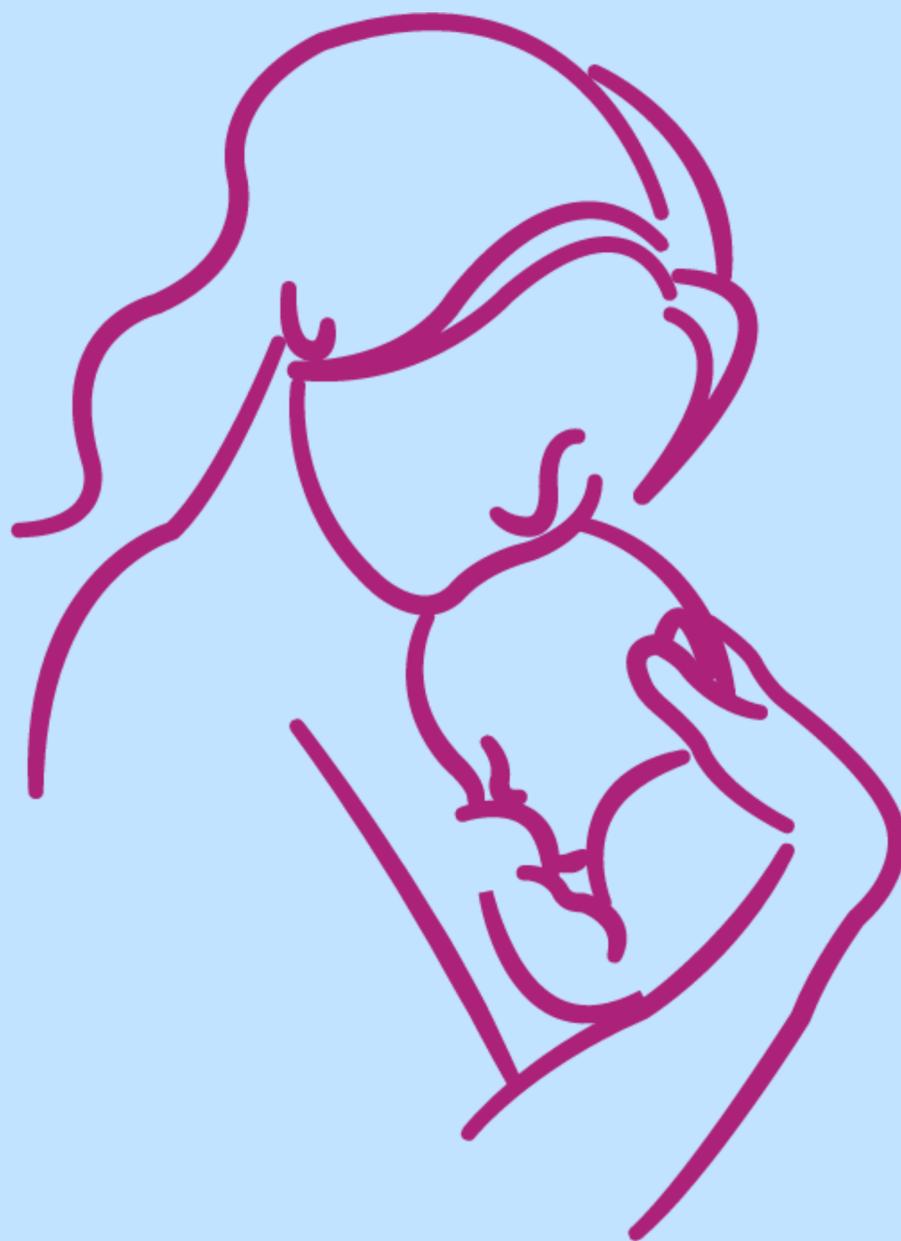




HIQA

Maternity Overview Report

Over 60,000 babies are born in Ireland every year.



HIQA has inspected all of Ireland's 19 maternity services over 13 months with a focus on obstetric emergencies.

