



Report of the follow-up inspection of the maternity service against the *National Standards for Safer Better Maternity Services.*

Name of healthcare service provider:	St Luke's General Hospital, Kilkenny
Address of healthcare service:	Freshford Road, Friarsinch, Kilkenny
Type of inspection:	Short-Notice Announced Follow-up Inspection
Date of inspection:	16 February 2022
Healthcare Service ID:	OSV-0001042

The following information describes the service the hospital provides.

Model and Profile of Hospital

St. Luke's General Hospital, incorporating Carlow District Hospital, is a model 3* statutory acute hospital which is part of the Ireland East Hospital Group. The maternity unit is co-located with the general hospital, providing maternity services to meet the needs of women from Carlow and Kilkenny and adjoining counties Laois and Tipperary. There were 1,501 births at the hospital in 2021.

The maternity unit in St Luke's General Hospital is a 29 bedded unit providing antenatal, intrapartum and postnatal care for women and babies in the catchment area. The labour ward contains five beds. The hospital also has a Special Care Baby Unit with five cots providing care to babies over 34 weeks' gestation.

Previous HIQA inspections of the maternity service at the hospital

The Health Information and Quality Authority (HIQA) conducted a two-day unannounced inspection of the maternity service in St Luke's General Hospital in November 2018. Findings from that inspection identified a high level of non-compliance with a number of the national standards monitored from the *National Standards for Safer Better Maternity Services*¹ and areas of associated risk in the hospital's obstetric and anaesthetic services.² HIQA escalated the identified risks to hospital management and management of the Ireland East Hospital Group who in turn committed to addressing the risks.

HIQA carried out a one-day follow-up inspection of the maternity service at the hospital in September 2019.² The aim of that inspection was to assess the level of progress made by hospital management and the hospital group in addressing the risks identified by HIQA in the obstetric and anaesthetic services in 2018. Inspectors assessed compliance with the national standards that the hospital was found to be substantially, partially or non-compliant in during the 2018 inspection. In the follow-up inspection, HIQA identified evidence of improved compliance with the national standards monitored and areas where further work was required to further improve compliance with the *National Standards for Safer Better Maternity Services*.

Since September 2019, HIQA has corresponded with the chief executive officer of the Ireland East Hospital Group seeking assurances on the progress of implementing measures to address HIQA's concerns and issues related to the obstetric and

* The National Acute Medicine Programme describes a Model 3 hospital as one that admit undifferentiated acute medical patients, provide 24/7 acute surgery, acute medicine, and critical care.

anaesthetic services at St Luke's General Hospital. In December 2021, HIQA requested documentation, data and information from the Ireland East Hospital Group regarding the governance arrangements and assessment of performance against quality and safety indicators for the maternity service at the hospital. HIQA conducted a desktop review of the information provided and subsequently carried out a one-day, short-notice announced inspection[†] of the hospital's maternity service. The aim of this inspection was to determine the progress made in addressing areas of concern previously identified by HIQA in relation to the maternity service.

How we inspect

Under Section 8(1) (c) of the Health Act 2007³ HIQA, among other functions, are responsible for setting and monitoring standards in relation to the quality and safety of healthcare services. During this inspection, inspectors assessed the hospital's compliance with six national standards (5.2, 5.8, 6.3, 2.2, 2.3 and 3.2) from the *National Standards for Safer Better Maternity Services*. HIQA carried out the short-notice announced inspection of the hospital's maternity service on 16 February 2022.

About the inspection report

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

Section 1: Capacity and capability

This section describes HIQA's evaluation of how effective the arrangements for the leadership, governance and management of the maternity service were in ensuring the delivery of a high-quality, safe maternity service at St. Luke's General Hospital. It describes progress made in establishing and implementing a maternity network from the perspective of the hospital. It also describes the way the hospital was resourced with a multidisciplinary workforce that was trained and supervised, and available to manage obstetric emergencies and clinical deterioration in women attending the maternity service.

[†] Short-notice announcement – Hospital management at St Luke's General Hospital was given 48 hours' notice of the follow-up inspection to facilitate meeting with key hospital or service personnel.

Section 2: Quality and safety

This section describes the arrangements in place at the hospital to ensure pregnant women were risk assessed and stratified to the most appropriate maternity care pathway. The section also outlines the arrangements in place to recognise and manage obstetric emergencies and clinical deterioration in women attending the maternity service. The arrangements in place to transfer women to another service for specialist and or critical care, if needed are also discussed.

The six national standards assessed as part of the inspection and the resulting compliance judgments are set out in Appendix 1. Table 1 below shows the main sections of the inspection report and the dimension, themes and national standards from the *National Standards for Safer Better Maternity Services* discussed in each section.

Table 1 Sections of the report and corresponding dimensions, themes and national standards

Section of Report	Theme	Relevant National Standard
Section 1: Capacity and Capability	Leadership, Governance and Management	5.2 and 5.8
	Workforce	6.3
Section 2: Quality and Safety	Effective Care and Support	2.2 and 2.3
	Safe Care and Support	3.2

Details of the inspection are outlined below.

