Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the unannounced inspection of maternity services at Wexford General Hospital

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

Dates of inspection: 11 June and 12 June 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.

Table of Contents

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 ongoing care to ill women and or their newborn babies in the most appropriate setting.

LOE 3:

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

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

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

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

1.1 Information about this inspection

Wexford General Hospital is a statutory acute hospital which is owned and managed by the Health Service Executive (HSE). The maternity unit at Wexford General Hospital is co-located with the general hospital and offers a number of options of care to pregnant women dependent on risk factors. The hospital is part of the HSE's Ireland East Hospital Group.[†] There were 1,684 births at the hospital in 2018.

To prepare for this inspection, inspectors reviewed a completed self-assessment tool[‡] and preliminary documentation submitted by Wexford General 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 Wexford General Hospital included in Table 1.

Table 1- Inspection details

Dates	Times of inspection	Inspectors
11 June 2019	12:30hrs to 19:00hrs	Dolores Dempsey Ryan Siobhan Bourke Aileen O' Brien Emma Cooke
12 June 2019	07:50hrs to 12:45hrs	

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

- representatives of the hospital's Board of Management
- the hospital's lead consultants in the clinical specialties of obstetrics and anaesthesiology and a delegated deputy in paediatrics.

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

- Assessment areas where pregnant and postnatal women who presented to the hospital with pregnancy-related concerns were reviewed. These included the Emergency Department and the assessment room in the Labour Ward.

[†] Ireland East Hospital Group (IEHG) comprises 11 hospitals operating across the counties of Dublin, Westmeath, Meath, Wexford and Kilkenny. This group is led by a Group Executive Officer with delegated authority to manage statutory hospitals within the group under the Health Act 2004. Maternity services are provided in four hospitals in the Group namely, the National Maternity Hospital, Holles Street, Wexford General Hospital, Midlands Regional Hospital Mullingar and St Luke's General Hospital Kilkenny.

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

- The Labour Ward where women were cared for during labour and childbirth.
- The Intensive Care Unit and the Coronary Care Unit where women who required additional monitoring and support were cared for.
- An operating theatre for women undergoing surgery, for example in the case of caesarean section.
- The Special Care Baby Unit where babies requiring additional monitoring and support were cared for.
- The 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.

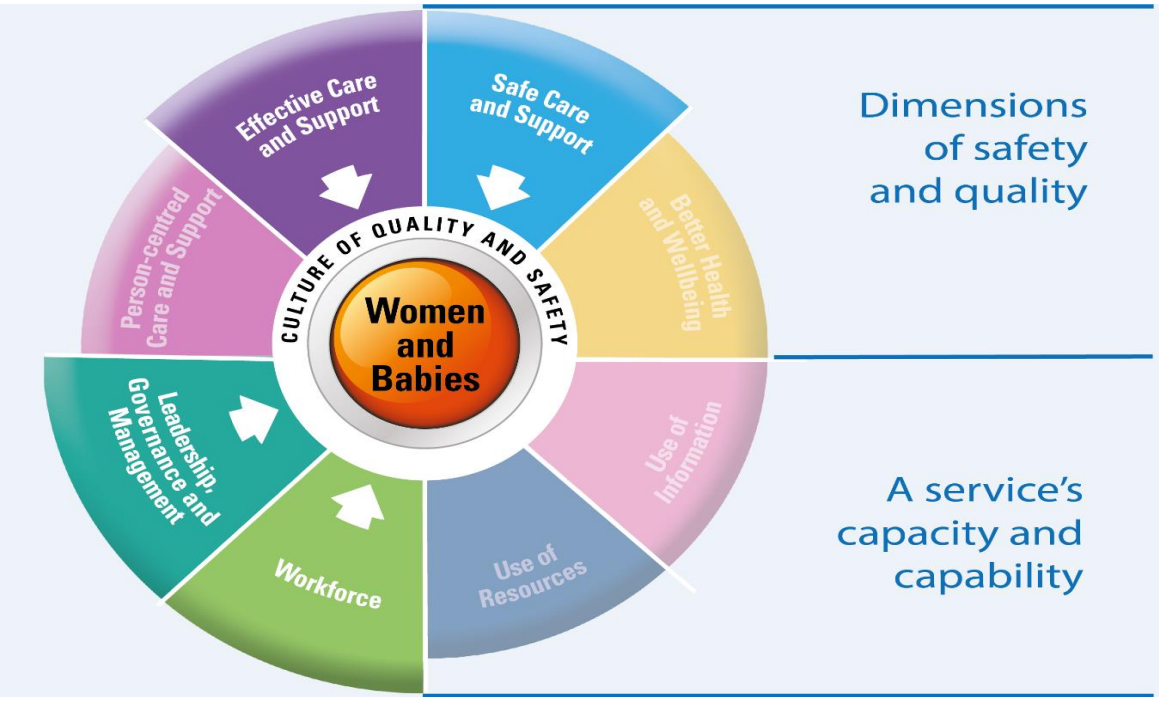
HIQA would like to acknowledge the cooperation of the hospital management team and all staff who facilitated and contributed to this unannounced inspection.

