Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the unannounced inspection of maternity services at Our Lady of Lourdes Hospital, Drogheda, Co Louth

Monitoring programme against the *National Standards for Safer Better Maternity Services* with a focus on obstetric emergencies

Dates of inspection: 23 and 24 January 2019

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

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

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

- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services —** Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

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

- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

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1.0 Information about this monitoring programme

The *National Standards for Safer Better Maternity Services*[1] were published by HIQA in 2016. Under the Health Act 2007,[2] HIQA's role includes setting such standards in relation to the quality and safety of healthcare and monitoring compliance with these standards.

HIQA commenced a programme of monitoring against the *National Standards for Safer Better Maternity Services*, with a focus on obstetric emergencies, in maternity hospitals and in maternity units in acute hospitals in May 2018. The *National Standards for Safer Better Maternity Services* will be referred to as the National Standards in this report.

For the purposes of this monitoring programme, obstetric emergencies are defined as pregnancy-related conditions that can present an immediate threat to the well-being of the mother and baby in pregnancy or around birth. HIQA's focus on such emergencies, as we monitor against the National Standards, intends to highlight the arrangements all maternity units have in place to manage the highest risks to pregnant and postnatal women and newborns when receiving care.

Pregnancy, labour and birth are natural physiological states, and the majority of healthy women have a low risk of developing complications. For a minority of women, even those considered to be at low-risk of developing complications, circumstances can change dramatically prior to and during labour and delivery, and this can place both the woman's and the baby's lives at risk. Women may also unexpectedly develop complications following delivery, for example, haemorrhage. Clinical staff caring for women using maternity services need to be able to quickly identify potential problems and respond effectively to evolving clinical situations.

The monitoring programme assessed if specified[3] National Standards in relation to leadership, governance and management had been implemented. In addition, maternity hospitals and maternity units were assessed to determine if they were resourced to detect and respond to obstetric emergencies which occurred, and explored if clinical staff were supported with specialised regular training to care for women and their newborn babies.

This monitoring programme examined if specified[3] National Standards in relation to effective care and support and safe care and support had been implemented. The programme assessed whether or not maternity hospitals and maternity units could effectively identify women at higher risk of complications in the first instance. It also examined how each maternity hospital or maternity unit provided or arranged for the care of women and newborns in the most appropriate clinical setting. The programme looked at how risks in relation to maternity services were managed and how the service was monitored and evaluated.

In monitoring against the *National Standards for Safer Better Maternity Services,* with a focus on obstetric emergencies, HIQA has identified three specific lines of enquiry (LOE). These lines of enquiry represent what is expected of a service providing a consistently safe, high-quality maternity service, particularly in its response to obstetric emergencies. These lines of enquiry have been used by HIQA to identify key relevant National Standards for assessment during this monitoring programme.

All three lines of enquiry reflect a number of themes of the National Standards. For the purpose of writing this report, compliance with the National Standards is reported in line with the themes of the National Standards. The lines of enquiry for this monitoring programme are listed in Figure 1.

Figure 1 – Monitoring programme lines of enquiry

LOE 1:

The maternity unit or maternity hospital has formalised leadership, governance and management arrangements for the delivery of safe and effective maternity care within a maternity network.*

LOE 2:

The maternity service has arrangements in place to identify women at higher risk of complications and to ensure that their care is provided in the most appropriate setting.

The maternity service has arrangements in place to detect and respond to obstetric emergencies and to provide or facilitate ongoing care to ill women and or their newborn babies in the most appropriate setting.

LOE 3:

The maternity service at the hospital is sufficiently resourced with a multidisciplinary workforce that is trained and available to detect and respond to obstetric emergencies at all times.

A further aspect of HIQA's monitoring programme was to examine progress made across the maternity services to develop maternity networks. The National Standards support the development of maternity networks in Ireland.

* Maternity networks are the systems whereby maternity units and maternity hospitals are interconnected within hospital groups to enable sharing of expertise and services under a single governance framework.

Further information can be found in the *Guide to HIQA's monitoring programme against the National Standards for Safer Better Maternity Services, with a focus on obstetric emergencies* [3] which is available on HIQA's website: www.higa.ie

1.1 Information about this inspection

Our Lady of Lourdes Hospital is a statutory hospital which is owned and managed by the Health Service Executive (HSE). The hospital is part of the Royal College of Surgeons in Ireland Hospital's group (RCSI Hospitals).[†] The maternity unit is co-located with the general hospital. The hospital provides a range of general and specialist maternity services designed to meet the needs of women with low risk and high risk pregnancies. There were 3,070 births at the hospital in 2018.

To prepare for this inspection, inspectors reviewed a completed self-assessment tool[‡] and preliminary documentation submitted by Our Lady of Lourdes Hospital to HIQA in June 2018. Inspectors also reviewed information about this hospital including previous HIQA inspection findings; information received by HIQA and published national reports. Information about the unannounced inspection at Our Lady of Lourdes Hospital is included in Table 1.

Table 1: Inspection details

Dates	Times of inspection	Inspectors
23 January 2019	11:37hrs to 18:50hrs	Aileen O' Brien Siobhan Bourke Emma Cooke Denise Lawler
24 January 2019	09:00hrs to 17:50hrs	

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

- representatives of the hospital's Senior Management Team and
- the hospital's clinical leads in the specialties of obstetrics, obstetric anaesthesiology and paediatrics.

[†] RCSI Hospitals is comprised of Beaumont Hospital, Cavan & Monaghan Hospital, Connolly Hospital, Louth County Hospital, Our Lady of Lourdes Hospital, Rotunda Hospital and the Royal College of Surgeons in Ireland (Academic Partner).
[‡] All maternity hospitals and maternity units were asked to complete a self-assessment tool designed by HIQA for this monitoring programme

In addition, the inspection team visited a number of clinical areas which included:

- The Antenatal Clinic and the Emergency Department, areas where pregnant and postnatal women who presented to the hospital with pregnancy-related concerns were assessed.
- The Labour Ward where women were cared for during labour and childbirth which also included a dedicated room for women who required closer monitoring.
- The Neonatal Unit where babies requiring additional monitoring and support were cared for.
- A postnatal ward where women were cared for following childbirth.
- The Operating Theatre Department where obstetric surgery was performed
- The Intensive Care Unit.

Information was gathered through speaking with midwifery and nursing managers and staff midwives in these clinical areas and with doctors assigned to the maternity service. Inspectors also spoke with operating theatre staff. In addition, inspectors looked at the clinical working environment and reviewed hospital documentation and data during the inspection.

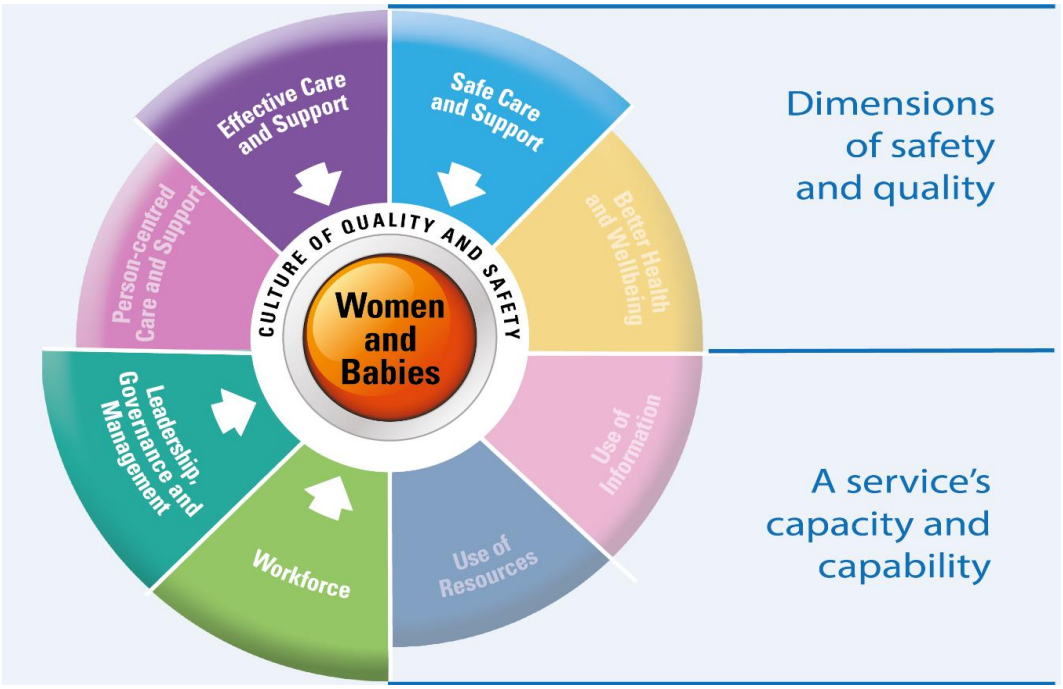
HIQA would like to acknowledge the cooperation of the hospital management team and all staff who facilitated and contributed to this unannounced inspection.

