Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the unannounced inspection of maternity services at Portiuncula University Hospital, Ballinasloe, Co Galway

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

Dates of inspection: 10 April 2019 and 11 April 2019

Safer Better Care

About the Health Information and Quality Authority (HIQA)

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 purposes 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.

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.hiqa.ie

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

1.1 Information about this inspection

Portiuncula University Hospital is a statutory acute hospital which is owned and managed by the Health Service Executive. The hospital is part of the Saolta University Health Care Group.[†] The Maternity Unit is co-located with the general hospital. There were 1602 births at the hospital in 2018.

To prepare for this inspection, inspectors reviewed a completed self-assessment tool[‡] and preliminary documentation submitted by Portiuncula University 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 Portiuncula University Hospital is included in the table below:

Table 1- Inspection details

Dates	Times of inspection	Inspectors
10 April 2019	10.30hrs to 19.30hrs	Aileen O' Brien Siobhan Bourke Denise Lawler Emma Cooke
11 April 2019	08.15hrs to 16.30hrs	

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

- representatives of the hospital's Senior Management Team; the General Manager and the Director of Midwifery
- the Women's and Children's Directorate Associate Clinical Director who was also the lead consultant obstetrician
- the hospital's lead consultants in the clinical specialties of anaesthesiology and paediatrics.

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

[†] Saolta University Health Care Group is a hospital group which includes Portiuncula University Hospital, University Hospitals Galway (University Hospital Galway and Merlin Park Hospital), Mayo University Hospital, Sligo University Hospital, Letterkenny University Hospital, and Roscommon University Hospital. Maternity services are provided in all of the hospitals in the group with the exception of hospitals in Roscommon and Merlin Park.
[‡] All maternity hospitals and maternity units were asked to complete a self-assessment tool designed by HIQA for this monitoring programme

- Assessment areas where pregnant and postnatal women who presented to the hospital with pregnancy-related concerns were reviewed. These included the Emergency Department and the Labour Ward.
- The Labour Ward where women were cared for during labour and childbirth.
- The Intensive Care Unit where women who required additional monitoring and support were cared for.
- An obstetric operating theatre in the Operating Theatre Department for women undergoing surgery, for example in the case of caesarean section.
- The Special Care Baby Unit where babies requiring additional monitoring and support were cared for.
- The Maternity Ward where women were cared for before and after childbirth.

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

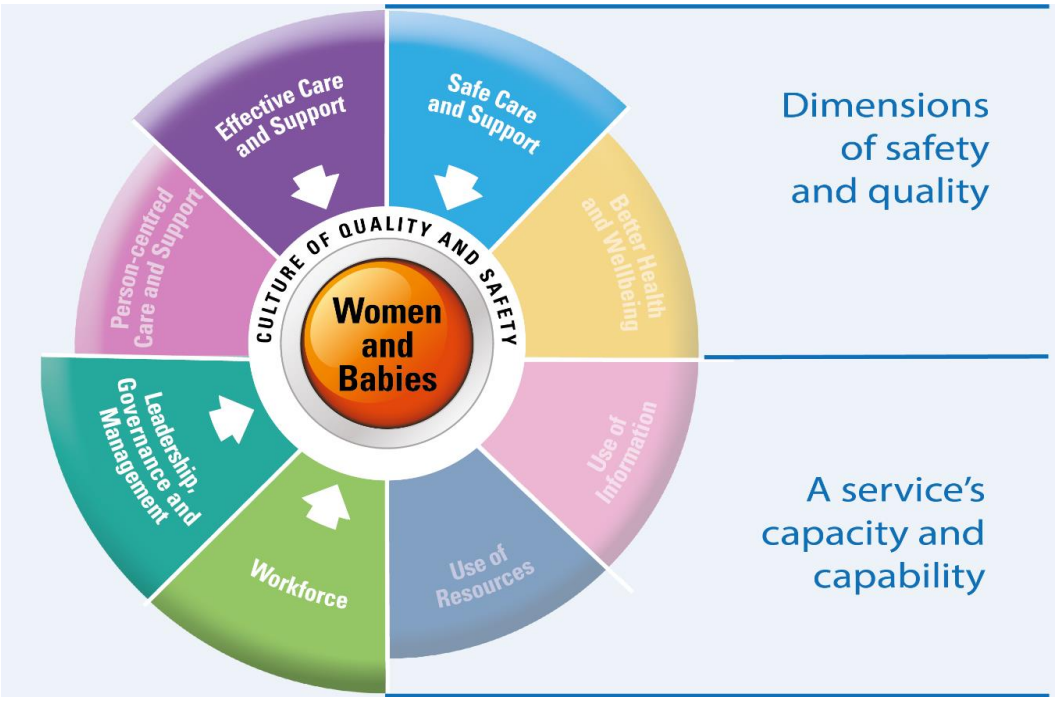
HIQA would like to acknowledge the cooperation of the hospital management team and all staff who facilitated and contributed to this unannounced inspection.

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.

Inspection findings will be presented in this report in sections 2 and 3. Section 2 outlines the inspection findings in relation to capacity and capability and Section 3 outlines the inspection findings in relation to the dimensions of safety and quality. 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	Lines 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, Portiuncula University Hospital was fully compliant with seven 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 3 and Table 4 within this section.

A risk identified during this inspection was escalated by HIQA in writing to the General Manager at Portiuncula University Hospital. The response from the hospital in relation to actions planned to address the risk identified is included in this report.

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

Saolta University Health Care Group had established arrangements that facilitated effective collaborative working between the five maternity units within the hospital group. A Women's and Children's Directorate management structure led by a clinical director incorporated maternity services across the hospital group. The hospital group had not yet implemented a managed clinical network for maternity services, which was recommended in both the report of an external independent review of maternity services at the hospital in 2015 which was published in 2018[4] and in the National Maternity Strategy.

At the time of inspection, inspectors were informed that the hospital group was actively progressing the implementation of a managed clinical and academic network and that the Women's and Children's Directorate would be integrated into this new structure. A trial of concept for a Women's and Children's managed clinical and academic network had commenced across the hospital group to assess the impact of this governance model prior to the roll out of additional managed clinical and academic networks in this hospital group.