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 National Standards monitored.

These categories included the following:

- **Compliant:** A judgment of compliant means that on the basis of this inspection, the maternity service is in compliance with the relevant National Standard.
- **Substantially compliant:** A judgment of substantially compliant means that the maternity service met most of the requirements of the relevant National Standard, but some action is required to be fully compliant.
- **Partially compliant:** A judgment of partially compliant means that the maternity service met some of the requirements of the relevant National Standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks which could lead to significant risks for patients over time if not addressed.
- **Non-compliant:** A judgment of non-compliant means that this inspection of the maternity service has identified one or more findings which indicate that the relevant National Standard has not been met, and that this deficiency is such that it represents a significant risk to patients.

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

Table 2 - Report structure and corresponding National Standards and Lines of Enquiry

Report sections	Themes	Standards	Line of enquiry
Section 2: Capacity and Capability:	Leadership, Governance and Management	5.1, 5.2, 5.3, 5.4, 5.5, 5.8 and 5.11	LOE 1
	Workforce	6.1, 6.3, 6.4	LOE 3
Section 3: Dimensions of Safet 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	

A summary of findings is included at the end of sections 2 and 3.

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, Wexford General Hospital was compliant with eight National Standards, substantially compliant with one National Standard and partially 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.

3.1 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 Wexford General Hospital was not part of a formal maternity network.[§] In 2018, the Ireland East Hospital Group established a number of forums to progress Women and Children's Health Clinical Academic Directorate to provide oversight of maternity and paediatric services across the hospital group.[4]

Inspectors found that the Ireland East Hospital Group had established a Maternity Oversight Group which aimed to develop the structures and processes to oversee and monitor the quality and safety within the hospital group's maternity units. Inspectors were informed that a consultant obstetrician and the director of midwifery from Wexford General Hospital attended these meetings. Clinical activity recorded in the Maternity Patient Safety Statements for each of the maternity units were reviewed and discussed at these meetings.

At the time of inspection, there were no joint consultant neonatologists or consultant obstetrician's appointments with Wexford General Hospital, the National Maternity Hospital or with other maternity units in the hospital group. In addition, there were no shared clinical meetings such as perinatal mortality or morbidity meetings with Wexford General Hospital and other maternity units within the Ireland East Hospital Group. There was however, evidence that a consultant neonatologist from the National Maternity Hospital attended Wexford General Hospital in November 2018 and May 2019 to provide training in relation to aspects of specialised care for premature newborns.

While there were no formalised written care pathways in place for the referral of women with complex pregnancies to other hospitals in the hospital group, inspectors were informed that in practice women and infants requiring specialist care were transferred from Wexford General Hospital to the National Maternity Hospital depending on maternal bed and neonatal cot capacity.

