Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the unannounced inspection of maternity services at Midland Regional Hospital Portlaoise

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

Dates of inspection: 28 May 2019 and 29 May 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 and hospitals 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 and hospitals 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 birth, and this can place both the woman's and the baby's lives at risk. Women may also unexpectedly develop complications following birth, 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 units and hospitals could effectively identify women at higher risk of complications in the first instance. It also examined how each maternity unit or hospital 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.

* 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.

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

1.1 Information about this inspection

The Midland Regional Hospital Portlaoise is a statutory hospital which is owned and managed by the Health Service Executive (HSE). The hospital is part of the Dublin Midlands Hospital Group.[†] 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 normal, medium and high risk pregnancies. There were 1,416 births at the hospital in 2018.

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

Table 1: Inspection details

Dates	Times of inspection	Inspectors
28 May 2019	11:00hrs to 18:45hrs	Denise Lawler Siobhan Bourke Aileen O' Brien Kay Sugrue
29 May 2019	08:00hrs to 16:00hrs	

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

- representatives of the hospital's Executive Management Team: the General Manager, Director of Midwifery and Clinical Director for the hospital
- the hospital's lead consultants in each of the clinical specialities of obstetrics, anaesthesiology and paediatrics.

[†] The Dublin Midlands Hospital Group comprises of seven hospitals – St. James' Hospital, Tallaght University Hospital, Naas General Hospital, Midland Regional Hospital Portlaoise, Midland Regional Hospital Mullingar, Coombe Women & Infants University Hospital and St. Luke's Radiation Oncology Network.
[‡] 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:

- Maternity Assessment Unit, where pregnant and postnatal women who presented to the hospital with pregnancy-related and postnatal concerns were assessed
- Labour Ward where women were cared for during labour and birth
- High Dependency Room where women who required additional monitoring and support during pregnancy and post birth were cared for
- Operating Theatre Department where women underwent surgery, for example in the case of caesarean section
- Maternity Ward where women were cared for during pregnancy and in the immediate postnatal period
- Special Care Baby Unit where babies requiring additional monitoring and support were cared for.

Information relevant to the monitoring programme was obtained by speaking with midwifery and nursing managers and staff midwives in the clinical areas identified above and doctors working in the maternity service. In addition, during the inspection, inspectors observed the clinical working environment and reviewed hospital documentation and data pertaining to the maternity service.

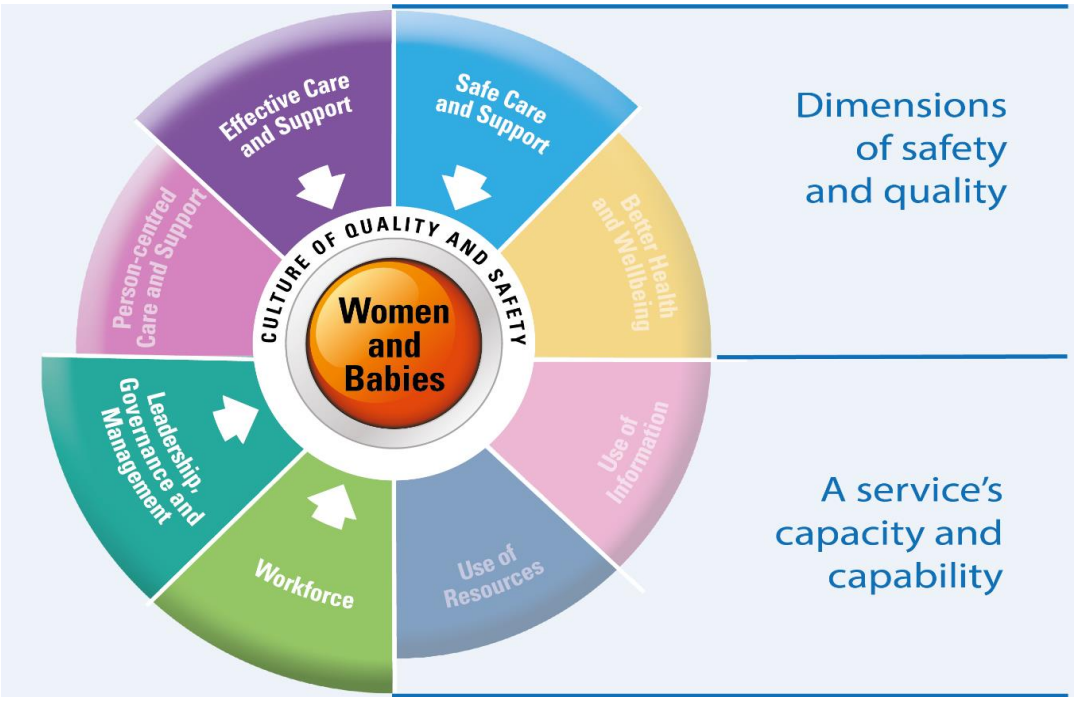
HIQA would like to acknowledge the cooperation of the hospital management team and all staff who facilitated and contributed to this unannounced inspection.

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, the Midland Regional Hospital Portlaoise was compliant with five National Standards and substantially compliant with the other five 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 organizational 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

One of the key findings from HIQA's Portlaoise investigation in 2015 was the need to implement in full a maternity network between the Midland Regional Hospital Portlaoise and the Coombe Women & Infants University Hospital.[4] The aim of this network was to create one single maternity unit over two sites.

Inspectors were informed that the Midland Regional Hospital Portlaoise was part of a collaborative network with the Coombe Women & Infants University Hospital to enable sharing of expertise and clinical services between the sites. However, this network was not formalised with a single governance structure, as recommended in the National Maternity Strategy.

At the time of the inspection there was no formal agreement between the Coombe Women & Infants University Hospital and the Health Service Executive (HSE) regarding the clinical oversight and governance of the Midland Regional Hospital Portlaoise. The senior management team in the Coombe Women & Infants University Hospital was not responsible for the governance, management or delivery of maternity services at the Midland Regional Hospital Portlaoise.

A Memorandum of Understanding setting out the intention that the Coombe Women & Infants University Hospital will assume responsibility for the governance, management and delivery of maternity services at the hospital was signed by the Coombe Women & Infants University Hospital and HSE in 2015. However, at the time of inspection the provisions set out in the Memorandum of Understanding had not been fully implemented.

In the interim, a number of structures were established that assisted in the effective collaborative working between the Midland Regional Hospital Portlaoise and the Coombe Women & Infants University Hospital. These included the:

- appointment of a Clinical Director for Integration who was a senior consultant obstetrician in the Coombe Women & Infants University Hospital. The Clinical Director for Integration attended the Midland Regional Hospital Portlaoise two days a week to provide support and clinical leadership
- joint appointment of consultants in the specialities of obstetrics and neonatology in the Midland Regional Hospital Portlaoise and the Coombe Women & Infants University Hospital. Two consultant obstetricians had joint appointment with both hospitals
- establishment of formalised care pathways for women at high risk of complications and babies requiring complex neonatal care in the hospital

group whereby all high-risk women and infants were transferred to the Coombe Women & Infants University Hospital during pregnancy or after birth

- co-operative approach to service delivery to ensure that both maternity units in the hospital group provided care appropriate to the resources, facilities and services available to them
- facilitation of shared perinatal mortality and morbidity and maternal morbidity meetings where performance data from the Midland Regional Hospital Portlaoise and the Coombe Women & Infants University Hospital were shared, reviewed, considered and discussed
- alignment of policies, procedures and guidelines in the Midland Regional Hospital Portlaoise with those from the Coombe Women & Infants University Hospital where appropriate
- rotation of midwife sonographers to the Coombe Women & Infant's University Hospital to attain and maintain essential skills in ultrasonography
- attendance of midwives from the Midland Regional Hospital Portlaoise at training programmes in the Centre of Midwifery Education located on the campus of the Coombe Women & Infants University Hospital.

HIQA note and welcome the very positive developments that have been progressed to improve collaboration and cooperation between the Midland Regional Hospital Portlaoise and the Coombe Women & Infants University Hospital over the past number of years. However, notwithstanding the collaborative efforts made to date, progress on the full clinical and corporate integration of the Midland Regional Hospital Portlaoise with the Coombe Women & Infants University Hospital has not progressed in the last three years.