Date	Times of Inspection	Inspector	Role
Tuesday, 16 February 2022	09:00hrs to 18:00hrs	Denise Lawler	Lead Inspector
		John Tuffy	Support Inspector
		Dolores Dempsey-Ryan	Support Inspector
		Danielle Bracken	Support Inspector

Information about this inspection

The short-announced inspection of the maternity service at St Luke's General Hospital focused on the following areas:

- Governance, management and oversight of the maternity service at the hospital.
- Risk assessment, stratification and assignment of pregnant women to the most appropriate maternity care pathway.
- Recognition, management and escalation of clinically deteriorating women attending the maternity service.
- Recognition, management and escalation of obstetric emergencies.
- Supervision and mentoring of non-consultant hospital doctors (NCHDs) in obstetrics.

During this inspection, inspectors spoke with the following staff at the hospital:

- Representatives of the hospital's executive management team
 - General Manager
 - Clinical Director
 - Clinical Lead for obstetrics
 - Director of Midwifery
 - Quality and Safety Manager
 - Clinical Risk Manager for maternity service
 - Business manager for maternity service
- Lead Representative for non-consultant hospital doctors
- A representative from the Ireland East Hospital Group.

In addition, inspections visited a number of clinical areas and spoke with midwifery and nursing managers and staff midwives. The clinical areas visited included:

- an antenatal booking (virtual using video conferencing)
- the mixed antenatal and postnatal ward where women were cared for before and after birth
- the labour ward where women were cared for during labour and birth
- an operating theatre in the Operating Theatre Department where pregnant women underwent surgery, for example in the case of caesarean section
- Intensive Care Unit where women requiring critical care were cared for.

Inspectors also reviewed a range of documentation, data and information relating to the maternity service, which included a sample of healthcare records of women attending the service who had an emergency caesarean section in January 2022 (13 out of 26 healthcare records were reviewed).

Compliance descriptors

Based on inspection findings, HIQA used four categories –compliant, substantially compliant, partially compliant or non-compliant – to describe the hospital’s level of compliance with the six national standards monitored. These categories are defined as follows:

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

Acknowledgements

HIQA would like to acknowledge the co-operation of the management team and staff who facilitated and contributed to this inspection.

Capacity and Capability Dimension

Inspection findings in relation to the capacity and capability dimension are presented under three national standards (5.2, 5.8 and 6.3) from the themes of leadership, governance and management and workforce. The hospital was found to be substantially compliant in all three national standards assessed. Key inspection findings leading to these judgments are described in the following sections.

Standard 5.2: Maternity service providers have formalised governance arrangements for assuring the delivery of safe, high-quality maternity care.

At the time of this inspection, inspectors were satisfied that there were integrated corporate and clinical governance arrangements governing the maternity service at St Luke’s General Hospital. The corporate and clinical governance structures in place at the time of this

inspection were the same as those previously reported by HIQA² and were set out in the organisation organogram for the maternity service reviewed by inspectors.

Inspectors were satisfied that the governance arrangements in place on the day of inspection clearly defined those with accountability and responsibilities for assuring the quality and safety of the maternity service at both hospital and hospital group levels. From the evidence gathered during inspection, inspectors were assured that the primary focus was on quality and safety outcomes for women using the maternity service.

The governance arrangements showed that the general manager had overall managerial responsibility and accountability for the maternity service at the hospital. The general manager reported to the chief executive officer of the hospital group and attended performance meetings with the hospital group management team each month.

Clinical governance for the maternity service was led by the clinical director for the hospital. The clinical director reported to the hospital's general manager and liaised with the designated clinical leads at hospital group level.

The hospital had also appointed a clinical lead in the speciality of obstetrics on a rotational basis of two years who was responsible for:

- representing the obstetric team at the hospital and hospital group level
- supporting the hospital executive management team to communicate and liaise with consultant obstetricians in relation to developments or initiatives in obstetrics
- overseeing training of non-consultant hospital doctors in obstetrics.

The director of midwifery was the designated person assigned responsibility for the organisation and management of the midwifery service at the hospital. The director of midwifery reported to the hospital's general manager and liaised with the chief director of nursing and midwifery at hospital group level.

The executive management team was the key governance committee with responsibility for the governance and oversight of the quality and safety of the hospital's maternity service. The committee had oversight of collated information from the HSE's maternity patient safety statements,[‡] other key performance indicators and metrics, and patient-safety incidents related to the maternity service. The committee reported to the governance committee and chief executive officer of the Ireland East Hospital Group.

Other committees with a reporting relationship to the executive management team regularly reviewed information about the quality and safety of the maternity service. These included the:

- Maternity Services Governance Committee.

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

- Safety and Quality Executive Committee.