While it was evident to inspectors that preliminary work to foster greater collaboration between maternity services across the hospital group had commenced, the Ireland East Hospital Group needs to progress with the development of a formal maternity network under a single governance structure, as recommended in the National Maternity Strategy.

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

Wexford General Hospital leadership, governance and management

HIQA found that Wexford General Hospital had effective leadership, governance and management arrangements in place to ensure the quality and safety of the maternity services provided at the hospital. The General Manager at Wexford General Hospital had overall managerial responsibility and accountability for the maternity service at the hospital. The General Manager reported to the Chief Executive Officer of the Ireland East Hospital Group and 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 Board of Management in line with National Standards.

The hospital had a Board of Management that also functioned as the Executive Management Team and had overall responsibility for decision making and leadership for the hospital including monitoring performance. This Board met monthly and membership included the general manger, the clinical director and the finance manager, the director of nursing, the director of midwifery and a general practitioner. The clinical lead for obstetrics and the director of midwifery attended every second board meeting to provide an update on maternity services. Documentation provided to inspectors indicated that agenda items discussed at these meetings included clinical incidents, the risk register and a maternity service report was also presented at every second meeting.

The hospital had a Quality and Safety Executive Committee that reported to the Board of Management to provide assurance on known risks and incident reporting. Maternity services were represented at this meeting by the Director of Midwifery. The Quality and Safety Executive Committee was chaired by the Clinical Director and met three times in 2018. Inspectors were informed that the hospital planned to recruit a quality and safety manager and following this appointment, this committee would meet every two months in line with its terms of reference. Agenda items discussed at these meetings included clinical incidents, medication safety updates, infection prevention and control issues, quality improvement projects, patient experience, complaints, policies, education and training, audit report and maternity service updates.

Clinical governance for the maternity service was overseen by the Women and Children's Services Governance Group. This group was chaired by a consultant obstetrician, met quarterly and reported to the Quality and Safety Executive Committee. Membership was multidisciplinary and included consultant obstetricians, a consultant paediatrician, a consultant anaesthesiologist, the director of midwifery, the clinical midwifery manager for the labour ward and the neonatal unit in addition to other senior operational managers at the hospital. Agenda items discussed at these meetings included key performance

indicator results, Irish Maternity Indicator System (IMIS) data,** audits, quality improvement initiatives, policies, risk register, clinical incidents and staffing levels.

Clinical leads had been appointed in each of the specialties of obstetrics, anaesthesiology and paediatrics and reported to the hospital general manager. 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.

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 governance structure of the hospital and the maternity service.

The hospital had a three-year strategic plan from 2018-2021 aligned to the operational plan for the Ireland East Hospital Group. This plan provided details on key elements to be prioritised with timelines, action plans, resources required and information on how the implementation plan was progressing. Inspectors were informed by hospital management that the hospital was expanding their integrated hospital and community midwifery led service in line with their maternity services strategic and operational plan 2018-2021 which was aligned to the National Maternity Strategy.

Overall, inspectors found that the hospital had clear accountability arrangements in place to achieve the delivery of safe care at the hospital.

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

**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.

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

Standard 5.1 Maternity service providers have clear accountability arrangements to achieve the delivery of safe, high-quality maternity care. **Judgment:** Compliant
Standard 5.2 Maternity service providers have formalized governance arrangements for assuring the delivery of safe, high-quality maternity care. **Key findings:** Maternity network arrangements, with a single governance structure were not formalised at time of inspection. **Judgment:** Substantially compliant
Standard 5.3 Maternity service providers maintain a publicly available statement of purpose that accurately describes the services provided to women and their babies; including how and where they are provided. **Judgment:** Compliant
Standard 5.4 Maternity service providers set clear objectives and have a clear plan for delivering safe, high-quality maternity services. **Judgment:** Compliant
Standard 5.5 Maternity service providers have effective management arrangements to support and promote the delivery of safe, high-quality maternity services. **Judgment:** Compliant
Standard 5.8 Maternity service providers systematically monitor, identify and act on opportunities to improve the safety and quality of their maternity services. **Judgment:** Compliant
Standard 5.11 Maternity service 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, paediatrics and obstetric anaesthesiology at the hospital. Inspectors also reviewed the uptake and provision of training and education of staff relevant to obstetric emergencies.