1.2 How inspection findings are presented

This inspection was focused specifically on maternity services and the systems in place to detect and respond to obstetric emergencies, as outlined in the published Guide[3] to this monitoring programme. Therefore as part of this inspection programme, HIQA monitored compliance with some, but not all of the National Standards. Report findings are based on information provided to inspectors during an inspection at a particular point in time.

The National Standards themes which were focused on in this monitoring programme are highlighted in Figure 2. Inspection findings are grouped under the National Standards dimensions of Capacity and Capability and Safety and Quality.

Figure 2: The four National Standard themes which were focused on in this monitoring programme



Based on inspection findings, HIQA used four categories to describe the maternity service's level of compliance with the National Standards monitored.

These categories included the following:

- **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 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 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 patients 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 patients.

Table 2 shows the main report sections and corresponding National Standards, themes and monitoring programme lines of enquiry.

Table 2: Report sections and corresponding National Standard themes and inspection lines of enquiry

Report section	Themes	Standards	Line of enquiry
Section 2: Capacity and Capability	Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4, 5.5, 5.8 and 5.11	LOE 1
	Workforce	6.1, 6.3, 6.4	LOE 3
Section 3: Dimensions of Safety and Quality	Effective Care and Support	2.1, 2.2, 2.3, 2.4, 2.5, 2.7, 2.8.	LOE 2
	Safe Care and Support	3.2, 3.3, 3.4, 3.5	

2.0 Capacity and Capability

Inspection findings in relation to capacity and capability will be presented under the themes of the National Standards for Safer Better Maternity Services of Leadership, Governance and Management and Workforce.

This section describes arrangements for the leadership, governance and management of the maternity service at this hospital, and HIQA's evaluation of how effective these were in ensuring that a high quality safe service was being provided. It will also describe progress made in the establishment of a maternity network from the perspective of this hospital. This section also describes the way the hospital was resourced with a multidisciplinary workforce that was trained and available to deal with obstetric emergencies twenty-four hours a day.

During this inspection, inspectors looked at 10 National Standards in relation to leadership, governance and management and workforce. Of these, Our Lady of Lourdes Hospital was compliant with six National Standards and substantially compliant with four National Standards.

Inspection findings leading to these judgments and key findings in relation to the hospital's level of compliance with the National Standards monitored during this inspection are included in Table 3 and Table 4 within this section.

2.1 Leadership, Governance and Management

Leadership, governance and management refers to the arrangements put in place by a service for clear accountability, decision-making and risk management as well as meeting its strategic and statutory obligations.

A well-governed maternity service is clear about what it does, how it does it, and is accountable to the women who use the service and the people who fund and support it. Good governance arrangements acknowledge the interdependencies between organisational arrangements and clinical practice and integrate these to deliver safe, high-quality care.

Inspection findings in relation to leadership, governance and management are described next.

Inspection findings

2.1.1 Maternity service leadership, governance and management

Maternity network

At the time of inspection HIQA found that the maternity service at Our Lady of Lourdes Hospital was not part of a formal maternity network. In making this observation, HIQA noted that RSCI Hospitals group had established structures and arrangements that facilitated effective collaborative working between maternity units within this hospital group. These maternity units included those located in Our Lady of Lourdes Hospital and Cavan Hospital, and the tertiary maternity hospital within the group which is the Rotunda Hospital in Dublin. Leadership in relation to maternity services in RCSI Hospitals was provided by the Master of the Rotunda Hospital as Clinical Director for women and children's health for the hospital group. A directors of midwifery forum facilitated collaboration between the directors of midwifery in these three maternity units.

An RCSI Hospitals Incident Management Model was developed to standardise and streamline serious incident review processes across the hospital group. RCSI Hospitals Women and Children's Serious Incident Management Forum was established in July 2016. This forum facilitated the three maternity units within RCSI Hospitals to work together. The primary purpose of this forum was to provide oversight of clinical incident reviews in the Women and Children's Directorate. Performance and outcome data in respect of the maternity service was reviewed at this forum on a quarterly basis which enabled hospital group management to monitor trends and outcomes for maternity services across the hospital group. Sharing of learning from adverse events was facilitated at the Serious Incident Management Forum. The Serious Incident Management Forum also supported shared guideline development and had recently drafted a guideline in relation to clinical scenarios where a consultant should be present at a delivery. Shared guidelines had also been developed to support staff following a critical incident. Inspectors were informed of plans to hold an annual review meeting in 2019 to share learning and incident review recommendations across maternity units in the hospital group.

The hospital group had a well-established neonatal network that facilitated the transfer of newborn babies between the three maternity units so that their care could be provided in the most appropriate location in line with the National Model of Care for Neonatal Services.[4] Neonatal network meetings were held twice a year and the network also held joint guideline committee meetings. These meetings were attended by clinical staff from Our Lady of Lourdes Hospital.

The hospital group in collaboration with the Rotunda Hospital facilitated the implementation of a maternal-fetal medicine care programme across the hospital group catchment area. Funding had been approved for the appointment of four consultant obstetricians specialising in maternal-fetal medicine to joint posts within the hospital group. Four of these positions had been advertised and two of these positions had been filled. Sonographer positions and ultrasound equipment had also been funded. Through this programme RCSI Hospitals had facilitated training for sonographers from Our Lady of Lourdes Hospital at the Rotunda Hospital, Dublin. In addition, a consultant obstetrician specialising in maternal-fetal medicine with a joint appointment in the Rotunda Hospital led a weekly maternal-fetal medicine clinic at Our Lady of Lourdes Hospital. Funding for additional computer software licences to facilitate ultrasound scan image management and reporting had been approved by the hospital group to expand fetal ultrasound scanning services at Our Lady of Lourdes Hospital.

A further example of collaborative working was that pregnant women with diabetes mellitus and gestational diabetes booked at Cavan Hospital were referred to antenatal clinics at Our Lady of Lourdes Hospital to access specialist care at a combined obstetric endocrinology clinic.

A structured onsite interactive maternity and gynaecology teaching programme for clinical staff commenced at Our Lady of Lourdes Hospital and also at Cavan Hospital in 2016. At the time of inspection this programme was facilitated by a consultant obstetrician from the Rotunda Hospital.

RCSI Hospitals had facilitated direct access to a perinatal pathology service within the hospital group since 2017. Shared policies in relation to pathology specimen taking had been developed in order to standardise practice across the three units. There were plans to roll out a document management system across hospitals within the hospital group.

RCSI Hospitals should build on the current established arrangements that facilitate effective collaborative working between maternity units within the hospital group. This should include progressing the development of a managed clinical network for maternity services under a single system of clinical governance, as recommended in the National Maternity Strategy.

Our Lady of Lourdes Hospital leadership, governance and management

The General Manager at Our Lady of Lourdes Hospital had overall managerial responsibility and accountability for the maternity service at the hospital. The General Manager reported to the Chief Executive of RCSI Hospitals and attended monthly performance meetings with the hospital group management team. The Senior Management Team chaired by the General Manager met every two weeks

and membership included the Clinical Director for Women and Children's Services and the Director of Midwifery in addition to other senior operational managers at the hospital. The hospital had recently formed an executive quality and safety committee which had met once. Inspectors were informed that the purpose of the committee was to provide assurance to the General Manager in relation to the quality and safety of services provided at the hospital.

Clinical governance for the maternity service was led by the Clinical Director for Women and Children's Services who was a consultant obstetrician with responsibility for the quality and safety of the maternity service at the hospital. The hospital's clinical governance structure included a Women's Health Governance Group. This group was responsible for reviewing risks in relation to the maternity service and for overseeing the implementation of recommendations from reviews of clinical incidents and also national recommendations. Inspectors were informed that this group had met four times in 2018.