In the interim of this transition, the clinical governance teams in the Maternity Units at Portiuncula University Hospital and University Hospital Galway had integrated to form a single Women's and Children's Clinical Directorate Team. The aim of this team was to provide a framework for integrated clinical governance within the directorate and within and between the two hospitals. Joint meetings were held every two weeks and were chaired alternately by the associate clinical directors for the Women's and Children's Directorate from each hospital. This group reported to the General Manager at local level and to the Clinical Director for the Women's and Children's Directorate at hospital group level. In January 2019, the two hospitals had also integrated their staff education committees and their policy, procedure, guideline and audit committees.

A Local Maternity Service Implementation Group merged in January 2019 with the corresponding group at University Hospital Galway. This group reported to a hospital group-level Maternity Services Strategic Group which oversaw the implementation of national recommendations in relation to maternity care across the five hospitals in the hospital group that provided maternity services. Performance metrics and activity levels related to the maternity service were also reviewed at this forum.

A separate implementation group entitled the Portiuncula Implementation Group had been established following an external independent review of maternity services at the hospital in 2015. Membership of this group included family representatives involved in

the external review. This group was responsible for overseeing the implementation of recommendations arising from the external review and from systems analyses investigations[§] that were conducted during the review. This group was chaired by the Clinical Director of the Women's and Children's Directorate. Documentation reviewed and discussion with hospital management showed that there was also oversight of the implementation of recommendations of the external review at hospital group level.

The Women's and Children's Directorate serious incident management team oversaw the review of serious adverse clinical events across maternity services in the hospital group and the implementation of any subsequent recommendations.

The Women and Children's Directorate policy, procedure, guideline and audit committee facilitated the development, revision, implementation and audit of evidence-based policies, procedures and guidelines for maternity services, inclusive of neonatal care. Multiple guidelines that had been developed at Portiuncula University Hospital had been approved for use across the hospital group.

The hospital group was progressing the development of neonatal services at University Hospital Galway and was working to expand neonatal service capacity for the Saolta University Health Care Group. It was anticipated that this would facilitate the transfer of newborns requiring a higher level of neonatal care from Portiuncula University Hospital to University Hospital Galway. An annual clinical report from the Women's and Children's Directorate included clinical data for all five maternity units in the group. All seven hospitals in the group had an integrated electronic system for recording incidents, complaints and audits and managing documents.

Portiuncula University Hospital leadership, governance and management

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

The General Manager at Portiuncula University Hospital had overall managerial responsibility and accountability for the maternity service at the hospital. Recent changes which included the closer integration of maternity services between Portiuncula University Hospital and Galway University Hospital had not altered hospital-level management accountability arrangements. The Director of Midwifery position at the hospital was filled by the Saolta University Health Care Group Director of Midwifery pending the appointment of a new Director of Midwifery at the hospital. The Director of Midwifery was responsible for the organisation and management of the midwifery service.

[§] A systems analysis investigation is a methodical investigation of an incident which involves collection of data from the literature, records, individual interviews with those involved where the incident occurred and analysis of this data.

The Hospital Management Team led by the General Manager was responsible for ensuring that services were delivered at the hospital within the clinical and corporate governance framework established as part of the Saolta University Healthcare Group. The team met monthly and membership included senior hospital managers in addition to the Associate Clinical Director for Women's and Children's Directorate and the Director of Midwifery in line with the National Standards. This team reported through the General Manager to Saolta University Health Care Group. The Women's and Children's Directorate and the Director of Midwifery provided monthly written reports to the Hospital Management Team which were structured to include key priorities and progress, risks for escalation, staffing levels, audits and quality initiatives and service improvements.

Clinical governance and strategic direction for the maternity service was overseen and led at local level by the General Manager at the hospital, the Director of Midwifery and the appointed Associate Clinical Director for the Women's and Children Health Directorate who was the lead consultant obstetrician.

The Portiuncula Implementation Group with the hospital management team was actively involved in progressing, tracking and monitoring the implementation of recommendations of the external review report. Inspectors were informed that the majority of these recommendations had been implemented at the hospital and hospital management was able to demonstrate this through ongoing monitoring and audit.

Clinical leads had been appointed in the specialties of anaesthesiology and paediatrics at Portiuncula University Hospital. These clinicians were appointed on a rotational basis and were responsible for arranging training for non-consultant hospital doctors and representing their respective specialties in relation to service provision at hospital and directorate management level.

A neonatal resuscitation programme working group met regularly to discuss issues in relation to neonatal resuscitation and to progress service improvements. A perinatal bereavement group with maternity service staff and service user representation was responsible for progressing improvements in relation to perinatal bereavement. A midwife education group overseen by the Director of Midwifery coordinated clinical education for midwives and nursing staff in the Maternity Unit.

Safety alerts in relation to medical devices and medicines were communicated to staff at the hospital. The hospital had a statement of purpose which referenced the maternity service. This should be expanded upon and made publicly available in line with the National Standards.

Table 3 on the next page 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:** Maternity network arrangements with a single governance structure were not formalised at time of inspection. **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. **Judgment:** 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
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, paediatrics 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 did not meet the HSE's national benchmark for midwifery staffing in line with the HSE's Midwifery Workforce Planning Project.[5] The hospital had 55.35 whole time equivalent[**] (WTE) clinical midwifery positions approved at the hospital at the time of the inspection, but had four permanent vacancies despite ongoing recruitment campaigns. Hospital management was working to address these deficiencies. A further six WTE midwives were on temporary leave at the time of the inspection. The hospital did not employ agency midwifery staff, existing midwifery staff filled vacant shifts in the Maternity Unit. Internal rotation of midwifery staff enabled hospital management to redeploy midwives to areas of high activity when required. A clinical midwife manager was in place for each shift in the Labour Ward. Clinical midwifery managers rostered outside of core working hours in the Labour Ward were included in WTE numbers so therefore were not always supernumerary. Women in labour had one-to-one support from a midwife and compliance with this practice was monitored as a key performance indicator by hospital management. Data reviewed showed that one to one care of women in labour was achieved at the hospital.