Previously, the 2016 follow-up review of progress achieved after HIQA's Statutory Investigation at Portlaoise[5] likewise identified many of the positive developments outlined above. That review also found that progress on the full clinical and corporate integration of the Midland Regional Hospital Portlaoise with the Coombe Women & Infants University Hospital was delayed as discussions around for overall governance responsibility and budgetary control continued. This more recent inspection found that this situation remains unchanged.

Midland Regional Hospital Portlaoise leadership, governance and management

HIQA found that Midland Regional Hospital Portlaoise had effective leadership, governance and management structures to ensure the quality and safety of the maternity service provided at the hospital.

The General Manager at the hospital had overall managerial responsibility and executive accountability for the maternity service at the hospital and reported to the Chief Executive Officer of the Dublin Midlands Hospital Group. The General Manager, Clinical Director, Director of Midwifery and Quality and Patient Safety Manager attended performance meetings, held every month with the Dublin Midlands Hospital Group where operational issues, patient safety incidents, risks and quality improvement were items on the agenda.

Clinical leads were appointed at the hospital in each of the specialities of obstetrics, anaesthesiology and paediatrics. These clinicians were appointed on a rotational basis. They provided clinical oversight in their respective specialties and were responsible for overseeing training for non-consultant hospital doctors in obstetrics, anaesthesiology and paediatrics. The Director of Midwifery was responsible for the organisation and management of midwifery services and was a member of the Hospital Management Team.

The Hospital Management Team, led by the General Manager, were responsible for ensuring that services at the hospital, including the maternity service, were delivered within the clinical and corporate governance framework established as part of the hospital group. Membership of the team included the Clinical Director, Director of Midwifery, Director of Nursing, Operations Manager and Quality and Patient Safety Manager. The team met every week to discuss the operation and management issues at the hospital and within the maternity service. Clinical outcomes, service user feedback, patient safety incidents and quality improvement initiatives were standard agenda items reviewed, considered and discussed at the meeting every week. Inspectors were informed that members of the Hospital Management Team and the Dublin Midlands Hospital Group conducted walkarounds in the hospital two times a year.

The hospital's Quality and Patient Safety Executive Committee had oversight of quality and safety in the hospital. This multidisciplinary committee was chaired by the General Manager and met every three months. Standard agenda items included patient feedback, quality assurance, clinical incidents, risks and infection prevention. The committee was responsible for the development, implementation and evaluation of quality and safety in the hospital. It had oversight of the hospital's performance and provided assurance to the Hospital Management Team on known risks. This committee was operationally accountable to the Hospital Management Team. Documentation from the Quality and Patient Safety Executive Committee meetings reviewed by inspectors showed that the level of reporting of clinical incidents in the maternity unit had declined over the last three years. This decline was not consistent with other maternity units of similar size or with similar birth rates. Hospital management who spoke with inspectors were aware of the decline and were looking

at ways to address this including increasing staff education and training on reporting of clinical incidents. This is discussed further in section 3.2.1 of this report.

The Maternity Governance Committee had oversight of the obstetric and gynaecology services provided at the hospital. This committee was chaired by the Clinical Lead for Obstetrics and Gynaecology. Membership of the committee comprised of the Clinical Director for Integration, obstetric consultants, Director of Midwifery and Quality and Patient Safety Manager. The committee met every two weeks to review and monitor performance data, clinical incidents, reports and recommendations from serious reportable events and serious incidents, audit activity, complaints, feedback from service users and risks relevant to the maternity service. This committee was operationally accountable to the Hospital Management Team.

The hospital had a statement of purpose that detailed the specific services provided at the hospital. It included the hospital's vision, mission statement, guiding values and information relating to the organisational structure of the hospital. The statement of purpose was publicly available.

Hospital management at the Midland Regional Hospital Portlaoise had identified a number of strategic priorities in their annual report of 2017 that were to be advanced to enhance the quality and safety of maternity services at the hospital. These included the:

- upgrading of facilities in the maternity unit
- recruiting midwifery, nursing staff and allied health professionals
- appointment of Clinical Midwife Specialist in bereavement
- recruiting consultants in obstetrics and gynaecology, perinatal psychiatry and perinatal pathology.

While the hospital had identified the above strategic priorities, hospital management told inspectors that the absence of any national and regional guidance and direction for the hospital had significantly impacted on the hospital's ability to develop a clear strategy for maternity services within the short, medium and long term. Again, this finding remains consistent with those findings made by HIQA in its 2016 follow-up review at the hospital.

Overall, HIQA found that the Midland Regional Hospital Portlaoise had formalised leadership, governance and management arrangements in place with clearly defined reporting structures within the maternity service and through the Dublin Midlands Hospital Group to ensure the quality and safety of the maternity service provided at the hospital. However, any strategic planning of the maternity services within the hospital is constrained by the lack of any clear national and regional guidance and direction on the services in the hospital.

Table 3 on this and the next page lists the National Standards relating to leadership, governance and management 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 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 single governance arrangement for the maternity network was not formalised or agreed and elements of the Memorandum of Understanding were yet to be fully implemented. **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. **Key findings:** While the hospital had referred to some strategic objectives for 2018 in its annual report, uncertainty regarding the future plans for the Midland Regional Hospital Portlaoise had impacted on the hospital's ability to develop a clear strategy for maternity services. **Judgment:** Substantially 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

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 5.8 Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services. **Key findings:** The hospital should continue to promote and encourage reporting of clinical incidents so that all opportunities are used to improve the safety and quality of the maternity services. **Judgment:** Substantially 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 babies accessing the maternity service. The 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

At the time of inspection the hospital did not meet the HSE's national benchmark for midwifery staffing in line with the HSE's Midwifery Workforce Planning Project.[6] The maternity unit was funded for 53 whole-time equivalent (WTE)[§] permanent midwife positions. Inspectors were informed that the maternity unit had 46 WTE midwife positions filled on a permanent basis. The hospital employed agency midwifery staff when needed and inspectors were informed that the agency staff employed in the maternity unit were familiar with the workings of the unit. The hospital was actively working to recruit additional midwives, both nationally and internationally, to fill vacant midwifery positions.

An experienced midwife shift leader was in place for each shift in the Labour Ward during and outside of core working hours.[**] However, shift leaders took a caseload when activity was high in the Labour Ward so they were not always supernumerary. Inspectors were informed that one-to-one support from a midwife was prioritised for women in labour. The Special Care Baby Unit met the recommended nursing ratios of one nurse to two babies in higher dependency care and one nurse to four babies in special care.

Outside core working hours, one nursing team comprising of three nurses were on call for the operating theatre from 20:00hrs to 08:00hrs to manage emergency surgery including caesarean section. A major trauma bypass protocol[††] was in place

[§] 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.
[**] For the purpose of this monitoring programme core working hours are considered to be 09.00am-05.00pm.
[††] A trauma bypass protocol is a protocol whereby patients involved in a major trauma are brought to a trauma unit or major trauma centre with the capacity and capability to provide appropriate treatment and care. Hospitals with a major trauma bypass protocol should have processes in place to ensure that if a person self presents

at the hospital. If a second nursing team was required out-of-hours for coinciding surgical emergencies in the operating theatre, nursing administration deployed staff from other areas in the hospital. The hospital did not audit the number of times that a coinciding surgical emergency occurred, however staff who spoke with inspectors described the occurrence as occasional. Following this inspection, the hospital should audit the number of times that a coinciding surgical emergency occurs and the capacity of the hospital to effectively manage this situation outside of core working hours. Midwifery staff rotated through the different clinical areas in the maternity unit and this enabled the redeployment of midwives familiar with the clinical areas during times of high activity. Staff who spoke with inspectors were clear about their role and responsibilities, and the reporting structure to be used if they had any concerns or issues that would impact on the provision of safe, high-quality care.