Serious reportable events related to the maternity service were reviewed by the Serious Incident Management Team who also had a reporting structure to the hospital's executive management team.

Since HIQA's last inspection of the maternity service in 2019, the hospital group had established and implemented a formalised maternity network.[§] The hospital had also developed a forum for consultant obstetricians – the consultant obstetrician governance meeting – to enhance the professional working relationship and communication between consultant obstetricians and hospital management.

At the time of inspection, it was evident to inspectors that the Ireland East Hospital Group was working towards incorporating the four maternity services** within the hospital group into a maternity network under a single governance structure. The overall aim of the maternity network was to develop and facilitate a whole system approach, linking professionals and sharing learning across the maternity services. The network, chaired by the hospital group's executive director of women's health and neonatal services, comprised representatives from the four maternity units and members of the hospital group's executive management team. Members of the Health Service Executive's (HSE) National Women and Infants Health Programme^{††} attended meetings of the maternity network every three months. Inspectors were satisfied that the network had oversight of the data from the Irish Maternity Indicator System,^{‡‡} clinical activity and quality and improvement initiatives across the four maternity services in the hospital group.

It was evident to inspectors that the maternity network was underpinned by the principles of cooperation and collaboration but at the time of inspection, the network was still evolving and was not fully functioning as described in the National Maternity Strategy.⁵

Inspectors found that there was:

- no joint appointments in obstetrics between St. Luke's General Hospital and the other maternity hospital or units in the Ireland East Hospital Group
- no shared clinical meetings such as maternal and perinatal mortality and morbidity meetings between St. Luke's General Hospital and the other maternity hospital or units within the Ireland East Hospital Group

[§] The National Maternity Strategy 2016 states that smaller maternity services require formal links to larger maternity units to enable sharing of expertise and clinical services to support safe quality maternity services across the country.

^{**} The four hospitals providing maternity services in the Ireland East Hospital Group were the National Maternity Hospital, Wexford General Hospital, St Luke's General Hospital and the Regional Hospital Mullingar.

^{††} The National Women and Infants Health Programme was established in January 2017, to lead the management, organisation and delivery of maternity, gynaecology and neonatal services.

^{‡‡} Irish Maternity indicator system data was gathered at the hospital each month and reported in line with national Health Service Executive reporting requirements.

- no capacity for the rotation of medical or midwifery staff between the maternity sites across the hospital group. Moreover, there were no written formalised care pathways to enable and ensure that women with complex high-risk pregnancies were cared for in the most appropriate clinical setting.

Operational issues that were or had the potential to impact on the quality and safety of the service were also discussed at an informal meeting held every week with members of the hospital group's executive team and the hospital's general manager and director of midwifery. These informal meetings were in addition to meetings of the maternity network.

Poor communication and lack of cohesive teamwork among consultant obstetricians was a key finding from HIQA's previous inspection in 2018 and at the time was escalated as a risk to the hospital group. During this inspection, hospital management informed inspectors that the communication and team working among consultant obstetricians had improved and that the consultant obstetrician governance meeting had played a significant part in that improvement. It was also evident from the documentation reviewed by inspections that the consultant obstetricians and hospital management were working on improving teamwork and communication.

Overall, inspectors were satisfied that, at the time of this inspection, there were formalised governance arrangements in place at the hospital and hospital group level to assure the delivery of a safe, high-quality maternity service at St Luke's General Hospital. Since HIQA's last inspection in 2019, the hospital group had established a maternity network under a single governance framework. Following this inspection, the Ireland East Hospital Group should actively progress further the implementation of the maternity network to facilitate the rotation of staff between maternity sites, to meet training and service requirements and to enable the implementation of mandatory acceptance policies for the transfer of women and neonates from and to maternity services in the hospital group. The hospital should also continue to support and promote measures that enable the effective, professional working relationships and communication among clinicians to ensure the delivery of quality, safe maternity care.

Judgment for national standard 5.2: Substantially compliant

Standard 5.8: Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services.

In line with the national HSE reporting requirements, the hospital collected data on a range of different clinical measurements related to the quality and safety of the maternity service each month. Irish Maternity Indicator System data was collated nationally by the office of the HSE's National Women and Infants Health Programme. This facilitated national oversight by the HSE of specific clinical outcome and activity measures across the 19 maternity

hospitals and units in Ireland. St Luke's General Hospital used the collated information from the Irish Maternity Indicator System to compare and benchmark their performance against other similar sized maternity services in Ireland.

The hospital published their maternity patient safety statements each month. The hospital also collected information on midwifery care planning, monitoring in labour, fetal heart monitoring and the use of the Irish Maternity Early Warning System^{§§} as part of the HSE's nursing and midwifery quality care-metrics^{***} every month. Performance data related to the maternity service was reviewed by relevant governance structures and was presented at performance meetings between the hospital and hospital group every month.