The Special Care Baby Unit had approval for 15 WTE nursing and midwifery staff and 13 of these positions were filled at the time of the inspection.

[**] 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

Recruitment for a perinatal psychiatrist was at an advanced stage. This position will have eight sessions dedicated for a perinatal psychiatry service for the Saolta Health Care Group. A further four sessions for this post were for general psychiatry at Portiuncula University Hospital. A hospital group-wide recruitment campaign for a perinatal mental health midwife was in progress at the hospital at the time of inspection.

The hospital had a full-time midwifery practice development coordinator. The hospital also had a 0.5 WTE nursing position to provide training and support in relation to neonatal resuscitation to medical, midwifery and nursing staff. The hospital did not have a midwifery clinical skills coordinator as recommended in the National Standards. The primary purpose of the post of midwifery clinical skills facilitator is to provide clinical support, education and instruction to midwives in developing skills and competencies in order to fulfil their roles and responsibilities. This deficiency needs to be addressed at the hospital.

The hospital had approval for four WTE positions to provide a fetal ultrasound scanning service in line with National Standards. At the time of inspection two of these positions were filled. Inspectors were informed that one staff member was in training for a position as fetal ultrasonographer. The hospital had a service level agreement with a service provider to provide fetal ultrasound services in the interim of filling vacant ultrasonographer positions.

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 arrest.

All except one consultant across the specialties of obstetrics, anaesthesiology and paediatrics were registered as specialists with the Medical Council in Ireland. There was some dependency on locum medical staff at the hospital and inspectors were informed that hospital management was working to address this through recruitment of permanent consultants.

Obstetric medical staff

The hospital has approval for five WTE consultant obstetricians. At the time of inspection, four of these WTE positions were permanently filled and 0.5 WTE was filled by a locum consultant on a long-term basis. A further 0.5 WTE was a joint temporary appointment with University Hospital Galway. The joint temporary post was in the permanent recruitment phase.

At the time of inspection, consultant obstetricians were on call one in every four nights. There was some reliance on locum consultants to cover weekend on-call rotas. A consultant obstetrician was rostered to be on call for the Labour Ward from Monday to Friday during core working hours. On-call consultant obstetricians conducted ward rounds weekdays and on Saturdays, Sundays and public holidays in the Maternity Unit. A rota of two non-consultant hospital doctors in obstetrics, one at registrar grade and one at senior house officer grade was in place 24 hours a day in the Maternity Unit.

Anaesthesiology staff

The hospital had approval for six WTE consultant anaesthesiologists who provided anaesthetic services at Portiuncula University Hospital. Five consultant positions were filled on a permanent basis and one consultant position was filled by a locum consultant. Two positions were jointly appointed between Portiuncula University Hospital, University Hospital Galway and Roscommon University Hospital.

The hospital had an on-call rota outside of core working hours for consultant anaesthesiologists whereby consultants were on call usually one in every six nights.

National Standards recommend that specialised birth centres[††] have resident on-call non-consultant hospital doctors in anaesthesiology and a dedicated obstetric anaesthetic service.[1] The anaesthetic team on call outside of core working hours at Portiuncula University Hospital was responsible for patients in the Intensive Care Unit, the Emergency Department and general wards as required. The team was also responsible for anaesthetic service provision in the Operating Theatre Department for both general and obstetric cases and for epidural anaesthesia for women in labour.

Inspectors were informed that the on-call rota for anaesthesiology outside of core working hours at the hospital comprised one consultant anaesthesiologist and two non-consultant hospital doctors usually at registrar and senior house officer grades. The consultant anaesthesiologist on-call was off site unless attendance was needed onsite at the hospital. The registrar in anaesthesiology stayed onsite for the duration of the

[††] A specialised birth centre is a delivery suite or labour ward in a maternity unit or maternity hospital.

on-call shift and the senior house officer stayed onsite until 10pm and then went off site but was on call for the remainder of the shift.

Inspectors found that anaesthetic medical staff resources at the hospital at the time of inspection were not in line with national recommendations for hospitals with co-located maternity units. These recommendations specify that there should be enhanced anaesthesia cover with two consultant anaesthesiologists and two non-consultant hospital doctors on call outside of core working hours to deal with two concurrent emergencies requiring an immediate and sustained response.[6]

HIQA was concerned because this level of cover at Portiuncula University Hospital meant that there was usually only one doctor in anaesthesiology instead of two onsite between 10pm and 8am to provide an immediate response in an emergency situation.

Following this inspection, risk identified by HIQA in relation to anaesthetic cover at Portiuncula University Hospital was escalated for remedial action to the General Manager.

Risk escalation by HIQA, and reciprocal response from Portiuncula University Hospital

In response to HIQA's correspondence about this risk, hospital management, with ultimate accountability, subsequently informed HIQA that they were satisfied that their operational arrangements, within available resources, mitigated the risk identified during this inspection.

Hospital management outlined the controls that were in place at the hospital to mitigate the risk identified which included the following:

- The senior house officer on call for anaesthesiology remained on site after 10pm when there were surges in activity at the hospital.
- The senior house officer on call was available and in attendance as required within a clinically acceptable time frame and there were no recorded incidents or difficulty with this availability.
- The hospital no longer accepted major trauma cases since April 2018 which had significantly reduced out of hours operating theatre activity.
- The consultant anaesthesiologist was always on site when there was increased operating theatre activity.

Hospital management stated that resources around the time of inspection in April 2019 did not allow the hospital to provide for two tier onsite non-consultant hospital doctors in anaesthesiology but that roster changes would be implemented in July 2019 to facilitate additional resources for a second level of anaesthetic senior house officer cover onsite.

In August 2019, hospital management confirmed to HIQA that as of 8 July 2019 there were two non-consultant hospital doctors in anaesthetics onsite at the hospital outside of core working hours. This is a welcome development.