Specialist support staff

The Midland Regional Hospital Portlaoise, in line with National Standards, had sufficient numbers of trained fetal ultrasonographers to offer fetal ultrasound scans to all pregnant women attending the hospital during the first and second trimester of pregnancy. This is discussed further in section 3.1.1 of this report.

The hospital was staffed and managed so that emergency caesarean sections could be performed when required. The hospital employed a neonatal resuscitation trainer to provide training and support in neonatal resuscitation to medical, midwifery and nursing staff.

The hospital had two clinical skills facilitators for the maternity service, one for the maternity unit and one for the Special Care Baby Unit. They planned, co-ordinated and conducted regular clinical training sessions thus ensuring that medical, midwifery and nursing staff maintained essential clinical skills and competencies. Staff told inspectors that multidisciplinary practical training sessions for staff, such as clinical skills and drills in obstetric emergencies, were conducted every week in the Labour Ward, Maternity Ward and Operating Theatre Department. Clinical based scenario training skills and drills were provided each month in the Special Care Baby Unit.

2.2.2 Medical staff

Medical staff availability

Consultants in the specialities of obstetrics, anaesthesiology and paediatrics were employed in the hospital on permanent or locum contracts. Inspectors were informed that the use of locum and agency medical staff was kept to a minimum and

following a trauma requiring treatment beyond the capacity and capability of their unit, the person is stabilised and transferred to a trauma unit or major trauma centre as appropriate.

any locum or agency staff employed were familiar with the hospital. All consultants obstetricians, anaesthesiologists and paediatricians employed in the hospital were registered as specialists in their speciality with the Medical Council in Ireland. The hospital was staffed with non-consultant hospital doctors at registrar and senior house officer grade in the specialties of obstetrics and paediatrics, and registrar grade in the speciality of anaesthesiology. Rapid response teams were available on site 24 hours a day, seven days a week to attend to emergencies such as obstetric and neonatal emergencies and cardiac arrests.

Obstetrics

The hospital had approval for six WTE permanent consultant obstetrician positions. At the time of inspection, five consultant obstetrician positions were filled on a permanent basis and one was filled by a locum consultant. Two consultant obstetricians had joint appointments between the Midland Regional Hospital Portlaoise and the Coombe Women & Infants University Hospital. These consultants spent the majority of their time (equivalent to 1.3 WTE) in the Midland Regional Hospital Portlaoise where they conducted antenatal clinics and participated in the consultant on call rota. The remaining time (equivalent to 0.7 WTE) was spent in the Coombe Women & Infants University Hospital. Women transferred to the Coombe Women & Infants University Hospital were, where possible, admitted under the care of one of the two consultants with joint appointments. The six consultant obstetricians were supported by 12 non-consultant hospital doctors in obstetrics, one at specialist registrar grade, five at registrar grade and six at senior house officer grade.

At the time of inspection, a consultant obstetrician was rostered to be on call for the Labour Ward Monday to Friday, during core working hours but this person was not always free from other duties as they also covered outpatient clinics.

A rota of two non-consultant hospital doctors in obstetrics, one at registrar grade and one at senior house officer grade was in place in the Labour Ward twenty-four hours a day, seven days a week.

Outside core working hours, the hospital had an on-call rota where one consultant obstetrician was on call off site, unless attendance was needed at the hospital, one in every five nights. The two non-consultant hospital doctors were on call onsite in the hospital.

Obstetric anaesthesiology

National Standards recommend that specialised birth centres have resident on-call non-consultant hospital doctors in anaesthesiology and a dedicated obstetric anaesthetic service.[1] Three WTE consultant anaesthesiologists were employed at the

hospital. All three consultant anaesthesiologist positions were filled on a permanent basis. A consultant anaesthesiologist with experience in obstetric anaesthesia led the obstetric anaesthetic service at the hospital. The anaesthetic team worked to respond to obstetric emergencies and calls from the Labour Ward in a timely manner. The three consultant anaesthesiologists were supported by six non-consultant hospital doctors in anaesthesiology at registrar grade.

Outside core working hours the anaesthetic team on call at the hospital was responsible for the provision of care in the Intensive Care Unit, the Emergency Department, general wards, the Operating Theatre Department for both general and obstetric cases and epidural anaesthesia for women in labour.

Inspectors were informed that the on-call rota outside core working hours for doctors in anaesthesiology at the hospital comprised of one consultant anaesthesiologist and two non-consultant hospital doctors usually, one at registrar grade and one at senior house officer grade. Consultant anaesthesiologists were on call off site, unless attendance was needed at the hospital, one in every three nights. The registrar in anaesthesiology was on site in the hospital for the duration of the on-call shift and the second non-consultant doctor in anaesthesiology was in the hospital until midnight.

Inspectors found that anaesthesiology 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.[7] These recommendations specify that there should be enhanced anaesthesia cover with two consultant anaesthesiologists and two non-consultant hospital doctors on call outside core working hours to manage two concurrent emergencies requiring an immediate and sustained response. Hospital management and the anaesthetic team reviewed and assessed the risk associated with anaesthesiology staffing levels in the hospital outside core working hours and had determined that clinical activity levels in the hospital were not sufficient to warrant a second non-consultant doctor at senior house officer or registrar grade in the hospital during these hours. However, it was determined that a second registrar in anaesthesiology was needed in the hospital until midnight and this rota was implemented. Hospital management should consider the sustainability of a 1:3 on call rota for consultant anaesthesiologists going forward.

Paediatrics

Senior clinical decision makers in paediatrics were available in the hospital 24 hours a day, seven days a week. Care of babies in the hospital was shared by four WTE consultant paediatricians. Three consultant paediatrician positions were filled on a permanent basis and one was filled by a locum consultant. Two consultant neonatologists from the Coombe Women & Infants University Hospital were onsite at

the Midland Regional Hospital Portlaoise for 16 weeks of the year whereby they provided support and advice to the paediatric team in the Special Care Baby Unit, assisted in the training and supervision of non-consultant doctors in paediatrics and supported the standardisation of policies, procedures and guidelines for neonatal care in the unit. The four consultant paediatricians were supported by 15 non-consultant hospital doctors in paediatrics, one at specialist registrar grade, six at registrar grade and eight at senior house officer grade.

Outside core working hours, the hospital had a rota where one consultant paediatrician was on call off site, unless attendance was needed at the hospital, one in every four nights. Three non-consultant hospital doctors, two at registrar grade and one at senior house officer grade, were on call onsite in the hospital from 17:00-24:00hrs. Thereafter, two non-consultant hospital doctors, one at registrar grade and one at senior house officer grade, were on call onsite in the hospital from 22:00-08:00hrs. Hospital management should consider the sustainability of a 1:4 on-call rota for consultant paediatricians going forward.

Medical, midwifery and nursing staff who spoke with inspectors confirmed that all consultants in the speciality of obstetrics, anaesthesiology and paediatrics were accessible during and outside core working hours.

National Standards recommend that staffing levels are maintained at adequate and nationally accepted levels to meet service need and that workforce planning takes into account annual leave, study leave, maternity leave and sick leave. Inspectors were informed by hospital management that despite continually campaigning to recruit staff, the hospital had experienced difficulty in recruiting and retaining midwives, consultant obstetricians and paediatricians. The uncertainty of the future and range of services to be provided at the hospital impacts on the hospital's ability to attract and retain permanent staff. The HSE and Dublin Midlands Hospital Group should ensure that the hospital is supported to address these challenges so as to ensure the safety and quality of the maternity service at the hospital.

2.2.3 Training and education of multidisciplinary staff

Mandatory training requirements

The hospital had defined mandatory training requirements for all midwifery, nursing and medical staff. Medical staff in obstetrics were required to undertake multidisciplinary training in the management of obstetric emergencies and fetal monitoring every two years. In addition, medical staff in obstetrics received training in the Irish Maternity Early Warning System and sepsis screening when starting employment in the hospital. These medical staff were expected to attend update sessions and workshops on the Irish Maternity Early Warning System and sepsis when scheduled. Medical staff in paediatrics were required to undertake training in

neonatal resuscitation prior to staffing the on call paediatric rota and every two years thereafter.

