Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the inspections of maternity services at University Hospital Kerry

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

Inspection dates

Unannounced inspection: 17 October 2018 and 18 October 2018

Announced inspection: 21 August 2019

About the Health Information and Quality Authority (HIQA)

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

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

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

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

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

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

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

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

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

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1.0 Information about this monitoring programme

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

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

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

Pregnancy, labour and birth are natural physiological states, and the majority of healthy women have a low risk of developing complications. For a minority of women, even those considered to be at low risk of developing complications, circumstances can change dramatically prior to and during labour and 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 occur, 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.

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

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

1.1 Information about this inspection

University Hospital Kerry is a statutory acute hospital which is owned and managed by the Health Service Executive (HSE). The hospital is part of the South/South West Hospital Group.[†] The Maternity Unit is co-located with the general hospital. There were 1,254 births at the hospital in 2018.

HIQA carried out a two-day unannounced inspection of the maternity services in this hospital on 17 and 18 October 2018. To prepare for this inspection, inspectors reviewed a completed self-assessment tool[‡] and preliminary documentation submitted by University Hospital Kerry to HIQA in June 2018. Inspectors also reviewed information about this hospital including previous HIQA inspection findings; information received by HIQA and published national reports.

The findings of this inspection identified a high level of non-compliance with a number of the National Standards assessed and areas of associated risk. Following the inspection, HIQA engaged with the hospital and the South/South West Hospital Group to escalate concerns and identified risks. During this engagement process which included correspondence, telephone contact and a face-to-face meeting, hospital management and the South/South West Hospital Group committed to addressing the risks identified.

Due to the level of identified non-compliance and the nature and level of risk involved, HIQA determined that a follow-up inspection of the maternity services at University Hospital Kerry was necessary. An announced inspection was carried out at the hospital on 21 August 2019. The purpose of the follow-up inspection was to determine the progress made in addressing the risks and areas of non-compliance with National Standards identified during the HIQA inspection carried out in October 2018.

This follow-up inspection identified both evidence of improved compliance, and also a requirement for some further work to be progressed if compliance with the national standards is to be achieved.

Information about these inspections are included in Table 1.

[†] The South/South West Hospital Group includes University Hospital Kerry, Cork University Hospital, Cork University Maternity Hospital, University Hospital Waterford, Mercy University Hospital, South Tipperary General Hospital, South Infirmary Victoria University Hospital, Bantry General Hospital, Mallow General Hospital and Kilcreene Orthopaedic Hospital.

[‡] All maternity hospitals and maternity units were asked to complete a self-assessment tool designed by HIQA for this monitoring programme.

Table 1 - Inspection details

Dates	Times of inspection	Inspectors
17 October 2018	14:30hrs to 18:30hrs	Aileen O' Brien Siobhan Bourke Joan Heffernan Emma Cooke
18 October 2018	08:30hrs to 19:15hrs	
21 August 2019	09:30 to 17:30hrs	Aileen O' Brien Susan Cliffe

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

- Representatives of the hospital's Executive Management Board; the General Manager and the Director of nursing.
- Lead consultants in each of the clinical specialties of obstetrics, anaesthesiology and paediatrics.

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

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

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

HIQA would like to acknowledge the cooperation of the Hospital Management Team and all staff who facilitated and contributed to both inspections.

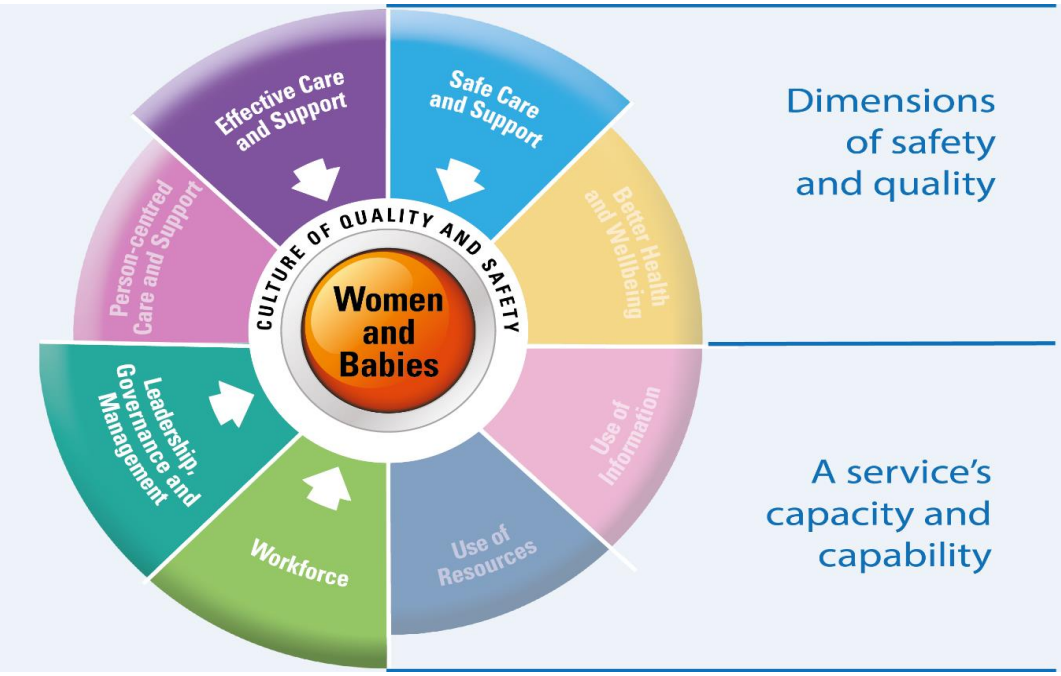
The remainder of this report presents the findings of both the unannounced and announced inspections in University Hospital Kerry on 17 and 18 October 2019 and 21 August 2019.

1.2 How inspection findings are presented

Both inspections at University Hospital Kerry were 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 the observations of inspectors, a review of documentation and information provided to inspectors during both inspections.

The National Standards themes which were focused on in this monitoring programme are highlighted in Figure 1. Inspection findings are grouped under the National Standards dimensions of Capacity and Capability and Safety and Quality.

Figure 1 - 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 at the hospital. 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 24 hours a day.

As set out in the methodology, inspectors looked at 10 of the National Standards relevant to leadership, governance and workforce. During the first inspection in October 2018, University Hospital Kerry was found to be substantially compliant with two National Standards, partially compliant with six National Standards and non-compliant with two National Standards relevant to leadership, governance and workforce. Inspection findings leading to these judgments and key findings in relation to University Hospital Kerry's level of compliance with the National Standards monitored during both inspections are included in Tables 3 and Table 4 within this section.

A number of risks relating to the leadership, governance, workforce and safety and quality of the maternity service at the hospital were identified at that time. Details of these risks were communicated in writing to the Chief Executive Officer of the South/South West Hospital Group. Further communication and correspondence followed between HIQA and the Chief Executive Officer of the South/South West Hospital Group from October 2018 to December 2018. The purpose of this communication was to provide an update to HIQA on the progress made to implement the planned actions to address the risks identified. The actions implemented by hospital management and the South/South West Hospital Group to address the risks identified are included in this report.

The follow-up inspection at the hospital on 21 August 2019 found significant improvement in the level of compliance with the National Standards relevant to leadership, governance and management and workforce. At that time, the hospital was found to be compliant with three National Standards, substantially compliant

with five National Standards and partially compliant with two National Standards relevant to leadership, governance and management and workforce.

2.1 Leadership, Governance and Management

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

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

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

Inspection findings

2.1.1 Maternity service leadership, governance and management

Maternity network

At the time of both inspections in October 2018 and August 2019, HIQA found that the maternity service at University Hospital Kerry was not part of a formalised maternity network under a single governance framework as recommended in the National Maternity Strategy.[§] In making this observation, HIQA acknowledges preparatory efforts advanced by the South/South West Hospital Group in working to progress a maternity network to incorporate maternity services within the hospital group under one governance structure.

In the interim, while transitioning to a formalised maternity network, the hospital group had established a Maternity Directorate which was under the leadership of the Clinical Director for Maternity Services in the South/South West Hospital Group. The Clinical Director for Maternity Services reported to the Chief Executive Officer of the South/South West Hospital Group. Management of the Maternity Directorate was overseen by the Directorate's Executive Management Committee. The committee met every two weeks to monitor and review clinical, operational, quality and safety issues relating to the maternity services in the South/South West Hospital Group. In

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

October 2018, the Clinical Lead for the maternity service and Director of Nursing[**] at University Hospital Kerry were members of this committee. However, at that time, there was no representation from senior midwifery management in University Hospital Kerry on the Maternity Directorate's Executive Management Committee.

While the Maternity Directorate's Executive Management Committee provided oversight of risks and capital projects associated with the Maternity Unit in University Hospital Kerry, it did not supersede hospital management's executive governance function. This was because the Clinical Director for Maternity Services in South/South West Hospital Group did not have formally delegated responsibility and accountability for the governance, management or delivery of maternity services at University Hospital Kerry.

Collaborative working arrangements in the interim of a formal maternity network

During both inspections HIQA found examples of good collaborative working arrangements and practices within the South/South West Hospital Group in the interim while the formation of a formal maternity network was being progressed. These included the following:

- The Maternity Unit at University Hospital Kerry along with other maternity units in the hospital group attended a daily meeting which was facilitated by the Clinical Director for Maternity Services in the South/South West Hospital Group.
- A formally ratified policy relating to the mandatory inter-hospital transfer of women and babies who required specialised care from University Hospital Kerry to Cork University Maternity Hospital.
- Training, clinical support and ongoing mentorship for two newly appointed sonographers in the fetal ultrasound service at University Hospital Kerry was facilitated by the tertiary maternity hospital in the hospital group - Cork University Maternity Hospital. This intervention meant that fetal anomaly scanning at intervals outlined in National Standards was offered to all pregnant women accessing maternity services at the hospital.
- University Hospital Kerry had implemented the National Maternal and Newborn Clinical Management System.[††] This facilitated the sharing of healthcare records between the hospital and Cork University Maternity Hospital.