In 2020, the hospital's obstetric blood transfusion, peripartum hysterectomy and caesarean section rates were higher than the national rate. For that year, the hospital's obstetric blood transfusion rate was 45.0 per 1,000 women compared to the national rate of 25.9 per 1,000 women. The hospital's peripartum hysterectomy rate was 1.41 per 1,000 women compared to the national rate of 0.54 per 1,000 women and the hospital's caesarean section rate was 39.1% compared to the national rate of 35.4%.⁴

The hospital had introduced a number of quality improvement initiatives to address the higher rates of obstetric blood transfusion, peripartum hysterectomy and caesarean section. They had developed and implemented a standardised procedure for the estimation and measurement of maternal blood loss. The hospital had also introduced a practice that improved the decision making process around the conduct of peripartum hysterectomies whereby each case needed to be signed off by two senior obstetricians (or clinical director in the absence of a second obstetrician). Quality improvement initiatives implemented to address the rising caesarean section rate included the introduction of an external cephalic version⁺⁺⁺ clinic and a vaginal birth after caesarean⁺⁺⁺ clinic. Staff in the maternity unit were also using the Robson 10-Group Classification Scheme^{§§§} for assessing, monitoring and comparing caesarean sections rates for women attending the hospital's maternity service.⁶

The Irish Maternity Indicator System data provided to HIQA by hospital management showed significant improvement in the hospital's rate of obstetric blood transfusion and peripartum hysterectomy in 2021. The data showed that the hospital's rate of obstetric blood transfusion had decreased from 45.0 per 1,000 women in 2020 to 4.11 in 2021. There

^{§§} The Irish Maternity Early Warning System is a bedside track and trigger system that midwifery and nursing staff calculate from the vital signs recorded, and aims to indicate early signs of clinical deterioration.

^{***} Nursing and midwifery quality care-metrics provide an indication of the quality of nursing and midwifery care. The metrics consist of a core suite of quality indicators across seven care groups.

⁺⁺⁺ External cephalic version (ECV), or version, is a procedure used to turn a fetus from a breech (bottom) position or side-lying (transverse) position into a head-down (vertex) position before labour begins.

⁺⁺⁺ Vaginal birth after caesarean (VBAC) means giving birth through the vagina after giving birth previously by caesarean section.

^{§§§} The Robson classification also called the Ten Group Classification System (TGCS), classifies caesarean section into ten groups based on the category of the pregnancy, the previous obstetric record of the woman, the course of labour and delivery, and the gestational age of the pregnancy.

was no reported incident of peripartum hysterectomy in 2021. However, notwithstanding the initiatives introduced to manage the rising caesarean section rate, the hospital's caesarean section rate had increased from 39.1% in 2020 to 44% in 2021.

HIQA was provided with three clinical audits carried out in the maternity service in 2021 and 2020. These were:

- An audit of maternal and fetal outcome of instrumental delivery in St Luke's General Hospital.
- Debriefing after obstetric complication.
- Review of emergency bleeds in maternity.

While these provided some evidence of clinical audit in the maternity unit, auditing of the maternity service could be better. Furthermore, it was not clear to inspectors that there was a system in place to ensure that all of the clinical audits conducted in the maternity unit were consistently followed up with clear action plans to address any identified opportunities for improvement.

The auditing of the maternity service should be improved so as to provide hospital management with assurance on the quality and safety of the maternity service and to identify areas for improvement.^{7,8,9,10} Hospital managers told inspectors that they had recently recruited and appointed a clerical officer at grade VI level specifically for the maternity service and that part of this role would be to coordinate and follow up on clinical audits conducted in the maternity service.

Inspectors observed and were provided with evidence of quality improvements initiatives introduced in the maternity unit to improve the quality and safety of the service. These included the development and implementation of:

- a suite of QR codes**** specific to the maternity service that provide women with health promotion and other relevant information
- the TCUPPS – Theatre, Consent, Understanding, Pain relief, Paediatrician, Senior Support – initiative for the management of obstetric emergencies used in the labour ward.

While inspectors found that the hospital did have structures and processes in place to monitor, identify and act on opportunities to improve the safety and quality of the maternity service, greater clinical auditing and oversight of audit activity for the maternity service is needed to provide hospital management with assurance on the quality and safety of the maternity service.

Judgment for national standard 5.8: Substantially compliant

**** A QR code is a type of barcode that a smartphone can scan. When the smartphone scans this code, it translates that information into something that can be easily understood by women.

Standard 6.3 Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care.

During previous inspections, HIQA identified that there was a reported lack of supervision and training of non-consultant hospital doctors in obstetrics, which posed a potential risk to effective care planning and management that was escalated to the hospital group.

During this inspection, inspectors reviewed the medical team's work rosters and schedules over a three week period. These showed that a senior registrar in obstetrics and a consultant obstetrician was allocated to the labour ward rota every day. Hospital management informed inspectors that the hospital had received approval to appoint another permanent consultant obstetrician. When appointed, this will increase the complement of consultant obstetricians in position at the time of HIQA's last inspection in 2019 from five to six. Having a sixth consultant obstetrician will further support the supervision of non-consultant hospital doctors and will result in a more sustainable on call roster.

