Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the unannounced inspection of maternity services at Cavan & Monaghan Hospital

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

Dates of inspection: 27 March and 28 March 2019

Safer Better Care

About the Health Information and Quality Authority (HIQA)

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

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

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

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

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

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

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

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

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

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1.0 Information about this monitoring programme

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

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

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

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

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

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

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

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

Figure 1 – Monitoring programme lines of enquiry

LOE 1:

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

LOE 2:

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

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

LOE 3:

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

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

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

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

1.1 Information about this inspection

Cavan & Monaghan Hospital is a statutory acute hospital which is owned and managed by the Health Service Executive. The hospital is part of the Royal College of Surgeons in Ireland (RCSI) Hospital's Group.[†] Cavan & Monaghan Hospital, as part of the RCSI Hospitals Group, worked together as a single cohesive entity managed as one hospital over two sites. The maternity unit is co-located within Cavan & Monaghan Hospital on the Cavan General Hospital site. The hospital provides a range of general and specialist maternity services designed to meet the needs of women with low risk and high risk pregnancies. There were 1,512 births at the hospital in 2018.

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

Table 1: Inspection details

Dates	Times of inspection	Inspectors
27 March 2019	10:50hrs to 19:45hrs	Dolores Dempsey Ryan Siobhan Bourke Emma Cooke Denise Lawler
28 March 2019	07:50hrs to 15:30hrs	

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

- representatives of the hospital's Executive Management Committee
- the hospital's lead consultants or a delegated deputy in each of the clinical specialties of obstetrics, anaesthesiology and paediatrics.

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

[†] RCSI Hospitals is comprised of Beaumont Hospital, Cavan & Monaghan Hospital, Connolly Hospital, Louth County Hospital, Our Lady of Lourdes Hospital – Drogheda, Rotunda Hospital and RCSI (Academic Partner).

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

- Assessment areas where pregnant and postnatal women who presented to the hospital with pregnancy-related concerns were reviewed. These included the hospital's Emergency Department and the Emergency Assessment Unit located in the Maternity Unit.
- 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.
- Operating Theatre Department where women underwent surgery, for example in the case of caesarean section.
- The Special Care Baby Unit where babies requiring additional monitoring and support were cared for.
- The combined antenatal and postnatal ward where women were cared for before and after childbirth.

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

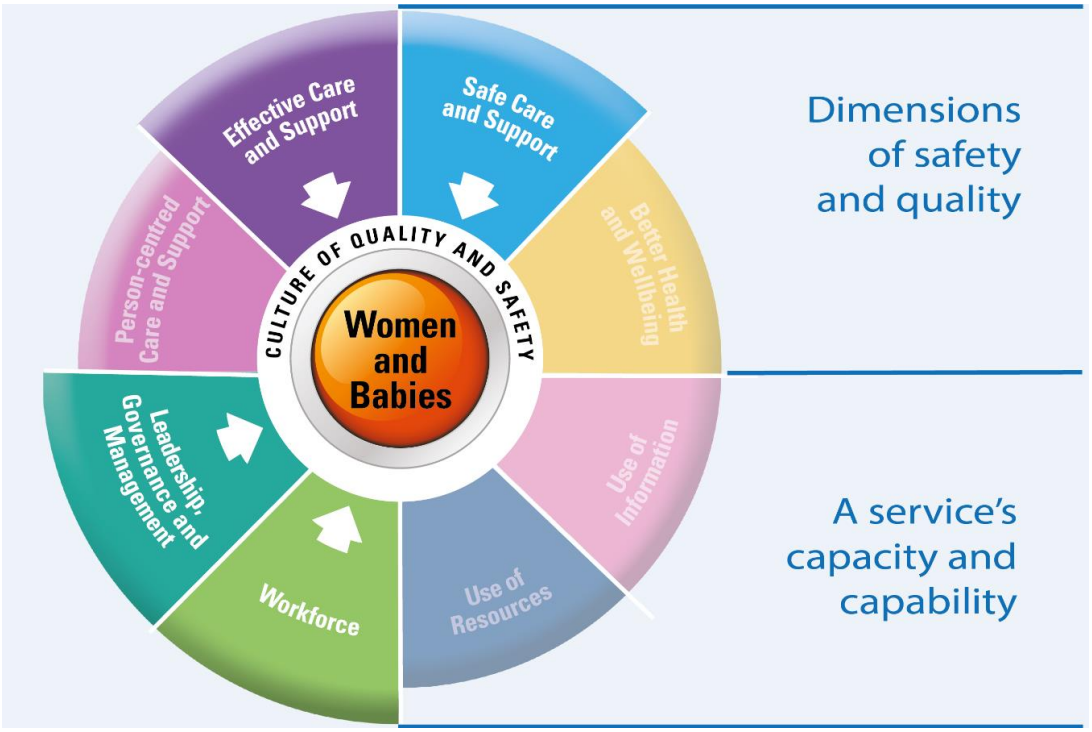
HIQA would like to acknowledge the cooperation of the hospital management team and all staff who facilitated and contributed to this unannounced inspection.

1.2 How inspection findings are presented

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

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

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



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

These categories included the following:

- **Compliant:** A judgement of compliant means that on the basis of this inspection, the maternity service is in compliance with the relevant National Standard.
- **Substantially compliant:** A judgement 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 judgement of non-compliant means that this inspection of the maternity service has identified one or more findings which indicate that the relevant National Standard has not been met, and that this deficiency is such that it represents a significant risk to patients.

Inspection findings will be presented in this report in sections 2, and 3. Section 2 outlines the inspection findings in relation to capacity and capability and Section 3 outlines the inspection findings in relation to the dimensions of safety and quality. Table 2 shows the main report sections and corresponding National Standards, themes and monitoring programme lines of enquiry.

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

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

2.0 Capacity and Capability

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

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

During this inspection, inspectors looked at 10 National Standards in relation to leadership, governance and management and workforce. Of these, Cavan & Monaghan Hospital was compliant with seven National Standards, substantially compliant with two and non-compliant with one National Standard.

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

Inspectors identified a risk during this inspection. Detail of the risk identified was communicated by HIQA in writing to the General Manager at Cavan & Monaghan Hospital and to the Chief Executive Officer of the RCSI Hospitals Group. The response received from the General Manager of the Cavan & Monaghan Hospital on how this risk identified by HIQA was mitigated is described this report.

2.1 Leadership, Governance and Management

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

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

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

Inspection findings

2.1.1 Maternity service leadership, governance and management

Maternity network

At the time of inspection, HIQA found that the maternity service at Cavan & Monaghan Hospital was not part of a formal maternity network under a single governance framework in line with the national maternity strategy.[§]

HIQA noted that the RSCI Hospitals Group had established structures and arrangements that facilitated effective collaborative working arrangements between the maternity units within this hospital group. These maternity units included those located in Cavan & Monaghan Hospital, Our Lady of Lourdes Hospital, Drogheda and the Rotunda Hospital in Dublin. A directors of midwifery forum facilitated collaboration between the directors of midwifery in these three maternity units. Leadership in relation to maternity services in the RCSI Hospitals Group was provided by the Master of the Rotunda Hospital who was the Clinical Director for women and children's health for the hospital group.

The RCSI Hospitals Group had implemented a number of elements of a maternity network that included the formation of Women and Children's Senior Incident Management Forum and the implementation of care pathways for women at higher risk of complications and babies requiring complex neonatal care.

The hospital group had established a Women and Children's Senior Incident Management Forum in 2016. This forum met monthly. The purpose of this forum included the following:

- to provide oversight of clinical incidents and share learning from adverse events across maternity services within the hospital group
- to monitor performance and outcome data and trends in respect of the maternity services and supported the implementation of quality improvement initiatives across the group
- to support shared policies and guideline development. This included guidance documents for consultant obstetrician and gynaecologists, consultant paediatricians and neonatologists outlining certain clinical scenarios where consultants were expected to attend in person. The forum was also progressing with the development of an attendance trigger list for consultant anaesthesiologists.

[§] 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.

Inspectors were informed of plans to hold an annual review meeting in 2019 to share learning and incident review recommendations across all maternity units in the RCSI Hospitals Group.