Midwifery and nursing staff were required to undertake training in neonatal resuscitation and basic adult resuscitation every two years. Midwives were also required to undertake multidisciplinary training in the management of obstetric emergencies and fetal monitoring every two years. Nurses in the Special Care Baby Unit were required to undertake training and education relevant to the post resuscitation/pre-transport stabilisation care of sick babies (S.T.A.B.L.E. programme[‡‡]) every two years. All midwives and nurses received training in the Irish Maternity Early Warning System and sepsis screening when starting employment in the hospital. All midwifery and nursing staff were expected to attend update sessions and workshops on Irish Maternity Early Warning System and sepsis when scheduled. Multidisciplinary caesarean section review meetings were held in the hospital every week[8] and cardiotocography tracings were reviewed at these meetings.[9,10]

Uptake of mandatory training

Training records were stored electronically and were accessible by all clinical midwife and nurse managers in the clinical areas inspected.

Training records reviewed by inspectors showed that 90% of midwives and 70% of medical staff in obstetrics were up to date with fetal monitoring training. Ninety percent of medical staff in paediatrics and 57% of midwives were up to date with training in neonatal resuscitation. All nursing staff in the Special Care Baby Unit were up to date with training in neonatal resuscitation. All medical staff in obstetrics and 71% of midwives were up to date with multidisciplinary training in the management of obstetric emergencies. All medical staff, 88% of nursing staff and 78% of midwifery staff were up to date with training in basic life support.

Hospital management should ensure that all midwifery, nursing and medical staff are facilitated to undertake mandatory and essential training, appropriate to their scope of practice in line with National Standards.

Orientation and training of new staff

New staff employed at the hospital were provided with a comprehensive, corporate and specialty specific orientation and induction. A three day orientation and induction programme was conducted for non-consultant hospital doctors in January and July of

[‡‡] The National Neonatal Transport Programme conducts the S.T.A.B.L.E. programme in maternity hospitals nationally. It is an education tool developed for healthcare providers to organise care during post resuscitation/pre-transport stabilisation period. The aim of the programme is to enhance the knowledge and skills of all staff involved in providing care to the sick infant following resuscitation with a focus on Sugar, Temperature, Artificial breathing, Blood pressure, Lab work and Emotional support.

each year. Information packs were provided for non-consultant hospital doctors in the speciality of paediatrics.

Other training and education opportunities for staff

The hospital was recognised as a clinical training site for undergraduate and higher specialist training for doctors in the specialties of obstetrics. Inspectors were informed that hospital had signed a Memorandum of Understanding with the School of Nursing and Midwifery, Trinity College Dublin in October 2018 and it was anticipated that the hospital would become a clinical training site for undergraduate midwifery training from September 2019. In addition, paediatric registrars on the specialist training programme would be rostered to the hospital from 2020.

Non-consultant doctors informed inspectors that they received good support from consultants in all specialities and that they had no hesitation about contacting the consultant on call to discuss a clinical case or to seek advice and support.

Inspectors were informed that midwives rotated between the Labour Ward and Maternity Ward which helped them maintain essential clinical skills and competence appropriate to their scope of practice. Midwife sonographers rotated to the Coombe Women & Infants University Hospital to attain and maintain essential skills for ultrasonography.

Table 4 on the next page 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:** This inspection found staffing deficiencies in relation to midwifery and consultant positions in anaesthesiology and paediatrics at the hospital. **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 midwifery and medical staff were up to date with mandatory training requirements. **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 of the National Standards in relation to Effective Care and Support and Safe Care and Support. Of these, the Midland Regional Hospital Portlaoise was compliant with seven National Standards, substantially compliant with two National Standards, partially 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

The Midland Regional Hospital Portlaoise provided a range of general and specialist maternity services for women with normal 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

The hospital had confirmed pathways for the assessment, management and admission of pregnant and postnatal women presenting with obstetric complications 24 hours a day, seven days a week. This ensured that women who were at risk of developing complications during pregnancy, at birth and in the postnatal period were cared for in the most appropriate setting. Assessment services for pregnant and postnatal women included:

- Medical-led antenatal clinics
- Maternity Assessment Unit
- Early Pregnancy Assessment Unit.

At the time of the inspection, the hospital manager informed inspectors that a supported care pathway[§§] for normal risk women was being developed as outlined in the National Maternity Strategy. All pregnant women who attended the hospital for their first antenatal appointment were risk assessed by a consultant obstetrician. Women at high risk of developing complications and those who had complex obstetric or medical needs were identified and care was planned by the multidisciplinary team and provided in the most appropriate setting.

The hospital had a Maternity Assessment Unit where women of any gestation who presented to the hospital outside of scheduled appointments with suspected complications were reviewed and assessed by the obstetric team. The unit was open 24 hours a day, seven days a week and had clear documented pathways. Women were referred to the unit by their general practitioner, self-referral or obstetric team. The unit was staffed by one midwife supported by the multidisciplinary team.

The Early Pregnancy Assessment Unit provided a service for pregnant women of all gestations requiring assessment and evaluation of fetal and maternal wellbeing. The

[§§] This care pathway is intended for normal-risk women and babies, with midwives leading and providing care within a multidisciplinary framework. Responsibility for the co-ordination of a woman's care is assigned to a named Clinical Midwife Manager, and care is provided by the community midwifery team, with most antenatal and postnatal care being provided in the community and home settings. The woman can exercise a choice with her healthcare professional with regard to the birth setting, which may be in an Alongside Birth Centre in the hospital, or at home.

Early Pregnancy Assessment Unit was open Monday to Friday from 09.00hrs to 17:00hrs. Women were referred to the unit by their general practitioner or obstetric team. The unit was staffed by one midwife and one clinical midwife specialist in sonography who were supported by the multidisciplinary team. Routine and emergency pregnancy ultrasound scans were conducted by the clinical midwife specialist during core working hours. Inspectors were informed that if a woman needed an ultrasound scan outside of core working hours, it was performed by the on call consultant obstetrician or obstetric registrar who had completed the required training in ultrasound scanning. If not urgent, it was performed the following day by the ultrasonographer in the Early Pregnancy Assessment Unit.

Since late 2017, the hospital provided access to fetal ultrasound scanning services in accordance with the intervals outlined in the National Standards. Ultrasound scans were conducted by midwives trained in ultrasonography. There was an agreed pathway in place with the Coombe Women & Infants University Hospital whereby women with a suspected fetal anomaly were referred to a fetal medicine specialist in the Coombe Women & Infants University Hospital.

Admission pathways

There were established pathways for the assessment, management and admission of pregnant and postnatal women who attended the hospital with obstetric complications 24 hours a day, seven days a week. Pregnant women of any gestation and postnatal women, who presented to the hospital outside of scheduled appointments or as an emergency, during or outside core working hours, were referred to the Maternity Assessment Unit where they were reviewed and assessed by a midwife and a senior member of the obstetric team at or above registrar grade.

The hospital had arrangements in place for the assessment of pregnant and postnatal women who presented to the Maternity Assessment Unit with surgical or medical conditions unrelated to pregnancy. As the maternity unit was co-located within a general hospital, pregnant or postnatal women who presented with a surgical or medical condition unrelated to pregnancy were referred to medical or surgical specialists in the general hospital. All pregnant and postnatal women who presented to the Emergency Department were reviewed by a member of the obstetric team at registrar grade or above.

Women who required complex or specialist maternity care and those who presented with or developed significant medical conditions and complications such as intrauterine growth restriction and preterm birth less than 32 weeks gestation were transferred to the Coombe Women & Infants University Hospital for specialist care.

3.1.2 Access to specialist care and services for women and newborns

Access to clinical specialists

Women booked for maternity care in the Midland Regional Hospital Portlaoise with a history of diabetes mellitus were referred by obstetric team at their first antenatal appointment to a combined obstetric and specialist clinic in endocrinology. This clinic comprised of consultant obstetricians, endocrinologist, clinical midwife specialist in diabetes and a dietician. In 2017, 840 women attended the gestational diabetic/endocrine clinic.