[**] In October 2018 the Director of nursing was responsible for midwifery at the hospital in the absence of a director of midwifery position.

[††] The National Maternal and Newborn Clinical Management System project is the design and implementation of an electronic health record for all women and babies in maternity services in Ireland. This record allows information to be shared with relevant providers of care as and when required.

- The hospital group planned to employ additional support staff including a risk manager and a business manager to support the implementation of a maternity network.
- Funding for the positions of midwifery tutor, perinatal mental health midwife, clinical midwife, dietitian and an information technology support midwife had been sanctioned. The hospital had plans to increase consultant microbiologist sessions at University Hospital Kerry. A clinical midwife specialist for diabetes mellitus had been appointed at the hospital.
- The hospital group was in the final stages of recruitment of four new consultant pediatricians. The Clinical Director had engaged with all paediatricians to identify neonatal training requirements and Cork University Hospital's Paediatric Department had been contacted regarding assisting in organising this training and that of the non-consultant hospital doctor cohort at University Hospital Kerry. Cork University Maternity Hospital management had also committed to supporting and facilitating ongoing training needs around neonatal care.

University Hospital Kerry leadership, governance and management of maternity services

Findings from HIQA's inspection in October 2018 raised serious concerns about local governance and management arrangements in place for the maternity services in University Hospital Kerry. At that time, it was unclear who had oversight of the maternity services at the hospital and there was no clear separation of the lines of accountability between the hospital's Executive Management Board and the Maternity Directorate's Executive Management Committee at South/South West Hospital Group level.

At that time inspectors also found there was ambiguity regarding the oversight and decision-making roles of and the interface between the hospital's Executive Management Board, the Maternity Clinical Governance Group at hospital level and the Maternity Directorate's Executive Management Committee at hospital group level. This was a significant concern because the General Manager of University Hospital Kerry was operationally responsible and accountable for the maternity services at the hospital but the governance arrangements did not reflect this.

In addition, the hospital did not have a Director of Midwifery or Clinical Director in place in October 2018. The Director of Midwifery is critical to the oversight and provision of safe quality maternity services, for enhancing the standard of midwifery care, improving multidisciplinary working relationships, improving staff morale and influencing a sustainable, woman-centred approach to maternity care. Not having a Director of midwifery is contrary to recommendations made by HIQA[4] in 2015 and requirements of the National Standards. Essentially, the hospital was operating

without midwifery leadership and input at executive management level. This significantly impacted on the Executive Management Board's ability to effectively govern and oversee the quality and safety of maternity services for which they had executive accountability and responsibility. The serious gaps in clinical and midwifery leadership presented a significant risk to the safety and quality of maternity services at the hospital. This risk was escalated by HIQA to the South/South West Hospital Group in October 2018.

At the time of HIQA's first inspection, the hospital had a Maternity Clinical Governance Group which met every week. This group co-ordinated the development and provision of safe, high-quality obstetric and gynaecology services at the hospital in line with best practice and National Standards. The group's membership was extensive including representation from doctors and midwives working in maternity and gynaecology services at the hospital. The group could escalate risks to both the hospital's Executive Management Board and the South/South West Hospital Group Maternity Services Executive Management Committee as deemed necessary. However, in October 2018, inspectors were unable to clearly establish how and when the Maternity Clinical Governance Group would formally report to the hospital's Executive Management Board.

Significantly improved leadership, governance and management arrangements were in place at the hospital at the follow-up inspection in August 2019. The leadership, governance and management structure at hospital level was clearly defined. Two key management positions, the Clinical Director and Director of midwifery were filled in January 2019 and June 2019 respectively.

It was also evident during that inspection that there was clarity as to who was responsible and accountable for the maternity services at the hospital and the local governance structures for the maternity service had been reviewed since October 2018. The General Manager and members of the hospital's Executive Management Board were clear about their responsibility and were able to provide the evidence demonstrating how they executed this responsibility and oversight of the maternity services. The hospital's Maternity Clinical Governance Group reported to the hospital's Executive Management Board once a month and also to the Maternity Directorate's Executive Management Committee at hospital group level. The hospital's revised organisational structure diagram indicated that the Maternity Clinical Governance Group had a reporting relationship to the hospital's Quality and Safety Committee. However, the terms of reference for the group did not indicate a reporting relationship to this committee. This should be reviewed.

Following the October 2018 inspection, hospital management had established a Maternity Incident Management Team. The team comprising senior clinicians and

members of hospital management were responsible for overseeing the review clinical incidents that occurred in the Maternity Unit.

Despite the progress made in the governance, leadership and management at the hospital, HIQA believe that two significant concerns remain. First, the director of midwifery was not a member of the hospital's Executive Management Board which significantly impacted this board's ability to effectively govern and oversee the quality and safety of maternity services for which they had executive accountability and responsibility. The Executive Management Board was updated about developments in the maternity services by the lead consultant obstetrician and director of midwifery. Formal integration of the director of midwifery into the Executive Management Board structure needs to be progressed in line with the National Standards.

A second concern relates to the control of midwifery and nursing staffing resources in the Maternity Unit. The director of midwifery did not have delegated control of midwifery and nursing staffing resources for the Maternity Unit. This remained within the remit of the director of nursing. Hospital management informed inspectors that there were plans to delegate control of nursing and midwifery staffing in the Maternity Unit to the director of midwifery but no definitive date was given as to when this will occur. These arrangements need to be progressed and finalised.

Statement of Purpose

The hospital developed a Statement of Purpose for the maternity service which was approved in February 2019. This document should be revised to reflect revised midwifery management and hospital committee structures and maternity clinical governance group membership. The Statement of Purpose should be made publicly available in line with National Standards requirements.

Overall findings related to Leadership Governance and Management of maternity services

In line with National Standards, governance arrangements should always ensure that services are only provided where they can be done so safely, effectively and sustainably. Effective management also includes deploying the necessary resources through informed decisions and actions to help with the delivery of safe, high-quality care.

Overall, HIQA found that the arrangements for the governance oversight of maternity services at University Hospital Kerry had improved significantly between October 2018 and August 2019 with notably improved compliance with relevant National Standards. The hospital now needs to ensure that these arrangements are strengthened and sustained. The hospital should immediately assign delegated

control over midwifery and nursing staffing resources for the Maternity Unit to the Director of midwifery. The hospital should also immediately appoint the Director of midwifery to the hospital's Executive Management Board.

Table 3 on this and the following pages lists the National Standards relating to leadership, governance and management focused on during both inspections and key findings in relation to the hospital's level of compliance with the National Standards monitored during these inspections. The follow-up inspection in August 2019 focused on assessing compliance with the six National Standards relevant to leadership, governance and management that the hospital were found to be substantially, partially or non-compliant in October 2018.

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 October 2108	**Judgment August 2019**
Non-compliant	Substantially compliant
Key findings: Absence of a director of midwifery and a clinical director from the Executive Management Board. There was ambiguity as to the oversight and decision making roles of and the interface between the hospital and the South/South West Hospital Group.	**Key findings:** There was a clearly defined leadership, governance and management structure at hospital level. Two key management roles, the Clinical Director position and the Director of midwifery position were filled in January 2019 and June 2019 respectively. The Executive Management Board was regularly updated about developments in the maternity service by the lead consultant obstetrician, the director of nursing and more recently the director of midwifery. The director of midwifery also submitted monthly reports to the South/South West Hospital Group.
Going forward, the director of midwifery should be a member of the hospital Executive Management Board and in addition should have delegated control over midwifery and nursing staff resources for the Maternity Unit.	

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

Standard 5.2 Maternity service providers have formalized governance arrangements for assuring the delivery of safe, high-quality maternity care.	
Judgment October 2018	**Judgment August 2019**
Partially compliant	Substantially compliant
Key findings: There was a lack of effectiveness of assurance mechanisms in place to oversee the maternity service, and the level of expertise in this area at a senior management level to enable this. Maternity network arrangements were not formalised at time of inspection.	**Key findings:** There was improved oversight of the maternity service by the hospital management team. Local governance structures for the maternity service had been reviewed. This improved oversight was informed by review of maternity metrics, a formal audit plan, surgical site infection surveillance and review and discussion of clinical performance data. A Maternity Incident Management Team had been formed to have oversight of clinical incidents by senior clinicians and management. Development of the South/South West Hospital Group maternity network was still not formally implemented.
Going forward, implementation of a maternity network under a single governance structure at hospital group level should be appropriately resourced and progressed.	

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

Standard 5.3 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 October 2018	**Judgment August 2019**
Substantially compliant	Substantially compliant
Key findings: Statement of purpose in development**.**	**Key findings:** Hospital management completed a Statement of Purpose for the maternity service in February 2019. This document required revision to reflect revised midwifery management and hospital committee structures and maternity clinical governance group membership.
Going forward, the Statement of Purpose should be made publicly available in line with the National Standards.	

Standard 5.4 Maternity service providers set clear objectives and have a clear plan for delivering safe, high-quality maternity services.	
Judgment October 2018	**Not reviewed in August 2019**
Substantially compliant	Substantially compliant
Key findings: Lack of clearly defined plans for the maternity service at local level.[‡‡]	

[‡‡] Following inspection University Hospital Kerry management told HIQA that services were planned in accordance with the National Service Plan, the National Women and Infants Health Programme objectives and the South/South West Hospital Group Operational Plan.