The formation of the RCSI Hospitals Group maternity network supported the risk stratification of mothers to ensure that women with higher risk pregnancies were transferred and cared for at the most appropriate setting.

The Rotunda Hospital facilitated the implementation of a maternal-fetal medicine care programme across the group. As a result, one consultant obstetrician had a joint appointment between the Rotunda Hospital and Cavan & Monaghan Hospital. This meant that pregnant women identified at higher risk of developing complications following fetal medicine assessment in Cavan & Monaghan Hospital had their care transferred to the Rotunda Hospital. Cavan & Monaghan Hospital had a standard operating procedure for the transfer of a woman to another hospital within the RCSI Hospital Group.

There was also an established neonatal network transfer care pathway in place where infants less than 30 weeks' gestation (in-utero or after birth) and or newborns requiring therapeutic cooling[**] were transferred from Cavan & Monaghan Hospital to the Rotunda Hospital and babies born between 27 and 30 weeks' gestation were transferred to Our Lady of Lourdes Hospital, Drogheda.

A structured onsite interactive maternity and gynaecology teaching and learning programme for clinical staff was facilitated at Cavan & Monaghan Hospital by a consultant obstetrician from the Rotunda Hospital. The RCSI Hospitals Group also facilitated direct access to a perinatal pathology service within the hospital group since 2017.

Cavan & Monaghan Hospital was collaborating and working with the arrangements and structures in place for maternity services across the RCSI Hospitals group. However, the RCSI Hospitals Group needs to progress with the implementation of a managed clinical network for maternity services under a single system of clinical governance, as recommended in the National Maternity Strategy.[4]

Cavan & Monaghan Hospital leadership, governance and management

The General Manager at Cavan & Monaghan Hospital had overall managerial responsibility and accountability for the maternity service at the hospital. The General Manager reported to the Chief Executive of the RCSI Hospitals Group and

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

attended monthly performance meetings with the hospital group management team. The Director of Midwifery, who was responsible for the organisation and management of the midwifery service, was a member of the hospital's Executive Management Team in line with National Standards.

The General Manager was supported in the operational management of the maternity and general hospital services by the Executive Management Committee. This committee was chaired by the General Manager, met monthly and membership included the clinical director, associate clinical directors, clinical leads for obstetrics and paediatric services and the director of midwifery in addition to other senior operational managers at the hospital. The hospital had identified in 2018 that not all members of the Executive Management Committee attended these meetings in line with the terms of reference. To facilitate staff work commitments and improve attendance at the Executive Management Committee meetings, hospital management told inspectors that they were in the process of revising the terms of reference to reflect current membership, to reduce the quorum from seven members to five and to reduce the frequency of meetings from monthly to every second month.

Clinical Leads had been appointed in each of the specialties of obstetrics, anaesthesia and paediatrics at the hospital. These clinicians were responsible for arranging training for non-consultant hospital doctors and representing their respective specialties in relation to service provision at hospital management level. On the day of inspection, the Executive Management Team told inspectors that the hospital's organogram was currently being revised to reflect reporting arrangements between the clinical leads and the clinical director. Inspectors were informed that the General Manager met with the Clinical Lead for obstetrics and paediatrics each month.

Clinical lead consultants in obstetrics and paediatrics, the director of midwifery, the quality and patient safety manager attended the RCSI Hospitals Group Women and Children's Senior Incident Management Forum meetings each month. Documentation provided to inspectors indicated that metrics, maternal and neonatal outcomes, serious reportable incidents, recommendations and quality improvement initiatives were presented for discussion at these meetings.

Senior hospital managers told inspectors that the RCSI Hospitals Group provided assurance and support for the maternity services in Cavan & Monaghan Hospital through the Women and Children's Senior Incident Management Forum.

Quality and Safety Executive Committee

The hospital had a Quality and Safety Executive Committee that reported to the Executive Management Committee to provide assurance on known risks and the

quality and safety of services provided at the hospital. Documentation provided to inspectors showed that the Director of Midwifery represented the maternity services at these meetings. This committee was chaired by the Clinical Director and met every six weeks to review key performance indicator results, incident analysis, the corporate risk register, audit, policies, quality and safety reports and updates from local committees. Inspectors were informed that the Quality and Safety Executive Committee was responsible for ratifying policies, procedures and guidelines. Inspectors found that a number of policies and guidelines in use in the clinical areas visited were awaiting ratification. The governance and oversight arrangements for the development and ratification of policies, procedures and guidelines should be reviewed and streamlined.

Women's Health Clinical Governance Committee

The hospital had a Women's Health Clinical Governance Committee that was chaired by a consultant obstetrician and met four times a year. Membership of this committee included the lead consultant obstetrician, consultant obstetricians, clinical midwife managers and the director of midwifery, non-consultant hospital doctors, the general manager and the quality and safety manager. The committee's responsibilities included providing assurance to senior hospital management that all known risks and complaints were being managed through the risk management process. Agenda items discussed at these meetings included, Irish Maternity Indicator System data,[††] monthly metrics including metrics collated for the Women and Children's Senior Incident Management Forum, risk register, clinical audits, updates on patient safety incidents and complaints, policies and quality improvement plan update.

The hospital also had a Paediatric Clinical Governance Group Committee that was chaired by a lead consultant paediatrician. This committee's responsibilities included ensuring that quality and risk issues were managed within the service.

The Maternity Unit had a statement of purpose that detailed the specific services provided at the hospital. It included their mission statement and information that related to the organisational structure of the hospital and workforce arrangements. This statement of purpose should be made publicly available in line with the National Standards.

The hospital had a maternity services strategic plan (2018-2019) that detailed the hospital's short, medium and long term plans for the maternity services within this time frame. The short term strategic plan included implementing anomaly scanning for all pregnant women and a supported care pathway for normal-risk mothers and

[††] The Irish Maternity Early Warning System (IMEWS) is a nationally agreed system developed for early detection of life threatening illness in pregnancy and the postnatal period.

babies within a multidisciplinary framework. The hospital's medium term strategic plan included the recruitment of a fourth nurse for theatre to manage the opening of a second theatre during out of hours and the recruitment of a fifth consultant obstetrician. The hospital's long-term strategic plan included developing onsite diabetic services for pregnant women.

Inspectors found that Cavan & Monaghan Hospital had established leadership, governance and management structure in place and had identified that it needed to strengthen its reporting structures and governance arrangements.

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

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

Standard 5.1 Maternity service providers have clear accountability arrangements to achieve the delivery of safe, high-quality maternity care. **Judgment:** Compliant
Standard 5.2 Maternity service providers have formalized governance arrangements for assuring the delivery of safe, high-quality maternity care. **Key findings:** Maternity network arrangements with a single governance structure were not formalised at time of inspection. The governance and oversight arrangements for the development and ratification of policies, procedures and guidelines should be reviewed and streamlined. **Judgment:** Substantially compliant
Standard 5.3 Maternity service providers maintain a publicly available statement of purpose that accurately describes the services provided to women and their babies; including how and where they are provided. **Judgment:** Compliant
Standard 5.4 Maternity service providers set clear objectives and have a clear plan for delivering safe, high-quality maternity services. **Judgment:** Compliant

Table3: HIQA's judgements 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:** Compliant
Standard 5.8 Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services. **Judgment:** Compliant
Standard 5.11 Maternity service provider's act on standards and alerts, and take into account recommendations and guidance issued by relevant regulatory bodies. **Judgment:** Compliant

2.2 Workforce

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

Inspection findings in relation to workforce are described next.

Inspection findings

2.2.1 Midwifery and nursing staffing

The hospital met the HSE's national benchmark for midwifery staffing in line with the HSE's Midwifery Workforce Planning Project.[5] The hospital had 54 whole time equivalent clinical midwifery positions filled at the hospital with the exception of the Special Care Baby Unit and the operating theatre. The Special Care Baby Unit had 12.5 whole time equivalent positions filled and 1.5 vacancies.

Inspectors were informed by nursing staff that staffing levels for nursing in the Special Care Baby Unit were not always maintained at adequate levels, but paediatric nurses and or midwives were deployed to the Special Care Baby Unit to fill vacancies when they arose to meet service need.[6] In addition, maintaining skill-mix was a challenge as not all staff deployed to the unit had a specialist qualification in neonatal intensive care nursing. Members of the Executive Management Committee told inspectors that the hospital was seeking to recruit additional neonatal nurses. The hospital offered overtime to their midwifery staff and nursing staff to fill vacant shifts when required.