Hospital management informed inspectors that the issue of non-training non consultant doctors identified in previous HIQA inspections remained an issue for the hospital. The Royal College of Physicians of Ireland⁺⁺⁺⁺ does not recognise St Luke's General Hospital as a site for higher specialist training for doctors in obstetrics and gynaecology. Being part of, or completing a higher training schemes, provides hospital managers with an assurance of the competence of non-consultant hospital doctors who rotate into the service from other hospitals. Non-consultant hospital doctors at registrar grade on a higher specialist training complete log books that record the competencies achieved and skills attained during their training. However, non-consultant hospital doctors that are not on a higher specialist training scheme do not. During this inspection, inspectors were told that the hospital continues to rely on non-consultant hospital doctors who were not on a training programme to deliver the maternity service. Inspectors were also told that non-consultant hospital doctors in obstetrics were supervised until deemed competent to undertake procedures independently.

HIQA has previously identified how many maternity units and hospitals in Ireland were heavily reliant on non-training non-consultant hospital doctors in obstetrics and how these individuals have often remained in post for a number of years providing a degree of staffing stability. This was particularly important where the alternative might have been a more transient and therefore unstable workforce.¹¹ Furthermore, HIQA has described the lack of a formalised training and career pathway for non-training non-consultant hospital doctors in obstetrics, combined with the opportunities available for career progression in other countries, as a potential risk to the sustainability of maternity services in Ireland. The HSE and medical training bodies should progress with the implementation of identified measures to address the issue of non-training non-consultant hospital doctors in obstetrics.¹²

⁺⁺⁺⁺ Higher specialist training in obstetrics and gynaecology is a five-year programme that when successfully completed to doctors can enter the Specialist Division of the Register with the Medical Council of Ireland.

It was evident from staff training records reviewed by inspectors that medical staff in obstetrics, midwives and nurses undertook multidisciplinary team training in the management of obstetric emergencies, clinical deterioration and the Irish Maternity Early Warning System every two years, or sooner if the need was identified.

The training records showed that the uptake of multi-professional training in the management of obstetric emergencies for obstetric medical staff had improved from a rate of 37.5% in 2019 to 90% at the time of this inspection. However, the uptake of multi-professional training in the management of obstetric emergencies for midwives had decreased from 87% in 2019 to 60% at the time of this inspection.

The uptake of training in basic life support (resuscitation of a pregnant woman) had also decreased since HIQA's last inspection. In 2019, 60% of midwives and 64% of nurses were up to date with basic life support training, but at the time of this inspection 29% of midwives, 50% of nurses and 59% of medical staff in obstetrics were up to date with this training.

Inspectors were informed that the COVID-19 pandemic had affected the delivery and uptake of training in the management of obstetric emergencies and basic life support over the last 22 months. However, to address this, the hospital had re-commenced the roll out of mandatory training in the management of obstetric emergencies for all staff since February 2022. Training schedules provided to HIQA showed that the hospital had planned to provide three multi-professional training programmes in the management of obstetric emergencies over the course of 2022, which should have a positive effect on the number of staff up to date with this training.

Sixty percent of midwives and 90% of medical staff in obstetrics were up to date with training in clinical handover. Sixty percent of midwives and 78% of obstetric medical staff were up to date with training in the Irish Maternity Early Warning System.

Multidisciplinary obstetric emergency scenario based skills and drills (simulation training) sessions were also facilitated by the clinical placement co-ordinator/clinical skills facilitator in the labour ward, with 24 of these sessions held in 2020 and 16 sessions held in 2021. The staff training records showed that 80% of midwives, 80% of nurses and 78% of medical staff in obstetrics had attended these sessions. Weekly multidisciplinary obstetric emergency skills and drills sessions in the labour ward had re-commenced since February 2022.

At the time of this inspection, the hospital was implementing other educational initiatives for staff working in the maternity service. The hospital was implementing the HSE's national healthcare communication programme^{****} across the maternity unit and special care baby

^{****} The National Healthcare Communication Programme was developed by the HSE to support healthcare staff to learn, develop and maintain their communication skills with patients, their families

unit. The obstetric medical team held educational sessions on topics such as fetal monitoring, wound healing and COVID-19 vaccines every week. Midwifery education sessions on a range of topics, including breastfeeding and mental health were provided by clinical midwife specialists^{§§§§} and advanced midwife practitioners every week, as part of the midwifery team meeting.