Paediatrics

Neonatal care at the hospital was led by consultant paediatricians. The hospital had approval for 5.5 WTE consultant paediatricians. At the time of the inspection, 4.5 WTE positions were filled on a permanent basis by seven consultants. A full-time locum consultant paediatrician was due to commence at the hospital in May 2019. The hospital had an on-call rota outside of core working hours where a full time consultant paediatrician was on call usually one in every seven nights and every fourth weekend. Part-time consultant paediatricians were rostered on call once a fortnight and every eighth weekend. A rota of two onsite non-consultant hospital doctors in paediatrics, one at registrar grade and one at senior house officer grade was in place to provide emergency neonatal care at the hospital 24 hours a day.

2.2.3 Training and education of multidisciplinary staff

Mandatory training requirements

The hospital had clearly defined mandatory training requirements for clinical staff which were documented in the hospital's mandatory training policy. Non-consultant hospital doctors in obstetrics were required to undertake a formal training course in fetal ultrasonography before they were assigned to perform fetal ultrasounds.

Mandatory training requirements for medical, midwifery and nursing staff working in the maternity service included practical obstetric multi-professional training and basic life support every two years. Non-consultant hospital doctors in paediatrics and midwives were required to undertake training in neonatal resuscitation every two years. Doctors and midwives were also required to undertake fetal monitoring training every year.

Inspectors were informed that neonatal resuscitation provider courses were scheduled monthly and that skills and drills for neonatal emergencies were scheduled every two weeks at the hospital and that this practice was overseen by a neonatal skills facilitator at the hospital. Debriefing sessions were carried out following neonatal resuscitation to facilitate feedback and learning.

Uptake of mandatory training

Training records provided to inspectors showed that 79% of midwifery staff and 91% of obstetric medical staff had attended electronic fetal monitoring training in the previous 12 months. The skills gained by staff through this training were further supported by

weekly cardiotocography review meetings and weekly caesarean section review meetings.

One hundred percent of obstetric medical staff and 88% of midwifery staff had attended practical training in the management of obstetric emergencies in the previous two years. Eighty six percent of midwifery staff had attended neonatal resuscitation training in the past two years.

Outside of quarterly practical training courses in the management of obstetric emergencies, it was not practice at the hospital to run regular multidisciplinary skills and drills in relation to obstetric emergencies. It is recommended that skills and drills for obstetric emergencies are held on a more frequent basis. This is important in smaller maternity units where obstetric emergencies occur less frequently than in larger maternity units.

Training records showed that 44% of midwives and 50% of obstetric medical staff had undertaken basic life support training in the previous two years. National Standards recommend that relevant staff undertake training in basic adult life support, including resuscitation of the pregnant woman every two years. It is however recommended that all relevant staff undertake a basic life support training course every two years.

Hospital management must ensure that clinical staff are facilitated to undertake mandatory and essential training at the required frequency, appropriate to their scope of practice.

Orientation and training of new staff

Induction training was provided for new non-consultant hospital doctors in January and July each year. New medical staff were provided with training on clinical handover, the Irish Maternity Early Warning System and sepsis. Midwifery and nursing staff were provided with induction training when commencing employment at the hospital. Each of the clinical areas in the Maternity Unit had an orientation and induction programme for newly registered midwives, newly employed midwives and for staff midwives on internal rotation.

A hospital information manual had been developed at the hospital to support locum doctors and non-consultant hospital doctors who were new to the hospital. This manual contained information about the hospital and also contained speciality-specific information for doctors working in obstetrics and in paediatrics. The hospital had also developed induction booklets containing information about the maternity service for midwives and doctors who were new to the hospital.

Other training and education opportunities for staff

There was a regular schedule of structured shared learning for multidisciplinary clinical staff in the Maternity Unit. Weekly multidisciplinary meetings were held to review elective and emergency caesarean sections which were categorised using Robson 10 classification criteria.[7] On one day each week medical staff presented cases of interest and audit findings. This forum was also used to review guidelines and journal publications. Weekly cardiotocograph review meetings were held in the Labour Ward and weekly grand rounds were held to facilitate staff education. Training was provide to clinical staff in relation to fetal blood sampling in 2018. Clinical staff at the hospital also attended a multi-disciplinary lecture series in relation to perinatal bereavement.

The majority of nurses employed in the Operating Theatre Department had undertaken postgraduate training in perioperative nursing. In addition, the majority of nurses in the Special Care Baby Unit had undertaken postgraduate training in neonatal intensive care. A number of midwifery staff had completed training courses in relation to high dependency care, perinatal mental health, bereavement and loss, examination of the newborn and healthcare informatics.

Regular training was provided to staff in relation to record keeping, incident recognition and reporting, risk assessment and risk registers, open disclosure and consent. Training was also provided regularly around the use of the hospital's incident reporting system.

Anaesthetic medical staff at the hospital undertook training in advanced cardiac life support.

Table 4 on the next page lists the National Standards relating to workforce 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 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:** Anaesthesiology cover outside of core working hours was not in line with national recommendations. **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 basic life support training. Lack of regular skills and drills for clinical staff in relation to obstetric emergencies. **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, Portiuncula University Hospital was compliant with nine National Standards, substantially compliant with one National Standard and non-compliant with one National Standard.

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

Portiuncula University Hospital provided a range of general and specialist maternity services for women with low 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 and postnatal women

Assessment and referral

The hospital had confirmed pathways in place 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 fetal assessment unit
- an assessment room in the Emergency Department
- antenatal clinics – consultant-led and midwife-led
- outreach clinics
- a birth after caesarean section clinic
- a high risk maternal fetal medicine clinic
- combined antenatal and endocrine clinic for women with diabetes mellitus and gestational diabetes.

Women at risk of developing complications had consultant obstetrician-led care with multi-disciplinary care provided by midwives and doctors. The hospital provided a consultant-led high-risk fetal maternal medicine clinic in addition to a combined obstetric and endocrine clinic for women with pre-pregnancy or gestational diabetes mellitus. Consultant-led outreach antenatal clinics were provided in Loughrea and Athlone.

Women who were referred by their general practitioner could attend low risk midwife-led clinics or consultant-led antenatal clinics depending on their risk factors or underlying medical conditions.

In addition midwife-led outreach antenatal clinics were also facilitated in Loughrea and Athlone for women at low risk of developing complications. Birth after caesarean section support was offered to all women following one previous caesarean at a midwifery-facilitated clinic at the hospital.