*National Standards for Safer Better
Maternity Services*



AREAS OF GOOD PRACTICE



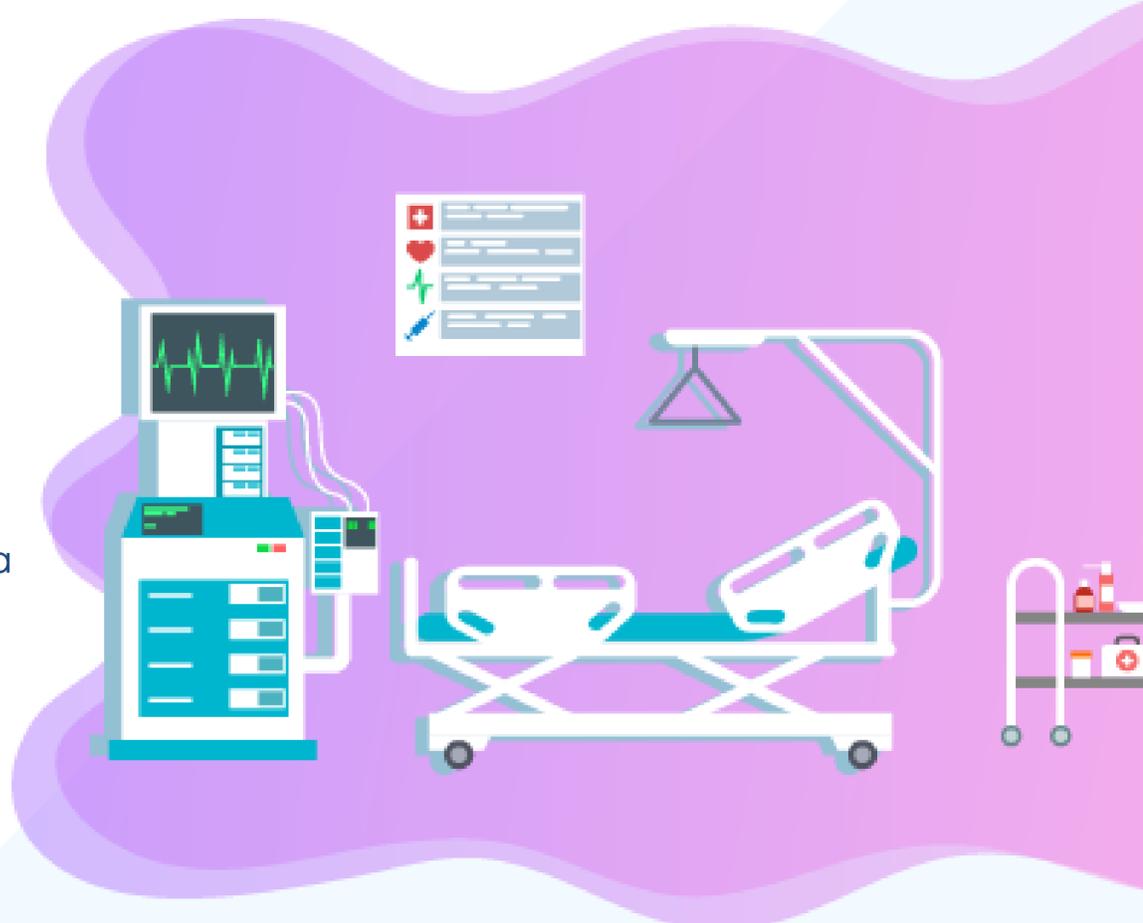
Quality and Safety of Care

Generally, levels of compliance against the national standards monitored were high.

All maternity services regularly monitored the care they provided.

Obstetric Emergencies

All maternity services had arrangements in place to respond to obstetric emergencies on a 24-hour basis.





AREAS FOR IMPROVEMENT



Strategy

Limited progress has been made to implement the National Maternity Strategy.

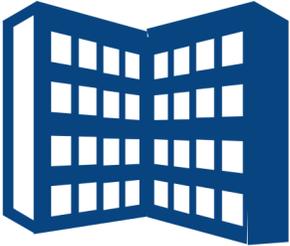
Networks

The formation of maternity networks must progress to ensure that all women and newborns in Ireland have access to the same level of care.



Infrastructure

The layout and infrastructure of many maternity units and hospitals presented an infection risk for mothers and babies, and impacted on a woman's comfort, dignity and privacy.



Staffing & Training

Services were reliant on front-line staff working onerous rosters and overtime. This is not sustainable or safe in the long term. Uptake of training on the management of obstetric emergencies needs to improve in many maternity services.





RECOMMENDATIONS

1 STRATEGY



Immediately develop a comprehensive, time-bound and fully-costed plan to implement the National Maternity Strategy

2 INFRASTRUCTURE



Address the infrastructural deficits in all maternity units and hospitals

3 WORKFORCE



Conduct a review of workforce arrangements

4 TRAINING



Ensure that all clinical staff who manage obstetric emergencies have received the necessary training

5 TRANSFER



Ensure that all hospital groups immediately agree to mandatory transfer and acceptance protocols

6 LEARNING



Develop a national system that facilitates the sharing of learning from the review of clinical incidents

7 WORDING



Remove the word 'patient' from 'maternity patient safety statements', and all references to Midlands Reginal Hospital Portlaoise

8 ACTION PLAN



Develop a clear action plan for the implementation of the recommendations of this report