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

Standard 5.5 Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services.	
Judgment October 2018	**Judgment August 2019**
Partially compliant	Compliant
Key findings: Absence of a director of midwifery and a clinical director.	**Key findings:** There was significant improvement in the management arrangements at hospital level as both the director of midwifery and the clinical director had been appointed and were in position.
Standard 5.8 Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services.	
Judgment October 2018	**Judgment August 2019**
Partially compliant	Substantially Compliant
Key findings: This inspection identified inadequate oversight of the quality and safety of maternity services at the hospital, as demonstrated by low incident reporting rates, low levels of audit and limited morbidity and mortality meetings. There was also a lack of consensus among staff who spoke with inspectors regarding the type of clinical incidents that required reporting.	**Key findings:** There was improved clinical incident reporting, a clinical audit schedule had been formally ratified and clinical audits were in progress. Annual clinical report data was reviewed and discussed at a maternity clinical governance meeting. The director of midwifery met with women who had used the maternity service to hear their feedback.

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

Standard 5.11 Maternity service providers act on standards and alerts, and take into account recommendations and guidance issued by relevant regulatory bodies.	
Judgment October 2018	**Judgment August 2019**
Partially compliant	Compliant
Key findings: Lack of implementation of a key national recommendation specifically the appointment of a director of midwifery.	**Key findings:** The director of midwifery had been appointed and was in position.
Going forward, the hospital should consider employing midwifery staff at the grade of assistant director of midwifery so that the midwifery management structure in University Hospital Kerry comes into line with that of other maternity units in Ireland.	

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. Both HIQA inspections looked at the number of nursing and midwifery staff who were available to provide care to women and infants using the maternity service. Both HIQA inspections also looked at the number and grade of medical staff who worked in the specialities of obstetrics, paediatrics and obstetric anaesthesiology at the hospital. Inspectors also reviewed the uptake and provision of training and education of staff relevant to obstetric emergencies.

Inspection findings in relation to workforce are described next.

Inspection findings

2.2.1 Midwifery and nursing staffing

The 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.

Midwifery staffing levels at the hospital were not in line with the HSE's Midwifery Workforce Planning Project.[5] In October 2018, there was a midwifery and nursing staffing deficit of 7.27 WTE for maternity services. Work practices accepted at the hospital to compensate for deficiencies in staff numbers were less than ideal. These practices included the allocation of registered general nurses without a midwifery qualification to the postnatal ward.[§§]

Midwifery staffing levels had improved at the hospital in August 2019 but at that time there were still some staffing deficiencies due to maternity leave and sick leave. The deficit of midwifery staff at this time was 4.11 WTE. Inspectors were informed that the practice of registered general nurses without a midwifery qualification caring for women in the postnatal ward had ceased. Registered general nurses working in the postnatal ward were allocated to care for newborn babies and worked within their scope of practice. Going forward, it was anticipated that registered general nurses would not be allocated to the postnatal ward.

The hospital had also filled a number of specialised roles in the Maternity Unit which were unfilled at the time of HIQA's first inspection in October 2018. Hospital

[§§] Subsequent correspondence from the hospital group following escalation of concern by HIQA in October 2018 related to this practice outlined that nurses deployed to such tasks were closely supervised by midwives, and were required to only work within their scope of practice.

management had successfully appointed a clinical midwife specialist in bereavement and a diabetic nurse specialist to support the care of women attending the maternity service at the hospital. Nonetheless, due to HSE employment controls, some specialist support positions such as a perinatal mental health midwife and lactation consultant remained unfilled at the hospital in August 2019.

National Standards recommend that a supernumerary shift co-ordinator at senior midwife grade was available for each shift in the Labour Ward. At the time of the first inspection, the hospital had not appointed supernumerary shift co-ordinators in the Labour Ward. However, during the inspection in August 2019, inspectors found that this had improved. The hospital had appointed 4.5 WTE shift leaders at midwife manager 2 grade. This meant that a shift leader was on duty 24 hours a day in the Labour Ward. Shift leaders supported and developed staff and were responsible for aspects of Labour Ward management. However, the shift leaders were not always supernumerary. Hospital management had requested additional funding from the HSE to make these positions supernumerary.

Operating theatre nursing staff

Features in the National Standards state that a staffed dedicated obstetric operating theatre should be in place. During both inspections, HIQA found that in the event of two concurrent emergency surgical cases, hospital management did not have adequate contingency arrangements in place to draft in additional operating theatre nursing staff to staff two operating theatres.

Documentation provided to inspectors in October 2018 showed that 62% (188 of 302) of emergency caesarean sections were performed outside of core working hours and at weekends. HIQA also found evidence that over a 12 month period there were 11 occasions where an obstetric and general surgical emergency were conducted concurrently outside core working hours.

Outside of core working hours, the on-call operating theatre nursing team comprising three staff nurses was responsible for staffing operating theatres for both general surgical and obstetric cases. In the event of a concurrent emergency surgical case, it was practice to redeploy two of these nurses to the second theatre. Such a practice is not in keeping with minimum expected staffing levels for perioperative nurses in published international guidance.[6,7] This risk had been identified on the hospital's corporate risk register since February 2010, but at the time of both HIQA inspections the risk had not been resolved.

HIQA's concerns regarding the non-employment of healthcare assistants in the Maternity Unit remained following the follow-up inspection in August 2019. With no maternity assistants employed, midwives restocked supplies in the Labour Ward, which impacted on and took from the time spent caring for women and newborns. In

August 2019, hospital management told inspectors that a business case for healthcare assistants in the Maternity Unit submitted to the HSE had been declined. This needs to be revisited.

Special Care Baby Unit nursing staff

During HIQA's first inspection, risks identified relating to the hospital's Special Care Baby Unit were escalated to the Chief Executive Officer of the South/South West Hospital Group. The risk related to nursing staff levels in the Special Care Baby Unit and the practice of deploying nurses from the Special Care Baby Unit to the paediatric ward. This meant that, at times, the unit was only staffed by one nurse. At the time of HIQA's first inspection, inspectors were not provided with an assurance in relation to the safe management of emergencies in this scenario.

In August 2019, there was some change, inspectors were told then that there was a minimum of two nurses on duty in the Special Care Baby Unit at all times and that this staffing allocation was closely monitored and maintained. In practice, this meant that when there were two nurses on duty in the unit, the practice of redeployment to other clinical areas did not occur.

2.2.2 Medical staff

Medical staff availability

During both HIQA inspections, the hospital was staffed with non-consultant hospital doctors[***] in the medical specialties of obstetrics, anaesthesiology and paediatrics who were available onsite to provide care to women and newborns on a 24-hour basis. Rapid response teams were available on site 24/7 to attend to obstetric emergencies, neonatal emergencies and cardiac arrests.

Consultants in the medical specialties of obstetrics, anaesthesiology and paediatrics were not all employed on permanent contracts. Two consultants working in these specialties were not registered as specialists with the Medical Council in Ireland. This information was included on the hospital risk register and hospital management were working to address this.

Obstetric medical staff

The hospital had four WTE consultant obstetricians employed at the hospital. Three of these were filled by permanent appointments and one position was filled by a locum consultant. A recruitment campaign run in 2019 to fill the temporary position was unsuccessful. The hospital had an on-call rota outside of core working hours for

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

consultant obstetricians whereby consultants were on call usually one in every four nights. HIQA is of the view that this level of consultant obstetrician staffing at the hospital should be reviewed to ensure that it enables a sustainable on-call rota.

A consultant obstetrician was rostered to be on call for the Labour Ward from Monday to Friday during core working hours. Inspectors were informed that consultants on call for the Labour Ward had other responsibilities - for example outpatient's clinics - but would not have an allocated operating theatre list when on call for the Labour Ward. This meant that they were available to attend the Labour Ward when required.

In October 2018, the practice of allocating an intern, the most junior grade of doctor, in addition to a registrar to the on-call rota for obstetrics outside core working hours was of concern to HIQA. At that time, a rota of two non-consultant hospital doctors in obstetrics, one at registrar grade and one at either senior house officer or intern grade was in place at the hospital 24-hours a day. This practice presented a risk to the safety of women in the management of obstetric emergencies. This risk identified by HIQA was escalated for remedial action to the Chief Executive Officer of the South/South West Hospital Group. HIQA recommended that the practice should be reviewed.

The hospital did review the rostering of interns and in August 2019 HIQA found interns were no longer rostered to be on call after 11.00pm. Furthermore, hospital managers told inspectors that these doctors operated within their scope of practice, were not permitted to make any clinical decisions and were required to work at all times under the clinical supervision of the onsite obstetric registrar or consultant. Hospital management had identified that additional senior house officer positions were required to fully staff the on-call rota with registrars and senior house officers. This deficiency should be addressed.

Anaesthesiology staff

Best practice guidelines recommend that a duty anaesthesiologist should be immediately available for the Labour Ward 24 hours a day and must have no other responsibilities outside obstetrics.[8,9] At the time of both HIQA inspections, anaesthesiology medical staff resources at the hospital were not in line with national recommendations for hospitals with co-located maternity units. Staff who spoke with inspectors said that sometimes women experienced delays in receiving epidural anaesthesia if the anaesthesiologist was busy elsewhere in the hospital. The level of anaesthetic cover at the hospital outside of core working hours presented a potential risk to safety where immediate attendance by an anaesthesiologist may be required at two or more coinciding emergencies. Hospital management told inspectors that

they had submitted a business case for an increase in the number of doctors in anaesthesiology at registrar grade to the HSE.