Maternity clinical governance meetings were held weekly at the hospital and followed a structured format whereby different aspects of service delivery were reviewed on alternating weeks. Within this structure meeting agendas included the following:

- perinatal morbidity and mortality, admissions and transfers
- gynaecology and radiology issues
- maternity dashboard, clinical activity, maternal morbidity and case presentations
- educational meeting for example grand rounds or session with consultant obstetrician from the Rotunda Hospital.

A number of local committees and groups were established in relation to the Maternity Unit and these included the following:

- a Delivery Suite Advisory Committee
- a multidisciplinary policies, procedures, guidelines and pathways committee
- an audit committee
- a bereavement committee.

The hospital's organisational diagram showed that these committees reported to the Women's Health Governance Group. The hospital's organisational structure diagram was under review at the time of inspection to reflect the establishment of the quality and safety committee and related reporting lines.

The General Manager chaired a local level Louth Hospitals[§] pre-serious incident management forum where hospital management reviewed patient safety incidents soon after they occurred. Clinical and management staff then determined which incidents required review and investigation. Following this meeting, serious incidents and serious reportable events were presented at the RSCI Hospitals Serious Incident Management Forum.

The General Manager met with the hospital's clinical leads for specialties including obstetrics, obstetric anaesthesiology and neonatology and paediatrics at regular meetings of the Lead Clinicians Forum. Consultant obstetricians and midwives also held regular meetings to discuss service issues.

Clinical leads had been appointed in each of the specialties of obstetrics, anaesthesiology and paediatrics at the hospital. These clinicians were appointed on a rotational basis every two years and were responsible for arranging training for non-consultant hospital doctors and representing their respective specialties in relation to service provision at local and hospital group level. The Director of Midwifery who was responsible for the organisation and management of the midwifery service was a member of the hospital's senior management team.

The Delivery Suite Advisory Committee chaired by a consultant obstetrician met monthly and membership included midwifery and nursing managers from both the Delivery Suite and the Operating Theatre Department. This committee reported to the Women's Health Governance Group and worked to progress implementation of new practice and revised local policies. Issues in relation to communication and patient flow between the Labour Ward and the Operating Theatre Department were addressed at this forum. There was good inter-specialty working with consultant anaesthesiologists and consultant paediatricians who were also members.

Safety alerts in relation to medical devices and medicines were communicated to staff at the hospital. The hospital's statement of purpose gave a very brief overview of services. This should be expanded to include maternity service aims, services available at the hospital and staffing resources. An updated statement of purpose should be made publicly available in line with the National Standards.

Inspectors found that there was a clearly defined and effective leadership, governance and management structure to ensure the quality and safety of maternity services provided at the hospital.

[§] Louth Hospitals includes Our lady of Lourdes Hospital in Drogheda and Louth County Hospital in Dundalk

Table 3 lists the National Standards relating to leadership, governance and management focused on during this inspection and outlines HIQA's findings in relation to the hospital's level of compliance with the National Standards monitored during this inspection.

Table 3 - HIQA's judgments against the National Standards for Safer Better Maternity Services for leadership, governance and management that were monitored during this inspection
Standard 5.1 Maternity service providers have clear accountability arrangements to achieve the delivery of safe, high-quality maternity care. **Judgment:** Compliant
Standard 5.2 Maternity service providers have formalized governance arrangements for assuring the delivery of safe, high-quality maternity care. **Key findings:** A maternity network with a single governance structure was not established but there were good collaborative working for both perinatal and maternal care. **Judgment:** Substantially compliant
Standard 5.3 Maternity service providers maintain a publicly available statement of purpose that accurately describes the services provided to women and their babies, including how and where they are provided. **Key findings:** The statement of purpose did not detail the services provided at the hospital. **Judgment:** Substantially compliant
Standard 5.4 Maternity service providers set clear objectives and have a clear plan for delivering safe, high-quality maternity services. **Judgment:** Compliant
Standard 5.5 Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services. **Judgment:** Compliant
Standard 5.8 Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services. **Judgment:** Compliant

Table 3 - HIQA's judgments against the National Standards for Safer Better Maternity Services for leadership, governance and management that were monitored during this inspection

Standard 5.11 Maternity service providers act on standards and alerts, and take into account recommendations and guidance issued by relevant regulatory bodies.

Judgment: Compliant.

2.2 Workforce

Effective maternity services need to ensure that there are sufficient staff available at the right time, with the right skills to deliver safe, high-quality care. Training specific to maternity care is required to enable staff to acquire the skills and knowledge to detect and respond to obstetric emergencies. This inspection looked at the number of nursing and midwifery staff who provided care to women and infants using the maternity service. This inspection also looked at the number and grade of medical staff who worked in the specialities of obstetrics, neonatology and obstetric anaesthesiology at the hospital. Inspectors also reviewed the uptake and provision of training and education of staff relevant to obstetric emergencies.

Inspection findings in relation to workforce are described next.

Inspection findings

2.2.1 Midwifery and nursing staffing

The hospital met the HSE's national benchmark for midwifery staffing in line with the HSE's Midwifery Workforce Planning Project.[5] At the time of this inspection, inspectors were informed that there were two whole time equivalent[**] (WTE) permanent midwifery positions vacant at the hospital, which equated to less than 2% of the midwifery workforce at the hospital. The hospital was actively working to recruit additional midwives. Midwifery graduates who trained at the hospital were encouraged to apply for permanent staff midwife positions following registration. There were no agency midwifery staff at the hospital and any unfilled shifts were filled by existing staff who worked overtime shifts. Internal rotation of midwifery staff enabled midwifery management to redeploy midwives to areas of high activity when required. An experienced midwife shift leader was in place for each shift in the Labour Ward and all women in established labour had one to one support. Shift leaders in the Labour Ward were included in WTE numbers so therefore were not always supernumerary.

There were effective contingency arrangements in place at the hospital to manage concurrent emergency surgery cases outside of core working hours. To manage such situations, three nurses were rostered onsite in the Operating Theatre Department outside of core working hours and a second team of three nurses was rostered on call off site. The second team could be called in to staff an operating theatre whenever the need arose.

[**] Whole-time equivalent: 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.

Specialist support staff

The hospital had received additional funding to provide two midwives with training in fetal ultrasonography and at the time of this inspection, these midwives had completed their training. One other midwife had received funding to complete a master's degree in fetal ultrasonography. A specialist perinatal mental health midwife had been appointed on a temporary contract at the hospital.

Clinical staff were supported in relation to education and training by an assistant director of midwifery in charge of practice development, two WTE clinical skills facilitators and a 0.3 WTE neonatal resuscitation facilitator at clinical nurse manager 1 grade and also by an advanced neonatal nurse practitioner.

2.2.2 Medical staff

Medical staff availability

On-call consultant obstetricians, anaesthesiologists and paediatricians were accessible to medical and midwifery staff and staff who spoke with inspectors said that they were onsite promptly when called to attend. The hospital was staffed with medical staff at specialist registrar, registrar and senior house officer grade in the specialties of obstetrics, anaesthesiology and paediatrics who were available onsite to provide care to women and newborns on a 24-hour basis. Rapid response teams were available on site 24 hours a day, seven days a week to attend to obstetric emergencies, neonatal emergencies and cardiac arrests.

Consultants in the specialties of obstetrics, anaesthesiology, paediatrics and neonatology were employed on permanent contracts and were registered as specialists with the Medical Council in Ireland. The use of locum and agency staff was kept to a minimum in the Maternity Unit. There was good onsite consultant presence at the hospital during core working hours during this inspection.

Obstetrics

The hospital had approval for nine WTE consultant obstetricians and eight of these positions were filled at the time of inspection. Five of these positions were filled by consultants with permanent contracts, two positions were filled by consultants on temporary contracts and one position was filled on a locum contract.

Inspectors were informed that a recent recruitment campaign to fill four consultant obstetrician positions specialising in maternal-fetal medicine at hospital group level resulted in two positions being appointed. Following these joint hospital appointments, a consultant obstetrician based at the Rotunda Hospital attended Our

Lady of Lourdes Hospital one day a week to support the maternal-fetal medicine service at the hospital.