Inspection findings in relation to workforce are described next.

Inspection findings

2.2.1 Midwifery and nursing staff

The hospital did not meet the Health Service Executive's (HSE) national benchmark for midwifery staffing in line with the HSE's Midwifery Workforce Planning Project. The hospital had 48 whole time equivalent[††] (WTE) midwifery positions approved at the time of the inspection, but had two vacancies for permanent positions due to recent retirements. Senior managers told inspectors that the hospital was actively recruiting midwifery staff to address these deficiencies. Agency midwifery staff, which were familiar with the hospital, were offered overtime to backfill vacant shifts where possible.

The Special Care Baby Unit had 12 WTE positions approved and had its full complement of staff at the time of the inspection.

Three midwives (2.4 WTE) were assigned to the hospital's integrated hospital and community midwifery led service to provide care in the community and hospital for women with normal risk pregnancies in line with the supported care pathway[‡‡] of the National Maternity Strategy. These midwives provided outreach antenatal clinics in Gorey, a hospital based clinic at Wexford General Hospital, home visits and did night duty at the maternity unit every six weeks. Two hundred and ninety-eight (298) pregnant women availed of this care pathway in 2018.

[††] Whole-time equivalent: one whole-time equivalent employee is an employee who works the total number of hours possible for their grade. WTEs are not the same as staff numbers as many staff work reduced hours.
[‡‡] This care pathway is intended for normal-risk women and babies, with midwives leading and providing care within a multidisciplinary framework. Responsibility for the co-ordination of a woman's care is assigned to a named Clinical Midwife Manager, and care is provided by the community midwifery team, with most antenatal and postnatal care being provided in the community and home settings. The woman can exercise a choice with her healthcare professional with regard to the birth setting, which may be in an Alongside Birth Centre in the hospital, or at home.

The hospital had appointed shift leaders at clinical midwifery manager grade two for the Labour Ward, but they were not always supernumerary.

Outside of core working hours, the on-call nursing team comprised of three nurses who were rostered to manage emergency cases for both general surgery and obstetrics. If a second nursing team was required for the operating theatre out-of-hours, the hospital site manager had a list of operating theatre nurses who lived near the hospital who would be contacted in an emergency situation. Staff within the hospital with relevant experience could also be redeployed to assist in the operating theatre. The lack of a second on-call nursing team to manage concurrent emergency surgery cases outside of core working hours had been identified as a risk and was recorded on the hospital's risk register. Inspectors were also informed that the hospital planned to train a number of midwives to act as scrub nurses and be available to assist in the operating theatre during out of hours if required.

The hospital had a procedure for booking emergency surgery during out of hours and also had a written contingency procedure for an emergency caesarean section when all operating theatres were occupied during core working hours.

Specialist support staff

The hospital did not have a sufficient number of trained fetal ultrasonographers employed to provide a full fetal ultrasound service during core working hours in line with National Standards. This is discussed further in section 3.1.1.

The Maternity Unit had employed a clinical skills facilitator to support midwives to develop their required skills and competencies in line with National Standards.

2.2.2 Medical staff

Medical staff availability

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

Rapid response teams were available on site 24 hours a day, seven days a week to attend to obstetric emergencies, neonatal emergencies and cardiac arrests.

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

Obstetric medical staff

The hospital had approval for six consultant obstetrician positions. At the time of the inspection, all of these positions were filled by consultants on permanent contracts. Consultant obstetricians were on call one in every six nights. 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 operating theatre commitments. 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.

On-call consultant obstetricians conducted ward rounds on Saturdays, Sundays and public holidays in the Labour Ward and in the Maternity Unit.