Specialised consultants available in the maternity unit included endocrinology, cardiology, respiratory and psychiatry.

General surgeons were accessible in the general hospital. Fetal medicine, perinatal and pathology services were available and accessed through the Coombe Women & Infants University 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 providing pain relief such as epidural anaesthesia for women in labour and anaesthesia for women who require caesarean section and other surgery during and post birth.

The obstetric anaesthesiology service at the hospital was led by a consultant anaesthesiologist. This person was responsible and accountable for the organisation and management of the obstetric anaesthesiology service in the hospital. Consistent with guidelines[11] and the National Standards, the anaesthetic team were given sufficient notice of women at high risk of potential complications. An anaesthetic pre-assessment clinic, facilitated by a consultant anaesthesiologist and nurse, was held every week for pregnant women who presented with risk factors for anaesthesia or with a history of previous complications during anaesthesia. In accordance with best practice recommendations, a safe surgery checklist[†††12] was used for all elective and emergency surgical procedures in the hospital's operating theatres and compliance with the checklist was audited.

[***] 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.
[†††] 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.

Critical care

The National Standards recommend that specialised birth centres have a high-dependency or observation unit to manage the clinically deteriorating woman.

The maternity unit had an observation unit, comprising of one bed, located in the Labour Ward where women requiring close observation and monitoring before, during and after birth were cared for. Critical care facilities at the hospital included a level 2 High Dependency Room[‡‡‡]. The hospital had formal arrangements in place for the transfer of pregnant or postnatal women who required intensive or high dependency care to the High Dependency Room. Inspectors were informed that the admission of these women was prioritised and there was no reported delay transferring women needing high dependency care. Documentation reviewed by inspectors showed that in the first three months of 2019 (January-April) a small number of women were transferred for critical care.

Women who required more specialised critical care in a level 3 Intensive Care Unit[§§§] were transferred to a model 4 general hospital in the Dublin Midlands Hospital Group. Midwives from the Labour Ward worked closely with staff in the High Dependency Room to ensure that midwifery care was provided to all pregnant and postnatal women admitted to the unit. Documentation reviewed by inspectors showed that in 2018, 20 pregnant or postnatal women were admitted to the High Dependency Room in the hospital or another general hospital for more specialised critical care.

The Irish Maternity Early Warning System was used to assess, monitor and detect clinical deterioration in pregnant and postnatal women. The use of the Irish Maternity Early Warning System was audited at the hospital. Inspectors were informed that when a woman's clinical condition deteriorated or the parameters of the Irish Maternity Early Warning System triggered, the woman was reviewed by members of the obstetric team at senior house officer or obstetric registrar grade.

Neonatal care

The hospital had a level 1 regional Special Care Baby Unit which provided high dependency and special care for babies born at or greater than 32 weeks gestation, and sick babies born at term. Babies requiring more specialist care were transferred to the Coombe Women & Infants University Hospital.

‡‡‡ Level 2 critical care is described as the active management by the critical care team to treat and support critically ill patients with primarily single organ failure.
§§§ 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.

Women at risk of preterm birth less than 32 weeks gestation were transferred to the Coombe Women & Infants University Hospital or another tertiary maternity unit outside the hospital group if a neonatal cot was not available in the Coombe Women & Infants University Hospital. Documentation reviewed by inspectors showed that 12 women were transferred to the Coombe Women & Infants University Hospital during pregnancy in the first five months of this year. Reasons for transfer included preterm pre-labour rupture of membranes, small babies and pre-eclampsia. The hospital had an up-to-date guideline that guided the transfer of pregnant women to another hospital in and outside the hospital group.

In line with the National Model of Care for Neonatal Services,[13] premature babies born less than 32 weeks gestation at the Midland Regional Hospital Portlaoise were stabilised and transferred soon after birth to a tertiary maternity hospital with a level three Neonatal Intensive Care Unit. The National Neonatal Transport Programme was used when transferring these babies.

Newborns that required therapeutic cooling[****] for neonatal encephalopathy[††††] had passive cooling commenced at the hospital and they were then transferred to the Coombe Women & Infants University Hospital for therapeutic cooling. The hospital provided ongoing care for babies transferred from the Coombe Women & Infants University Hospital or another level three Neonatal Intensive Care Unit.

Communication

The hospital had formal arrangements in place for clinical handover among midwifery, nursing and medical staff in all the clinical areas inspected. Inspectors observed that the clinical areas inspected used communication books to disseminate and share information. Information was shared using the Identify-Situation-Background-Assessment-Recommendation communication tool.[‡‡‡‡] Clinical handover was also used to provide feedback on any clinical incidents, midwifery and multidisciplinary meetings including the perinatal mortality and morbidity meetings.

Safety huddles[§§§§14] were conducted daily in the Special Care Baby Unit, Labour Ward and Maternity Ward. Staff informed inspectors that a variety of issues relating to activity, new admissions, social concerns, new guidelines or policies and safety issues were discussed during the daily huddle.

[****] 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. WBNC is provided in the large tertiary maternity hospitals in Dublin and Cork.
[††††] Neonatal encephalopathy, also known as neonatal hypoxic-ischemic encephalopathy, is defined by signs and symptoms of abnormal neurological function in the first few days of life in a baby born at term.
[‡‡‡‡] The ISBAR (Identify -Situation-Background-Assessment-Recommendation) technique is a way to plan and structure communication. It allows healthcare staff an easy and focused way to set expectations for what will be communicated and to ensure they get a timely and appropriate response.
[§§§§]Safety huddles involving the multidisciplinary team when used improve communication, situational awareness, and care for women and babies.

The hospital had a clear process in place to inform midwifery, nursing and medical staff of external and internal safety alerts relating to medications and medical equipment. All information about safety alerts were shared at clinical handover and documented in ward communication books.

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. At the time of inspection, there was an established procedure for requesting the attendance of a designated response teams for obstetric and neonatal emergencies. A multidisciplinary response team were called for an emergency using either the telephone system or activating the red button alarm system located in the Maternity Ward, Operating Theatre Department and Special Care Baby Unit. Staff in the clinical areas inspected were very clear about the procedure to be used in an obstetric or neonatal emergency.

The on-call consultant anaesthesiologist, obstetrician and paediatrician were contacted to attend for all obstetric and neonatal emergencies. Staff who spoke with inspectors stated that the response times for an obstetric or neonatal emergency were appropriate. However, emergency response times were not audited at the hospital. Following this inspection, the hospital should audit the timeliness and effectiveness of the emergency response systems to provide assurance that the hospital can provide an effective timely response to obstetric and neonatal emergencies.

Multidisciplinary handover

There were formal arrangements in place for multidisciplinary clinical handover. A multidisciplinary handover was held every day in the Maternity Ward at 09:00hrs. Inspectors were informed that a range of clinically relevant topics were discussed at handover including the activity in the Labour Ward and Maternity Ward, admissions to the maternity unit in the previous 24 hours, pregnant and postnatal women at risk of complications, maternity related transfers in and out of the hospital and staffing issues. The anaesthetic or paediatric teams did not attend the multidisciplinary clinical handover. It is important that the huddle is multidisciplinary involving input from obstetric, anaesthetic, paediatric, midwifery, operating theatre and support staff. Following this inspection, the hospital should review the arrangements in place for multidisciplinary clinical handover to ensure that all specialities involved in the care of pregnant and postnatal women share information to identity potential clinical concerns and to improve the safety of care provided in the maternity unit.

Inspectors were informed that the on-call consultant obstetricians conducted daily ward rounds with members of the obstetric team in the Labour Ward and Maternity

Ward during and outside of core working hours including Saturdays, Sundays and public holidays. The consultant obstetricians not on call also conducted ward rounds every day to review women they were clinically responsible for.

Other findings relevant to communication

The Midland Regional Hospital Portlaoise had a clear guideline detailing when on call consultant obstetricians should attend at birth. Consultant obstetricians attended if there was a maternal collapse, caesarean section, preterm birth less than 32 weeks gestation, haemorrhage, breech presentation, all seriously ill women and all cases of severe eclampsia and pre-eclampsia.