There was sufficient nursing staff allocated to the operating theatres during core working hours. However, outside core working hours, three nurses were on call of which a minimum of two nurses were always onsite and one nurse off site. In a situation where there were two coinciding emergencies in out of hours, the assistant director of nursing redeployed staff from other areas of the hospital including the Midwifery Led Unit (MLU) to facilitate the opening of a second operating theatre. In addition, staff could also be called in from home to assist. The hospital had a standing operation procedure to facilitate opening of a second operating theatre in out of hours for an obstetric emergency case. Hospital managers who spoke with inspectors reported that they were progressing with the recruitment of a fourth

nurse for theatre to cover out of hours particularly to provide cover for two coinciding emergencies.

Clinical nurse and midwife managers who spoke with inspectors were clear about their role and responsibilities and who to report their concerns to. An experienced shift leader was in place for each shift in the Labour Ward and all women in established labour had one to one support. Shift leaders in the Labour Ward were included in WTE numbers so therefore were not always supernumerary.

Specialist support staff

Inspectors found that the hospital had a fetal ultrasound scanning service in place. This will be discussed further in section 3.1.1.

The hospital had recently appointed a Clinical Skills Facilitator in line with the National Standards to provide clinical support, education and instruction to midwives and nurses in developing skills and competencies.

2.2.2 Medical staff

Medical staff availability

On-call consultant obstetricians, anaesthesiologists and paediatricians were accessible to medical and midwifery staff and staff who spoke with inspectors said that they were onsite promptly when called to attend.

The hospital was staffed with medical staff at registrar and senior house officer grade in the specialties of obstetrics and anaesthesiology and at specialist registrar grade and at senior house officer grade in the specialties of paediatrics who were available onsite to provide care to newborns on a twenty four hour basis. Rapid response teams were available on site 24 hours a day, seven days a week to attend to obstetric emergencies, neonatal emergencies and cardiac arrests.

Consultants in the specialties of obstetrics, anaesthesiology and paediatrics were employed on permanent contracts and were registered as specialists with the Medical Council in Ireland.

Obstetric medical staff

The hospital had approval for five consultant obstetricians at the hospital. At the time of inspection, three of these positions were permanently filled, one position was filled by a locum consultant and one position was not filled. Inspectors were informed that the locum consultant was familiar with the hospital because of previous employment at the hospital. One consultant obstetrician with a joint appointment between the Rotunda Hospital and Cavan & Monaghan Hospital

attended the hospital one day each week to provide a fetal medicine service at the hospital.

A consultant obstetrician was rostered to be on call for the Labour Ward from Monday to Friday during core working hours and had other responsibilities that included attendance at the outpatient's clinics and the operating theatre. A rota of two non-consultant hospital doctors in obstetrics, one at registrar grade and one at senior house officer grade was in place in the Maternity Unit 24 hours a day. The on-call obstetric registrar and senior house officer covered the Labour Ward and the Emergency Department.

At the time of inspection, consultant obstetricians were on call one in every three nights[‡‡]. HIQA is of the view that this level of consultant obstetrician staffing does not enable a sustainable on-call rota. Members of the Executive Management Committee who spoke with inspectors highlighted that the deficiencies in staffing levels relating to consultant obstetricians was recorded on the hospital's corporate risk register and had been escalated to the RCSI Hospitals Group. The hospital was actively seeking to recruit consultant obstetricians to fill the two vacant posts. Documentation provided to inspectors indicated that increasing consultant obstetrician staffing levels was included in the hospital's strategic plan for maternity services 2018-2019.

In line with National Standards, on-call consultants are required to conduct morning ward rounds on Saturdays, Sundays and public holidays to review women and or babies that they are clinically responsible for.[1] Staff who spoke to inspectors stated that the on-call consultant obstetrician conducted ward rounds on Saturdays, Sundays and public holidays in the Labour Ward. However, staff also reported that ward rounds were not routinely carried out at weekends and public holidays on the combined antenatal and postnatal ward unless required.

Paediatric medical staff

Neonatal care at the hospital was led by consultant paediatricians. The hospital had approval for four WTE consultant paediatricians and at the time of the inspection, there were four WTE positions filled on a permanent basis. A rota of three non-consultant hospital doctors in paediatrics, one at registrar grade and two at senior house officer grade was in place to provide emergency neonatal care up to 22:00hours.The hospital had one paediatric registrar and one senior house officer on call onsite after 22:00hours. The hospital had an on-call rota outside of core working hours where a consultant paediatrician was on call from home usually one in every four nights.

[‡‡] Following inspection, hospital management informed inspectors that the consultant obstetrician rota had since reverted to on-call rota of one in every four nights.

Anaesthesiology staff

The hospital had approval for six WTE consultant anaesthesiologist positions. Inspectors were informed that five consultant positions were filled on a permanent basis and one position was not filled.

The hospital had an on-call rota outside of core working hours for consultant anaesthesiologists whereby consultants were on call from home usually one in every four nights. During core working hours, one consultant anaesthesiologist and one registrar in anaesthesiology were assigned to the emergency operating theatre to manage elective and emergency caesarean sections and a second registrar in anaesthesiology was rostered to the Labour Ward to provide an epidural service.

Outside core working hours, the hospital had one registrar in anaesthesiology on call onsite, and a consultant anaesthesiologist and a second registrar in anaesthesiology on call from home. Inspectors found that anaesthesiology medical staff resources at the hospital at the time of inspection were not in line with national recommendations for hospitals with co-located maternity units. These recommendations specify that there should be enhanced anaesthesia cover with two consultant anaesthesiologists and two non-consultant hospital doctors on call outside of core working hours to deal with two concurrent emergencies requiring an immediate and sustained response.[7] Similar to other smaller hospitals with co-located maternity units, the anaesthesiology team on call outside of core working hours at Cavan & Monaghan Hospital were responsible for anaesthesiology service provision for the both the maternity service and the general hospital. This meant that the work of the on-call anaesthesiology team included critical care, emergency department care, general operating theatre cases and transfer of critically ill patients in addition to the maternity service.

Best practice guidelines also recommend that a duty anaesthesiologist should be immediately available for the Labour Ward 24-hours a day and be free from other responsibilities.[8] The level of anaesthesiology cover at the hospital outside of core working hours presented a potential risk to patient safety in situations where immediate attendance by an anaesthesiologist may be required at two or more coinciding emergencies.

Following this inspection, the risk identified by HIQA in relation to anaesthesiology cover at Cavan & Monaghan Hospital was escalated by HIQA for remedial action to the General Manager of the hospital.

Risk escalation by HIQA, and reciprocal response from Cavan & Monaghan Hospital

In response to HIQA's correspondence about this risk, hospital management, with ultimate accountability, subsequently informed HIQA that the hospital had completed a risk assessment and was assured that controls were in place to mitigate this risk that included the following:

- an out of hours management policy was in place since 2015 which allowed the site manager to call the second on-call anaesthesiologist in at any time and to escalate any concerns to the executive manager on call
- the risk associated with a registrar in anaesthesiology not being immediately available 24-hours a day was deemed as negligible and in the previous year the requirement for two theatres in out of hours was 1.3% in total for the total out of hour's theatre activity
- no incident relating to this issue had occurred and hospital management were constantly monitoring all out of hours activity.

2.2.3 Training and education of multidisciplinary staff

Mandatory training requirements

The hospital had clearly defined mandatory training requirements for clinical staff. Mandatory training courses included multi-professional training in the management of obstetric emergencies, fetal monitoring training and basic life support. In addition, all non-consultant hospital doctors were required to attend additional education training as scheduled locally.

Obstetric medical staff were required to undertake multi-professional training in the management of obstetric emergencies and fetal monitoring training every two years and also complete sepsis training. Non-consultant hospital doctors in paediatrics were required to undertake training in neonatal resuscitation within the first two to three weeks of employment. Medical staff in anaesthesiology were required to undertake multidisciplinary training courses in the management of obstetric emergencies and undertake training in advanced cardiorespiratory resuscitation for adults two yearly.

