerHospitals.pdf

(16) Higgins J R and Department of Health. *The Establishment of Hospital Groups as a transition to Independent Hospital Trusts. A report for the Minister for Health, Dr James Reilly TD*. Dublin: Department of Health; 2013. Available online from: http://health.gov.ie/blog/publications/the-establishment-of-hospital-groups-as-a-transition-to-independent-hospital-trusts/.

(17) Health Service Executive. *National Service Plan 2015*. Health Service Executive; 2015. Available online from: http://www.hse.ie/eng/services/publications/corporate/sp2015.pdf.

(18) Health Service Executive, Quality and Patient Safety Directorate. *Quality and Safety Walk-rounds Toolkit.* Dublin: Health Service Executive; 2013. Available online from: https://www.hse.ie/eng/about/Who/qualityandpatientsafety/Clinical_Governance/CG_docs/QPSwalkarounds240513.pdf

(19) Health Service Executive. *HSE Dublin Mid-Leinster Regional Service Plan 2013.* Dublin: Health Service Executive; 2013. Available online from: https://www.hse.ie/eng/services/publications/corporate/dmlserviceplan2013.pdf

(20) Health Service Executive. *Dublin Midlands Hospital Group. Operational Plan 2016.* Dublin: Health Service Executive; 2016. Available online from: https://hse.ie/eng/services/publications/serviceplans/serviceplan2016/OpPls16/DMHGopplan16.pdf

(21) Health Information and Quality Authority. *International review of patient safety surveillance systems.* Dublin: Health Information and Quality Authority; 2016. Available online from: https://www.hiqa.ie/press-release/2016-01-25-hiqa-highlights-need-improved-patient-safety-surveillance

(22) Hutchinson, A, Young T A, Cooper KL, McIntosh A, Karnon JD, Scobie S, Thomson RG, Trends in healthcare incident reporting and relationship to safety and quality data in acute hospitals: results from the National Reporting and Learning System. *Quality Safety Health Care 2009;18:5-10*

(23) State Claims Agency. *Clinical incidents and claims report in maternity and gynaecology services. A five year review: 2010 – 2014.* Dublin: State Claims Agency; 2015 http://stateclaims.ie/wp-content/uploads/2015/10/SCAClinicalIncidentsClaimsReportOct2015FINAL.pdf

(24) Health Service Executive. *Serious Reportable Events (SREs) HSE Implementation Guidance Document*. Dublin: Health Service Executive; 2015. Available online from: https://www.hse.ie/eng/services/publications/performancereports/srejan15.pdf

(25) Health Service Executive. *Safety Incident Management Policy.* Dublin: Health Service Executive; 2014. Available online from: https://www.hse.ie/eng/about/Who/qualityandpatientsafety/incidentrisk/Riskmanagement/SafetyIncidentMgtPolicy2014.pdf

(26) Health Service Executive. *'Your Service, Your Say' The Policy for the Management of Consumer Feedback to include Comments, Compliments and Complaints in the Health Service Executive.* Dublin; Health Service Executive: 2015. Available online from: http://www.hse.ie/eng/services/yourhealthservice/feedback/Complaints/Policy/complaintspolicy.pdf

(27) Health Service Executive, National Advocacy Unit, Quality and Patient Safety Directorate. *National Healthcare Charter. You and your health service*. Kildare: Health Service Executive; 2012. Available online from: https://www.hse.ie/eng/services/yourhealthservice/hcharter/National_Healthcare_Charter.pdf

(28) Applied Research Ltd. *Assessment of Safety Culture in Midland Regional Hospital, Portlaoise (MRHP) Using the Safety Culture Index (SCI) Unpublished*. 2014.

(29) Sammer CE, Lykens K, Singh KP, Mains DA, Lackan NA. What is patient safety culture? A review of the literature. *Journal of Nursing Scholarship*. 2010; 42(2): pp.156-65.

(30) Department of Health and Children. *Building a Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance*. Dublin: The Stationery Office; 2008. Available online from: http://health.gov.ie/blog/%20publications/building-a-culture-of-patient-safety-report-of-the-commission-on-patient-safety-and-quality-assurance/

(31) Healthcare Pricing Office and Health Service Executive. *Perinatal Statistics Report 2014.* Dublin: Health Service Executive, 2016. Available online from: http://www.lenus.ie/hse/bitstream/10147/617014/1/PerinatalStatisticsReport2014.pdf

(32) Corcoran P, Manning E, O'Farrell IB, McKernan J, Meaney S, Drummond L, de Foubert P, Greene RA, on behalf of the Perinatal Mortality Group. Perinatal Mortality in Ireland Annual Report 2014. Cork: National Perinatal Epidemiology Centre, 2016. Available online from: https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/NPECMortality2014.pdf

(33) HSE Clinical Programme for Obstetrics in Gynaecology. *Irish Maternity Indicator System National Report 2014.* Dublin: HSE Clinical Programme in Obstetrics and Gynaecology; 2016. Available online from: https://www.hse.ie/eng/services/publications/hospitals/IMISnationalreport14.pdf

(34) Institute of Obstetricians and Gynaecologists. *Report from Institute Subgroup. The Future of Maternity and Gynaecology services in Ireland 2006 - 2016.* Dublin: 2006. Available online from: https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/databriefs/DocumentFile,32196,en.pdf