Since October 2018 all pregnant women attending the hospital were offered a formal dating fetal ultrasound scan in the first trimester. Inspectors were informed that not all booked pregnant women were offered a detailed fetal assessment ultrasound scan at 20–22 weeks' gestation. This poses a potential risk to the woman and infant's safety as some fetal and placental complications may not be detected. Consequently, additional referrals and support may not be identified or implemented during pregnancy and at birth. [8] [9] [10] This type of ultrasound scan was offered to all pregnant women with identified risks. The hospital had expanded this service during 2018 so that at the time of the inspection over 55% of women were offered a detailed fetal assessment ultrasound at 20-22 weeks gestation. The hospital, in conjunction with the Saolta University Healthcare Group needs to ensure that all women have access to fetal ultrasound scans at intervals recommended in the National Standards.

Women with complications in early pregnancy could access an Early Pregnancy Assessment Unit by appointment through self-referral, general practitioner referral or referral by a member of the obstetric team.

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 two entry points to the hospital for the assessment and admission of pregnant and postnatal women who presented with concerns. During and outside core working hours women up to 20 weeks gestation attended the Emergency Department where they were reviewed in a designated assessment room by medical staff from the obstetric team. During and outside of core working hours, women at greater than 20 weeks gestation and women in labour were reviewed in an assessment room in the Labour Ward. Women who required admission for pregnancy-related concerns were admitted to the Maternity Ward.

The report of the external review of maternity services at Portiuncula University Hospital recommended that women presenting to the Maternity Unit should be reviewed in an area separate to the Labour Ward to reduce interruptions to the workflow of labour ward staff. In response to this recommendation, the hospital had recently fitted out and equipped a maternity assessment room in the Maternity Ward. Hospital management was working to progress the operation of this assessment area.

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. In addition, the hospital had implemented an early warning score for neonates in 2018.

3.1.2 Access to specialist care and services for women and newborns

Where preterm birth at 32 weeks gestation or less was anticipated, women were referred to a specialist maternity hospital with higher level neonatal intensive care facilities in line with current national guidelines.[11]

Access to clinical specialists

As the maternity unit was co-located with a general hospital, pregnant or postnatal women who presented to the maternity unit with a surgical or medical condition unrelated to pregnancy were referred to medical or surgical specialists who were available on site. Women who developed medical or surgical complications during pregnancy had access to general surgeons and to specialists in cardiology, respiratory medicine, gastroenterology, endocrinology and psychiatry when required.

There was 24-hour access to advice from consultants in the specialties of haematology and microbiology at the hospital. Microbiology advice was available by telephone from University Hospital Galway. A joint consultant microbiologist position was vacant at the time of inspection. Recruitment for this position was progressing. There should be sufficient timely access to consultant microbiologist advice at the hospital. Interventional radiology services were available for women through referral to University Hospital Galway for the management of pregnancy-related complications such as placental abnormalities.

There was 24-hour access to emergency obstetric surgery at the hospital.

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 anaesthesiology service in the Maternity Unit was led by a consultant anaesthesiologist with specialist training in obstetric anaesthesiology. The anaesthesiology service was largely staffed by anaesthesiologists from the general anaesthesiology rota at the hospital.

Guidelines[12] and National Standards recommend that there is an agreed system in place for the antenatal assessment of high-risk mothers to ensure that the anaesthesiology

‡‡ 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.

service is given sufficient notice of women at higher risk of potential complications. The hospital held a monthly anaesthetic pre-assessment clinic for pregnant women with risk factors for anaesthesia or a history of previous complications during anaesthesia. This clinic was delivered by the lead consultant anaesthesiologist for the maternity service. The hospital had a formal policy in place for antenatal referral for anaesthetic review at Portiuncula University Hospital. The reason for referral to this service was tracked and trended at the hospital.

Inspectors were informed that it was established practice that the on-call registrar in anaesthesiology regularly visited the Maternity Unit every day to determine if there were women who may require anaesthetic input in their care in either the Labour Ward or the Maternity Ward. The anaesthesiologist on-call also followed up women in relation to ongoing epidural analgesia and any care needs relating to epidural analgesia.

Critical care

Pregnant and postnatal women who required cardiovascular monitoring and or intensive care, for example women with pre-eclampsia, sepsis or obstetric haemorrhage, were cared for in the Intensive Care Unit at the hospital. The hospital had a policy in place for the transfer of a woman to the Intensive Care Unit. This was a combined critical care unit which could provide high dependency care, coronary care and level 3[§§] intensive care. Following initial assessment and admission to the unit, women were reviewed jointly by a consultant obstetrician and a consultant anaesthesiologist every day and more frequently as required. Midwifery review and care was provided by midwives from the Labour Ward as needed. If women required more advanced critical care, they could be transferred to University Hospital Galway or to a tertiary referral hospital depending on the type of care necessary.

Neonatal care

Portiuncula University Hospital had a level 1 special care baby unit which meant that the hospital provided care for infants born at greater than 32 weeks gestation and for sick term infants. Where there was a risk of premature delivery of a baby at less than 32 weeks gestation, the hospital arranged for in-utero transfer to a tertiary maternity hospital usually in Dublin in line with the HSE's model of care for neonatal services in Ireland. If babies were born at less than 32 weeks gestation at the hospital they were stabilised and transferred soon after birth to a maternity hospital that could provide level 3[***] neonatal care. Newborns that required therapeutic cooling[†††] for neonatal

[§§] 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.

[***] Level 3 neonatal care is specialised care for very preterm infants, unwell term infants and infants with major congenital malformation.

encephalopathy had passive cooling commenced at the hospital before transfer to a tertiary maternity hospital. Urgent transfers of newborns requiring neonatal intensive care were organised through the National Neonatal Transport Programme.[‡‡‡] The Special Care Baby Unit at the hospital again provided care for these babies when they were transferred back from the specialist hospital for ongoing care.

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 communication procedure for requesting the attendance of an emergency response team.