The risk relating to anaesthetic service staffing levels, especially outside core working hours, was escalated by HIQA to the Chief Executive Officer of the South/South West Hospital Group. Anaesthesiology staffing levels at the hospital should be in accordance with national recommendations.

At the time of both HIQA inspections, the hospital employed six WTE consultant anaesthesiologists. The hospital had an on-call rota outside core working hours whereby consultants were on call one in every six nights. These consultant anaesthesiologists were responsible for providing anaesthetic services for the Emergency Department, the Intensive Care Unit, general surgery and the Maternity Unit. The anaesthetic cover for the maternity service at the hospital was provided by the general pool of anaesthesiologists. It was practice that the consultant anaesthesiologist on call was off site outside core working hours. Both on-call registrars in anaesthesiology were onsite between 3pm-11pm from Monday to Friday to cover general hospital services and the maternity service. After 11pm Monday to Friday and after 9pm on Saturday and Sunday, there was only one registrar in anaesthesiology onsite at the hospital. The second registrar in anaesthesiology was on call during these times but was not onsite. Inspectors were informed that the second registrar was on call specifically to cover the hospital in circumstances where a woman or patient needed to be transferred to another hospital with an anaesthesiologist in attendance.

Paediatric medical staff

In line with the model of care for a level one neonatal unit, the hospital was staffed by consultant general paediatricians who undertook routine newborn care as part of their duties and on-call roster. In October 2018, the hospital group was in the process of recruiting three additional permanent paediatricians. At that time the hospital had four WTE consultant paediatrician positions filled at the hospital but only one consultant paediatrician position was filled permanently. So there was a dependence on both locum and agency consultant medical staff within the paediatric service. The hospital had an on-call rota outside of core working hours whereby a consultant paediatrician was on call from home usually one in every three nights. A rota of two non-consultant hospital doctors in paediatrics, one at registrar grade and one at senior house officer was in place at the hospital 24 hours a day.

During HIQA's inspection in August 2019, hospital managers told inspectors that the hospital had successfully recruited four new paediatric consultants. This will bring the number of permanent consultant paediatricians to five WTEs. Two of these

consultants were due to take up employment at the hospital in August and September 2019 and it was anticipated that the remaining two consultants would take up their positions between October and December 2019.

2.2.3 Training and education of multidisciplinary staff

Mandatory training requirements

During both HIQA inspections, inspectors were informed that midwifery and medical staff were provided with training in relation to basic life support, neonatal resuscitation, practical obstetric multi-professional training for obstetric emergencies, fetal monitoring, anaphylaxis, and, the identification and management of sepsis.

Uptake of mandatory training

During both HIQA inspections, inspectors identified that the uptake of training by medical staff was not formally recorded at the hospital. Mandatory training requirements should be clearly set down in maternity service guidelines and uptake of mandatory training should be clearly recorded for all doctors, midwives and nurses employed at the hospital.

In October 2018, HIQA found that there were poor levels of attendance at multidisciplinary training in relation to the management of obstetric emergencies and fetal monitoring among midwifery staff. The levels of uptake of mandatory training were significantly lower than expected. HIQA escalated the risk related to insufficient uptake of mandatory training to the Chief Executive Officer of the South/South West Hospital Group. By August 2019 the hospital had made significant progress in relation to the provision and uptake of multidisciplinary training in the management of obstetric emergencies, fetal monitoring, neonatal resuscitation and basic life support.

Training records provided to inspectors indicated that attendance at:

- multidisciplinary training in the management of obstetric emergencies had increased from 22% to 66%
- fetal monitoring training had increased from 19% to 61%
- neonatal resuscitation training had increased from 69% to 92%
- basic life support training had increased from 69% to 88%.

While there was improvement in attendance at mandatory training, improvement is still required if the hospital is to be compliant with the specific national standard relating to competencies and training needed to deliver safe, high-quality maternity care.

A number of staff had attended training in relation to the practical management of obstetric emergencies at Cork University Maternity Hospital. Ideally, this training

should be provided regularly at University Hospital Kerry and the hospital management was working to achieve this. To that end, a multidisciplinary team from the Maternity Unit were scheduled to undertake a training course in the United Kingdom in October 2019.

The National Standards recommend that the skills gained in cardiotocography interpretation should be supported by cardiotocography review meetings. In October 2018, the hospital did not hold regular cardiotocography review meetings but by August 2019, the hospital had implemented regular cardiotocograph review meetings and staff were required to attend these meetings.

All midwifery staff attended live drills in the management of obstetric emergencies that were held every week in the Maternity Unit. The hospital did not employ a midwifery clinical skills facilitator as recommended in the National Standards. Hospital managers told inspectors that a business case to fund this post had been declined by the HSE. This decision needs to be reviewed for the hospital to be compliant with the National Standard.

Senior paediatric medical staff expressed concern to inspectors during the first inspection that there was limited scope for paediatric medical staff to maintain the clinical skills necessary to manage neonatal emergencies. A maternity network structure would enable the rotation of clinical staff from a smaller unit to a larger unit providing more complex care, which will support and facilitate training and maintenance of these skills. At the time of the follow-up inspection the rotation of staff had not been advanced.

The Clinical Director had engaged with all five paediatricians[†††] to identify neonatal training requirements for the new consultants and the non-consultant hospital doctor cohort at University Hospital Kerry. Cork University Hospital's Paediatric Department had been contacted regarding assisting in organising this training for paediatric medical staff.

Orientation and training of new staff

Medical, midwifery and nursing staff were provided with formal induction upon commencing employment at the hospital. New staff were provided with induction packs.

Other training and education opportunities for staff

The hospital was not recognised as a site for higher specialist training for doctors in the specialty of obstetrics and gynaecology.

[†††] This includes the four consultants due to take up positions in University Hospital Kerry.

Table 4 on this and the following page list the National Standards relating to workforce focused on during both inspections and key findings in relation to the hospital's level of compliance with the National Standards monitored during this inspection. The follow-up inspection focused on assessing compliance with two National Standards relevant to workforce that the hospital were found to be substantially or non-compliant with during the first 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	
Judgment October 2018	**Judgment August 2019**
Partially compliant	Partially compliant
Key findings: This inspection identified staffing deficiencies in relation to; medical, midwifery staff and nursing staff; anaesthesiology cover outside of core working hours; the rota of operating theatre nurses to staff a second operating theatre outside core working hours. HIQA also identified a practice of replacement of nurses with healthcare assistants and replacement of midwives with nurses as a measure to address deficiencies.	**Key findings:** A number of improvements had been made at the hospital in relation to staffing levels. Midwifery staffing levels had improved. There was a minimum of two nurses on duty in the Special Care Baby Unit at all times. Non-consultant hospital doctors at the most junior grade of intern were no longer rostered to be on call after 11.00pm. These doctors operated within their scope of practice, and were required to work at all times under the clinical supervision of the onsite obstetric registrar or consultant obstetrician.
Going forward, with deficiencies in anaesthesiology cover, the hospital should review and address the potential risk to patient safety, in the management of obstetric emergencies outside care working hours. The hospital should also address the risk arising from the rota of operating theatre staff needed to operate a second operating theatre for coinciding emergencies.	

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

Standard 6.3 Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care.	
Judgment October 2018	**Judgment August 2019**
Non-compliant	Substantially-compliant
Key findings: Poor levels of multidisciplinary training in the area of obstetric emergencies among midwives. Training uptake for doctors not recorded. Redeployment of nursing staff to specialist areas normally staffed by midwives and/or neonatal nurses. Lack of scheduled training drills. No maternity clinical skills facilitator.	**Key findings:** Significant progress had been made by hospital management in relation to the provision of training for staff who deal with obstetric emergencies. Training uptake in relation to the skills required by staff to manage an obstetric emergency had improved substantially since the previous HIQA inspection. However, training uptake for doctors was still not recorded.
Going forward, hospital management should ensure that all clinical staff attends mandatory and essential training at the required frequency appropriate to their scope of practice, and that attendance and uptake of training is recorded for all staff, including medical staff.	
Standard 6.4 Maternity service providers support their workforce in delivering safe, high-quality maternity care.	
Judgment October 2018	**Not reviewed in August 2019**
Partially compliant	Partially compliant
Key findings: Multidisciplinary team training in the management of obstetric emergencies and practical obstetric emergency updates were not provided onsite and staff shortages made it difficult for staff to attend training at Cork University Maternity Hospital.	

3.0 Safety and Quality

Findings in relation to safety and quality from both HIQA inspections 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 the monitoring programme, inspectors looked at 11 of the National Standards in relation to Effective Care and Support and Safe Care and Support. In October 2018, University Hospital Kerry was found to be compliant with one National Standard, substantially compliant with three National Standards, partially compliant with five National Standards and non-compliant with two National Standards relevant to effective care and support and safe care and support.

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, both HIQA inspections 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

University Hospital Kerry provided a range of general and specialist maternity services for women with low and high-risk pregnancies. In line with the National

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

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

The hospital had confirmed pathways in place to identify, assess and ensure that women who were at risk of developing complications during pregnancy or around the time of birth were cared for in an appropriate setting.

Assessment services for pregnant and postnatal women included:

- a perinatal ultrasound service
- an early pregnancy assessment unit
- a maternal fetal medicine clinic
- the hospital Emergency Department
- an antenatal ward which was part of the Labour Ward
- the Labour Ward.

The hospital had an Early Pregnancy Assessment Unit for women with complications in early pregnancy. This unit operated by appointment from 8am to 10am and from 5pm to 6pm from Monday to Friday. An early pregnancy assessment clinic operated, if required on Saturday mornings and this was facilitated by the obstetric registrar on call and staff from the gynaecology ward.