Midwifery and nursing staff were required to undertake multidisciplinary training courses in the management of obstetric emergencies, neonatal resuscitation, and basic adult resuscitation training every two years. Midwives were also required to undertake fetal monitoring training two yearly.

The RSCI Hospitals Group were provided with attendance rates relating to cardiotocography interpretation and neonatal resuscitation training for consultants, non-consultant hospital doctors, midwifery staff and neonatal nursing staff. This arrangement facilitated oversight of mandatory training attendance rates in two key areas by the hospital group.

Uptake of mandatory training

Training records provided to inspectors showed that 100% of obstetric medical staff including consultant obstetricians and 100% of midwives had completed a fetal monitoring training programme in the previous two years.

Two-thirds of medical staff and 72% of midwives had undertaken multi-professional training in the management of obstetric emergencies.

All paediatric medical staff including consultant paediatricians had completed the neonatal resuscitation programme. Ninety-seven per cent of midwives and all of the nurses had completed neonatal resuscitation training at the hospital in the last two years. Nurses in the Special Care Baby Unit were also required to undertake updates on neonatal resuscitation every six months.

Seventy-seven per cent of midwives and nurses and 55.3% of medical staff had attended training in adult basic life support (including resuscitation of the pregnant woman) in the two years prior to the onsite inspection.

Seventy-eight per cent of midwives and nurses had completed sepsis training and 100% of non-consultant hospital doctors had completed an online sepsis training course.

Overall, the hospital had achieved a high level of compliance with some mandatory training programmes most notably neonatal resuscitation and cardiotocography interpretation. Notwithstanding this finding, following this inspection the hospital needs to ensure that all mandatory and essential training is always completed by medical, midwifery and nursing staff within recommended timeframes in line with the National Standards.

Orientation and training of new staff

Medical, midwifery and nursing staff were provided with induction training when commencing employment at the hospital. Some medical staff who spoke with inspectors stated that they would like if the induction programme was longer in duration. Non-consultant hospital doctors working in the paediatric speciality were provided with an additional induction programme. Paediatric senior house officers also completed neonatal resuscitation training and a neonatal exam as part of their induction programme.

The Maternity Unit had an orientation and induction programme for newly registered midwives and newly employed midwives. A mentor was also assigned to support and guide a new staff member.

Other training and education opportunities for staff

The hospital was recognised as a site for undergraduate and postgraduate midwifery training and higher specialist training for doctors in the specialties of paediatrics.

Each consultant obstetrician provided mentorship to two obstetric registrars and two obstetric senior house officers and these non-consultant hospital doctors were not included in the on-call roster until deemed competent. Paediatric medical staff had to be deemed competent by a consultant paediatrician before being included in the on-call roster. Anaesthesiology staff who spoke with inspectors stated that there was no formal competency training for registrars in anaesthesiology as they were not on a specialist training programme. However, direct supervision was provided by consultant anaesthesiologists to these registrars for a minimum of three months until they were deemed competent.

Multidisciplinary obstetric emergencies were practiced through live skills and drills (simulation training). A clinical midwife manager provided multidisciplinary skills and drills training twice a month to staff in the Labour Ward and also provided training to theatre staff every three months. Training records viewed by inspectors confirmed this. Clinical scenario training was also provided weekly in the Special Care Baby Unit by the clinical skills facilitator.

Nursing staff who spoke with inspectors reported that of the 15 nursing staff working in the Special Care Baby Unit, five staff had a specialist qualification in neonatal intensive care, eight staff had a paediatric qualification and two staff were midwives. The hospital planned to facilitate one nurse or midwife from the Special Care Baby Unit to be released to do a neonatal course in a larger tertiary maternity hospital. Inspectors were informed that approximately 20-25% of theatre nursing staff had undertaken a perioperative nursing course.

Midwifery staff who spoke with inspectors stated that there was a system in place for the rotation of staff to the different clinical areas within the Maternity Unit to maintain competency and one staff midwife recently rotated to the Labour Ward. The hospital had identified the rotation of medical and midwifery staff as a key objective in their quality improvement plan for 2018-2019.

Cardiotocography interpretation master classes were provided twice a year and documentation provided to inspectors indicated that 79% of midwives had attended cardiotocography interpretation study day training. The hospital had funding in place to provide medical staff and all staff midwives with training on the functionality and

basic operation of electronic fetal monitoring equipment used in the Labour Ward in 2019.

Grand rounds[§§] were held every Monday in the hospital and case presentations were presented by medical obstetric staff on maternity clinical activity. Journal club meetings were held every other Monday where non-consultant doctors in obstetrics and gynaecology presented articles to consultants for discussion.

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

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

Standard 6.1 Maternity service providers plan, organize and manage their workforce to achieve the service objectives for safe, high-quality maternity care **Key findings:** Staffing deficiencies in relation to consultant obstetricians to support a safe service. Anaesthesiology cover outside of core working hours was not in line with national recommendations. **Judgment:** Non-compliant
Standard 6.3 Maternity service providers ensure their workforce has the competencies and training required to deliver safe, high-quality maternity care. **Key findings:** Not all staff were up to date with mandatory training in the management of obstetric emergencies and adult resuscitation. **Judgment:** Substantially compliant
Standard 6.4 Maternity service providers support their workforce in delivering safe, high-quality maternity care. **Judgment:** Compliant.

[§§] Grand rounds are formal meetings where physicians and other clinical support and administrative staff discuss the clinical case of one or more patients.

3.0 Safety and Quality

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

During this inspection, inspectors looked at eleven National Standards in relation to safe and effective care. Of these, Cavan & Monaghan Hospital was compliant with six National Standards and substantially compliant with five National Standards.

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

3.1 Effective Care and Support

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

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

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

Inspection findings

Cavan & Monaghan Hospital provided a range of general and specialist maternity services for women with low and high risk pregnancies. In line with the National

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

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

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

- an Early Pregnancy Unit
- an emergency assessment unit located in the Maternity Unit
- consultant led antenatal clinics
- midwife led antenatal clinics.

The Early Pregnancy Unit was open Monday to Friday from 09.00hours to 13.00 hours where women with complications of early pregnancy were reviewed. Women could access the Early Pregnancy Unit service by self-referral, general practitioner referral or referral by a member of the obstetric team.

The hospital also had an emergency assessment unit which was located in the Maternity Unit and also functioned as a maternity day ward. Women could be referred to this assessment unit from the Emergency Department following obstetric review, from antenatal clinics or from a general practitioner referral or self-referrals. The unit comprised of a single room which was primarily used to assess and review pregnant women for the following:

- pre-operative workup for elective caesarean section
- blood pressure monitoring
- iron infusions
- decreased foetal movement
- steroid administration.

On the day of inspection, inspectors were informed that all women were offered a formal dating fetal ultrasound scan in the first trimester of pregnancy in line with National Standards. However, not all booked pregnant women were offered a fetal assessment ultrasound scan at 20–22 weeks' gestation. A fetal anomaly scan was offered only to pregnant women identified at higher risk of developing complications, women who had a previous fetal anomaly or increased maternal age. Inspectors were informed that about 50% to 60% of pregnant women had anomaly scans at 20–22 weeks' gestation.

Senior Hospital Managers told inspectors that the hospital had expanded the fetal ultrasound service during 2018 and an anomaly scan would be offer to all pregnant women who were booked at the hospital from March 1 2019.

Four consultant obstetricians provided consultant led obstetric clinics at Cavan General Hospital and an outreach antenatal clinic at Monaghan Hospital. A consultant obstetrician who specialised in fetal medicine attended the hospital from the Rotunda Hospital one day a week and provided oversight of the fetal ultrasound and fetal assessment service. This meant that pregnant women identified at higher risk of developing complications following fetal medicine assessment in Cavan & Monaghan Hospital had their care transferred to the Rotunda Hospital.

Midwifery and medical staff carried out risk assessments of women at booking clinics during pregnancy and during and after birth. Women were referred by the obstetric team at their booking appointment to a number of specialised clinics which were led by consultants in specialities including endocrinology, cardiology, nephrology, neurology respiratory and psychiatry.