Anaesthesiology medical staff

The hospital had four whole time equivalent consultant anaesthesiologists employed at the hospital. All of these positions were filled on a permanent basis. Consultant anaesthesiologists and registrars in anaesthesiology were rostered to the operating theatre during core working hours. The on-call anaesthetic team were responsible for epidural anaesthesia for women in labour and were also responsible for responding to obstetric emergencies. One on-call registrar in anaesthesiology was always rostered to cover the Labour ward.

Outside core working hours, the hospital had a rota whereby one consultant anaesthesiologist was on call from home and two registrars in anaesthesiology were on call onsite for the hospital with responsibility for intensive care, general and maternity services.[5] Consultant anaesthesiologists were on call one in every four nights.

Paediatrics

Neonatal care at the hospital was led by consultant paediatricians. The hospital had approval for five consultant paediatricians at the hospital. At the time of inspection, four consultant paediatrician positions were permanently filled and one position was filled by a locum consultant. Outside core working hours the hospital had a rota where one consultant paediatrician was on call from home. Consultant paediatricians were on call one in every five nights.

A rota of two non-consultant hospital doctors in paediatrics, one at registrar grade and one at senior house officer grade was in place to provide emergency neonatal care at the hospital 24-hours a day, seven days a week.

2.2.3 Training and education of multidisciplinary staff

Mandatory training requirements

The hospital had clearly defined training requirements for clinical staff in relation to, fetal monitoring, adult and neonatal resuscitation and multi-professional training for the management of obstetric emergencies. Mandatory training requirements for obstetric medical staff working in the maternity service included multi-professional training courses in the management of obstetric emergencies every two years and electronic fetal monitoring every year. Non-consultant hospital doctors in paediatrics were required to undertake training in neonatal resuscitation either prior to commencing employment at the hospital or during induction. Medical staff in anaesthesiology were required to undertake training in advanced critical life support and multi-professional training courses in the management of obstetric emergencies.

Midwifery staff were required to undertake training in electronic fetal monitoring every year and multi-professional training courses in the management of obstetric emergencies, basic life support and neonatal resuscitation every two years. In addition, midwifery staff were also required to attend a cardiotocography[§§] workshop every year to maintain their competencies.

The hospital had changed their programme for multidisciplinary team training for the management of obstetric emergencies in 2018. To facilitate this change in practice, a consultant obstetrician, a consultant anaesthesiologist and two midwives had completed a training programme in the United Kingdom. The hospital had provided the first training course of the new programme to staff in March 2019.

Uptake of mandatory training

Training records provided to inspectors indicated that 47% of midwifery staff were up to date with electronic fetal monitoring training. However, no training records were provided to inspectors to indicate that obstetric medical staff had completed electronic fetal monitoring training in the previous 24 months.

As previously discussed, the hospital had introduced a new programme for multi-professional team training in the management of obstetric emergencies in March 2019. Sixty-four per cent of medical staff and 33% per cent of midwives had completed this new programme of training. On the day of inspection, inspectors were informed by senior hospital managers that prior to March 2019, medical and midwifery staff had completed the advance life support in obstetrics training course. However, these training records were also not available to inspectors on the day of inspection.

[§§] Cardiotocography (CTG) is used during pregnancy to monitor the fetal heart and contractions of the uterus. It is most commonly used in the third trimester.

Sixty-seven per cent of midwives and 77% of nurses in the Special Care Baby Unit had completed neonatal resuscitation training. All medical staff were up to date with neonatal resuscitation training.

Sixty-four per cent of obstetric medical staff, 75% of nursing in the Special Care Baby Unit and 40% of midwifery staff in the Maternity Unit had completed basic life support in the previous two years.

In light of the findings above, hospital management should ensure that all clinical staff attend mandatory and essential training appropriate to their scope of practice in line with the National Standards and accurate recording of the uptake of mandatory training should also be maintained.