A detailed fetal-assessment ultrasound scan was offered at 20–22 weeks' gestation to all pregnant women attending the maternity service at University Hospital Kerry as recommended in the National Standards. Women requiring review by a fetal medicine specialist were referred to the fetal medicine unit at Cork University Maternity Hospital for a multidisciplinary assessment, management and support. This is also good practice.

Midwifery and medical staff carried out a risk assessment on all women attending the maternity service by at the booking visit, during pregnancy, during and after birth. A consultant obstetrician triaged all general practitioner referral letters received at the hospital. The hospital had a high-risk antenatal clinic which ran three times a week and was led by a consultant obstetrician.

The hospital also had combined obstetric and diabetic antenatal clinic which ran weekly and was facilitated by a consultant obstetrician and a consultant endocrinologist. Women were referred to these specialist clinics based on their risk factors or underlying medical conditions.

Women with significant co-morbidities, for example, those with cardiac and or respiratory conditions and or severe obesity were referred to the fetal medicine unit

in Cork University Maternity Hospital. Similarly, women with placental abnormalities requiring interventional radiology were referred to Cork University Maternity Hospital.

The South/South West Hospital Group had formally ratified and implemented a mandatory policy for the inter-hospital transfer of women and or infants across the maternity services in the hospital group. This meant that women who required specialised care were transferred from University Hospital Kerry to Cork University Maternity Hospital. This is good practice.

Admission pathway

There were various pathways for the admission of pregnant women at the hospital. During and outside of core working hours[‡‡‡] pregnant women at less than 24 weeks' gestation and postnatal women who presented with pregnancy-related problems were assessed and reviewed in the Emergency Department at the hospital. If admission to the hospital was indicated following assessment, women at less than 24 weeks gestation were admitted to the gynaecology ward.

Pregnant women who presented to the hospital at greater than 24 weeks' gestation went directly to the antenatal ward for assessment which was part of the Labour Ward. Staff reported that women booked at the hospital were familiar with this arrangement and usually phoned the antenatal ward in advance. Pregnant women who presented to the hospital in labour went directly to the Labour Ward for assessment and management. After 10pm, access to the maternity unit was through the hospital Emergency Department.

Pregnant or postnatal women who presented to the hospital's Emergency Department with a surgical or medical condition unrelated to their pregnancy were assessed by the Emergency Department medical team and were then referred to the relevant surgical team or medical team. Inspectors were informed that the obstetric team would also be contacted to review or advise on the care of these pregnant women in line with the National Standards.

3.1.2 Access to specialist care and services for women and newborns

There was direct access to general surgeons, consultant endocrinologists and consultant psychiatrists onsite at the hospital. Clinical staff could access these specialties as needed for women attending the maternity service.

[‡‡‡] The self-assessment tool submitted by University Hospital Kerry reported that core working hours for medical staff at the hospital ranged from 08.00hrs to 17.00hrs Monday to Friday.

At the time of both inspections, the hospital did not employ consultant doctors in the specialties of cardiology, haematology or respiratory medicine.[§§§] Women requiring referral to a consultant cardiologist or respiratory physician were referred to Cork University Hospital. There was telephone access to the haematology team in Cork University Hospital on a 24 hour basis.

Previous HIQA inspections at University Hospital Kerry in 2015 and 2017,[10] highlighted the lack of 24 hour consultant microbiologist cover at the hospital as an area requiring improvement. In October 2018, inspectors were informed that a consultant microbiologist was onsite at University Hospital Kerry two days a week and outside of that, consultant microbiologist advice was available by telephone from Cork University Hospital 24 hours a day. At the time also, the hospital did not have a bereavement support midwife or an onsite medical social worker. Hospital managers had worked to address this specialist staffing deficit and by August 2019 the hospital had appointed a number of specialised roles in the Maternity Unit. These included a clinical midwife specialist in bereavement and a diabetic nurse specialist to support the care of women attending the maternity service at the hospital.

However, despite this development, some specialist support positions, described in section 2.2.1 of this report, remained unfilled at the hospital in August 2018. Hospital management had identified the need for one WTE consultant microbiologist, two WTE consultant respiratory physicians and two WTE consultant cardiologists. Deficiencies in relation to specialist staff resources at the hospital need to be addressed.

Anaesthesiology services

Obstetric anaesthesiologists are required on-site to assist with the resuscitation and care of women who become critically ill due to pregnancy-related conditions such as haemorrhage and pre-eclampsia.[****] They are also responsible for the provision of pain relief such as epidurals for women in labour and for the provision of anaesthesia for women who require caesarean section and other surgery during birth. Guidelines[8] and National Standards recommend that there is an agreed system in place for the antenatal assessment of high risk mothers to ensure that the anaesthetic service is given sufficient notice of women at higher risk of potential complications.

Pregnant women requiring anaesthetic review were referred antenatally to the anaesthetic team in University Hospital Kerry and were then reviewed by a

[§§§] Subsequent correspondence from hospital management in July 2019 stated that part-time cardiology and haematology services were available at the hospital with onsite presence 1-2 days weekly.

[****] Pre-eclampsia is a medical condition where high blood pressure and protein in the urine develop during pregnancy. This condition can lead to the development of eclampsia which may be life threatening.

consultant anaesthesiologist. Inspectors were informed that women scheduled for elective caesarean section with identified anaesthetic risks were referred to Cork University Maternity Hospital.

High dependency and intensive care

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

Inspectors found that the Maternity Unit at University Hospital Kerry was not resourced or equipped to facilitate the provision of Level 2 care.[††††] In the absence of this facility, as is the case in a number of smaller maternity units in Ireland,[11] pregnant and postnatal women were cared for in the general Intensive Care Unit at the hospital if their condition necessitated level 2 or level 3[‡‡‡‡]care.

Care of pregnant and postnatal women in the Intensive Care Unit at the hospital was overseen by the obstetric team in conjunction with the anaesthetic team. Pregnant or postnatal women admitted to this unit were reviewed daily by the obstetric team and midwifery care was provided by midwives from the Maternity Unit. Women who required more advanced critical care in a Level 3[§§§§] critical care unit were transferred to Cork University Hospital. This is good practice.

Neonatal care

Neonatal care was led by consultant general paediatricians who undertook routine newborn care as part of their duties and on-call roster. The paediatric team provided 24 hour cover to the Labour Ward and for operative births. Newborns that required therapeutic cooling[*****] for neonatal encephalopathy[†††††] had passive cooling commenced at the hospital and were then transferred to a level 3 neonatal unit in Cork or Dublin. Urgent transfers of newborns requiring neonatal intensive care were

[††††] Level 2 is the level of care needed for patients requiring invasive monitoring and or intervention including support for a single failing organ system (excluding advanced respiratory support).

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

[§§§§] A level 3S critical care unit provides general critical care, multi-organ support, multispecialty support and critical care specialties for example neurocritical and cardiothoracic.

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

[†††††] Neonatal encephalopathy (NE) is a broad term for neurological dysfunction in an infant and can stem from a wide variety of causes, including hypoxic-ischemic injury, infection, neonatal stroke, traumatic birth, and more.

organised through the National Neonatal Transport Programme.[‡‡‡‡‡] The Special Care Baby Unit at the hospital provided care for these babies when they were transferred back from the level 3 neonatal unit for ongoing care.

Documentation submitted by hospital management to HIQA in 2018 stated that University Hospital Kerry had a Level 1 Neonatal Unit. Level 1 neonatal units provide routine neonatal care to term infants, and special care to infants of 32 weeks gestation or more. Infants of 30-31 weeks' gestation can be cared for in a Level 1 neonatal unit if the appropriate nursing and paediatric medical staffing complement is available. During HIQA's first inspection, there was an apparent lack of clarity among staff regarding the gestational age of newborns that the hospital was capable of managing in line with the nationally agreed neonatal model of care for a level 1 neonatal unit.[12] It is imperative that all staff are clear in relation to local arrangements and controls for the provision of neonatal care in line with the national model of care. The risk identified by HIQA in relation to the lack of a clearly defined pathway for neonatal care was escalated to the Chief Executive Officer of the South/South West Hospital Group in October 2018.

Some improvement was noted during the follow-up inspection in August 2019. At that time inspectors found that there was increased awareness regarding the management of cases of newborns born at 32 weeks' gestation or less at the hospital. Obstetric and paediatric consultant staff liaised closely with tertiary level maternity hospitals to ensure that all newborns were cared for in the most appropriate clinical setting.

3.1.3 Communication

Emergency response teams

There was an established communication procedure for requesting the attendance of designated response teams 24 hours a day for obstetric and neonatal emergencies at the hospital whereby a multidisciplinary response team could be summoned for an emergency.

Multidisciplinary handover

Inspectors identified that, during both HIQA inspections in October 2018 and August 2019, the nationally mandated guideline[13] in relation to clinical handover in maternity services had not been fully implemented at the hospital. Clinical handover in the Labour Ward appeared to comprise largely of verbal communication between

[‡‡‡‡‡] The National Neonatal Transport Programme is a retrieval service for the stabilisation and transportation of premature and sick neonates up to the age of six weeks corrected gestational age, who require transfer for specialist care within Ireland and abroad. The service operates 24/7.

obstetric team non-consultant hospital doctors going off call and obstetric medical staff coming on duty. HIQA is of the view that this deficiency should be addressed at the hospital.

A clinical handover meeting in the Labour Ward was scheduled for 8am each day and staff attendance was recorded. Records reviewed by inspectors and discussions had with midwifery and medical staff indicated that consultant medical staff did not consistently attend the clinical handover meeting. In that situation, inspectors were informed that clinical information about women in the Labour Ward was communicated during ward rounds.