Medical and midwifery staff who spoke with inspectors said that they would have no hesitation about contacting a consultant if they had concerns about the wellbeing of a woman or baby or when advice or additional support was needed. The hospital had an agreed process for staffing an operating theatre for emergency surgery during and outside core working hours. Contingency plans were in place to manage two coinciding emergencies 24 hours a day, seven days a week.

During the inspection, inspectors observed how a number of white boards were used in the designated obstetric theatre to record information for the clinicians during an obstetric emergency case and facilitated the sharing of information as the case was progressing. This is a practice to be commended.

3.1.4 Written policies, procedures and guidelines

The hospital had a number of policies, procedures and guidelines in relation to obstetric emergencies, for example major obstetric haemorrhage, shoulder dystocia, umbilical cord prolapse and pre-eclampsia. The hospital implemented National Clinical Effectiveness Committee[*****]guidelines relating to sepsis, clinical handover in maternity services and the Irish Maternity Early Warning System. Policies, procedures and guidelines developed by the HSE such as umbilical cord prolapse were also implemented.

The hospital, where possible, aligned their clinical policies, procedures and guidelines with those used in the Coombe Women & Infants University Hospital. The hospital's policies, procedures and guidelines committee had oversight of policies, procedures and guidelines developed in the hospital. All policies, procedures and guidelines were ratified by the Maternity Governance Committee.

Policies, procedures and guidelines were available in hard copy and electronically through the hospital's intranet system in the clinical areas visited by inspectors and

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

staff could readily access them. The hospital did not use a controlled document management system. However, six of the policies, procedures and guidelines viewed by inspectors during inspection were out-of-date. Following this inspection, the hospital should ensure that all policies, procedures and guidelines available to staff are up to date.

3.1.5 Maternity service infrastructure, facilities and resources

Assessment Areas

The maternity service was in the main located on the second floor of the hospital. All women attending the maternity unit outside of scheduled appointments presented to the Maternity Assessment Unit on the second floor. This unit comprised of three single rooms. Inspectors observed that space in the unit was limited and staff told inspectors that providing care in such a confined space was a challenge. There were no clean or dirty utility facilities within the unit and also a lack of space to store essential equipment such as adult resuscitation equipment. The maternal emergency resuscitation trolley was located on the main corridor of the Maternity Ward. The waiting area was small and resulted in women waiting in corridors when the unit was busy. In the absence of appropriate facilities in the Maternity Assessment Room, urinalysis and HCGs testing,[†††††] were undertaken in the room where the women were assessed. This is not in line with best practice.

Antenatal and postnatal ward

Care was provided to antenatal and postnatal women and babies in the Maternity Ward. The Maternity Ward consisted of 28 beds with the equivalent number of baby cots. The ward comprised of four three-bedded rooms, a seven-bedded room, eight single rooms and one bereavement room. One three-bedded ward was converted to a two bedded room for the women having an induction of labour. On the day of the inspection there were 24 women and five babies in the ward, equating to an occupancy rate of 83%. While the Maternity Ward and bathroom facilities had been recently refurbished, multiple infrastructural deficiencies were observed at the time of the inspection. For example, there were seven beds in a room designed for six, and the three-bedded rooms looked cluttered. This was discussed with the hospital's management team at the time of the onsite inspection and inspectors were told that the seventh bed would be removed from the six-bedded room that day. Overall, the design and physical infrastructure in the Maternity Ward did not meet recommended design and infrastructural specifications needed to provide safe, high-quality care in a modern maternity service.[15]

[†††††] Human chorionic gonadotropin (hCG) testing is done to check for the hormone hCG in blood or urine. The test is used to determine if a woman is pregnant.

Labour ward

The Labour Ward comprised of four single birthing rooms. If a woman's condition warranted close observation, one of these rooms was used as an observational unit. Women who required higher level of monitoring and observation were cared for in the observational unit. None of the birthing rooms had en-suite toilet or shower facilities. Modern delivery rooms should all be single occupancy with en-suite facilities. Overall, although spacious enough to manage a maternal or neonatal emergency, the physical infrastructure and environment in the Labour Ward did not meet recommended design and infrastructural specifications needed to provide safe, high-quality care in a modern maternity service.[15]

Operating theatres for obstetrics and gynaecology

There was 24-hour access to an operating theatre at the Midland Regional Hospital Portlaoise. The Operating Theatre Department was not adjacent to the Labour Ward so was not in line with the National Standards. The three operating theatres were located on the first floor of the hospital. The Operating Theatre Department had a designated theatre manager who was responsible and accountable for the department. Elective operating procedures were conducted in two of the three operating theatres Monday to Friday. The third operating theatre was kept free during and outside core working hours for emergencies including obstetric emergencies. Inspectors observed there was sufficient space in each operating theatre to attend to women and babies during an emergency. Access to the Operating Theatre Department was via a lift situated on the main corridor of the Maternity Ward. During emergency situations there was no override key for this lift. Staff informed inspectors there were no difficulties encountered when accessing a lift in the case of an emergency.

The hospital had conducted drills on transferring a woman to the operating theatre from the Labour Ward and Maternity Ward. The hospital did not audit the timeline between a decision to conduct an emergency caesarean section and actual birth of the baby (decision to deliver interval) but hospital management informed inspectors there were no concerns regarding the decision to delivery interval. Following this inspection, the hospital should audit the time from decision to conduct an emergency caesarean section to the actual birth of the baby as part of their clinical audit plan.

Special Care Baby Unit

The hospital had a Level 1 Special Care Baby Unit that provided special care to babies greater than 32 weeks gestation and sick babies at term. The unit had capacity for eight cots which included one isolation cot, two high dependency cots and five special care cots. On the day of inspection there were four babies in the Special Care Baby Unit.

Laboratory services

Blood and blood replacement products were accessible when required in an emergency for women and babies. Microbiology and haematology services were available during and outside core working hours, at weekends and public holidays.

3.1.6 Maternity service equipment and supplies

Emergency resuscitation equipment for women and babies was available in the clinical areas inspected. The Labour Ward, Maternity Ward and Maternity Assessment Unit were located on the same floor proximal to each other. Maternal emergency resuscitation equipment and neonatal resuscitaires were shared between the three clinical areas. During inspection, inspectors observed the following:

- One maternal emergency resuscitation trolley was shared between the three clinical areas of Labour Ward, Maternity Ward and Maternity Assessment Unit. This trolley was located on the main corridor of the Maternity Ward. Successful resuscitation is influenced by the timely access to appropriate equipment.[16] Following this inspection, hospital management should review and assess procedures for ensuring the adequate provision of resuscitation equipment in all clinical areas.
- Each birthing room in the Labour Ward had a neonatal resuscitaire. The Maternity Ward had access to two neonatal resuscitaires. One was located in the Maternity Assessment Unit and the other was positioned in the lactation room located in the Labour Ward, accessible via swipe access door. In the event of a neonatal collapse, staff in the Maternity Unit reported that they used the equipment located in the lactation room. If staff exited the Maternity Ward to use the neonatal resuscitaire in the Maternity Assessment Unit this activated the baby tagging system so it was not the chosen location during a neonatal emergency. Following this inspection, the hospital needs to review the position and location of neonatal resuscitaires.

Inspectors observed that the contents of resuscitation trolleys, defibrillators and suction machines were checked daily. Checklists reviewed by inspectors confirmed that emergency equipment was checked but inspectors observed a small number of emergency equipment checklists were not being checked daily in line with hospital policy.

Emergency supplies and medications were available to manage obstetric emergencies such as haemorrhage, eclampsia and neonatal resuscitation in all the clinical areas inspected. Fetal monitoring equipment including cardiotocography machines viewed by inspectors were labelled to indicate that they had been serviced.

Inspectors observed that the oxygen and suction points in the Maternity Ward did not have essential equipment such as tubing and oxygen masks readily available at the point of care. Following this inspection, the hospital should review the availability and accessibility of maternal emergency resuscitation equipment, neonatal resuscitaires, tubing and oxygen to ensure such equipment is readily available in the case of an obstetric and neonatal emergency.