Orientation and training of new staff

Medical, midwifery and nursing staff were provided with induction training when commencing employment at the hospital. Medical staff were provided with a half day induction programme. The Maternity Unit had an orientation and induction programme for newly employed midwives including nurses and midwives in the Special Care Baby Unit. 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 obstetrics, anaesthesiology and paediatrics. Medical staff were also provided with weekly teaching sessions following induction.

Inspectors were informed that operating theatre nursing staff and medical staff in anaesthesiology at the hospital were provided with a three hour training programme in relation to difficult airway management.

All nursing staff in the Intensive Care and Coronary Care Units had undertaken training in advanced cardiac life support and basic life support and two nurses in the Intensive Care Unit were advanced cardiac life support instructors. Nursing staff in the Special Care Baby Unit had undertaken training in relation to post-resuscitation and pre-transport stabilisation care of sick infants. Nursing staff from the Operating Theatre Department, Intensive Care Unit and Coronary Care Unit at the hospital had participated in multi-professional training in the management of obstetric emergencies.

The hospital held weekly meetings to review all caesarean section cases and cardiotocography*** documentation from the previous week.

Obstetric emergencies were practised through live skills and drills (simulation training) that were led by the clinical skills facilitator every week. Skills and drills training in relation to neonatal resuscitation were also held every two months.

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 **Judgment:** 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, electronic fetal monitoring and basic life support training. Medical staff training uptake was not always recorded. **Judgment:** Partially compliant
Standard 6.4 Maternity service providers support their workforce in delivering safe, high-quality maternity care. **Judgment:** Compliant

*** Cardiotocography (CTG) is used during pregnancy to monitor the fetal heart and contractions of the uterus. It is most commonly used in the third trimester.

3.0 Safety and Quality

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

During this inspection, inspectors looked at 11 National Standards in relation to safe and effective care. Of these, Wexford General 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 ongoing evaluation of the outcomes for women and their babies to determine the effectiveness of the design and delivery of maternity care. Women and their babies should have access to safe, high-quality care in a setting that is most appropriate to their needs. How this care is designed and delivered should meet women's identified needs in a timely manner, while working to meet the needs of all women and babies using maternity services.

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

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

Inspection findings

Wexford General 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, or a midwife in the case of women attending for a midwifery-led clinic 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 post-natal women included:

- an early pregnancy assessment unit
- a fetal assessment unit
- the emergency department.

Midwifery and medical staff carried out risk assessments of women at the time of booking, during pregnancy and after birth. Pregnant women were referred by their general practitioner to either midwifery-led or consultant-led antenatal services at the hospital. Pregnant women attended the hospital for their first booking visit at 18 to 20 weeks' gestation. However, pregnant women deemed to be at higher risk of complications were referred earlier by their GP at eight to 12 weeks' gestation to the antenatal clinic.

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

- A combined obstetric endocrine service where women with conditions such as diabetes mellitus were cared for by a multidisciplinary team including a consultant obstetrician, a consultant endocrinologist and a midwifery specialist in diabetes.
- A high risk antenatal clinic for women with known risk factors or previous complications in pregnancy.
- Pregnant women with complex medical conditions including cardiac disease were referred to the National Maternity Hospital for the management of their pregnancy.
- Community midwives clinics offering midwifery managed care, choice and continuity to normal risk pregnant women within a multidisciplinary team framework.

The hospital had a dedicated Early Pregnancy Assessment Unit that was open Monday to Friday from 09.00hrs to 17.00hrs. All women were offered a detailed fetal ultrasound scan at 20 weeks' gestation in line with National Standards. However, not all pregnant women were provided with a dating fetal ultrasound scan[†††] in the first trimester of pregnancy in line with National Standards. Inspectors were informed that the hospital had sought approval to recruit an additional fetal ultrasonographer in order to provide a

[†††] A dating ultrasound scan is an early pregnancy assessment ultrasound that includes number of fetuses, viability and assessment of gestational age during the first trimester.

fetal ultrasound scanning service to all pregnant women at intervals recommended in the National Standards.