A consultant obstetrician was rostered to be present in the Labour Ward during core working hours from Monday to Friday. A rota of one registrar and one senior house officer was in place in the Labour Ward 24 hours a day. The hospital had an on-call rota outside of core working hours for consultant obstetricians whereby consultants were on call from home usually one in every seven nights. One obstetric team senior house officer was rostered to the Antenatal Clinic and one was rostered to the Emergency Department during core working hours to review women with unplanned attendance at the hospital. Outside core working hours, the senior house officer on call for the Labour Ward was also responsible for reviewing women who attended the Emergency Department. Inspectors were informed that sometimes there was a delay in women being reviewed in the Emergency Department if the registrar and senior house officer were attending women in the Delivery Suite or Operating Theatre. This finding needs to be reviewed by hospital management to determine if the current non-consultant obstetric medical staff rota is sufficient.

Obstetric anaesthesiology

The hospital had approval for 17 WTE consultant anaesthesiologists who provided anaesthetic services at Our Lady of Lourdes Hospital, Navan Hospital and Louth Hospital. Three consultant anaesthesiology posts were filled on temporary contracts. A consultant anaesthesiologist and a registrar in anaesthesiology were assigned to the Labour Ward during core working hours. Outside of core working hours there were three registrars in anaesthesiology on call onsite at the hospital, with one of these registrars assigned to the Maternity Unit, one registrar assigned to the Operating Theatre Department and one registrar assigned to the Intensive Care Unit. Two consultant anaesthesiologists were on call from home at the hospital outside of core working hours and one of these consultants was assigned to the Maternity Unit. This level of anaesthetic cover is in line with national recommendations for general hospitals with a co-located maternity unit.[6]

Anaesthetic pre-assessment referrals were facilitated by the anaesthetic team. Inspectors were informed that there were an insufficient number of anaesthesiologists at the hospital to provide a dedicated anaesthetic pre-assessment clinic for the maternity service. This service needs to be resourced for women attending Our Lady of Lourdes Hospital and access should be provided for booked pregnant women who attend outreach antenatal clinics in Navan and Dundalk.

Paediatrics and neonatology

The hospital had an on-call rota outside of core working hours where a consultant paediatrician was on call from home usually one in every seven nights. The hospital had three WTE consultant neonatologists and eight WTE consultant paediatrician positions filled at the hospital. At the time of inspection, one consultant neonatologist position and four consultant paediatrician positions were filled on temporary contracts. Outside of core working hours two paediatric registrars and also two paediatric senior house officers, one on a 12 hour shift one on an eight hour shift from 4pm to midnight, were onsite to manage neonatal emergencies at the hospital. At the time of the onsite inspection, inspectors were informed that hospital management was in the process of developing business plans to enable the neonatal and paediatric rota to be spilt in line with the National Model of Care for Neonatal Services in Ireland[4] and were in the process of recruiting two more consultant neonatologists to enable this.

2.2.3 Training and education of multidisciplinary staff

Mandatory training requirements

The hospital had mandatory training requirements for clinical staff. Obstetric medical staff were required to undertake practical training in obstetric emergencies every two years and fetal monitoring training annually. In addition these doctors were required to undertake training in relation to the Irish Maternity Early Warning System and sepsis screening at induction and to attend update sessions as scheduled locally. Medical staff had to complete neonatal resuscitation training prior to staffing the on-call paediatric rota.

Midwifery and nursing staff were required to undertake practical training in obstetric emergencies, neonatal resuscitation, and basic adult resuscitation training every two years. Midwives were required to undertake fetal monitoring training annually. Nurses in the Neonatal Intensive Care Unit were required to undertake training in post-resuscitation and pre-transport stabilisation care of sick infants every two years. All nurses and midwives were required to undertake training in relation to the Irish Maternity Early Warning System and sepsis screening at induction and to attend update sessions as scheduled locally.

Uptake of mandatory training

Training records reviewed showed that 100% of midwifery staff and 95% of medical staff had attended fetal monitoring training in the past two years. All obstetric consultants had completed this training. Inspectors were informed that it was practice to review cardiotocographs for learning purposes once a week at the clinical handover meeting.

One hundred percent of medical, midwifery and nursing staff had attended neonatal resuscitation training. Data provided by hospital management showed that 99% of midwifery staff had attended training in the management of obstetric emergencies. However, only 39% of relevant medical staff had attended this training. Seventy eight percent of nurses and 50% of midwives had undertaken basic life support refresher training in the past two years. Data was not available in respect of the uptake of this training by doctors. Inspectors were informed that the nursing and midwifery practice development team organised regular monthly training drills in clinical areas including the Labour Ward and the Midwifery-Led Unit. Clinical scenario training was provided regularly in the Neonatal Unit.

Hospital management should ensure that relevant clinical staff have undertaken mandatory and essential training at the required frequency, appropriate to their scope of practice. Inspectors were informed that uptake of training other than fetal monitoring and neonatal resuscitation by doctors was not routinely recorded. This should be addressed so that hospital management are assured that relevant staff have undertaken training in line with National Standards.

Orientation and training of new staff

New staff at the hospital were provided with corporate and specialty specific induction upon commencing employment. Orientation and training of new nursing and midwifery staff in the Maternity Unit was supported by clinical staff and two WTE clinical skills facilitators. The hospital had developed a structured induction programme for newly appointed midwives and nurses.

Other training and education opportunities for staff

The hospital was recognised as a site for undergraduate and postgraduate midwifery training and higher specialist training for doctors in the specialties of obstetrics and gynaecology, anaesthesiology and paediatrics. Regular meetings were held to provide teaching and learning opportunities for non-consultant hospital doctors in obstetrics, anaesthesiology and paediatrics.

At the time of inspection, 87% of nursing and midwifery staff in the Neonatal Intensive Care Unit had undertaken post-graduate training in neonatal intensive care nursing. These staff had completed courses at either higher diploma or foundational level. A relatively small number of staff in the Operating Theatre Department had completed post-graduate training in perioperative nursing. Hospital management stated that there was no requirement for staff to undertake a postgraduate course to work in the Operating Theatre Department. However, staff who expressed an interest in advancing their studies were facilitated and funded to attend postgraduate programmes in Dublin universities. Sixteen nurses had completed specialist training in anaesthetic recovery nursing.

A number of midwifery and nursing staff at the hospital had undertaken third level academic education which included courses in relation to management of the acutely ill women in maternity services, clinical examination of the newborn, palliative care, perinatal mental health, teaching and learning, clinical education, prescribing, and leadership.

Educational sessions were held weekly for staff in the Operating Theatre Department which covered topics such as 'decision making scenarios', midwifery bereavement support and blood transfusion safety.

There was a defined system in place for the rotation of midwives and healthcare assistants to various clinical areas, to maintain competence and skills. Inspectors were informed that newly qualified midwives rotated through all the core areas in the Maternity Unit within the first year to 18 months following registration. All other staff rotated as required to maintain their competencies.

There was a modular training programme in place for non-consultant hospital doctors who were new to the anaesthetic team. Consultant anaesthesiologists also facilitated an annual training course in relation to difficult airway management. A consultant obstetrician facilitated two training sessions per week to mentor non-consultant hospital doctors at registrar grade on the obstetric team.

RCSI Hospitals facilitated an ongoing teaching programme for clinical staff in relation to obstetrics and gynaecology in maternity units across the group. This programme was facilitated by a consultant obstetrician from the Rotunda Hospital. There was also a level 8 certificate in the recognition and management of the acutely ill woman in maternity services. This course was run in conjunction with Our Lady of Lourdes Hospital's academic partners in Dundalk Institute of Technology for all staff midwives.

Grand rounds[††] were held at the hospital every month. Inspectors were informed that a study day in relation to the management of a deteriorating patient was being developed at the hospital. The hospital had facilitated training for midwives in relation to immersion in water during labour in August 2018.

A number of clinical staff in the Maternity Unit were scheduled to attend a cardiotocograph master class at University Maternity Hospital Limerick in February 2019.

[††] Grand rounds are formal meetings where physicians and other clinical support and administrative staff discuss the clinical case of one or more patients. Grand rounds origninated as part of medical training.

Table 4 lists the National Standards relating to workforce focused on during this inspection and key findings in relation to the hospital's level of compliance with the National Standards monitored during this inspection.