Multidisciplinary handover

There was twice daily consultant obstetrician-led multidisciplinary clinical handover 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 safety pauses were conducted in the Labour Ward, the Maternity Ward and the Special Care Baby Unit twice a day to discuss key safety issues. Implementation of safety pauses across these clinical areas was audited at local level in 2018 and there was good practice recorded. Opportunities for improvement in relation to documentation of the discussion at safety pauses were addressed locally. 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-Record communication format to verbally communicate information about patients in line with national guidelines.[13]

The HSE at national level conducted an audit of compliance with implementation of multidisciplinary clinical handover guidelines at the hospital between November 2017 and July 2018 and found that there was a formal structure for clinical handover within the Maternity Unit which followed the recommended communication format. Documentation reviewed showed that opportunities for improvement identified through

[†††] 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 maternity 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.

audit in relation to local policies and communication formats had been addressed by hospital management. A number of guidelines in relation to communication had been reviewed and approved at the hospital. These included guidelines in relation to medical handover and midwifery and nursing staff handover. Medical handover guidelines included templates for clinical handover in each clinical area in the Maternity Unit and in the Emergency Department. Terminology in relation to the Identity-Situation-Background-Assessment-Recommendation-Record communication format was not consistent across all maternity service local level guidelines reviewed by inspectors, this should be addressed.

There were a number of clinical situations where relevant obstetric, anaesthesiology and paediatric consultants were routinely notified so that they could be in attendance at birth, for example in cases of massive obstetric haemorrhage, complex delivery, anaesthetic risks, medical comorbidities, difficult caesarean section, placental abnormalities or anticipated complex neonatal issues. There was a written policy in relation to the escalation of care of women and newborns in situations of clinical concern or deterioration.

The hospital had developed a written procedure for calling urgent assistance in the Labour Ward. This policy clearly stated how staff could summon medical assistance in an emergency situation. The policy also included guidance on when to consider consultant anaesthesiologist input and clinical situations where consultant obstetrician attendance was required. Inspectors were informed that 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.

The anaesthesiologist on duty was informed by midwifery staff when women with known anaesthetic risks were admitted. Clinical assessment information from the anaesthetic pre assessment clinic was included in the woman's healthcare record.

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. 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.

[§§§] 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

3.1.4 Written policies, procedures and guidelines

The hospital had a comprehensive suite of policies, procedures and guidelines in relation to maternal care and obstetric emergencies. These were readily accessible electronically to staff in clinical areas.

A number of policies and guidelines in relation to maternal care that had been developed at Portiuncula University Hospital had been approved by the Women's and Children's Directorate for implementation across maternity services in the Saolta University Health Care Group. Examples of group-wide guidelines included:

- electronic fetal monitoring
- birth after caesarean section
- management of women in the first stage of labour
- resuscitation of the newborn
- management of antepartum haemorrhage
- induction of labour
- fetal blood sampling
- recruitment of locum medical staff
- preparation for caesarean section.

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

A national maternal sepsis audit was carried out by the HSE at the hospital in May 2018. This audit identified good practice and some areas requiring further improvement. A quality improvement plan was developed to address audit findings.

A safe surgery checklist[††††] was completed for emergency and elective surgical procedures in obstetric operating theatres in line with best practice recommendations. The Maternity Unit did not have a standardised procedure for the estimation and or measurement of maternal blood loss in the Maternity Unit. This needs to be developed following this inspection.

[****] Guidelines produced by the national clinical effectiveness committee have been formally mandated by the Minister for 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.

3.1.5 Maternity service infrastructure, facilities and resources

Overall, the infrastructure in inpatient areas in the Maternity Unit was outdated.

Assessment areas

The Emergency Department was located on the ground floor within the hospital and had a designated room in which pregnant women were assessed. This room was not en-suite which is less than ideal.

Maternity Ward

The Maternity Ward comprised 33 beds and provided antenatal and postnatal care for women and care for newborn babies. The ward comprised two five-bedded rooms, two four-bedded rooms, one three-bedded room, one two-bedded room and eight single en-suite rooms. Overall space in multi-occupancy rooms was limited when occupied by both mothers and babies. Toilet and bathroom facilities for women in multi-occupancy rooms were located on the ward corridor opposite patient rooms. The hospital had worked to upgrade patient bathrooms and ensuite facilities in single rooms. Works had also been carried out to widen room door frames to facilitate the movement of beds.

Labour Ward

The Labour Ward was adjacent to the Maternity Ward and these two areas were separated by a relatively narrow corridor. The Labour Ward was not self-contained and comprised four single delivery rooms none of which were en-suite. The assessment room in the Labour ward was not en-suite and did not have a window to provide natural lighting. Ancillary rooms such as storage, clean and dirty utility rooms were shared with the Maternity Ward. The design and layout of the unit did not meet recommended guidelines for maternity care.[14]

Operating theatres for obstetrics and gynaecology

The Operating Theatre Department comprised four operating theatres and a five bay recovery room located on the floor below the Labour Ward. Ideally an obstetric operating theatre should be in or adjacent to the Labour Ward. A designated operating theatre was available for emergency surgery 24 hours a day. The time taken to carry out an emergency caesarean section following the decision to deliver by caesarean section was monitored consistently and delays were not experienced.

Special Care Baby Unit

The Special Care Baby Unit comprised eight cots with six cots in an open plan area and two single rooms. One cot was dedicated for intensive care. There was limited space between cot spaces and therefore limited space and privacy for breastfeeding mums. The design and layout of the unit did not meet recommended guidelines for neonatal units.[15]

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. Point of care blood analysers were available to staff in the Labour Ward, the Operating Theatre Department and the Intensive Care Unit.

3.1.6 Maternity service equipment and supplies

The clinical areas visited by inspectors had emergency resuscitation equipment for women and newborns. Inspectors found that a daily equipment checklist for one piece of equipment in a clinical area inspected had not been completed as specified. This finding was addressed by hospital staff at the time of inspection.

Emergency supplies and medications were readily available in the clinical areas inspected to manage obstetric emergencies such as maternal haemorrhage and pre-eclampsia. Paediatric medical staff at the hospital were reviewing specialised equipment to facilitate neonatal endotracheal intubation.