Admission pathways

3.1.2 Access to specialist care and services for women and newborns

There were established pathways for the assessment, management and where necessary admission of women who attended the hospital with pregnancy related problems 24 hours a day, seven days a week.

- Pregnant women less than 20 weeks' gestation with pregnancy related problems attended the Emergency Department for assessment and review 24 hours a day, every day. Pregnant women were triaged by emergency department staff and then reviewed by the obstetric team.
- Pregnant women requiring admission were transferred to the Gynaecology Ward or the Maternity Ward depending on bed availability. During core working hours, these women could also be referred by the obstetric team to the Early Pregnancy Assessment Unit from the Emergency Department if required.
- Pregnant women greater than 20 weeks' gestation who presented to the Emergency Department were transferred to the Labour Ward for assessment and review by the obstetric team.
- Pregnant women presenting to the Emergency Department in labour during and outside core working hours were transferred directly to the Labour Ward.
- Pregnant women who presented to the Emergency Department with a surgical or medical condition unrelated to the pregnancy were assessed by the obstetric team, and referred for review to the medical or surgical team on call at the hospital depending on their presenting condition.

Access to clinical specialists

As the maternity unit was co-located with a general hospital, women with medical conditions or women who developed medical or surgical complications during pregnancy had access to consultants in cardiology, endocrinology, respiratory and surgery when required. The hospital also had systems in place to access specialists that were not located onsite including consultants in neurology, nephrology, urology, psychiatry and vascular surgery.

There was 24-hour access to advice from consultants in the speciality of microbiology at the hospital. Advice from consultant haematologists was accessed through University Hospital Waterford.

Obstetric anaesthesiology services

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

Guidelines[5] 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 and provided anaesthetic services for both the maternity unit and the general hospital. The hospital had a duty anaesthesiologist immediately available to attend women in the Labour Ward 24-hours a day in line with relevant guidelines.[5]

Guidelines[5] and National Standards recommend that there is an agreed system in place for the antenatal assessment of high-risk mothers to ensure that the anaesthetic service is given sufficient notice of women at higher risk of potential complications. A consultant anaesthesiologist held an anaesthetic pre-assessment clinic every week where pregnant women with risk factors for anaesthesia or a history of previous complications during anaesthesia were reviewed.

Critical care

Critical care facilities at Wexford General 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 or in the Coronary 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 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.[6]

Inspectors were informed that critically ill pregnant or postnatal women were prioritised for admission to the intensive care unit or coronary care unit and there were no reported

‡‡‡ Pre-eclampsia is a medical condition where high blood pressure and protein in the urine develop during pregnancy. If left untreated, it may result in seizures at which point it is known as eclampsia.

§§§ 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.

**** 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.

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. Inspectors were informed that ten women were admitted to the Intensive Care Unit in 2018 for high dependency care.

Neonatal care

Wexford General Hospital had a Special Care Baby Unit (level 1) which meant that the hospital provided high dependency and intensive neonatal care for premature infants born at greater than 34 weeks' gestation and for sick term infants.[7] Documentation viewed by inspectors indicated that there were 23 in-utero transfers to other hospitals in 2018.

Inspectors were informed that where a premature birth was anticipated, the National Maternity Hospital was contacted in the first instance to access a bed for the mother and a neonatal cot for the newborn. However, if the National Maternity Hospital could not accommodate the mother or infant, the hospital would then contact University Hospital Waterford or one of the other Dublin maternity hospitals, depending on the anticipated needs of the neonate. In 2018, four neonates were transferred to University Hospital Waterford and five were transferred to the National Maternity Hospital.