When compared to HIQA's inspection findings of 2019, inspectors found that the supervision, mentoring and training of non-consultant hospital doctors in obstetrics at the hospital had improved. However, given the hospital's continued reliance on non-training non-consultant hospital doctors and the potential associated risk to service delivery, the HSE and training bodies should progress the implementation of measures previously identified to address the issue of non-training non-consultant hospital doctors.¹² It is also essential that hospital management ensure that all clinical staff providing maternity care have undertaken mandatory and essential training appropriate to their scope of practice, at the required frequency in line with national standards.

Judgment for national standard 6.3: Substantially compliant

and colleagues. The Programme is underpinned by the core values of care, compassion, trust and learning with a focus on person-centred and clinical communication skills.

^{§§§§} Clinical Midwife Specialists – a midwife working in a speciality area such as bereavement, infant feeding, ultrasonography and mental health providing specialist midwifery practice.

Quality and Safety Dimension

Inspection findings in relation to the quality and safety dimension are presented under three national standards (2.2, 2.3 and 3.2) from the two themes of effective care and support and safe care and support. The hospital was found to be compliant with one national standard (2.2) and substantially compliant with the remaining two national standards (2.3 and 3.2) monitored. Inspection findings leading to these judgments are described in the following sections.

Standard 2.2: Maternity care is planned and delivered to meet the initial and ongoing assessed needs of women and their babies, while working to meet the needs of all women and babies using the service.

St Luke's General Hospital provided maternity services for women with normal and high-risk pregnancies. From documents reviewed prior to, and evidence collected on the day of inspection, inspectors were satisfied that the hospital had arrangements in place to identify, assess and ensure that women who were categorised as high risk and or at higher risk of developing complications were cared for by the most appropriate person, in the relevant maternity care pathway and setting. Each woman, regardless of risk category had a named consultant who was assigned clinical responsibility for her care.

Midwifery and medical staff carried out risk assessments on all women at the first antenatal booking appointment and women were assigned to the most appropriate care pathway based on their risk profile in line with national clinical guidelines.^{5,10} Women categorised with normal-risk pregnancies were assigned to the supported care pathway^{*****} where care was provided by a senior house officer in obstetrics and an advanced midwife practitioner.⁺⁺⁺⁺⁺ Women categorised with medium-risk and or high-risk pregnancies were assigned to the assisted care pathway⁺⁺⁺⁺⁺ or the specialised care pathway.^{§§§§§} Women categorised with medium-risk pregnancies assigned to the assisted care pathway were seen by a registrar in obstetrics and an advanced midwife practitioner. Women categorised with high-risk pregnancies assigned to the specialised care pathway were seen by a registrar in obstetrics and a consultant obstetrician. It was evident from the review of a sample of healthcare

***** Supported care pathway is described in the Creating a Better Future Together: National Maternity Strategy 2016-2026 as the care pathway intended for normal-risk mothers and babies, with midwives leading and delivering care within a multidisciplinary framework.

+++++ Advanced Midwife Practitioner is a midwife who practices at a higher level of capability as independent, autonomous and expert advanced practitioners.

+++++ Assisted care pathway is described in the Creating a Better Future Together: National Maternity Strategy 2016-2026 as the pathway intended for mothers and babies considered to be at medium risk, and for normal risk women who choose an obstetric service.

§§§§§ Specialised care pathway is described in the Creating a Better Future Together: National Maternity Strategy 2016-2026 as the pathway for high-risk mothers and babies. The pathway is led by a named obstetrician, and delivered by obstetricians and midwives, as part of a multidisciplinary team.

records that a woman's level of risk was kept under review before, during and after birth, that risks were modified after clinical assessment and that women were moved from lower risk to higher risk categories and vice versa if clinically indicated.¹⁰

The hospital had emergency medical response teams in place 24 hours a day, to provide an immediate response to obstetric and neonatal emergencies. There was 24-hour access to emergency obstetric surgery, for example emergency caesarean section. The hospital was staffed and managed so that emergency caesarean sections could be performed within the recommended time frame^{*****} although the hospital did not audit the decision to delivery time interval for emergency caesarean sections. Auditing the time between a decision to perform emergency caesarean section and the actual delivery of the baby is an important measure of the quality of care in a maternity service.¹³

Multidisciplinary clinical handover with obstetrics, midwifery and anaesthetic teams occurred twice daily in the labour ward. Daily safety huddles¹⁴ were also held after the morning clinical handover in the labour ward where issues such as staffing levels and women admitted with high-risk pregnancies were discussed. In line with national guidance, clinical staff used the Identify-Situation-Background-Assessment-Recommendation (ISBAR) communication tool to communicate information about women attending for maternity care.⁹

Inspectors reviewed local policies, procedures, protocols and guidelines for the management of obstetric emergencies and the care of the critically ill obstetric patient. The hospital had implemented the HSE's clinical practice guidelines relating to the management of obstetric emergencies.^{15,16} The hospital had also implemented policies based on National Clinical Effectiveness Committee⁺⁺⁺⁺⁺ guidance on sepsis, clinical handover in maternity services and the Irish Maternity Early Warning System. The hospital had a standardised procedure for the estimation and measurement of maternal blood loss. It was clear from documentation reviewed by inspectors that the maternity services governance committee was the governance structure that had oversight of the policies, procedures, protocols and guidelines used in the maternity service.