The hospital had clear criteria for referral of women with complex medical conditions. Pregnant women identified at higher risk of complications were provided with an earlier appointment in the antenatal clinic or were transferred for combined care to another site within the RCSI Hospitals Group. Combined obstetric maternal medicine care included the following:

- Pregnant women with diabetes mellitus or gestational diabetes were referred to the combined endocrine obstetric clinic at Our Lady of Lourdes Hospital, Drogheda for management and birth.
- Pregnant women with a renal condition were also transferred to Our Lady of Lourdes Hospital, Drogheda for management and birth.
- Pregnant women with a cardiac history were referred to the combined obstetric clinic at the Rotunda Hospital for management and birth.

The hospital had a standard operating procedure for the emergency or urgent transfer of pregnant women to either Our Lady of Lourdes Hospital or the Rotunda Hospital. This procedure listed the reasons for transfer and stated which hospital pregnant women should be transferred to in each situation. Pregnant women with complex medical histories, triplet pregnancy or requiring twin to twin transfusions were transferred to the Rotunda Hospital. Pregnant women in preterm labour less than 30 weeks' gestation were transferred to either Our Lady of Lourdes Hospital or to the Rotunda Hospital depending on the gestation of the pregnancy. Critically ill women requiring multidisciplinary specialist care including interventional radiology were transferred to St James's Hospital, the Mater Misericordiae University Hospital

or Beaumont Hospital and pregnant or postnatal women requiring oncology treatment were transferred to the Mater Misericordiae University Hospital.

Information provided to inspectors indicated that there were seven inutero transfers and nine maternal transfers to other hospitals in 2018. This indicates that women were being risk categorised to ensure they were cared for in the most appropriate setting in line with National Standards.

The hospital had a designated Midwifery Led Unit that provided midwifery led care to normal risk women. In 2017, 109 normal risk pregnant women delivered in the Midwifery Led Unit.

The hospital was piloting the introduction of a supported care pathway for normal-risk mothers and babies, with midwives leading and delivering care within a multidisciplinary framework.[4] This supportive care pathway was supported by the consultant obstetrician lead for maternity services.

The maternity service had implemented the Irish Maternity Warning System (IMEWS) for pregnant and postnatal women.

Admission pathways

There were established pathways for the assessment, management and admission of women who attended the hospital with obstetric problems 24 hours a day, seven days a week. Pregnant women of any gestation were seen and reviewed in the Emergency Department during and outside core working hours by members of the obstetric team. Following triage, pregnant women were reviewed by the senior house officer and any concerns were escalated to the obstetric registrar and consultant obstetrician if required. If a pregnant woman greater than 20 weeks' gestation was stable on presentation to the Emergency Department, the woman would be directed to the Maternity Unit and the obstetric senior house officer was contacted to inform them of the women's presentation. If nursing staff in the Emergency Department were concerned about pregnant women on presentation, and required an urgent obstetric registrar review they could use an obstetric fast bleep system to contact the obstetric registrar. Inspectors were informed that IMEWS was used on all pregnant women in the Emergency Department up to 42 days post-delivery.

Pregnant women who required admission and were less than 20 weeks' gestation were transferred to the combined gynaecological and surgical one unit. Pregnant women who required admission and were greater than 20 weeks' gestation were transferred to the Maternity Unit. The Maternity Unit had 34 beds and provided care for pregnant women during the antenatal period and for women and their babies during the postnatal period.

Pregnant women presenting to the Emergency Department in labour during and outside core working hours were transferred directly to the Maternity Unit or the Labour Ward. However, if the pregnant woman was in an advanced stage of labour, an assessment would be completed by a midwife from the Labour Ward to determine if the woman should be transferred to the Labour Ward. This midwife carried an emergency bleep for this purpose. The hospital had a draft guideline for the management of mothers and or their babies presenting in the Emergency Department at the hospital.

The Emergency Department had documented pathways in place for the following:

- early pregnancy scan (less than 14 weeks' gestation)
- communication of ultrasound findings
- attendance at the early pregnancy unit
- pregnant women presenting in the Emergency Department with a miscarriage.

The hospital had arrangements in place for pregnant women who presented to the Emergency Department with surgical or medical conditions. Pregnant women presenting with concerns or clinical conditions that were not pregnancy related were reviewed by the Emergency Department medical team and by the medical and or surgical consultant who contacted the obstetric senior house officer or registrar. These pregnant women were then admitted to the Maternity Unit if their pregnancy was greater than 20 weeks' gestation under the care of medical or the surgical team.

3.1.2 Access to specialist care and services for women and newborns

Access to clinical specialists

As the Maternity Unit was co-located with a general hospital, women with complex medical conditions or women who developed medical or surgical complications during pregnancy had access to specialists in cardiology, respiratory medicine, endocrinology, nephrology and surgery when required. The hospital also had systems in place to access specialists within the RCSI Hospitals Group that were not located onsite. A consultant neurologist and a consultant vascular surgeon were on site one day per week and a consultant cardiologist was on site two days per week.

There was 24-hour access to clinical advice from consultants employed at the hospital in the speciality of microbiology. Advice from consultant haematologists was accessed through the Mater Misericordiae University Hospital 24-hours a day, seven days a week.

Obstetric 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] recommend that there is a duty anaesthesiologist immediately available to attend women in the Labour Ward 24-hours a day.

The anaesthetic service in the hospital was led by a consultant anaesthesiologist who was head of the anaesthetic department. The anaesthetic service was staffed by anaesthesiologists from the general anaesthetic rota at the hospital. During core working hours, the on-call registrar in anaesthesiology provided cover to the Labour Ward. Staff who spoke with inspectors said that if there was a delay with a pregnant woman receiving an epidural, a consultant anaesthesiologist was always available and there was never a problem accessing a consultant. The reported epidural rate for women in labour in the hospital was 27.3% in 2017 and 26.4% in December 2018, which is below the national rate of 40%.

Guidelines[8] and National Standards recommend that there is an agreed system in place for the antenatal assessment of high risk women to ensure that the anaesthetic service is given sufficient notice of women at higher risk of potential complications. The hospital held anaesthetic obstetric pre-assessment clinics every week for women with risk factors for anaesthesia or a history of previous complications during anaesthesia. This clinic was provided by one of five consultant anaesthesiologists.

Critical care

Critical care facilities at Cavan & Monaghan Hospital included a Level 3††† intensive care unit. Critically ill pregnant and postnatal women who required invasive monitoring or close observation, for example women with pre-eclampsia, sepsis or obstetric haemorrhage, were monitored in the Intensive Care Unit at the hospital. National Standards recommend that specialised birth centres have a high-dependency or observation unit to manage the clinically deteriorating woman. In the absence of this facility, as is the case in a number of smaller maternity units in

*** 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.

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

Ireland, pregnant and post-natal women are cared for in the general Intensive Care Unit at the hospital if their condition necessitated level 2[‡‡‡] or level 3[§§§] critical care.[9]

Inspectors were informed that critically ill pregnant or postnatal women were prioritised for admission to the intensive care unit and there were no reported delays in the transfers of these women. These women were reviewed jointly by the consultant obstetrician and consultant anaesthesiologist every day and more frequently as required. However, if the woman was ventilated, the consultant anaesthesiologist was clinically responsible for the woman and the care of the woman was shared with the consultant obstetrician. A midwife from the Maternity Unit reviewed the pregnant woman on a daily basis and more frequently if required. There was a consultant anaesthesiologist allocated to the Intensive Care Unit Monday to Friday with the on-call registrar in anaesthesiology. Inspectors were informed that on average less than 10 pregnant women would be admitted to the Intensive Care Unit per year.

If a woman required a higher level of critical care, the hospital had a standing operating procedure as discussed in section 3.1.1 which outlined the process for the transfer of a woman to another hospital in the RCSI Hospitals Group.

Neonatal care

The hospital had a level 1 neonatal unit which meant that the hospital provided high dependency and intensive neonatal care for premature infants born at greater than 30 weeks' gestation and for sick term infants.[6] Where a premature birth less than 30 weeks' gestation was anticipated, the hospital arranged for in-utero transfer of the pregnant woman to Our Lady of Lourdes Hospital, Drogheda or to the Rotunda Hospital depending on the gestation of the pregnancy. Infants born less than 30 weeks' gestation at the hospital were stabilised at birth and transferred by the National Neonatal Transport team to either the Rotunda Hospital or to one of the other Dublin tertiary maternity hospitals if there was no availability of a neonatal cot in the Rotunda Hospital. Babies who were stabilised at the tertiary hospital were transferred back to the Special Care Baby Unit in Cavan & Monaghan Hospital. The hospital had a standard operating procedure for transferring babies from the Special Care Baby Unit in Cavan & Monaghan Hospital to other hospitals. The Special Care Baby Unit was part of a formalised neonatal network with Our Lady of Lourdes Hospital and the Rotunda Hospital.