Inspectors noted that cardiotocography machines reviewed in the clinical areas inspected indicated they were due for service in March 2019. However, following discussion with senior management, inspectors were informed that they were not due to be serviced until the end of April 2019. Hospital management should ensure that such equipment is labelled in a manner that accurately reflects service dates.

Table 5 on the next page lists the National Standards relating to effective care and support 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 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 detailed fetal anomaly scans at 20-22 weeks gestation. **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:** Outdated infrastructure in inpatient areas in the Maternity Unit. **Judgment:** Non-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 Women's and Children's Directorate risk register along with agreed risk treatment measures. Risks were also recorded in the hospital risk register. The risk register was reviewed and updated on a quarterly basis by hospital management. Risks that could not be managed at hospital level were escalated to the Saolta University Health Care Group Women's and Children's Directorate Management Team. Risks escalated to the hospital group were recorded in the Saolta University Health Care Group corporate risk register. Risks recorded in these risk registers relevant to this monitoring programme included:

- Delays and difficulties in recruiting new staff and replacing staff on leave
- Rising caesarean section rates
- Lack of universal anomaly scanning.

Clinical incident reporting

Staff who spoke with inspectors were aware of their responsibility to report clinical incidents and were clear about the process for reporting a clinical incident on the hospital's electronic reporting system.

A quality and safety subgroup of the Women's and Children's Directorate Team met every two weeks to perform initial review of incidents reported in the previous two weeks. Serious incidents and serious reportable events[‡‡‡‡] were discussed at meetings

[‡‡‡‡] 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.

of the Women's and Children's Directorate Team Serious Incident Management Team to determine the level of review indicated for incidents in line with local policy. This team also referred incidents to the Saolta University Health Care Group-level Serious Incident Management Team for further review.

There had been delays in 2018 at the hospital in uploading patient safety incidents onto the National Incident Management System.[§§§§] Hospital management had recently secured a 0.5 WTE administrative position to support the management of clinical incident reports. Inspectors were informed that patient safety incidents were reported onto the National Incident Management System in line with national guidelines.[16]

Feedback from women

There was a formalised process at the hospital to monitor compliments and respond to complaints from women using the maternity service. Women using the service were also encouraged to give direct feedback through comment cards used in the Maternity Ward and in the Special Care Baby Unit. Feedback from women was displayed on a notice board in the Maternity Ward and hospital management used this information to inform improvements at the hospital. Feedback from women was also welcomed in relation to the midwifery-led supported care pathway for pregnant women. Overall feedback in relation to the supported care pathway was positive. The hospital also facilitated a workshop in March 2019 that included participation from maternity service users and staff. The purpose of the workshop was to improve service user experience and multi-professional working across different groups.

3.2.2 Maternity service monitoring and evaluation

Hospital management used multiple sources of information to monitor and evaluate the quality and safety of the maternity service provided at the hospital. Clinical outcome and activity measurements in relation to the maternity service were gathered at the hospital each month in line with national HSE Irish Maternity Indicator System reporting requirements.[17] The hospital also published monthly maternity patient safety statements in line with national HSE reporting requirements.

In line with Royal College of Obstetricians and Gynaecologists guidelines the hospital used a maternity dashboard to monitor clinical activity, workforce issues, and clinical outcome indicators. Hospital management had modified the dashboard to reflect the complexity of their clinical workload, unit size, workforce requirements, priority issues

[§§§§] The State Claims Agency (SCA) National Incident Management System (NIMS) is a risk management system that enables public hospitals to report incidents in accordance with their statutory reporting obligations.

and clinical outcome indicators. Indicators monitored at the hospital included the following:

- birth types: normal, instrumental, caesarean section and vaginal birth after caesarean section including the number of emergency caesarean sections carried out within 30 minutes of the decision to deliver
- number of maternal and neonatal transfers
- percentage of women who had dating and anomaly fetal ultrasound scans
- one to one midwife care in labour
- staff training uptake for neonatal resuscitation, fetal monitoring and obstetric emergencies
- clinical indicators of maternal and neonatal morbidity.

This information was used to benchmark activity and monitor performance against the standards agreed locally for the Maternity Unit on a monthly basis.

Information in relation to midwifery care was gathered and analysed monthly in relation to the following Saolta Health Care Group Quality Care Metrics which included aspects of:

- medication management
- midwifery planning of care
- documentation
- clinical monitoring during labour
- Irish Maternity Indicator System Early Warning System observations and escalation
- invasive devices
- discharge planning.

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

Multidisciplinary perinatal mortality and morbidity meetings were held monthly at hospital level. Any untoward trends were reviewed and recommendations for practice, if indicated, were addressed.

Weekly meetings were held to discuss the cases of women who had caesarean sections and to review cardiotocographs. These meetings were attended by midwives and obstetric medical staff. Maternal morbidity meetings had recently commenced at the hospital.

Clinical audit

Portiuncula University Hospital had a comprehensive clinical audit programme with planned audits defined in the hospital's annual clinical audit programme. Clinical audits performed in the maternity service were aligned to national, hospital group, directorate and local-level priorities.

Two nationally-led audits were performed by the HSE in the maternity service in Portiuncula University Hospital Galway in 2018 relation to the implementation of national guidelines on clinical handover and maternal sepsis.

At local level, multiple clinical audits undertaken in the maternity service in the previous 12 months included audits in relation to aspects of:

- fetal monitoring
- shoulder dystocia cases
- vaginal birth after caesarean section
- induction of labour
- antepartum haemorrhage cases
- oxytocin administration
- neonatal resuscitation
- trial of instrumental delivery
- venous thromboembolism prevention
- management of labour that resulted in caesarean section
- perineal suturing
- gestational diabetes
- implementation of safety pauses in the Maternity Unit.

Staff in the Maternity Unit also gathered data in respect of:

- risk stratification at booking
- the number of women suitable for early transfer home.

This information was used to guide the establishment of a supported care pathway for women using the maternity service at the hospital.

Clinical audit was overseen by senior managers at the hospital and quality improvement plans were developed to progress any improvements indicated.