Table 4: HIQA's judgments against the National Standards for Safer Better Maternity Services for Workforce that were monitored during this inspection

Standard 6.1 Maternity service providers plan, organize and manage their workforce to achieve the service objectives for safe, high-quality maternity care **Key findings:** Some shortages of midwifery and permanent medical staff. **Judgment:** Substantially compliant
Standard 6.3 Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care. **Key findings:** Not all staff were up to date with mandatory training in relation to basic life support and obstetric emergencies. Medical staff training uptake not always recorded. **Judgment:** Substantially compliant
Standard 6.4 Maternity service providers support their workforce in delivering safe, high-quality maternity care. **Judgment:** Compliant

3.0 Safety and Quality

Inspection findings in relation to safety and quality will be presented under the themes of the National Standards of Effective Care and Support and Safe Care and Support. The following section outlines the arrangements in place at the hospital for the identification and management of pregnant women at greater risk of developing complications. In addition, this section outlines the arrangements in place for detecting and responding to obstetric emergencies and for facilitating ongoing care to ill women and newborns.

During this inspection, inspectors looked at 11 National Standards in relation to safe and effective care. Of these, Our Lady of Lourdes Hospital was compliant with eight National Standards and substantially compliant with three National Standards.

Inspection findings leading to these judgments and key findings in relation to the hospital's level of compliance with the National Standards monitored during this inspection are included in Table 5 and Table 6 within this section.

3.1 Effective Care and Support

The fundamental principle of effective care and support is that it consistently delivers the best achievable outcomes for women and their babies using maternity services. This can be achieved by using evidence-based information. It can also be promoted by ongoing evaluation of the outcomes for women and their babies to determine the effectiveness of the design and delivery of maternity care. Women and their babies should have access to safe, high-quality care in a setting that is most appropriate to their needs. How this care is designed and delivered should meet women's identified needs in a timely manner, while working to meet the needs of all women and babies using maternity services.

In relation to obstetric emergencies, this inspection included aspects of assessment and admission of pregnant women; access to specialist care and services; communication; written policies, procedures and guidelines; infrastructure and facilities; and equipment and supplies.

Inspection findings in relation to effective care and support are described next.

Inspection findings

Our Lady of Lourdes Hospital provided a range of general and specialist maternity services for women with low risk and high risk pregnancies. In line with the National

Standards, each woman and infant had a named consultant with clinical responsibility for their care.

3.1.1 Assessment, admission and or referral of pregnant or postnatal women

Assessment and referral

The hospital had agreed pathways to identify, assess and ensure that women who were at risk of developing complications during pregnancy or around the time of birth were cared for in an appropriate setting. Assessment services for pregnant and postnatal women included:

- an early pregnancy assessment unit
- a perinatal ultrasound service
- maternal fetal high risk clinics
- combined antenatal and endocrine clinics
- low risk antenatal clinics.

All pregnant women attending the hospital were offered a formal dating fetal ultrasound scan in the first trimester at 11 or 12 weeks gestation. A detailed fetal assessment ultrasound scan was routinely offered to pregnant women at 20-22 weeks gestation with risk factors such as family history of congenital fetal anomaly, increased maternal age and previous pregnancy complications. However, inspectors were informed that not all booked pregnant women were offered this type of scan as recommended in the National Standards. This poses a potential risk to the woman and infant's safety as some fetal and placental complications may not be detected.[7, 8, 9]

Hospital management planned to implement fetal assessment ultrasound scanning at 20–22 weeks' gestation for all booked women pending the appointment of approved positions for consultant obstetricians specialising in fetal maternal medicine. Two of four approved fetal medicine consultant obstetrician positions had been filled for the hospital group and at the time of inspection one of these positions was shared between Our Lady of Lourdes Hospital and the Rotunda Hospital. This meant that a consultant obstetrician specialising in fetal maternal medicine was onsite one day a week at the hospital. Hospital management was hoping to increase this to four days per week with the appointment of additional consultants to support the fetal ultrasound scanning service. Additional computer software licences and associated training were required at the hospital to facilitate ultrasound reporting and image management. Funding for this software had been approved at hospital group level. Inspectors were also informed that sonographers at the hospital were being supported by the Rotunda Hospital in relation to additional training. Implementation of universal detailed fetal assessment ultrasound scans at 20–22 weeks' gestation

needs to be progressed at the hospital in line with National Standards following this inspection.

Pregnant women who attended a booking appointment at the hospital were referred by a midwife to one of three care pathways which comprised:

- A low risk pathway where women at lower risk of developing complications were cared for by midwives within a multidisciplinary team framework. Women who met defined criteria gave birth in the Midwifery-Led Unit at the hospital. Midwife-led care was provided for women for the first seven postnatal days in the Midwifery-Led Unit and then in the community.
- A medium risk pathway where women were cared for by midwives and obstetricians within a multidisciplinary team framework. Women on this pathway gave birth in the Labour Ward at the hospital and had a named consultant obstetrician.
- A high risk pathway for women who were at greater risk of experiencing complications were cared for by midwives with consultant-led care within a multidisciplinary team framework. Women on this pathway gave birth in the Labour Ward at the hospital.

Women on a low risk care pathway were referred to the high risk care pathway when indicated. There was a written list of clinical indications for transfer of a woman to a tertiary care hospital.

Women with risks or complications at the time of booking or during the antenatal period were referred to consultant-led maternal fetal medicine clinics which also included joint obstetric and endocrine clinics for pregnant women with diabetes mellitus and gestational diabetes.

The hospital had an Early Pregnancy Assessment Unit for women with suspected complications in early pregnancy. This unit operated by appointment from 9am to 1pm from Monday to Friday every week.

Admission pathways

There were established pathways for the assessment, management and where necessary, admission of women who attended the hospital with obstetric problems 24 hours a day, seven days a week. There were a number of entry points to the hospital for the assessment and admission of pregnant and postnatal women who presented with concerns. During core working hours pregnant women up to 14 weeks gestation attended the Emergency Department and women over 14 weeks gestation attended the Antenatal Clinic. Outside of core working hours pregnant women up to 24 weeks gestation attended the Emergency Department and pregnant women at greater than 24 weeks gestation went directly to the Labour Ward.

Women who presented to the hospital in labour attended the Delivery Suite during and outside of core working hours.

Midwifery and medical staff carried out risk assessments of women at the time of booking, during pregnancy and during and after birth. The maternity service had implemented the Irish Maternity Early Warning System for pregnant and postnatal women.

3.1.2 Access to specialist care and services for women and newborns

There was 24 hour access to emergency obstetric surgery at the hospital. The hospital was staffed and managed so that emergency caesarean sections could be performed within recommended timeframes.

Obstetric anaesthesiology services

Obstetric anaesthesiologists are required to assist with the resuscitation and care of women who become critically ill due to pregnancy-related conditions for example haemorrhage and pre-eclampsia.[‡‡] They are also responsible for the provision of pain relief such as epidural anaesthesia for women in labour and for the provision of anaesthesia for women who require caesarean section and other surgery during birth.

The hospital had a dedicated obstetric anaesthesiology service in line with National Standards. There was a duty anaesthesiologist immediately available to attend women in the Labour Ward 24 hours a day in line with relevant guidelines.[10]

Guidelines[10] and National Standards recommend that there is an agreed system in place for the antenatal assessment of high-risk mothers to ensure that the anaesthetic service is given sufficient notice of women at higher risk of potential complications. Inspectors were informed that the hospital did not provide a dedicated consultant-led pre-assessment anaesthetic clinic. Instead women who were identified antenatally with risk factors for anaesthesia were reviewed by the anaesthesiologist on duty. The anaesthetic team liaised daily with the obstetric team and did regular ward rounds in the Maternity Unit so that women could be reviewed antenatally or postnatally as indicated. Lack of an anaesthetic pre-assessment clinic for the maternity service was included in the local level Women's Health Risk Register. The lack of an anaesthetic pre-assessment clinic potentially impacted on women who attended antenatal outreach clinics in that there was no formal referral pathway to directly access anaesthetic pre-assessment. There was no agreed time

‡‡ 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.

frame at the time of inspection by which an anaesthetic pre-assessment clinic would be established. This should be addressed following this inspection.

Critical care

Critical care facilities at the hospital included a High Dependency Unit and a Level 3[§§] Intensive Care Unit and a Coronary Care Unit.[11] Women who required additional monitoring or intervention or single organ support, for example women with pre-eclampsia or obstetric haemorrhage were monitored in a special observation room in the Labour Ward at the hospital. These women were reviewed jointly by a consultant obstetrician and a consultant anaesthetist every day or more frequently as required.