There was good collaboration with hospitals within the regional perinatal network to facilitate the provision of care for newborns in the most appropriate facility.

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

Documentation viewed by inspectors indicated that six babies were transferred from Cavan and Monaghan Hospital to other hospitals within the RCSI Hospitals Group in 2017 and 5 babies were transferred to hospitals outside the hospital group to include other tertiary maternity hospitals, Temple Street Children's University Hospital and Our Lady's Children's Hospital Crumlin.

Infants who required whole body cooling for the treatment of neonatal encephalopathy[****] had passive cooling commenced at the Special Care Baby Unit and were transferred to the Rotunda Hospital for whole body cooling. Urgent transfers of newborns requiring neonatal intensive care were organised through the National Neonatal Transport Programme.

3.1.3 Communication

Emergency response teams

The hospital had emergency medical response teams in place 24-hours a day, to provide an immediate response to obstetric and neonatal emergencies. There was an established communication procedure for requesting the attendance of an emergency response team for an emergency.

The hospital had carried out a retrospective audit of caesarean sections[††††] cases in July 2018. [10, 11] Findings from the audit indicated that the documentation by medical staff of the categorisation of caesarean sections required improvement.

Multidisciplinary handover

There were formal arrangements in place for multidisciplinary handover which occurred every day in the Midwifery Unit at 9am. On the day of inspection, inspectors observed six members of the multidisciplinary team in attendance. However, there was no representation from anaesthetics or paediatrics at this meeting. The clinical handover was delivered by the obstetric registrar on call and items discussed included activity within the Labour Ward and Maternity Unit and obstetric patients admitted within the previous 24-hours. Staffing issues relevant to maternity services were also discussed.

Clinical staff used the Identify-Situation-Background-Assessment-Recommendation (ISBAR) communication tool to communicate information about women and babies. A clinical audit of the use of the Labour Ward multidisciplinary daily handover tool was completed in February 2019. The audit findings indicated that there was a lack

[****] 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.
[††††] National Institute for Clinical Excellence (NICE) recommends four categories when determining the urgency of Caesarean Sections. Category 1 is the most urgent where there is an immediate threat to the life of the woman or fetus that necessitates prompt delivery of the baby by caesarean section.

of evidence that the full multidisciplinary team participated in clinical handover and this was identified as an area for improvement with a time bound action plan.

Medical staff who spoke to inspectors reported that the registrar in anaesthesiology going off call provided handover to the registrar in anaesthesiology coming on call at 9am daily and the consultant anaesthesiologist attended a daily anaesthetic handover at 1pm.

The hospital had developed a standard operating procedure for interdepartmental handover in maternity services which was based on National Clinical Guideline for Communication (Clinical Handover).[12] Staff who spoke with inspectors reported that an interdepartmental handover form was used when transferring patients from the Labour Ward to the intensive care unit, theatre and to the maternity unit.

Staff in clinical areas visited also held daily 'safety pause' meetings to discuss potential risk and to share relevant information such as audit findings, feedback from meetings and safety alerts. The hospital had a formal safety pause sheet where midwifery staff recorded patient safety issues and this was signed by the clinical midwifery manager or midwife.

There was a clear process in place to inform clinical staff about external safety alerts concerning medicines and medical equipment.

Clinical midwife managers and clinical nurse managers disseminated feedback and learning from some of the multidisciplinary team meetings. However, inspectors were told that it was not always possible for these staff to attend all multidisciplinary team meetings if the ward or theatre was busy. Information from these meetings was recorded in the ward communication book which was accessible to all staff in the clinical areas inspected.

Other findings relevant to communication

Clinical staff used the Irish Maternity Early Warning System (IMEWS) to assess and monitor women and to detect clinical deterioration. Inspectors were informed that if a woman's condition clinically deteriorates or IMEWS' parameters were triggered, the woman was reviewed by the obstetric senior house officer or registrar depending on IMEWS score and clinical presentation. The findings of an audit completed in March 2019 indicated 90% of IMEWS was escalated to the appropriate level as per escalation protocol and areas for improvement were identified in an action plan.

The hospital had recently introduced the neonatal early warning score system underpinned by a working draft guideline (2019). Staff reported that the introduction of this early warning score system had assisted with the timely escalation and clinical review of infants.

Medical, midwifery and nursing staff in the clinical areas visited told inspectors that consultants anesthetists, obstetricians and neonatologists were accessible at all times and were on site within 30 minutes of being called. Non-consultant hospital doctors on call in the specialties of obstetrics and anaesthesia said that they had no hesitation about contacting the consultant during core hours and outside core working hours if they had any concerns about the wellbeing of a woman. Midwives who spoke with inspectors were also clear about when to call consultant obstetricians.

Staff reported that formal and informal debriefing sessions occurred after an emergency or clinical incident. Informal debriefing sessions were facilitated by the clinical midwife manager and or others involved in the emergency or clinical incident. Staff who spoke with inspectors reported that formal debriefing sessions occurred in the form of After Action Reviews.[‡‡‡‡] Minutes of the Women's Health Clinical Governance Committee meetings in 2018 showed that four midwives had been trained in after action review with debriefing session's taking place following for example, when a woman had a post-partum haemorrhage.

3.1.4 Written policies, procedures and guidelines

The hospital had a number of policies, procedures and guidelines in relation to obstetric emergencies, for example pre eclampsia. Policies, procedures and guidelines were accessible both electronically and in hard copy to staff in the clinical areas visited. Staff also had access to National Clinical Effectiveness Committee[§§§§] guidelines in the clinical areas in relation to sepsis and the Irish Maternity Early Warning System and communication (clinical handover).[12]

Inspectors found that staff were using a number of national policies procedures and guidelines that were not ratified for local use and were also using working draft documents in the clinical areas that also required ratification by a formal governance committee. This included a working draft guideline on the prevention and management of primary post-partum haemorrhage.

Staff told inspectors that there was no formal policy, procedure and guideline committee in place and it could take up to eighteen months to get a policy, procedure or a guideline ratified. Neonatal guidelines from the Rotunda Hospital had been adopted and ratified for use in Cavan & Monaghan Hospital. Following this inspection, the governance and oversight arrangements for the development and

[‡‡‡‡] After Action Review (AAR): is an intervention that is undertaken before or soon after the event occurs and seeks to understand the expectations and perspectives of all those staff involved. It generates insight from the various perspectives of the multidisciplinary team, leads to greater safety awareness, changes team behaviours and assists in identifying actions required to support safety improvement
[§§§§] Guidelines produced by the national clinical effectiveness committee have been formally mandated by the Minister of Health.

ratification of policies, procedures and guidelines should be reviewed and streamlined.

A safe surgery checklist***** was completed for emergency and elective surgical procedures in obstetric operating theatres in line with best practice recommendations. An audit was completed on the use of safe surgery checklists in October 2018. The audit findings showed overall compliance was 95.5% with the national safe surgery policy and procedure.

On the day of inspection, inspectors found that there were two different systems in place in the hospital for the estimation of maternal blood loss. The Labour Ward used a standardised procedure and decision making aid for the estimation of maternal blood loss, which involved volume and weight assessment and this, was displayed in the Labour Ward. However, staff in the operating theatre who spoke with inspectors stated that they did not have a standardised procedure for the estimation and measurement of maternal blood loss. Blood loss was calculated if swabs weighed greater than 500gms or if there was a concern about heavy blood loss. Following this inspection, the hospital needs to have a standardised procedure for the estimation and measurement of maternal blood loss.

3.1.5 Maternity service infrastructure, facilities and resources

Cavan General Hospital was formally opened in 1989 and the maternity service infrastructure building supported the delivery of a maternity service. However, access to bathroom and ensuite facilities in the clinical areas visited required improvement.