Safety initiatives such as the availability of a difficult intubation trolley were observed by inspectors in the Operating Theatre Department.

Table 5 on this and 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.

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:** One adult resuscitation trolley shared among the Maternity Assessment Unit, Labour Ward and Maternity Ward. An anaesthesiologist is not immediately available 24/7 for emergency work on the delivery suite outside core working hours. **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

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 2.4 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 hospital had an outdated physical infrastructure that did not meet recommended design and infrastructural specifications for modern maternity services. **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 babies, 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 Midland Regional Hospital Portlaoise had systems in place to identify and manage risks. Clinical staff used the HSE risk assessment forms to document identified risks and the controls implemented to mitigate the risks. Risks in relation to the maternity service and agreed risk control measures were recorded on local and corporate risk registers. The corporate risk register was reviewed and updated quarterly by hospital management. Risks that could not be managed at hospital level were escalated to the Dublin Midlands Hospital Group.

Inspectors reviewed the hospital's corporate risk register. The risk register detailed the impact of the risks identified, existing control measures in place to limit the impact of the risk and associated actions required to mitigate against the risk. Identified risks were rated as high, medium or low.

Risks recorded in the hospital's corporate risk register relevant to this monitoring programme included risks associated with the:

- recruitment and retention of staff including medical staff, midwives, nurses and social worker
- age of the hospital and the suitability of the infrastructure for the provision of maternity and neonatal services
- lack of a dedicated operating theatre in or adjacent to the maternity unit
- lack of a structured governance arrangement with a tertiary maternity unit
- lack of information and communication technology support, 24 hours a day, seven days a week.

The hospital was engaged in a continuous recruitment campaign at a national and international level to address the risks in relation to midwifery and nursing shortages

for the maternity unit and Special Care Baby Unit. Overtime and redeployment of staff, where appropriate, was also undertaken by hospital management. Funding for a second social worker at the hospital was also sought from the Dublin Midlands Hospital group to increase social worker provision at the hospital.

The infrastructure of the maternity unit as stated previously was not in line with recommended guidelines.[15] The hospital had completed some refurbishments in the maternity unit and had escalated this risk to the Dublin Midlands Hospital Group. There was no agreed funding or time frame for any further redevelopment of the infrastructure.

The hospital had implemented some controls to mitigate the risk of not having a dedicated operating theatre in or adjacent to the maternity unit. These included the use of an override key and conducting drills to the operating theatre to determine the actual time it takes and practical issues associated with getting to the operating theatres located on the first floor of the hospital.

The lack of a structured governance arrangement with a tertiary maternity unit and lack of information and communication technology support, 24 hours a day, seven days a week where risks the hospital had escalated to the Dublin Midlands Hospital Group.

Clinical incident reporting

Inspectors found that there was an established system for reporting clinical incidents. Clinical staff used the National Incident Management System[‡‡‡‡‡] form to report clinical incidents. Staff who spoke with inspectors described the process for reporting clinical incidents and all were aware of their responsibility to report such incidents.

The hospital collated and analysed trends in the reporting of clinical incidents in the maternity unit. The Hospital Management Team and Quality and Patient Safety Executive Committee had oversight of the clinical incidents in the hospital. Documentation reviewed by inspectors showed that the level of reporting of clinical incidents had declined over the last three years. In 2016, the maternity unit reported 212 incidents to the National Incident Management System, 68 incidents were reported in 2017 and 78 incidents were reported in 2018. This decline in reporting of clinical incidents between 2017 and 2018 was not consistent with other maternity units of similar size or birth rates. At the time of inspection, hospital management were unable to provide a reason for the decline in the level of reporting of clinical incidents. Given the known association between higher levels of incident reporting

[‡‡‡‡‡] The National Incident Management System is a system where incidents are report annually. The system is used to improve patient and service user experience.

and a positive patient safety culture,[17,18,19,20] hospital management should explore why the reporting of incidents have declined and should implement initiatives to strengthen incident reporting in the maternity unit if needed.

All serious incidents were reviewed by the hospital's newly established Serious Incident Management Team. The Serious Incident Management Team and Hospital Management Team had oversight of all serious incidents that occurred in the hospital. Staff informed inspectors that feedback from review of clinical incidents was shared and discussed with staff in the clinical areas inspected.

Documentation reviewed by inspections provided examples on how learning and practice change had occurred following serious incidents, serious reportable events, and clinical incidents. This included the establishment of referral pathways with the Coombe Women & Infants University Hospital for urgent neonatal cases.

Feedback from women

The hospital had a formalised process to monitor compliments and respond to complaints received from women who used the maternity service. Women's complaints and feedback were reviewed and discussed at the Quality and Patient Safety Executive Committee and Executive Management Team meetings. Documentation reviewed by inspectors showed that complaints regarding the maternity service were managed within the timeframe of 30 days as specified in the 'Your service, Your say' guideline.[21]

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 HSE's Office of the National Women and Infants Health Programme and the National Clinical Programme for Obstetrics and Gynaecology.[22] This information also allows individual maternity units and maternity hospitals to benchmark performance against national rates over time.

The hospital, through the Hospital Management Team and the Quality and Patient Safety Executive Committee, proactively monitored, analysed and responded to information from multiple sources including serious reportable incidents, incident reviews, legal cases, risk assessments, complaints, audits and patient experience surveys to be assured about the effectiveness of the maternity service. The Irish Maternity Indicator System data was reviewed at the hospital management and operations meeting held every week; maternity governance meeting held every two weeks and the Quality and Patient Safety Executive Committee meetings held every quarter.

The hospital compared and benchmarked their performance against national rates for a variety of metrics. The hospital collected and published data every month on the 17 metrics included in the Maternity Patient Safety Statements.[§§§§§] This data measured clinical activity, major obstetric events, mode of birth and clinical incidents. The hospital used the Robson 10-Group Classification[******] for assessing, monitoring and comparing caesarean sections rates in the hospital and with other maternity hospitals and units.

Hospital management informed inspectors that the hospital's performance data including data submitted for the Irish Maternity Indicator System, National Perinatal Epidemiology Centre[††††††] and, where relevant, Vermont Oxford Network[‡‡‡‡‡‡] were reviewed, considered, discussed and compared with similar data from the other similar sized maternity units at the multidisciplinary perinatal mortality and morbidity meeting. Actions on key performance indicators such as caesarean section rates, maternal transfers to a level 2 or 3 critical care unit, neonatal metrics, infection control rates, serious reportable events and medication incidents were reported and discussed at the hospital's Quality and Patient Safety Executive Committee meeting.

Clinical audit

The hospital had a comprehensive clinical audit plan. Planned audits were included in the annual clinical audit plan and were overseen by the Clinical Audit Co-ordinator and the Quality and Patient Safety Department. Audits were completed by medical, midwifery and nursing staff and followed a prescribed structure. The audit report template identified the action plans to address any opportunities for improvement and learning in practice. Clinical audit reports were presented and discussed at the hospital's Quality and Patient Safety Executive Committee meeting.

Audits completed in 2018, relevant to this monitoring programme included:

- clinical handover
- Irish Maternity Early Warning System
- postpartum haemorrhage
- sepsis.

[§§§§§] The Maternity Patient Safety Statement (MPSS) contains information on 17 metrics covering a range of clinical activities, major obstetric events, modes of delivery and clinical incidents that are reported on by each of the 19 maternity hospitals or units and published each month on the Health Service Executive (HSE) website.
[******] The Robson classification is a system of classifying birth into 10 groups based on five obstetric characteristics that are routinely collected in all maternity hospital and units (parity, previous caesarean section, gestational age, onset of labour, fetal presentation and the number of fetuses).
[††††††] The National Perinatal Epidemiology Centre conducts on-going national audits of perinatal mortality, maternal morbidity and home births in Ireland.
[‡‡‡‡‡‡] The Vermont Oxford Network is a voluntary collaborative group of health professionals committed to improving the effectiveness and efficiency of medical care for newborn infants and their families through a coordinated program of research, education, and quality-improvement projects.