Of the 17 policies, procedures, protocols and guidelines related to the maternity service provided to HIQA, six were in date and 11 needed to be updated. Inspectors were told that the hospital had a practice of reviewing policies, procedures, protocols and guidelines every two years but the maternity services governance committee had agreed to extend that time frame to three years to align with the timeline recommended by the HSE.¹⁷ Therefore, eight of the 11 policies that needed updating, were actually within the HSE's three-year review period.

***** The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics set out that an emergency caesarean section is one which is performed within a time frame of 30 minutes from decision to perform caesarean delivery to the start (incision) of the procedure.

+++++ Guidelines produced by the National Clinical Effectiveness Committee have been formally mandated by the Minister of Health.

Staff could access policies, procedures, protocols and guidelines on a shared drive on the hospital's intranet. However, the hospital would benefit from a documentation management system to assist in document control and ensure staff providing maternity care have access to up-to-date versions of relevant policies, procedures, protocols and guidelines. The hospital did not audit compliance with policies, procedures, protocols and guidelines used in the maternity unit. Auditing provides assurance that maternity care is delivered in line with clinical guidance and standards.

Overall, the hospital had arrangements in place to ensure maternity care was planned and delivered to meet the initial and ongoing assessed needs of women attending the maternity service. Women attending the maternity service were risk assessed and assigned to the most appropriate care pathway based on their risk profile, with care provided by the most appropriate person. The hospital had implemented national guidance related to maternity services.

Judgment for national standard 2.2: Compliant

Standard 2.3: Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services.

The maternity unit in St Luke's General Hospital was co-located with a large acute hospital, and there was direct access to a number of specialties such as respiratory medicine, cardiology, endocrinology, psychiatry and general surgery. Like other similar sized acute hospitals in Ireland, there was no on-site access to a vascular surgeon or an interventional radiology service. Pregnant women likely to require these specialists were referred to the National Maternity Hospital, Dublin for further management. Advice from consultants in haematology was provided by consultants based at University Hospital Waterford which is aligned to the South/South West Hospital Group. This arrangement was in place in 2019 and was a legacy arrangement that preceded the Ireland East Hospital Group structure. Hospital management assured inspectors that the arrangement worked and that advice from consultants in haematology was available 24/7.

Staff who spoke with inspectors described the arrangements in place to ensure that women with high-risk pregnancies and those at risk of developing potential complications had an antenatal anaesthetic assessment in line with national standards. However, similar to previous inspection findings, these arrangements were not formalised. Hospital management should ensure that there is a formalised clinical pathway in place for the referral and review of pregnant women with risk factors for anaesthesia in line with national guidelines.¹⁸

Pregnant and postnatal women who required short-term invasive cardiovascular monitoring or close observation and women who required Level 3^{*****} care were managed in the hospital's Coronary Care/Intensive Care Unit. The hospital had a guideline governing the transfer and admission of women needing critical care to the Coronary Care/Intensive Care Unit. Pregnant and postnatal women admitted to hospital's critical care facilities remained under the care of their named consultant obstetrician. Care was shared between the consultant anaesthesiologist and consultant obstetrician. Inspectors were informed that these women were reviewed by the obstetric team daily or more frequently if needed and midwives from the maternity unit provided midwifery care as clinically indicated.

In 2019, HIQA found that women attending the maternity service did not have access to a medical social worker. At the time of this inspection, inspectors were informed that the lack access to a medical social worker remained an issue and was an identified risk recorded on the hospital's corporate risk register. Maternity service providers should ensure that women have timely access to interventions and support from social workers as required.

HIQA also previously identified that there was a reported prolonged history of poor communication and lack of cohesive teamwork among consultant obstetricians, which was a potential risk to the quality and safety of the maternity service. During this inspection, staff and hospital management who spoke with inspectors reported that teamwork and communication had improved since HIQA's previous inspections of the maternity service. Inspectors did observe the interactions of clinicians with each other and with hospital management and felt that the interactions were professional and respectful, and relationships had indeed improved.

The hospital had arrangements in place, through their maternity network to transfer women expected to give birth before 34 weeks' gestation, those with known underlying medical complications and or those who developed complications during pregnancy, such as severe pre-eclampsia^{§§§§§} or placenta accreta^{*****} to a specialist maternity hospital. However, the transfer arrangements were not formalised and there was no mandatory acceptance policy in place. This referral and transfer pathway needs to be formalised so that all women who require transfer for specialist maternity care from the hospital are facilitated within the Ireland East Hospital Group when possible.

Judgment for national standard 2.3: Substantially compliant

***** Level 3 is the level of care required for patients who need advanced respiratory support (mechanical ventilation) alone or basic respiratory support along with support of at least one additional organ.