Annual clinical report

Saolta University Health Care Group published an annual clinical report that included maternal and neonatal outcomes, service activity and initiatives at each hospital providing maternity services within the hospital group including Portiuncula University Hospital. The hospital used the Robson classification for assessing, monitoring and

comparing caesarean section data for women at the hospital as recommended nationally.[7] 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. This is good practice.

3.2.3 Quality improvement

Hospital management and staff had implemented a number of quality improvement measures aimed at improving the quality and safety of maternity care at Portiuncula University Hospital following an external independent review of maternity services at the hospital in 2015. A number of quality improvements were directly aligned to specific recommendations arising from the review of a number of clinical cases which were the subject of the external review. Examples of quality improvements that had been implemented in the maternity service at the hospital related to the following issues:

Cardiotocography

A revised hospital group-level cardiotocography guideline was ratified at the hospital in July 2015. The revised guideline included a process called 'fresh eyes' where a second midwife checks a cardiotocography trace on a scheduled basis. In addition the policy included the use of classification stickers for antenatal and intrapartum cardiotocographs. Peer review audits had been undertaken at the hospital with the assistance of a senior midwife manager from another maternity unit. Implementation of this policy was progressed through regular updates and education for midwives and obstetric medical staff. The policy was based on Irish and United Kingdom clinical practice guidelines and a decision had been made at senior management level to continue to use these guidelines pending review of the national clinical guidelines for intrapartum fetal heart rate monitoring. At the time of inspection, the national guidelines were due for review.

Guidelines had also been implemented in relation to escalation of care in relation to fetal monitoring findings. Training was provided in relation to fetal blood sampling in January 2018. Additional point of care testing equipment to facilitate this testing had been purchased for the Maternity Unit. A key performance indicator had been introduced to measure the time interval from decision to deliver a baby by emergency caesarean section to time of delivery to facilitate audit of escalation of care. Compliance with checks performed upon commencement of cardiotocograph monitoring was monitored through midwifery metrics.

Staff with responsibility for interpreting cardiotocographs were required to undertake training in cardiotocograph interpretation on an annual basis rather than on a two

yearly basis as recommended in National Standards. This training comprised an electronic training module, study days, ward-based tutorials and cardiotocograph interpretation master classes. A policy had been developed at the hospital which outlined training requirements for locum and temporary medical staff. Training was supported with weekly multi-disciplinary cardiotocograph review meetings and weekly caesarean section review meetings. Cardiotocographs were also discussed at perinatal morbidity and mortality meetings. Audit findings were presented regularly to clinical staff and any opportunities for improvement in practice were addressed through management structures.

Birth after caesarean section

A revised hospital group-level guideline in relation to vaginal birth after caesarean section was ratified at the hospital in October 2017 outlining when fetal monitoring was indicated. Implementation of this guideline was supported through the development of an information leaflet for women, an antenatal checklist and staff education. Pregnant women who had a previous caesarean section were offered an opportunity to attend a midwife-facilitated birth after caesarean section clinic in addition to a risk-based discussion with a consultant obstetrician.

Other quality improvements

A number of other quality improvements had been implemented in relation to maternity services at the hospital and these included the following:

- a specialised antenatal high risk clinic
- a prenatal blood test pathway
- revised clinical communication processes including formal clinical handover, safety pauses, a bleep communication system and implementation of policies, procedure and guidelines in relation to escalation of care, documentation, and clinical handover
- a hospital group-level policy around the recruitment of locum medical staff included pre-employment checks in relation to education, registration and training requirements and induction
- an induction information booklet and a pocket-sized card with essential information and telephone numbers for locum and non-consultant hospital doctors
- telephone triage records
- enhanced neonatal resuscitation training

- revised documentation tool for neonatal resuscitation
- free fetal deoxyribonucleic acid screening for the management of rhesus negative pregnant women
- improvements in the fetal ultrasound service including a consent form and information leaflets for women using the service
- development of a formal referral and access pathway for counselling for women
- in 2019 a number of revisions and improvements were made to the National Maternity Healthcare Record to enhance its operational use at the hospital
- appointment of a specialist bereavement midwife manager
- development of condition-specific information leaflets and an information booklet which was provided to women at the time of booking
- infrastructural improvements including refurbishment of fetal ultrasound rooms, an assessment room, a counselling room and upgrading of patient rooms in the maternity ward
- introduction of a media communication tool for expectant families to facilitate access to practical advice about pregnancy and baby care
- patient satisfaction surveys.

Table 6 on the next page lists the National Standards relating to safe care and support 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 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. **Judgment:** Compliant
Standard 3.5 Maternity service providers effectively identify, manage, respond to and report on patient safety incidents. **Judgment:** Compliant

4.0 Conclusion

Overall, inspectors found that Portiuncula University Hospital was compliant with the majority of the National Standards in relation to quality and safety and capacity and capability that were focused on during this inspection.

There was a clearly defined and effective leadership, governance and management structure at the hospital and within the Saolta University Health Care Group to ensure the safety and quality of maternity services. Hospital management was actively working to optimise maternal care and to progress implementation of the National Standards.

There was good scrutiny and oversight of the quality and safety of the maternity service by hospital management who used multiple sources of information to identify and address opportunities for improvement. Staff and management at the hospital had actively worked to implement the recommendations of an external review carried out at the hospital in 2015.

Effective collaboration arrangements in relation to maternity care had been developed with University Hospital Galway. Saolta University Health Care Group were actively progressing the implementation of a managed clinical academic network. This was not formalised at the time of inspection.

Hospital management was satisfied that they had implemented control measures to address risk identified by HIQA during this inspection in relation to the level of anaesthesiology cover at the hospital outside of core working hours. There were plans to increase the level of onsite anaesthesiologist presence outside of core working hours in July 2019.

Fetal 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. The frequency of skills and drills training for clinical staff in relation to obstetric emergencies should be increased, the hospital has already achieved provision of regular frequent skills and drills training for neonatal resuscitation. All relevant clinical staff should be facilitated to keep up to date with basic life support training.

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.

Opportunities for improvement identified through this inspection included the need for hospital management to further expand fetal ultrasound scanning services so that all booked pregnant women have access to detailed fetal anomaly scans in line with National Standards.

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