Assessment areas

Assessment areas for pregnant women were located in the Maternity Unit and in the Emergency Department.

The Emergency Department had a designated room in which pregnant women could be assessed in private. This was a one bedded room with no ensuite facilities and space was limited. The hospital had identified an alternative waiting area for a pregnant woman which was separate to the general waiting area within the Emergency Department.

The Maternity Unit also had a maternity emergency assessment unit which functioned as part of the day ward. The unit comprised of a single room.

***** 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.

Antenatal and postnatal wards

The Midwifery Unit comprised 34 beds in total and provided care to both antenatal and postnatal women and babies. The ward comprised of five three bedded rooms with toilet facilities, three five bedded rooms with toilet and shower facilities and four single rooms. One of the four single rooms had toilet facilities. The Maternity Unit also had a bereavement room with a bed and a couch.

Labour Ward

The Labour Ward had four spacious single rooms used for labour and birth with one shared bathroom. The Midwifery-Led Unit was situated on a separate corridor within the maternity unit which was adjacent to the Labour Ward. The Midwifery-Led Unit was a self-contained unit that had two suites with delivery bed, ensuite toilet and shower and overnight accommodation in each suite. These rooms were spacious with access to birthing pools for women who wanted to avail of immersion in water during labour.

Critical Care

The intensive care unit was a five bedded unit with one isolation room which provided level 2 and level 3 care for pregnant women when required.

Operating theatres for obstetrics and gynaecology

The hospital had four operating theatres with a designated obstetric theatre. One theatre was kept free at all times for emergencies. However, this operating theatre was not exclusive to obstetrics and was shared with other emergency surgery in the hospital. This meant that medical and nursing staff in theatre communicated regularly with midwifery staff in the Labour Ward to ensure a theatre was kept free for emergency cases such a category one caesarean section during core hours.

The Labour Ward was situated on the same floor and adjacent to the operating theatre. Staff reported that there was enough space within each theatre to attend to women and neonates requiring emergency care. Each theatre had its own anaesthetic room and scrub room.

Special Care Baby Unit

The hospital provided level 1 neonatal care services. The unit had capacity for seven cots and comprised one neonatal intensive care cot, three high dependency care cots and three special care baby cots.

The unit comprised of an open plan area with one isolation room available within the unit. Nursing staff reported that there was enough space to attend to neonates who

required emergency team care. However, inspectors observed limited space available for the storage of equipment that was not in use.

Laboratory services

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

3.1.6 Maternity service equipment and supplies

The clinical areas visited by inspectors had emergency resuscitation equipment for women and newborns. Checklists showed that emergency equipment was checked daily and weekly as scheduled in the majority of clinical areas inspected. However, inspectors found on inspection that some checklists were not always updated on a daily basis.

Emergency supplies and medications were available in the clinical areas inspected to manage obstetric emergencies such as maternal haemorrhage, eclampsia and neonatal resuscitation. Where medications were not available, they were sourced from the nearby Labour Ward.

Fetal monitoring equipment including cardiotocography machines viewed by inspectors was labelled to indicate that they had been serviced.

Inspectors found on the day of inspection that there was no adult resuscitation trolley on the 34 bedded combined antenatal and postnatal ward, but midwifery staff had access to the adult resuscitation trolley located on the Labour Ward which was beside the combined antenatal postnatal ward. This risk was raised by inspectors with senior hospital management and they planned to address this risk at the time of inspection to ensure the combined antenatal and postnatal ward had an adult resuscitation trolley on the ward.

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

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

Standard 2.1 Maternity care reflects best available evidence of what is known to achieve safe, high-quality outcomes for women and their babies. **Key findings:** The hospital had a number of national policies procedures and guidelines that were not ratified for local use and had working draft documents in the clinical areas that also required ratification by a formal governance committee. **Judgment:** Substantially compliant
Standard 2.2 Maternity care is planned and delivered to meet the initial and ongoing assessed needs of women and their babies, while working to meet the needs of all women and babies using the service. **Key findings:** Pregnant women attending the hospital prior to 01 March 2019 were not offered a fetal anomaly scan at 20-22 weeks' gestation. However, from 01 March 2019 all pregnant women will be offered this scan at 20-22 weeks' gestation. No adult resuscitation trolley on the combined antenatal post natal ward. **Judgment:** Substantially compliant
Standard 2.3 Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services. **Judgment:** Compliant
Standard 2.7 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:** Compliant
Standard 2.8 The safety and quality of maternity care is systematically monitored, evaluated and continuously improved. **Judgment:** Compliant

3.2 Safe Care and Support

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

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

Inspection findings

3.2.1 Maternity service risk management

The hospital had systems in place to identify and manage risk. Risks in relation to the maternity service were recorded in the hospital corporate risk register along with agreed control measures. The corporate risk register was reviewed at Executive Management Committee and at Quality and Safety Executive Committee meetings. In addition, the risk register was reviewed locally at the Women's Health Clinical Governance Committee and Paediatric Services Clinical Governance Committee meetings. Risks that could not be managed at hospital level were escalated to the RCSI Hospitals Group corporate risk register.

Risks relating to maternity services recorded on the corporate risk register included:

- recruitment of consultant obstetrician/gynaecologists
- potential risks to patients due to inadequate theatre staffing levels during out of hours.

Members of the Executive Management Committee told inspectors that the hospital was actively seeking to recruit additional consultant obstetricians and was progressing with the recruitment of a fourth theatre nurse.

Clinical incident reporting

The hospital had a Local Incident Management Forum that was responsible for reviewing serious reportable events,[†††††] serious incidents and complaints to determine the appropriate level and type of review or investigation required. This Local Incident Management Forum escalated serious incidents and serious reportable

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

events to the RCSI Hospitals Group Women and Children's Senior Incident Management Forum and to the National Incident Management System[‡‡‡‡‡] in line with national guidelines.[13] This Forum was also responsible for ensuring that there were implementation plans in place for all recommendations arising from reviews. The hospital also held weekly operational management meetings to review operational matters, complaints and any risks identified. These meetings were attended by the Clinical Lead for the obstetric service, the Director of Midwifery and the Risk Manager.

Staff who spoke with inspectors described the hospital process for reporting clinical incidents and were aware of their responsibility to report clinical incidents. The hospital had a trigger list which outlined the types of clinical incidents that staff were required to report. Inspectors found that the number of clinical incidents relating to maternity services reported by staff were low when compared with similar sized hospitals. Overall, inspectors found that the practice of incident reporting at the hospital required improvement.

Nursing and midwifery staff reported that feedback from clinical incidents was provided to the staff member directly involved in an incident and may also be discussed at safety pause meetings. However, staff told inspectors that improvements could be made with the process for providing feedback on clinical incidents. Medical staff who spoke with inspectors reported that feedback was provided on incidents during medical case presentations.

Feedback from women

There was a formalised process to monitor compliments and respond to complaints from women using the maternity service. Complaints were an agenda item at the Executive Management Committee and the Quality and Safety Executive Committee meetings. Documentation provided to inspectors indicated that the hospital was meeting national guidelines for the management of complaints.[14] In addition, the Women's Health Clinical Governance Committee and the Paediatric Service Clinical Governance Committee were also responsible for oversight of complaints relating to their service and complaints were an agenda item for discussion at these committee meetings. The Director of Midwifery provided feedback on complaints to clinical managers as required and this feedback was subsequently provided to ward clinical staff at safety pause meetings.

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

The hospital carried out a patient satisfaction survey in September 2018. The findings showed that while the overall feedback relating to obstetric and midwifery care was positive, an action plan relating to the areas for improvement identified had yet to be completed.

3.2.2 Maternity service monitoring and evaluation

A range of different clinical measurements in relation to the quality and safety of maternity care were gathered at the hospital each month in line with national HSE Irish Maternity Indicator System reporting requirements. This data is gathered nationally by the Office of the National Women and Infants Health Programme and the National Clinical Programme for Obstetrics and Gynaecology.[15] This information also allows individual maternity units and maternity hospitals to benchmark their performance against national rates over time. The hospital also published monthly maternity patient safety statements in line with national HSE reporting requirements.

RCSI Hospitals had developed a number of key performance indicators in relation to maternity services which were monitored at hospital group level monthly. Cavan & Monaghan Hospital reported against these parameters which included:

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

Performance measurements were overseen at meetings of the Women's Health Clinical Governance Committee and monthly hospital group performance meetings.