Critically ill pregnant and postnatal women who required intensive or high dependency care were transferred to the Intensive Care Unit at the hospital. Women requiring more specialised critical care were transferred to a tertiary hospital. There were clear referral and transfer pathways to access critical care locally or at a tertiary hospital. Clinical staff in the Maternity Unit worked closely with staff in the Intensive Care unit to ensure that maternal care was prioritised.

Neonatal care

Our Lady of Lourdes Hospital had a level 2 regional neonatal unit which provided high dependency and intensive neonatal care for premature infants born at greater than 27 weeks gestation and for sick term infants. There was good collaboration with hospitals within the regional perinatal network to facilitate the provision of care for newborns in the most appropriate facility. Infants born at less than 27 weeks gestation or newborns requiring therapeutic cooling[***] were transferred from Our Lady of Lourdes Hospital to the Rotunda Hospital in line with the National Model of Care for Neonatal Services.[4] Where possible, babies at less than 27 weeks gestation were transferred in utero to the Rotunda Hospital. Our Lady of Lourdes accepted transfers of infants born between 27 and 30 weeks gestation requiring level 2 neonatal care from Cavan Hospital.

Urgent transfers of newborns requiring neonatal intensive care were organised through the National Neonatal Transport Programme.[†††] The Neonatal Unit at the

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

*** Therapeutic cooling: Whole body neonatal cooling (WBNC) or therapeutic cooling is 'active' (not passive) cooling administered during the current birth episode as a treatment for Hypoxic Ischemic Encephalopathy (HIE). WBNC is only conducted in the four large tertiary hospitals in Dublin and Cork.

††† The National Neonatal Transport Programme is a retrieval service for the stabilisation and transportation of premature and sick neonates up to the age of six weeks corrected gestational age, who require transfer for specialist care within Ireland and abroad. The service operates 24 hours a day seven days a week.

hospital again provided care for these babies when they were transferred back from the specialist hospital for ongoing care. Medical care for newborns was led by consultant neonatologists and paediatricians who also provided an on-call rota for the maternity service outside of core working hours at the hospital.

Other specialist services

Specialised antenatal care was provided by midwifery staff in relation to epilepsy in pregnancy, diabetes in pregnancy, bereavement and teenage pregnancy. The hospital also provided parent craft teaching and breast feeding support. The hospital had recently appointed a perinatal mental health midwife. Inspectors were informed that the hospital did not have a clinical pharmacist allocated to the Neonatal Unit. This needs to be addressed.

3.1.3 Communication

Emergency response teams

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 an established procedure for requesting support for obstetric and neonatal emergencies whereby a multidisciplinary response team could be summoned for an emergency by telephoning the hospital emergency number. Contact lists for staff to be called in the event of an obstetric or neonatal emergency were available in the clinical areas inspected.

Multidisciplinary handover

There were formal arrangements in place for multidisciplinary clinical handover in each of the inpatient clinical areas inspected. Multi-disciplinary clinical handover took place every morning in the Maternity Unit when the on-call obstetric team handed over to the obstetric team on duty in the morning and this was repeated in the evening to hand over to the on-call team on duty. Short staff meetings called huddles were conducted in clinical areas during the day to discuss key safety issues. There was frequent team discussion around care planning during the day about existing and new admissions at both clinical handover and consultant-led rounds in the Labour Ward. Clinical staff used the Identity-Situation-Background-Assessment-Recommendation communication format to verbally communicate information about patients in line with national guidelines.[12]

There were a number of clinical situations where relevant obstetric, anaesthesiology or paediatric or neonatology consultants were routinely notified so that they could be in attendance at birth. These included, for example, massive obstetric haemorrhage, complex delivery, anaesthetic risks, medical comorbidities, difficult caesarean

section, placental abnormalities or anticipated complex neonatal issues. RCSI Hospitals had developed guidelines in relation to consultant attendance in respect of obstetrics and neonatology. It was practice for the most senior non-consultant hospital doctors[‡‡‡] on call to discuss complex cases and transfers with the relevant consultant on-call.

Other findings relevant to communication

Medical and midwifery staff who spoke with inspectors said that they would have no hesitation about contacting a consultant on duty if they had concerns about the wellbeing of a woman or when advice or additional support was needed. There was an agreed process in place for accessing an operating theatre for emergency surgery during and outside of core working hours. Staff who spoke with inspectors were clear about who was the most senior doctor to be called in line with the Irish Early Maternity Warning System escalation process.

The hospital had written guidelines in relation to weekend consultant obstetrician on-call duty arrangements and examples of situations where a consultant obstetrician was expected to attend in person.

3.1.4 Written policies, procedures and guidelines

The hospital had a suite of policies, procedures and guidelines in relation to obstetric emergencies for example, resuscitation of the pregnant woman and umbilical cord prolapse. Some policies, procedures and guidelines viewed by inspectors were due for review at the time of inspection. These documents were stored electronically and could be accessed by staff in clinical areas. Inspectors were informed that a hospital-group wide initiative to implement a document management system was planned.

The hospital also had policies based on National Clinical Effectiveness Committee[§§§] guidelines in relation to sepsis, clinical handover in maternity services and the Irish Maternity Early Warning System.[13,14,15]

A safe surgery checklist[****] was completed for emergency and elective surgical procedures in obstetric operating theatres in line with best practice

[‡‡‡] Non-consultant hospital doctor is a term used in Ireland to describe qualified medical practitioners who work under the (direct or nominal) supervision of a consultant in a particular speciality

[§§§] Guidelines produced by the national clinical effectiveness committee have been formally mandated by the Minister of Health.

[****] A surgical safety checklist is a patient safety communication tool that is used by operating theatre nurses, surgeons, anaesthesiologists and others to discuss together important details about a surgical case so that everyone is familiar with the case and that important steps are not forgotten. Surgical checklists work to improve patient safety during surgery.

recommendations. The hospital had a standardised procedure for the estimation and measurement of maternal blood loss.

3.1.5 Maternity service infrastructure and facilities and resources

Overall, the infrastructure and design of the Maternity Unit was outdated and did not meet recommended specifications for maternity services.[16] Space and infrastructure for the implementation of new services and technologies was limited by the size and age of the building. A new maternity unit was included in the hospital's site development plan with the aim of moving the Maternity Unit next to the newly built operating theatre facilities. Hospital management were planning to expand maternity outpatient facilities including the Maternity Day Unit and the Neonatal Unit. Capital funding was required to progress these improvements.

The hospital provided maternity day care facilities in the Maternity Unit where services such as blood pressure monitoring, fetal ultrasound, post-dates assessment, blood tests and medication administration were provided in a day care setting.

Hospital management had progressed the development of improved facilities for women and families who had experienced bereavement. A new room was created within the postnatal ward. Hospital management had also supported the refurbishment of a designated room where clinical staff could meet with women and families when sensitive information needed to be communicated in a quiet space. Hospital staff told inspectors that this work was enabled through the generosity of people who had donated resources to the Maternity Unit.

Antenatal Clinic

The Antenatal Clinic comprised a number of single assessment rooms. Women attending the hospital with concerns during pregnancy also attended this clinic as described previously. The area was well signposted but there wasn't a designated reception area which was less than ideal from a privacy perspective.

Emergency Department

The general Emergency Department had recently been refurbished and expanded and included a designated single room with en-suite facilities for the assessment of pregnant women. Hospital management told inspectors that they were hoping to create a designated maternity emergency department for women who presented with pregnancy-related concerns and or complications. This was part of wider site development plans in relation to the maternity service. There was no agreed timeframe by which this work would be completed.

Postnatal Ward

The postnatal ward comprised 28 beds and cots and included, three six bedded rooms, one three bedded room, two double rooms and three single rooms. The ward also had a single dedicated bereavement room for bereaved parents and their extended families. Overall space in this ward was limited.

Midwifery-led Unit

The Midwifery-Led Unit was a self-contained unit located on the floor directly above the Labour Ward. The Unit had three single rooms two of which were equipped with a birthing pool to facilitate women to use immersion in water for labour. All delivery rooms in the unit had ensuite toilet or shower facilities.