The antenatal ward was adjacent to the Labour Ward and was managed and staffed by staff from the Labour Ward. The care of women admitted to the antenatal ward was the responsibility of a woman's designated consultant obstetrician and corresponding obstetric team. During both HIQA inspections, inspectors were informed that some consultant obstetricians did not conduct daily ward rounds in the antenatal ward and or in the Labour Ward as recommended in the National Standards. It is HIQA's view that this arrangement requires review.

There are a number of clinical situations where relevant obstetric, anaesthesiology or paediatric consultants should be notified, for example in cases of massive obstetric haemorrhage, complex delivery, or difficult caesarean section. It was practice in the Maternity Unit for the most senior non-consultant hospital doctors in obstetrics to discuss complex cases and transfers with the relevant consultant obstetrician. The obstetric team discussed anticipated births of less than 32 weeks' gestation and or women with high-risk pregnancies with staff in the Special Care Baby Unit and the neonatal team on call. However, staff told inspectors that the anaesthetic team was not consistently informed of potential high-risk cases. HIQA recommends that the National Clinical Guideline in relation to Communication (Clinical Handover) in Maternity Services must be implemented. The hospital should have a policy on clinical handover which designates a lead healthcare professional to manage inter-departmental clinical handover and the shift clinical handover process. The policy should be clear about the transfer of responsibility during and following shift clinical handover. There should be guidelines around communication of information to consultant medical staff.

National Maternal and Newborn Clinical Management System

HIQA acknowledge the significant developments made in the implementation of the National Maternal and Newborn Clinical Management System at University Hospital Kerry. This electronic healthcare record system was available to staff in the Labour Ward, the Special Care Baby Unit, the Operating Theatre Department and the

Emergency Department. The hospital was planning to extend the system to other clinical areas.

Notwithstanding the developments with the electronic healthcare record system, opportunities exist to improve the system. Staff expressed a need for further support and training in relation to the use and navigation of the electronic healthcare system. To further support its implementation, the hospital should ensure that staff at the hospital can access the technical support and training required to optimise the use of this system.

3.1.4 Written policies, procedures and guidelines

Hospital policies, procedures and guidelines were accessible to staff in the clinical areas inspected. Policies, procedures and guidelines for use in the Maternity Unit were approved by and signed off at the Maternity Clinical Governance Group. At the time of both inspections, the hospital did not have a centralised document management system and the requirement for such a system had been communicated to the hospital group.

Staff in the Labour Ward had access to a number of guidelines in relation to obstetric emergencies for example, post-partum haemorrhage and umbilical cord prolapse. During the inspections, there was limited evidence to indicate that the effective implementation and adherence to policies, procedures and guidelines were routinely evaluated. Staff in the Special Care Baby Unit had access to policies, procedures and guidelines from both University Hospital Kerry and Cork University Maternity Hospital.

HIQA recommends that the storage and management of hospital policies, procedures and guidelines be improved at the hospital. Implementation of hospital policies, procedures and guidelines should be audited.

Inspectors were informed that a safe surgery checklist[§§§§§] was completed for emergency and elective surgical procedures in obstetric operating theatres. The Maternity Unit had a standardised procedure for the estimation and measurement of maternal blood loss. These are good practices.

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

3.1.5 Maternity service infrastructure, facilities and resources

Operating theatre for obstetric surgery

The National Standards recommend a staffed dedicated obstetric theatre in or adjacent to the Labour Ward. Obstetric surgery was performed in the Operating Theatre Department at the hospital which included five operating theatres located on the first floor of the hospital. The hospital's operating theatre complex was not adjacent to or directly vertically above or below the ground floor maternity unit. The location of the operating theatre in relation to the Labour Ward was identified as a risk on the hospital's risk register. In October 2018, hospital management told inspectors that plans to provide additional theatre capacity and to relocate the Labour Ward was prioritised as a capital project. When completed, this would mean that a dedicated obstetric operating would be adjacent to the Labour Ward. At that time, the risk identified by HIQA in relation to the lack of an obstetric operating theatre adjacent to the Labour Ward was escalated to the Chief Executive Officer of the South/South West Hospital Group.

By August 2019, hospital management had implemented a number of interventions to militate against the risk identified by HIQA in relation to the time it may take to transfer women to the operating theatre in the case of an obstetric emergency.

The first intervention was the installation of a self-grounding lift in the Maternity Unit which was used to transfer women from the Maternity Unit to the Operating Theatre during an obstetric emergency. This lift was only accessible by staff.

The re-organisation of operating theatre schedules was another intervention implemented so as to ensure that the hospital had an emergency operating theatre available at all times. This operating theatre was staffed from within the daily operating theatre staff complement. Inspectors were told by staff that obstetric emergency cases took priority. In order to ensure timely access to an operating theatre, an emergency case did not proceed in the Operating Theatre Department without first communicating with the Labour Ward to determine the potential of an obstetric emergency arising. By the time of the follow-up inspection in August 2019, work constructing a Maternity Unit on the same floor as the Operating Theatre Department had not commenced and there was no agreed timeframe for commencement of this work.

Given the type of services provided at University Hospital Kerry, there is always a potential for concurrent surgical emergencies (including obstetric surgical emergencies). The hospital must have the capacity to safely manage such occurrences. During both inspections, staff at the hospital had identified the need to

increase the number of operating theatre nurses on call outside of core working hours. Business cases for additional nurse and anaesthetic staffing outside of core working hours submitted by hospital management have been approved by the South/South West Hospital Group but funding is awaited from the HSE. In the interim, while waiting for the funding, in the event of concurrent emergencies outside of core working hours, hospital management need to have contingency plan to support the on-call operating theatre nursing and anaesthetic team. Arrangements for redeploying specific staff to the operating theatre outside of core working hours need to be formalised and strengthened through the provision of experience and training.

Maternity Unit

Maternity services at the hospital were provided in the following clinical areas:

- the Labour Ward
- the Fetal Assessment Unit
- a gynaecology ward
- an antenatal ward
- a postnatal ward
- a special care baby unit.

The Labour Ward and inpatient wards for women using the maternity service were located on the ground floor of the hospital. The Special Care Baby Unit, the Operating Theatre Department and the Intensive Care Unit were located on the floor above.

The midwifery staff allocated to the Labour Ward were also responsible for the care and oversight of women admitted to the antenatal ward. These areas were separated by secure doors. This configuration should be reviewed particularly in the context of observation of women and timely accessibility between these areas.

Emergency assessment areas

Pregnant women who presented at the hospital with bleeding and required resuscitation were taken directly to the resuscitation room in the Emergency Department. The Emergency Department had an assessment room designated for pregnant women with ensuite toilet facilities but this room was not always available because of activity levels in the Emergency Department. Hospital management should review the arrangements to ensure that there is consistent access to a suitable clinical assessment environment that promotes and protects the privacy and dignity of pregnant and or postnatal women who present to the Emergency Department.

Labour ward

The Labour Ward comprised a four-bedded assessment room and four single rooms. None of the single rooms in the Labour Ward had ensuite toilet and shower facilities.

Antenatal ward

The Antenatal Ward comprised one six-bedded room and a four-bedded assessment room. Two single rooms were shared with the gynaecology ward.

Postnatal ward

The Postnatal Ward comprised 22 beds which included three six-bedded rooms and four single rooms. Space in the six bedded rooms was very limited when the adult beds and baby cots were occupied.

Gynaecology ward

The Gynaecology Ward comprised one six-bedded room. There was also access to two single rooms which were interchangeable with the antenatal ward depending on service needs on a particular day.

Fetal Assessment Unit

This unit was upgraded in 2018. It comprised two examination rooms equipped with fetal ultrasound and fetal monitoring equipment.

Special Care Baby Unit

The Special Care Baby Unit at the hospital could accommodate up to 10 cots. Occasionally the unit accommodated up to 12 cots during busy periods. The layout of the unit included four single rooms, one multi-occupancy room for up to four cots and an intensive care room that could accommodate two cots. Overall, floor space in the unit was very limited.

In October 2018, inspectors found that an unused baby incubator was stored in a 'dirty' utility room[******] which was not an appropriate storage location for this equipment. At that time, inspectors were informed that babies less than one week old were sometimes re-admitted from home to the Special Care Baby Unit for the management of respiratory infection. This was a concern because of the potential risk of transmission of respiratory infection to other newborn babies.

[******] A room equipped for the disposal of body fluids and the decontamination of reusable equipment such as bedpans, urinals, commodes and body fluid measuring jugs. Waste, used linen and contaminated instruments may also be temporarily stored in this room prior to collection for disposal, laundering or decontamination.

The practice of re-admitting babies from home to the Special Care Baby Unit remained in place in August 2019. Although infrequent, this practice continues to present a risk of transmission of infection to newborns in the unit. This practice needs to be reviewed in the wider context of provision of paediatric services at the hospital.

Laboratory services

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

3.1.6 Maternity service equipment and supplies

Emergency supplies and medications were readily available in the clinical areas inspected to manage obstetric emergencies such as maternal haemorrhage, pre-eclampsia and neonatal resuscitation. There was also evidence that cardiotocography†††††† machines for fetal monitoring had been serviced. However, despite this, during the first inspection, HIQA identified risks in relation to limited access to emergency equipment and piped oxygen and suction in the postnatal ward.[14] These risks were escalated to the Chief Executive Officer of the South/South West Hospital Group in October 2018. At that time, hospital management provided written assurance to HIQA that deficiencies in relation to the availability of piped oxygen and suction and an automated external defibrillator would be addressed.

In August 2019, inspectors found some improvement in the availability of essential emergency equipment in the postnatal ward. A defibrillator was available on the ward. However, the work to supply piped oxygen and suction to bed spaces in multi-occupancy rooms in the postnatal ward was not completed. Hospital management told inspectors that a contingency plan was in place. The hospital were planning infrastructural works to supply piped oxygen and suction to the cohort of beds not currently supplied in the multi-occupancy rooms. Funding was required from the HSE to progress this.