The hospital held weekly Women and Children's multi-disciplinary team meetings that were attended by consultant obstetricians, anaesthesiologists and paediatricians and midwives. A consultant obstetrician from the Rotunda Hospital also attended these meetings. Topics discussed at these meetings included maternal morbidity, audit findings and Irish Maternity Indicator System (IMIS) reports. These meetings were also used as a forum to provide shared learning to medical and midwifery staff.

Perinatal morbidity and mortality meetings were scheduled monthly to review case presentations, clinical activity and outcome data. These meetings were attended by the multidisciplinary team. In addition, one consultant obstetrician with a joint appointment with the Rotunda Hospital and Cavan & Monaghan Hospital and a consultant pathologist attended perinatal morbidity and mortality meetings every six months where a number of cases were presented. This was an example of

collaborative working across the RCSI Hospitals Group to support small maternity units within the network.

The hospital had identified that it was an outlier for caesarean section rates whereby the hospital's caesarean section rate was 38.3% in 2017 compared with the national average rate of 32.1% in the same year. To address this, Cavan & Monaghan Hospital's maternity unit were required by the RCSI Hospitals Group to monitor their caesarean section rate using the Robson 10-Group Classification Scheme.[16]

At Cavan & Monaghan Hospital, the rate of general anaesthetic for caesarean section per total number of caesarean sections was 8.3% in 2017. This compares with 6.0% nationally. Medical staff who spoke with inspectors reported that consultant anaesthesiologists were monitoring general anaesthetic caesarean section rates and were informed about all general anaesthetic caesarean section cases.

Nursing and midwifery quality care metrics were also reviewed at local governance committee meetings.

Clinical audit

The hospital had developed a planned programme of clinical audit for 2018. The Quality and Safety Executive Committee was responsible for ensuring the each local governance committee contributed to the clinical audit plan each year. The clinical director reviewed audit findings and was responsible for signing off on them. The hospital had undertaken a number of audits in the maternity service (2018-2019) and these audits included the following:

- audit of antenatal scans
- audit of decision to delivery time for caesarean sections
- primary postpartum haemorrhage audit
- Irish Maternity Warning System audit
- clinical handover audit
- clinical audit on safe surgery checklist
- national sepsis baseline maternity audit
- Venous Thromboembolism[§§§§§] risk assessment audit
- use of Bishop Score[******] for induction of labour
- patient satisfaction audit
- cardiotocograph sticker audit.

[§§§§§] Venous thromboembolism (VTE) refers to a blood clot or thrombus occurring in the deep veins, usually of a leg (deep vein thrombosis, DVT) and/or which has fragmented and travelled to the lungs (pulmonary embolism, PE).
[******] Bishop score. Also known as cervix score is a pre-labour scoring system to assist in predicting whether induction of labour will be required.

A sepsis audit was performed at the hospital as part of a HSE national sepsis audit programme in May 2018. This audit showed that there was comprehensive documentation by both doctors and midwives relating to the care administered to women with good use of the sepsis forms to guide and document treatment. Areas for improvement were also identified with an action plan.

Annual clinical report

Cavan & Monaghan Hospital published a maternity service annual report. This report included information on maternal and neonatal outcomes.

3.2.3 Quality improvement initiatives developed by staff at the hospital

The hospital had initiated and developed a number of quality improvement initiatives aimed at improving the quality and safety of maternity care, but did not have a structured and resourced quality improvement programme.

Hospital management and midwifery staff had implemented a number of quality improvement initiatives in response to clinical incidents. This included:

- revision of the partogram[††††††] and an initiative called 'Fresh Eyes' was implemented in the Labour Ward. This change in practice provided a formalised approach to cardiotocograph interpretation. The hospital also regularly audited cardiotocograph interpretation.
- the introduction of a video laryngoscope to support enhanced viewing of the vocal chords and assist with difficult airway management for all patients including maternity patients.

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

- a rapid risk assessment tool for maternal venous thromboembolism in pregnancy
- an ISBAR 3 interdepartmental handover chart[‡‡‡‡‡‡]
- an operating theatre Grade 1 caesarean section check list which formed part of the peri-operative nursing chart
- the Edinburgh Postnatal Depression Screening Tool in August 2017 in association with other maternity services within the RSCI Hospitals Group.

[††††††] A partogram is a composite graphical record of key data (maternal and fetal) during labour entered against time on a single sheet of paper. Relevant measurements might include statistics such as cervical dilation, fetal heart rate, duration of labour and vital signs.
[‡‡‡‡‡‡] ISBAR 3 communication tool for inter-departmental handover (National Clinical Effectiveness Committee).

The hospital had completed a self-assessment quality improvement plan against the National Standards in 2018 to 2019. This plan identified areas for improvement towards meeting the National Standards and had an associated action plan with timeframes, status and person responsible for the implementation of the plan. Inspectors viewed the quality improvement plan and noted that one area identified for improvement was the development of a supported model of care for the maternity service which the hospital was piloting at the time of inspection.

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

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

Standard 3.2 Maternity service providers protect women and their babies from the risk of avoidable harm through the appropriate design and delivery of maternity services. **Judgment:** Compliant
Standard 3.3 Maternity service providers monitor and learn from information relevant to providing safe services and actively promote learning, both locally and nationally. **Key findings:** Low levels of clinical incident reporting and overall feedback on all clinical incidents reported was low. **Judgment:** Substantially compliant
Standard 3.4 Maternity service providers implement, review and publicly report on a structured quality improvement programme. **Key findings:** Undertaking quality improvement work, but did not have a structured and resourced quality improvement programme. **Judgment:** Substantially Compliant
Standard 3.5 Maternity service providers effectively identify, manage, respond to and report on patient safety incidents. **Judgment:** Compliant

4.0 Conclusion

Women and their babies should have access to safe, high-quality care in a setting that is most appropriate to their needs. Inspectors found that Cavan & Monaghan Hospital was compliant or substantially compliant with the majority of the National Standards in relation to quality and safety and capacity and capability that were focused on during this inspection.

The hospital had defined leadership, governance and management structure at the hospital and with the RCSI Hospitals Group to ensure the safety and quality of maternity services. Hospital managers had identified a need to strengthen reporting structures and were working towards improving attendance of all relevant staff at governance meetings.

There was good oversight of the quality and safety of services by senior managers at the hospital who used multiple sources of information to identify opportunities for improvement. The hospital's senior management team monitored performance data and benchmarked the hospital's performance against other similar sized hospitals. Hospital management was actively working to optimise maternal care and to progress implementation of the National Standards.

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

HIQA found that anaesthesiology medical staff resources at the hospital at the time of inspection were not in line with national recommendations for hospitals with co-located maternity units. Hospital management, with ultimate accountability and responsibility for the maternity service, subsequently informed HIQA that they were assured that controls were in place to mitigate the risk in relation to the level of anaesthetic cover at the hospital outside of core working hours.

The hospital employed medical staff in the specialties of obstetrics, paediatrics, neonatology and anaesthesiology that were available on site to provide care to women and babies on a 24-hour, seven days a week basis. However, there were deficiencies in staffing levels relating to consultant obstetricians and this was escalated to the RCSI Hospitals Group. The hospital was actively seeking to recruit consultant obstetricians to fill the two vacancies.

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

fetal ultrasound scan to all pregnant women and inspectors were informed that a fetal assessment ultrasound scan at 20-22 weeks' gestation scan would be offered to all women who were booked at the hospital from March 1 2019.

The hospital had clearly defined mandatory training requirements for clinical staff and had achieved a high level of compliance with some mandatory training programmes. Notwithstanding this, following this inspection the hospital needs to ensure that all mandatory and essential training is always completed by medical, midwifery and nursing staff within recommended timeframes in line with the National Standards.

The hospital had arrangements in place to identify women at higher risk of complications and to ensure that their care was provided in the most appropriate setting. Inspectors found that effective arrangements were in place to detect and respond to obstetric emergencies and to provide or facilitate on-going care to ill women and or their newborn babies. The hospital had a clinical audit plan in place and had implemented a number of quality improvement initiatives to support the delivery of a safe maternity service.

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

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