An audit ascertaining compliance with the national guideline on clinical handover conducted in the hospital in 2018 found that while there was good compliance with the guideline, some improvement was required in relation to recording all baseline observations and the inclusion of safety pause in the handover process. Following the audit, the hospital provided updated education to midwifery and medical staff on clinical handover. The hospital needs to ensure that this audit is repeated to ascertain if improvement has been achieved.

Another audit conducted in 2018 to determine compliance with the national guideline on postpartum haemorrhage found that cases of massive obstetric haemorrhage were managed appropriately in the maternity unit and all incidents of postpartum haemorrhages were reported as clinical incidents via the incident reporting system. Following the audit, the hospital provided updated education to midwifery and medical staff in obstetric to achieve and ensure consistency in the measurement of blood loss in the operating theatre and labour ward and developed a guideline and template to support consistent practice in measuring blood loss. The hospital needs to ensure that this audit is repeated to ascertain if consistency in measuring blood loss within the operating theatre and labour ward has been achieved.

Feedback on audit results was provided to staff in the clinical areas via the communication books and information notice boards.

Audits planned for 2019 included:

- clinical handover
- massive obstetric haemorrhage
- decision to delivery interval
- Robson group for caesarean section
- Irish Maternity Early Warning System
- sepsis.

Annual clinical report

The hospital published an annual report which provided a description of the maternity service provided at the hospital, service activity, maternal and neonatal outcomes and quality improvement initiatives.

Maternal and perinatal morbidity and mortality multidisciplinary meetings

Multidisciplinary perinatal mortality and morbidity meetings were held every month with the Coombe Women & Infants University Hospital. Staff told inspectors that maternal morbidity was discussed at these meetings too. The meetings were chaired by the Clinical Director for Integration. A record of those who attended the meeting was maintained and records of the meetings held in 2018 were reviewed by

inspectors. Learning from perinatal mortality and morbidity meetings was shared with staff at clinical handover.

3.2.3 Quality improvement initiatives

The hospital did not have a formally structured and resourced quality improvement programme but they had implemented a significant number of quality improvement initiatives aimed at improving the quality and safety of the maternity service at the Midland Regional Hospital Portlaoise. Quality improvement initiatives implemented in the hospital included:

- A difficult intubation trolley was introduced in the Operating Theatre Department and its use was audited.
- The Oxford Difficult Intubation pillow was introduced in 2017.
- Upgrading of bathrooms in the Maternity Ward.
- A Clinical Midwifery Manager II had been appointed to the maternity unit working Monday to Friday during core working hours. Consequently, a shift leader was on duty for every shift in the maternity unit.
- A critical care transport trolley was introduced in January 2019.
- An obstetric pre-assessment anaesthetic clinic was established in 2017.
- Fetal fibronectin testing[§§§§§§] was introduced as an indicator of preterm labour.
- Safety huddles were introduced in the maternity unit.
- Toolbox education sessions[*******] were introduced and are conducted two to three times every week in the maternity unit.
- The Willow Suite, a bereavement room for bereaved parents and families was opened.
- The implementation of Caring Behaviours Assurance System - Ireland (CBAS-I),[†††††††] Person-Centred Care Programme[‡‡‡‡‡‡‡] and What Matters to Me initiatives.[§§§§§§]

[§§§§§§] Fetal fibronectin is a protein used to test pregnant women who are between 22 weeks and 35 weeks pregnant and are having symptoms of premature labour. The test helps predict the likelihood of premature birth.
[*******] Toolbox education sessions are short, discussions or presentations that are generally focused on one specific topic or theme to help staff practice in a safer and more meaningful manner.
[†††††††] Caring Behaviours Assurance System – Ireland(CBAS-I) is an evidence based system for assuring the delivery of safe care and ensuring communication channels between wards/departments, directorates, the executive management team and the board of the hospital group.
[‡‡‡‡‡‡‡] A HSE quality improvement initiative to establish and enable a culture of person-centredness for persons who both use and provide services throughout the Irish healthcare system. The programme involves developing facilitators to lead culture change that supports person-centred practice within their own services.

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. **Key findings:** The level of reporting of clinical incidents in the maternity unit has declined over the past three years. **Judgment:** Partially compliant

§§§§§§§ A HSE quality improvement initiative that supports person-centeredness in care. It is an approach to capture issues that are important to each individual that when known by staff can improve patient experiences.

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. Inspectors found that the Midland Regional Hospital Portlaoise was compliant or substantially complaint with the majority of the National Standards that were focused on during this inspection.

There were clearly defined and effective leadership, governance and management structures at the hospital and with the Dublin Midlands Hospital Group to ensure the safety and quality of maternity services. While the hospital had identified strategic priorities in their annual report, any strategic planning of the maternity services within the hospital was constrained by the lack of an overall agreed and published strategy on the future direction and services to be provided in the hospital. The uncertainty on the future and long-term sustainability of services at the hospital had a significant impact on the hospital's ability to recruit and retain nursing, midwifery and medical staff.

Overall, HIQA found that the Midland Regional Hospital Portlaoise had formalised leadership, governance and management arrangements in place with clearly defined reporting structures within the maternity service and through the Dublin Midlands Hospital Group to ensure the quality and safety of the maternity service provided at the hospital.

There was 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 clinical outcomes, women's feedback and clinical incidents and benchmarked the hospital's performance against other similar sized hospitals. Hospital management was actively working to optimise maternal care and to progress implementation of the National Standards. Nonetheless, it is important that the hospital examine the reasons for the decline in incident reporting in the maternity unit and, and act on any findings from this process.

At the time on the inspection there was evidence that there were collaborative working arrangements between the Midland Regional Hospital and the Coombe Women & Infants University Hospital. This enabled sharing of expertise and clinical services and was an essential step in enhancing the quality and safety of the maternity services at the Midland Regional Hospital Portlaoise. However, a formalised network with a single governance structure arrangement for the maternity network was not established, formalised or agreed as recommended in the National Maternity Strategy and elements of the Memorandum of Understanding between the Coombe

Women & Infants University Hospital and the HSE were yet to be fully implemented. The hospital group and the HSE need to progress and resource the implementation of a managed clinical maternity network.

The hospital employed medical staff in the specialties of obstetrics, paediatrics, neonatology and anaesthesiology that were available on site to provide care to women and babies on a 24 hour, seven day a week basis. Notwithstanding this, the hospital had staffing deficiencies in relation to midwifery and consultant positions in anaesthesiology and paediatrics at the hospital. In line with National Standards and national guidelines, the hospital provided a dedicated obstetric anaesthetic pre-assessment clinic. The hospital had clearly defined training requirements for clinical staff in relation to fetal monitoring, adult and neonatal resuscitation and multi-professional training for the management of obstetric emergencies. However, the hospital needs to ensure that mandatory training is completed by medical, midwifery and nursing staff within recommended time frames.

The Midland Regional Hospital Portlaoise had procedures and processes in place to identify women at high risk of complications and to ensure that their care was provided in the most appropriate setting. Fetal ultrasound scans were offered to all pregnant women in accordance with the National Standards. Effective arrangements were in place to detect and respond to obstetric emergencies and to provide or facilitate on-going care to ill women and their babies. One maternal emergency resuscitation trolley was shared across three clinical areas. Following this inspection, hospital management should review and assess procedures for ensuring the adequate provision of resuscitation equipment in all clinical areas.

The reporting of clinical incidents in the maternity unit has declined over the past three years. Following this inspection, the hospital should continue to increase staff awareness, education and training about clinical incident reporting in the maternity unit. There was evidence that quality improvement initiatives had been implemented in the maternity unit but the hospital should implement a quality improvement programme in line with National Standards to further enhance safety and quality in the maternity unit.

The hospital had an outdated and restrictive physical infrastructure that did not meet the recommended design and infrastructural specifications for contemporary maternity services.

Following this inspection, the hospital, with the support of the Dublin Midlands Hospital Group and the HSE, needs to address the opportunities for improvement identified in this report and to continue to progress with the transition to a maternity network for the enhancement of a safe, high-quality maternity services at the Midland Regional Hospital Portlaoise.

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