Labour Ward

The Labour Ward had six delivery rooms and one of these rooms was a special observation room that was equipped for women who required close monitoring and observation during pregnancy or immediately after birth. One of the six delivery rooms had been recently renovated to include a birthing pool to facilitate women, booked for consultant-led care, to use immersion in water during labour. Delivery rooms did not have ensuite toilet or shower facilities.

Operating theatres for obstetric surgery

There were two dedicated operating theatres for obstetric cases within the Operating Theatre Department which was located on the same floor adjacent to the Labour Ward. Access to obstetric operating theatres was through the Labour Ward. One operating theatre was designated for obstetric emergencies. A new build operating theatre was almost complete at the hospital and this was due to open in 2019.

Neonatal Unit

The Neonatal Unit was a self-contained unit staffed for 16 cots, which consisted of three intensive care cots, two high dependency cots and 11 special care cots. There were isolation facilities for three cots in the unit. There were 14 babies in the unit on the first day of inspection. Inspectors were informed that occupancy rate in the unit was variable and that sometimes during busy periods had accommodated up to 21 babies. There were plans at the hospital to expand the size of the Neonatal Unit but there was no agreed funding for this at the time of inspection. Neonatal units should be designed to meet service requirements in line with relevant international guidelines for infrastructure and design.[17] If neonatal unit cots were not available at the hospital babies were usually transferred to the Rotunda Hospital or to another hospital as required.

Laboratory services

Blood and blood replacement products were accessible when required in an emergency for women and infants. Urgent haematology, biochemistry and microbiology laboratory results were available to medical staff when required.

3.1.6 Maternity service equipment and supplies

The Labour Ward had emergency resuscitation equipment for women and newborns. The Midwifery-Led Unit had emergency resuscitation equipment for newborns. An adult emergency resuscitation trolley and automated external defibrillator was shared between the Midwifery-Led Unit and the adjoining postnatal ward. Resuscitation equipment should be readily and easily accessible to staff for use in an emergency in individual clinical areas and this finding should be addressed so that there is ready access to this equipment in both clinical areas.

A resuscitaire for newborn babies was stored inappropriately in the Emergency Department and was not prepared for immediate use. This item of emergency equipment should be within easy access for the resuscitation area and should be ready for use at all times. This finding was brought to the attention of hospital management at the time of inspection and inspectors were subsequently informed that this issue had been addressed.

Emergency supplies and medications were readily available in the clinical areas inspected to manage obstetric emergencies such as maternal haemorrhage, pre-eclampsia and neonatal resuscitation. Cardiotocography[††††] machines for fetal monitoring seen by inspectors were labelled to indicate when they had been serviced.

Table 5 on the next page lists the National Standards relating to effective care and support focused on during this inspection and key findings in relation to the hospital's level of compliance with the National Standards monitored during this inspection.

†††† Cardiotocography is an electronic means of recording the fetal heart beat and the uterine contractions during pregnancy. The machine produces a trace known as a cardiotocograph which illustrates the fetal heart rate and uterine activity.

Table 5: HIQA's judgments against the National Standards for Safer Better Maternity Services for Effective Care and Support that were monitored during this inspection

Standard 2.1 Maternity care reflects best available evidence of what is known to achieve safe, high-quality outcomes for women and their babies. **Judgment:** Compliant
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. **Key findings:** Lack of universal anomaly scans at 20-22 weeks gestation. Lack of a dedicated anaesthetic pre-assessment clinic. **Judgment:** Substantially compliant
Standard 2.3 Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services. **Judgment:** Compliant
Standard 2.4 An identified lead healthcare professional has overall clinical responsibility for the care of each woman and that of her baby. **Judgment:** Compliant
Standard 2.5 All information necessary to support the provision of effective care, including information provided by the woman, is available at the point of clinical decision-making. **Judgment:** Compliant
Standard 2.7 Maternity care is provided in a physical environment which supports the delivery of safe, high-quality care and protects the health and wellbeing of women and their babies. **Key findings:** The overall infrastructure of the Maternity Unit requires improvement. **Judgment:** Substantially compliant
Standard 2.8 The safety and quality of maternity care is systematically monitored, evaluated and continuously improved. **Judgment:** Compliant

3.2 Safe Care and Support

A maternity service focused on safe care and support is continually looking for ways to be more reliable and to improve the safety and quality of its service. In relation to obstetric emergencies, this inspection sought to determine how risks to the maternity service were identified and managed, how patient safety incidents were reported and if learning was shared across the service. Inspectors also looked at how the hospital monitored, evaluated and responded to information and data relating to outcomes for women and infants, and feedback from service users and staff.

Inspection findings in relation to safe care and support are described next.

Inspection findings

3.2.1 Maternity service risk management

The hospital had systems in place to identify and manage risk. Risks in relation to the maternity service were recorded in the hospital risk register along with agreed control measures. The risk register was reviewed regularly at the Women's Health Governance Group. Risks that could not be managed at hospital level were escalated to the RCSI Hospital Group corporate risk register. Risks recorded in the corporate risk register included:

- medical, midwifery and nursing staffing deficiencies
- overcrowding in the Neonatal Unit.

Findings in relation to these issues have already been outlined in this report.

Clinical incident reporting

Inspectors found that there was an established practice of incident reporting at the hospital based on the number of clinical incidents reported each month. A standardised clinical incident trigger list had been developed at hospital group level through the RCSI Hospitals Serious Incident Management Forum. This list was available in the clinical areas inspected and staff who spoke with inspectors were clear about the type of clinical incidents that should be reported. Clinical incidents were tracked and trended and where improvements were required, plans were put in place to address these. Patient safety incidents were reported onto the National Incident Management System[‡‡‡‡] in line with national guidelines.[18] The management

[‡‡‡‡] 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.

of serious incidents and serious reportable events[§§§§] was initially overseen at a local level serious incident management forum and also at the RCSI Hospitals Serious Incident Management Forum. There was an established practice of sending written communications called 'alerts' to relevant clinical staff from hospital management where aspects of clinical practice and communication needed to be highlighted. These alerts were clearly presented in a one-page format. Inspectors saw evidence of good practice with regard to alerts that had been communicated to clinical staff in relation to the following:

- assessment of women presenting with complications
- documentation and record keeping
- medication administration
- management of induction of labour
- intrapartum fetal monitoring
- communication of information to consultant obstetricians.

Feedback from women

There was a formalised process to monitor compliments and respond to complaints from women using the maternity service. Hospital management gave examples of how feedback from women using the maternity service was used to make improvements. At the time of inspection the waiting area for the Early Pregnancy Assessment Unit was being reconfigured to afford women greater privacy. Inspectors saw a notice board in the Maternity Unit which outlined different ways that staff were working with women to enhance person-centred care. The hospital held a 'What Matters to you Day' in June 2018 to elicit feedback from women and families who use the maternity service.

3.2.2 Maternity service monitoring and evaluation

A range of different clinical measurements in relation to the quality and safety of maternity care were gathered at the hospital each month in line with national HSE Irish Maternity Indicator System reporting requirements. This data is gathered nationally by the Office of the National Women and Infants Health Programme and the National Clinical Programme for Obstetrics and Gynaecology.[19] This information also allows individual maternity units and maternity hospitals to benchmark their performance against national rates over time.

[§§§§] Serious Reportable Events are a defined subset of incidents which are either serious or that should not occur if the available preventative measures have been effectively implemented by healthcare providers. The HSE requires that Serious Reportable Events are mandatorily reportable by services to the Senior Accountable Officer of the service.

Midwifery metrics in relation to care planning, medication and guideline implementation were monitored monthly at the hospital.

RCSI Hospitals had developed a number of key performance indicators in relation to maternity services which were monitored at hospital group level monthly. These included parameters in relation to:

- maternity service activity including number of births, transfers, caesarean section rate, induction rate and instrumental delivery rate
- maternal morbidity and perinatal mortality
- staff uptake of cardiotocography and neonatal resuscitation training
- the number of fetal ultrasound anomaly scans performed.

Performance data in relation to these metrics were published on the RCSI Hospitals website and were reviewed at meetings of the hospital group-level Serious Incident Management Forum. The hospital published monthly maternity patient safety statements in line with national HSE reporting requirements. Performance measurements were overseen at meetings of the Women's Health Governance Group and monthly hospital group performance meetings.