(35) Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland, Directorate of Strategy and Clinical Programmes, Health Service Executive. *Clinical Practice Guideline. Oxytocin to accelerate or Induce labour. Haemorrhage*. Dublin: Health Service Executive; 2016. Available online from: https: https://www.rcpi.ie/wp-content/uploads/2016/05/31.-Oxytocin-to-Accelerate-or-Induce-Labour.pdf

(36) Manning E, Corcoran P, O'Farrell IB, de Foubert P, Drummond L, McKernan J, Meaney S, Greene RA, on behalf of the Severe Maternal Morbidity Group. *Severe Maternal Morbidity in Ireland Annual Report 2014*. Cork: National Perinatal Epidemiology Centre, 2016. Available online from: https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/SMMReport2014.pdf

(37) Health Service Executive (2016) *Final Report of the HSE Midwifery Workforce Planning Project.* Dublin: Health Service Executive; 2016.

(38) National Clinical Effectiveness Committee*. Communication (Clinical Handover) in the Maternity Services*. Dublin: Department of Health; 2014. Available online from http://health.gov.ie/patient-safety/ncec

(39) Robson, M.Murphy, M., Byrne,F. Quality assurance: The 10-Group Classification System (Robson classification), induction of labor, and cesarean delivery. *International Journal of Obstetrics and Gynaecology 1(1)S23-S27.*

(40) Harding Clark M. *The Lourdes Hospital Inquiry. An inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital Drogheda. Report of Judge Maureen Harding Clark SC*. Dublin: The Stationery Office; 2006. Available online from: http://health.gov.ie/wp-content/uploads/2014/05/lourdes.pdf.

(41) Health Service Executive. *National Miscarriage Misdiagnosis Review*. Dublin: Health Service Executive; 2011. Available online from: http://www.lenus.ie/hse/bitstream/10147/128265/1/miscarriagemisdiagnosis.pdf

(42) Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland, Directorate of Strategy and Clinical Programmes, Health Service Executive. *Clinical Practice Guideline. Fetal Growth Restriction – Recogition,Diagnosis and Management*. Dublin: Health Service Executive; 2014. Available online from: https://www.hse.ie/eng/about/Who/clinical/natclinprog/obsandgynaeprogramme/29-_Fetal_Growth_Restriction-IUGR_CPG_final_.pdf

(43) Health Service Executive. *National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death*. Dublin: Health Service Executive; 2016 Available online from: http://www.hse.ie/eng/about/Who/acute/bereavementcare/standardsBereavementCarePregnancyLoss.pdf

(44) National Institute for Health and Care Excellence. *Antenatal Care, NICE Clinical Guideline 62*. London: National Institute for Health and Clinical Excellence; 2008(updated March 2016). Available online from: https://www.nice.org.uk/guidance/cg62/resources/antenatal-care-for-uncomplicated-pregnancies-975564597445

(45) National Clinical Effectiveness Committee. *The Irish Maternity Early Warning System (IMEWS)*. National Clinical Guideline No. 4. Dublin: Department of Health; 2014. Available online from: http://health.gov.ie/wp-content/uploads/2015/01/National-Clinical-Guideline-No.-4-IMEWS-Nov2014.pdf

(46) National Clinical Programme for Emergency Medicine and the Office of the Nursing and Midwifery Services. *A Guide to Enhance Advanced Nurse Practitioner Services across Emergency Care Networks in Ireland.* Dublin: Health Service Executive; 2013 http://www.iaem.ie/wp-content/uploads/2013/02/guide-to-enhancing-anp-services-july-2013-final.pdf

(47) National Emergency Medicine Programme Working Group. *The National Emergency Medicine Programme.* Dublin: Health Service Executive; 2012. Available online from: https://www.hse.ie/eng/about/Who/clinical/natclinprog/emergencymedicineprogramme/empreport2012.pdf

(48) Advisory Committee on Emergency Medicine Training. Irish Association for Emergency Medicine. *The Development of Paediatric Emergency Medicine in Ireland.* Dublin: Irish Association for Emergency Medicine; 2010. http://www.iaem.ie/wp-content/uploads/2013/02/the_development_of_paediatric_emergency_medicine_in_ireland_as_agreed_with_hse_metr__fprcpi_october_2010_final.pdf

(49) National Clinical Programme for Paediatrics and Neonatology*. Draft National Clinical Programme for Paediatrics and Neonatology Model of Care for Paediatric Healthcare Services in Ireland*. Dublin: Health Service Executive; 2015. Available online from: http://www.hse.ie/eng/about/Who/clinical/natclinprog/paediatricsandneonatology/modelsofcare/EmergencyMedicine%20.pdf

(50) National Emergency Medicine Programme. *Irish Children's Triage System: National Emergency Medicine Programme*. Dublin: Health Service Executive;

2016. Available online from: http://emnow.ie/wordpress/wp-content/uploads/2015/03/National-Emergency-Medicine-Programme-Irish-Childrens-Triage-System-June-2016.pdf

(51) Health Service Executive. *Right Care, Right Now: Model of Care for Adult Critical Care. National Clinical Programme for Clinical Care*. Health Service Executive; 2014. Available online from: https://www.hse.ie/eng/about/Who/clinical/natclinprog/criticalcareprogramme/modelofcare/criticalcare.pdf

Published by the Health Information and Quality Authority

For further information please contact:

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7

Phone: +353 (0) 1 814 7400
Email: qualityandsafety@hiqa.ie
URL: www.hiqa.ie