Table 5 on the following pages list the National Standards relating to effective care and support focused on during both inspections and key findings in relation to the hospital's level of compliance with the National Standards monitored during both HIQA inspections.

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

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

Standard 2.1 Maternity care reflects best available evidence of what is known to achieve safe, high-quality outcomes for women and their babies.	
Judgment October 2018	**Not reviewed in August 2019**
Substantially compliant	Substantially compliant
Key findings: Some policies, procedure and guidelines required updating. There was limited evidence to indicate that implementation of maternity service policies, procedures and guidelines were evaluated.	
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.	
Judgment October 2018	**Judgment August 2019**
Partially compliant	Substantially compliant
Key findings: In the context of obstetric emergencies inspectors found the following; lack of a staffed dedicated obstetric operating theatre in or adjacent to the Maternity Unit; lack of consistent communication with anaesthetic team in relation to high risk for anaesthesia cases and lack of supernumerary lead senior midwife shift co-ordinators.	**Key findings:** The hospital had appointed a number of specialised roles in the Maternity Unit including a clinical midwife specialist in bereavement and a diabetic nurse specialist. Some specialist support positions remained vacant at the hospital.
Going forward, deficiencies in relation to specialist staff resources at the hospital need to be addressed.	

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 2.3 Women and their babies receive integrated care which is co-ordinated effectively within and between maternity and other services.	
Judgment October 2018	**Judgment August 2019**
Judgment: Substantially compliant	**Judgment:** Substantially compliant
Key findings: The National Clinical Guideline in relation to Communication (Clinical Handover) in Maternity Services was not fully implemented as attendance by consultant medical staff at clinical handover was inconsistent.	**Key findings:** Some consultant obstetricians did not undertake a daily ward round in the antenatal ward and did not consistently attend clinical handover.
Good forward, the National Clinical Guideline in relation to Communication (Clinical Handover) in Maternity Services must be implemented. The hospital should have a policy on clinical handover which designates a lead healthcare professional to manage inter-departmental clinical handover and the shift clinical handover process. The policy should be clear about the transfer of responsibility during and following shift clinical handover.	
Standard 2.4 An identified lead healthcare professional has overall clinical responsibility for the care of each woman and that of her baby.	
Judgment October 2018	**Not reviewed in August 2019**
Judgment: Compliant	**Judgment:** Compliant
Key findings: An identified lead healthcare professional has overall clinical responsibility for the care of each woman and that of her baby.	

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 2.5 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 October 2018	**Not reviewed in August 2019**
Judgment: Substantially compliant	**Judgment:** Substantially compliant
Key findings: Lack of consistency of consultant ward rounds at weekends.	
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.	
Judgment October 2018	**Judgment August 2019**
Judgment: Non-compliant	**Judgment:** Non-compliant
Key findings: Obstetric operating theatre for emergency cases was not adjacent to the Labour Ward. Limited space in the special care baby unit. Practice of admitting babies with infection from home into the Special Care Baby Unit.	**Key findings:** Dedicated self-grounding lift was installed in the Maternity Unit for use in the case of obstetric emergencies. However, there were no other improvements to the infrastructure of the Maternity Unit since the first inspection in October 2018.
Standard 2.8 The safety and quality of maternity care is systematically monitored, evaluated and continuously improved.	
Judgment October 2018	**Judgment August 2019**
Judgment: Partially compliant	**Judgment:** Substantially compliant
Key findings: Limited perinatal and maternal morbidity and mortality meetings. Limited clinical audit. Inconsistent attendance by senior clinicians at meetings where clinical incidents were discussed.	**Key findings:** There were improved measures in place to monitor, evaluate and continuously improve the safety and quality of maternity care as evident by a series of measures planned to address a caesarean section rate that was higher than the national rate.
Going forward, the multidisciplinary team need to increase clinical audit activity, implement regular perinatal morbidity and mortality meeting and regular maternal morbidity meetings to promote and enhance care and the sharing of learning.	

3.2 Safe Care and Support

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

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

Inspection findings

3.2.1 Maternity service risk management

Risks in relation to the maternity service were recorded in clinical area risk registers and in the corporate risk register for University Hospital Kerry. Inspectors were informed that the corporate risk register was reviewed by hospital management every month and also quarterly at hospital management performance meetings with the South/South West Hospital Group.

At the time of both HIQA inspections, there were risks recorded in the hospital's corporate risk register that were relevant to this monitoring programme. This included risk associated with the:

- staff recruitment difficulties and staff deficiencies
- lack of access to an emergency operating theatre
- absence of a second on-call nursing team for the operating theatre
- non-adjacent theatre in the Labour Ward
- inability to release staff for training
- lack of systemic audit
- lack of administrative support for risk management
- non-compliance with clinical handover.

Clinical incident reporting

In line with national guidelines, patient safety incidents that occurred at the hospital were reported onto the National Incident Management System.[‡‡‡‡‡‡] The

[‡‡‡‡‡‡] The State Claims Agency's National Incident Management System is a risk management system that enables public hospitals to report incidents in accordance with their statutory reporting obligations.
[‡‡‡‡‡‡]Serious Reportable Events are a defined subset of incidents which are either serious or that should not occur if the available preventative measures have been effectively implemented by healthcare providers. The HSE

management of serious incidents and serious reportable events[§§§§§§] was overseen at hospital-level by the serious incident management team. This team was convened whenever a serious incident occurred.

During the inspection there was evidence that clinical incidents reported by clinical staff were discussed at the Maternity Clinical Governance Group meetings every week. However, during the first HIQA inspection, inspectors identified that two specific significant clinical incidents referenced in minutes of meetings of the Maternity Clinical Governance Group did not appear to have been reviewed in a timely manner. In light of this finding, HIQA asked hospital management to review, as a priority, the two identified clinical incidents.

In October 2018, inspectors also found that not all clinical incidents at the hospital were regularly tracked and trended to identify common themes and areas for improvement. There was a lack of consensus among staff who spoke with inspectors regarding the type of clinical incidents that required reporting. A review of the hospital's Maternity Patient Safety Statements[*******] showed that there was a relative under reporting of clinical incidents at the hospital.

During the follow-up inspection in August 2019, inspectors found that the level of clinical incident reporting had improved at the hospital. All reported clinical incidents were reviewed at weekly maternity governance meetings. Incidents were also discussed at a daily teleconference with the Clinical Director for the Maternity Directorate of the South/South West Hospital Group. The hospital had recently formed a Maternity Incident Management Team to oversee the management of clinical incidents. Membership of this group comprised senior medical and midwifery staff and senior management representation.

During the August 2019 inspection, hospital management told inspectors that deficiencies in administrative staffing levels impacted on the timely uploading of data to the National Incident Management System. It is imperative that clerical supports be put in place to ensure that the necessary information is uploaded to the National Incident Management System within specified times. Deficiencies in this regard should be addressed.

requires that Serious Reportable Events are mandatorily reportable by services to the Senior Accountable Officer of the service.

[*******] 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.

Feedback from women

Staff in the Labour Ward endeavoured to deal with any concerns raised by women attending the unit as they arose. Compliments from women using the service were recorded.

3.2.2 Maternity service monitoring and evaluation

Clinical outcome and activity measurements in relation to the maternity service were gathered at the hospital each month in line with national HSE Irish Maternity Indicator System reporting requirements.[15] The hospital also published monthly Maternity Patient Safety Statements in line with national HSE reporting requirements.

The Irish Maternity Indicator System[†††††††] provides important information in relation to maternity service activities and outcomes. However, this data on its own does not provide an overall picture of the quality and safety of maternity services for all women receiving maternity care at University Hospital Kerry.

Due to considerable variation in caesarean section rates across Ireland, maternity services are advised to analyse births and outcomes using the Robson 10-Group Classification Scheme.[15] In October 2018 there was no evidence that the hospital was using Robson 10-Group Classification Scheme. At that time, the average monthly caesarean section rate at the hospital ranged from 42% to 49%.

In August 2019, inspectors found that hospital management had implemented improved measures to monitor, evaluate and continuously improve the safety and quality of the maternity service at the hospital. Such measures included:

- inclusion of discussions about vaginal birth after caesarean section with women at parent craft classes and in the postnatal ward
- implementation of a vaginal birth after caesarean section clinic
- formation of a subgroup to review the Robson Classification groups who contributed most to the increased caesarean section rate
- meeting with general practitioners who shared care of pregnant women.

The hospital also identified that the rate of general anaesthetic for caesarean sections was high and planned to address this through review of staff skills. Other improvements noted on this inspection included the proactive implementation of improvement measures to address a greater than expected surgical site infection

[†††††††] This Irish Maternity Indicator System (IMIS) encompasses a range of multidisciplinary metrics, including hospital management activities, deliveries, serious obstetric events, neonatal, and laboratory metrics. It provides within-hospital tracking of both monthly and annual data. It also provides national comparisons across all maternity units, allowing hospitals to benchmark themselves against national average rates and over time.

rate. These examples show that the multidisciplinary team were committed to making improvements.

Following both HIQA inspections, the multidisciplinary team now need to action the above plans and build on progress to date in relation to clinical audit. Implementation of regular perinatal morbidity and mortality meetings and maternal morbidity meetings is also essential in the context of sharing learning.