The quality and safety of the maternity service was also overseen at the hospital group Serious Incident Management Forum which reviewed hospital-level aggregate data and also requested clinical audits if concerns in relation to the maternity service were identified.

Other sources of information such as findings from national quality midwifery metrics, clinical incident reviews, risk assessments, feedback from women using the service, complaints, and audit were used by management at the hospital to identify potential risks to patient safety and opportunities for improvement.

There was a scheduled agenda for maternity service clinical governance meetings which were held weekly. Perinatal morbidity and mortality was routinely reviewed at this forum once a month. In addition, maternal morbidity was also reviewed at one of these meetings once a month. These meetings included case presentation and review of activity and outcome data. Clinical staff used a maternity dashboard to present and review service activity and outcome data for each month at the clinical governance forum. Minutes of meetings were recorded in line with National Standards. These meetings were attended by staff from the relevant clinical specialties. The clinical governance meeting schedule also included weekly review of cardiotocographs and review of caesarean sections in women who had experienced their first pregnancy.

Clinical audit

Our Lady of Lourdes Hospital had a clinical audit programme with planned audits defined in the hospital's annual clinical audit programme. A maternity service audit committee chaired by the clinical director had been established and an audit proposal document was in development. The aim of this committee was to formalise oversight of audit activity in the maternity service. Audits performed in 2018 were risk-based and included the following topics:

- vaginal birth after caesarean delivery
- post-partum haemorrhage
- sepsis
- documentation of assessments and reviews before and during labour
- fetal heart rate recording during labour
- maternal venous thromboembolism risk assessment
- cardiotocography record stickers
- use of Identity-Situation-Background-Assessment-Recommendation stickers in healthcare records to record escalation of care.

Through audit, clinical staff at the hospital identified a positive decrease in the rate of post-partum haemorrhage in 2018 compared to 2017 following the implementation of a number of measures. These measures included changes in practice around oxytocin use, recurring staff education around surgical techniques to minimise blood loss and regular training drills in the Labour Ward. It was also practice at the hospital for a consultant obstetrician to attend caesarean sections performed in the second stage of labour.

A sepsis audit was performed at the hospital as part of a HSE national sepsis audit programme in May 2018. This audit showed good compliance with national guidelines. Any opportunities for improvement were clearly highlighted in the completed audit report.

Following an audit in relation to vaginal birth after caesarean delivery, a revised assessment form had been implemented and managers in the maternity service were developing an information leaflet for women.

Documentation reviewed showed that not all of the audits scheduled for 2018 had been completed on schedule. Hospital management was aware of this and was working to review the audit schedule so that audits could be completed within agreed time frames. Audit findings and recommendations were presented and followed up at maternity clinical governance meetings.

Annual clinical report

Our Lady of Lourdes Hospital published a comprehensive maternity service annual report that detailed maternal and neonatal outcomes, service activity and information about the types of services provided for women using the maternity service. The hospital used the Robson Classification for assessing, monitoring and comparing caesarean sections rates for women at the hospital as recommended nationally.[20] Senior managers and clinical staff attended an annual meeting with colleagues from other maternity units in Ireland. At the Annual Clinical Reports Meeting, organised by the Institute of Obstetricians and Gynaecologists, maternity service annual clinical reports from participating hospitals are assessed by an external assessor and peer-reviewed to enable benchmarking of performance against similar sized units. Staff at Our Lady of Lourdes Hospital did not present maternity service data at this meeting but were hoping to do this going forward.

3.2.3 Quality improvement initiatives developed by staff at the hospital

Hospital management and staff had implemented a number of quality improvement projects aimed at improving the quality and safety of maternity care. Quality improvement projects were aligned to opportunities for improvement identified through monitoring and evaluation of the service. Examples of these included the implementation of the following:

- The Growth Assessment Protocol Project which was a multi-stranded process introduced with a view to improving detection of small for gestational age babies. Since the implementation of the Growth Assessment Protocol in 2017, hospital management reported that the stillbirth rate at the hospital had reduced from the previous year.
- 'After Action Reflection' which is a structured facilitated discussion of an event that has occurred. It is an intervention that is undertaken before or soon after the event has occurred and seeks to understand the expectations and perspectives all those staff involved. In 2017 a multidisciplinary team undertook an accredited After Action Reflection Facilitators Training Programme in the Royal College of Surgeons in Ireland. This training was ongoing for additional staff. After Action Reflection was facilitated for staff following incidents including positive events to support staff using a reflective, no-blame approach.
- Changes in practice and staff education which resulted in a reduction in the incidence of postpartum haemorrhage in 2018.
- A maternal venous thromboembolism risk assessment and management tool and associated standard operating procedure.
- A person-centred culture programme within the Maternity Unit.
- The Edinburgh Postnatal Depression Screening Tool in August 2017.

- Schwartz Rounds in the Maternity Unit in 2017 to facilitate staff to reflect on the emotional aspects of their work.
- National guidelines in relation to clinical handover in maternity services.

Inspectors found that there was a commitment to improving the quality and safety of maternity services at the hospital. Going forward, the hospital should implement, review and publically report on a structured quality improvement programme in line with National Standards.

Table 6 lists the National Standards relating to safe care and support focused on during this inspection and key findings in relation to the hospital's level of compliance with the National Standards monitored during this inspection.

Table 6: HIQA's judgments against the National Standards for Safer Better Maternity Services for Safe Care and Support that were monitored during this inspection

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. **Judgment:** Compliant
Standard 3.3 Maternity service providers monitor and learn from information relevant to providing safe services and actively promote learning, both locally and nationally. **Judgment:** Compliant
Standard 3.4 Maternity service providers implement, review and publicly report on a structured quality improvement programme. **Key findings:** Undertaking quality improvement work but did not have a structured and resourced quality improvement programme. **Judgment:** Substantially compliant
Standard 3.5 Maternity service providers effectively identify, manage, respond to and report on patient safety incidents. **Judgment:** Compliant

4.0 Conclusion

Women and their babies should have access to safe, high-quality care in a setting that is most appropriate to their needs. Overall, inspectors found that Our Lady of Lourdes Hospital was compliant with the majority of the National Standards that were focused on during this inspection.

Our Lady of Lourdes Hospital had a clearly defined and effective leadership, governance and management structure at the hospital and within RCSI Hospitals to ensure the safety and quality of maternity services. There was good oversight of the quality and safety of services by senior managers at the hospital who used multiple sources of information to identify opportunities for improvement. The hospital's senior management team monitored performance data including patient outcomes, service user feedback and patient safety incidents and benchmarked its performance against other similar sized hospitals. Hospital management was actively working to optimise maternal care and to progress implementation of the National Standards.

The hospital had developed strong collaborative working arrangements with other hospitals providing maternity services in RCSI Hospitals but this was not a formally managed clinical maternity network. The implementation of such a network needs to be progressed by the hospital group and the HSE in line with the National Standards and the National Maternity Strategy.

The hospital employed medical staff in the specialties of obstetrics, paediatrics, neonatology and anaesthesiology who were available onsite to provide care to women and newborns on a 24-hour basis.

Although there was close working arrangements between the anaesthesiology and obstetric medical staff to assess and manage women at greater risk of developing complications, the hospital did not provide a dedicated obstetric anaesthetic pre-assessment clinic. This service needs to be sufficiently resourced in line with National Standards and national guidelines.

Detailed fetal assessment ultrasound scans at 20-22 weeks gestation were not offered universally to pregnant women, this service needs to be sufficiently resourced and implemented in line with National Standards and National Maternity Strategy Implementation Plan priorities.

The hospital had clearly defined training requirements for clinical staff in relation to fetal ultrasound, fetal monitoring, adult and neonatal resuscitation and multi-professional training for the management of obstetric emergencies. However, hospital management needs to ensure that mandatory training is always completed

by medical, midwifery and nursing staff within recommended timeframes and that staff attendance at training is recorded.

The hospital had arrangements in place to identify women at higher risk of complications and to ensure that their care was provided in the most appropriate setting. Inspectors found that effective arrangements were in place to detect and respond to obstetric emergencies and to provide or facilitate on-going care to ill women and or their newborn babies. Specialist support around perinatal mental health needs to be sufficiently resourced at the hospital.

Following this inspection the hospital needs to address the opportunities for improvement identified in this report and requires the support of the hospital group and the HSE to progress the development of maternity services at the hospital and the transition to a maternity network.

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