§§§§§ Pre-eclampsia is a medical condition where high blood pressure and protein in the urine develop during pregnancy. If left untreated, it may result in seizures at which point it is known as eclampsia.

***** Placenta accreta (and the more severe forms increta or percreta) is a serious pregnancy condition that occurs when the placenta grows too deeply into the uterus: also known as abnormally adherent placenta. The management of abnormally adherent placenta requires specialist multidisciplinary care.

Standard 3.2: Maternity service providers protect women and their babies from the risk of avoidable harm through the appropriate design and delivery of maternity services.

Inspectors reviewed the systems and processes in place to identify, manage and escalate risks related to the maternity service and were satisfied that the hospital had effective arrangements in place to manage identified risks. The hospital's clinical risk manager attended meetings of the all key governance committees. Risks in relation to the maternity service were recorded in the hospital's corporate risk register. Risks on the corporate risk register were reviewed at meetings of the executive management team and the hospital's safety and quality executive committee. Risks that could not be managed at hospital level were escalated to the Ireland East Hospital Group.

At the time of this inspection, there were 12 risks related to the maternity service recorded on the hospital's corporate risk register. Six of the 12 risks was rated high. Risks recorded on the corporate risk register relevant to this inspection included:

- A risk that new models of service delivery may not be initiated due to the lack of capacity and inadequate infrastructure.
- Risks for women associated with the hospital's high caesarean section rate.
- Risks associated with the ageing physical infrastructure of the hospital.

Inspectors found that there was a positive attitude at the hospital to the reporting of patient-safety incidents. The hospital had a system and process in place to identify, report, manage and respond to patient-safety incidents. Staff who spoke with inspectors were aware of the type of patient-safety incidents that should be reported and the procedure to report them. In 2021, the maternity unit reported a total of 226 clinical incidents to the National Incident Management System.^{†††††††19} This level of reporting was comparable to other similar sized maternity units within and outside the Ireland East Hospital Group.²⁰

Patient-safety incidents were tracked and trended and the collated information was reviewed and discussed at meetings of the executive management team, maternity services governance committee and quality and safety executive committee. However, staff reported that they were not provided with regular feedback on patient-safety incidents reported and on actions required to reduce the risk of recurrence.

Inspectors found that the hospital had a system and process in place to support staff to recognise, manage and escalate maternal deterioration during pregnancy, birth or the postnatal period. The hospital had implemented the Irish Maternity Early Warning System for pregnant and postnatal women. Staff who spoke with inspectors were clear about the

^{†††††††} The State Claims Agency National Incident Management System is a risk management system that enables public hospitals to report incidents in accordance with their statutory reporting obligations.

escalation steps and response to be taken in the event of any Irish Maternity Early Warning System triggers.

The hospital had arrangements in place for the transfer and care of pregnant and postnatal women needing specialist critical care in another hospital. Women requiring such care were stabilised and transferred according to the HSE's emergency inter-hospital transfer protocol (protocol 37).^{*****} The hospital had developed a standard operating procedure to support and standardise the transfer process.

Overall, inspectors were satisfied that the hospital had arrangements in place to identify, manage and escalate risks in relation to the maternity service. There was evidence of a positive culture to the reporting of patient-safety incidents at the hospital, but feedback and sharing of learning from incidents could be improved. Feedback and the sharing of learning is important to minimise the risk of recurrence and prevent avoidable harm to women attending the service.

Judgment for national standard 3.2: Substantially compliant

^{*****} The Emergency Inter-hospital transfer protocol (Protocol 37) was developed for emergency inter-hospital transfers for patients who require a clinically time critical intervention that is not available within their current facility.

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

Compliance classifications

An assessment of compliance with the six national standards assessed during this inspection of the maternity service at St. Luke’s General Hospital was made following a review of the evidence gathered prior to and during HIQA’s inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed during the inspection is set out here. Hospital management should ensure that it implements actions to fully meet the national standard assessed during this inspection.

National Standard for Safer Better Maternity Services	
Capacity and Capability Dimension	Judgment
Theme 5: Leadership, Governance and Management	
Standard 5.2: Maternity service providers have formalised governance arrangements for assuring the delivery of safe, high-quality maternity care.	Substantially compliant
Standard 5.8: Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services.	Substantially compliant
Theme 6: Workforce	
Standard 6.3: Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care.	Substantially compliant

National Standard for Safer Better Maternity Services	
Quality and Safety Dimension	Judgment
Theme 2: Effective Care and Support	
Standard 2.2: Maternity care is planned and delivered to meet the initial and ongoing assessed needs of women and their babies, while working to meet the needs of all women and babies using the service.	Compliant
Standard 2.3: Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services.	Substantially compliant
Theme 3: Safe Care and Support	
Standard 3.2: Maternity service providers protect women and their babies from the risk of avoidable harm through the appropriate design and delivery of maternity services.	Substantially compliant

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