While noting the mechanisms in place to measure and benchmark outcome measures in this hospital, the National Standards also recommend that service providers use multiple sources of information to evaluate the effectiveness of maternity care for example, audit of clinical practice, feedback from healthcare professionals, and concerns, complaints and compliments from women using the service. Such information could be used to proactively implement maternity service improvements at the hospital. At the time of this inspection, hospital management were not optimising the use of multiple sources of valuable information to assess and assure the effectiveness of the maternity service.

Clinical audit

Maternity services should have an agreed annual plan for audit in line with a structured quality improvement programme with participation in national audit programmes, and local, targeted audits conducted in line with service requirements and priorities.

Inspectors found that during the first inspection in October 2018, clinical audit activity in the maternity service was limited and was not centrally planned or overseen at the hospital. When audits are completed, opportunities for improvement need to be addressed in a timely manner.

At that time, HIQA suggested that implementation of the national sepsis guidelines at the hospital should be regularly audited so that hospital management are assured that these guidelines have been fully implemented. This would, together with outcome measures, provide the necessary assurances about the quality and safety of maternity services at the hospital.

Inspectors found some improvement in audit activity during the follow-up inspection in August 2019. At that time, clinical audit in the Maternity Unit was in the early stages of development and hospital management were working to enhance this. A clinical audit plan for 2019 had been formally ratified by the hospital's Maternity Clinical Governance Committee and a number of audits were in progress. A hospital-group level audit in relation to sepsis identification and management has been carried out at the Maternity Unit in 2019. Overall findings from a small sample of six

cases were positive and highlighted improvements from previous audit results relating to sepsis.

Through surgical site infection surveillance, the hospital had identified an upward trend in the rate of caesarean section wound infection. This trend was proactively addressed by staff in the Maternity Unit through staff education and the implementation of a wound care bundle.

Maternal and perinatal morbidity and mortality multidisciplinary meetings

Formal maternal morbidity meetings facilitate regular consideration and detailed discussion of issues and learning relating to maternal and perinatal morbidity.

Inspectors were informed that perinatal morbidity and mortality meetings were held at the hospital every three months. However, in October 2018 it was reported that formal maternal morbidity meetings were not held at the hospital. Inspectors were informed that, instead, maternal morbidity was discussed during review of clinical incidents at the Maternity Clinical Governance Group. Inspectors were told that attendance by relevant hospital consultants was not always consistent.

By August 2019, the hospital had commenced maternal morbidity meetings. Hospital management should continue with the regular review of maternal and perinatal morbidity and mortality at the hospital and ensure reviews and reciprocal learning is co-ordinated and communicated in an appropriate manner.

3.2.3 Quality improvement initiatives

Maternity service providers should implement, review and publicly report on a structured quality improvement programme.[1] In October 2018, inspectors found that there was a lack of a structured proactive approach to quality improvement at the hospital. Notwithstanding this finding, HIQA also found that the South/South West Hospital Group had supported the implementation of a number of key improvements at the hospital in 2018 which included the following:

- Universal fetal anomaly scanning implementation at the hospital in July 2018.
- Implementation of the Maternal Newborn Clinical Management System in 2017 to facilitate electronic maternal healthcare record keeping.

In August 2019, the use of quality improvement methodology to improve maternity care at the hospital was in the early stages of development. There was evidence of the implementation of some quality improvement initiatives and measures to enhance the safety and quality of maternity service at the hospital. These measures included surveillance of surgical site infection and the implementation of care bundles.

Midwives at the hospital had participated in a hospital group-level project team working to standardise training, policies and care pathways. As a result of this collaboration additional improvements to support the management of an obstetric emergency had been implemented at the hospital. Each room in the Labour Ward had obstetric emergency flow charts which staff could refer to in an emergency situation. The Labour Ward and the postnatal ward were equipped with emergency trolleys which contained essential supplies for managing an obstetric emergency. A policy had also been developed in relation to the immediate management of a collapsed baby. Learning notices were used in the Maternity Unit to sharing learning with staff.

University Hospital Kerry needs to continue to expand upon quality improvement work and work towards implementing a structured quality improvement programme.

The position of quality manager was vacant in August 2019; this needs to be addressed by hospital management so that there is support to facilitate quality improvement at the hospital.

Table 6 on this and the following pages list the National Standards relating to safe care and support focused on during both HIQA inspections and key findings in relation to the hospital's level of compliance with the National Standards monitored during both inspections.

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 October 2018	**Judgment August 2019**
Partially compliant	Substantially compliant
Key findings: Underdeveloped measures to identify quality and safety risks in the service. An absence of evidence to demonstrate learning from safety concerns.	**Key Findings:** All reported clinical incidents were reviewed by members of the Maternity Governance Committee and were discussed at a daily teleconference with the Clinical Director for the hospital group's Maternity Directorate. The Maternity Incident Management Team oversaw the management of clinical incidents at the hospital. Learning notices were used as a means of sharing learning from reported clinical incidents with staff.

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 3.3 Maternity service providers monitor and learn from information relevant to providing safe services and actively promote learning, both locally and nationally.	
Judgment October 2018	**Not reviewed in August 2019**
Partially compliant	Partially compliant
Key findings: Lack of timely review of patient safety incidents.	
Standard 3.4 Maternity service providers implement, review and publicly report on a structured quality improvement programme.	
Judgment October 2018	**Judgment in August 2019**
Non-compliant	Partially compliant
Key findings: Limited evidence of quality improvement and absence of a structured quality improvement programme.	Key findings: Quality improvement in relation to the maternity service at the hospital was in the early stages of development. The Maternity Unit had implemented some quality improvement initiatives, for example the surveillance of surgical site. Measures to improve quality at the hospital included staff education, change to clinical practice and the implementation of care bundles. The position of quality manager was vacant in August 2019; this needs to be addressed by hospital management so that there is support at the hospital to facilitate quality improvement.
Going forward, the hospital needs to continue to expand on quality improvement and implement a structured quality improvement programme. A quality manager needs to be appointed to support and facilitate quality improvement at the hospital.	

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 3.5 Maternity service providers effectively identify, manage, respond to and report on patient safety incidents.	
Judgment October 2018	**Judgment August 2019**
Partially compliant	Substantially compliant
Key findings: Low levels of clinical incident reporting as evident in published Maternity Patient Safety Statements, relatively limited patient safety incident reviews, and poor mechanisms for dissemination of learning and feedback.	**Key findings:** There was improved clinical incident reporting in the Maternity Unit. A Maternity Incident Management Team had been formed to provide oversight of clinical incidents by senior clinicians and hospital management. However, clinical incidents were not uploaded to the National Incident Management System within specified timeframes.
Going forward, hospital management must provide a dedicated administrative resource to ensure that clinical incidents are uploaded to the National Incident Management System in a timely manner and within specified timeframes.	

4.0 Conclusion

Maternity services should have effective leadership, governance and management arrangements in place to ensure best practice and safe service provision. These arrangements should be underpinned by risk management and audit, multidisciplinary guidelines, adequate staffing resources, adequate equipment, and sufficient training and education for clinical staff, to facilitate the delivery of safe care and the effective management of obstetric emergencies.

During the first inspection at University Hospital Kerry in October 2018, HIQA identified a number of risks in relation to the quality and safety of the maternity services at the hospital. The risks identified related to:

- leadership, governance and management
- staff resources
- staff training
- hospital infrastructure and equipment.

In summary, HIQA found that the overall governance of the maternity service at the hospital was weak, the reporting of and learning from clinical incidents was limited, the practice of clinical handover was not aligned to nationally mandated guidelines and audit within the service was insufficiently resourced. The risks identified during this inspection were formally communicated by HIQA to the Chief Executive of the South/South West Hospital Group in October 2018.

In August 2019, at the time of the follow-up inspection, hospital management had successfully addressed the majority of risks identified by HIQA. However, a number of issues still need to be addressed. Specifically hospital management needs to:

- include the Director of midwifery in the Executive Management Board in line with National Standards
- increase anaesthesiology cover at the hospital in line with national recommendations, at a minimum there should be two non-consultant hospital doctors on call onsite at the hospital outside of core working hours
- improve nurse staffing arrangements outside of core working hours in the Operating Theatre Department so that concurrent surgical emergencies can be managed with ease
- progress the appointment of key support positions to optimise the provision of maternity services at the hospital
- implement the national guidelines for clinical handover in maternity services.

Hospital management had submitted business cases for essential medical and midwifery and support staff but these were declined or were pending approval. The

South/South West Hospital Group and the HSE need to support and fund the hospital to address deficiencies and workforce requirements.

At the time of both inspections, the South/South West Hospital Group was in the process of establishing a maternity network. In the interim, there was evidence of collaborative working arrangements which ensured that the smaller maternity units in the hospital group were supported by larger tertiary maternity hospital - Cork University Maternity Hospital or acute general hospital – Cork University Hospital. The arrangements in place to support the collaborative working across the maternity services included:

- A formalised hospital group level inter-hospital transfer policy facilitated the mandatory transfer of women and newborns requiring specialised care from University Hospital Kerry to Cork University Maternity Hospital and Cork University Hospital.
- University Hospital Kerry and University Maternity Hospital Cork had implemented the National Maternal and Newborn Clinical Management System in line with the National Standards. This facilitated the sharing of healthcare records between the two hospitals.
- Cork University Maternity Hospital facilitated and supported the training of fetal ultrasonographers to implement fetal anomaly scanning at University Hospital Kerry.

During both inspections, the mechanisms used to determine the quality and safety of the maternity service at the hospital were insubstantial. It is critically important that such measures are enhanced at the hospital, so that risk issues might be more effectively identified and militated in a timely way.

The opportunities for improvement identified as part of this monitoring programme and reflected in this report should be reviewed by the maternity hospital/unit and the relevant hospital group with actions for improvement identified alongside a standardised approach for implementation across the maternity hospital/units and hospital group.

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