If babies were born at less than 34 weeks' gestation at the hospital, they were stabilised and transferred soon after birth to a tertiary maternity hospital with a level 3 neonatal unit. These arrangements were clearly outlined in the hospital's Special Care Baby Unit policy. Infants who required therapeutic cooling[‡‡‡‡] for the treatment of neonatal encephalopathy[§§§§] had passive cooling commenced at the hospital and were transferred to a larger maternity hospital for whole body cooling. Urgent transfers of newborns requiring neonatal intensive care were usually facilitated by the National Neonatal Transport Programme.[*****] The Special Care Baby Unit at the hospital provided care for these babies when they were transferred back from the specialist hospital for ongoing care. Senior hospital mangers told inspectors that the hospital had not transferred any babies for therapeutic cooling in over two years.

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

[§§§§] 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.

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

3.1.3 Communication

Emergency response teams

The hospital had emergency medical response teams in place 24-hours a day, to provide an immediate response to obstetric and neonatal emergencies. There was an established procedure for requesting the attendance of designated response teams for cardiac arrest, obstetric and neonatal emergencies whereby a multidisciplinary response team could be summoned for an emergency using either an electronic pager number or by telephoning the hospital emergency number. Staff in the clinical areas were clear about the systems in place to manage emergency situations.

Clinical staff used the Irish Maternity Early Warning System (IMEWS) to assess and monitor the woman and detect clinical deterioration. Inspectors were informed that if a woman's condition clinically deteriorated or IMEWS parameters were triggered, the woman was reviewed by the obstetric senior house officer and also reviewed by the obstetric registrar and or consultant obstetrician if required.

The hospital had introduced a Neonatal Early Warning Score [†††††] for newborns with an escalation guide. Inspectors were informed that the paediatric team reviewed infants or newborns according to the escalation process.

Outside core working hours, the on-call consultant obstetrician, consultant anaesthesiologist and consultant pediatrician were off site. Staff told inspectors that these consultants were accessible and were on site within 30 minutes of being called.

The hospital had audited the timing of Category 1 caesarean section cases[‡‡‡‡‡] and the emergency bleep system in July 2017 to provide assurance that category 1 caesarean sections were conducted within recommended timeframes.[8,9] Twelve category one caesarean section cases were reviewed and all these cases met the auditable standard of 30 minutes.[8] Areas for improvement were identified in relation to communication with all members of the obstetric team including staff off site and an action plan was devised to address these concerns.

Multidisciplinary handover

Consultant-led clinical handover took place every morning in the conference room when the on-call obstetric team provided clinical handover on women at higher risk of

[†††††] Neonatal early warning score is used to assist clinicians in recognising and responding to signs of deterioration earlier in neonates, thereby preventing a serious adverse event.
[‡‡‡‡‡] 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 foetus that necessitates prompt delivery of the baby by caesarean section.

complications, women in the Labour Ward and Maternity Ward and any admissions over night to the obstetric team coming on duty in the morning. However, midwifery or paediatric medical staff did not attend these clinical handover meetings.[10] Inspectors were informed that medical staff in anaesthesiology attended these meetings if required.

There were formal arrangements in place for clinical handover for midwifery staff at the start of each shift in the clinical areas inspected. Clinical handover meetings were held at 08:30am and 20:30pm in the maternity unit.

Short staff meetings called safety pause meetings were conducted in the Labour Ward, the Maternity Unit and the Special Care Baby Unit twice a day to discuss key safety issues.

Following this inspection, the hospital should review the arrangements in place for multidisciplinary clinical handover to ensure that all specialities involved in the care of pregnant and postnatal women share information to identify potential clinical concerns and to improve the safety of care provided in the maternity unit.

Other findings relevant to communication

Staff who spoke with inspectors were clear regarding the circumstances where consultant obstetricians, consultant neonatologists and consultant anaesthesiologists were expected to attend the Delivery Suite. These included cases of massive obstetric haemorrhage, complex delivery, instrumental deliveries, anaesthetic risks and caesarean section.

The hospital had a guideline on the management of the patient pathway for emergency caesarean section cases in the operating theatre. This guideline outlined that a consultant obstetrician should endeavour to be in attendance at a category one and a category two caesarean section.

Medical and midwifery staff who spoke with inspectors said that they would have no hesitation about contacting a consultant on duty if they had concerns about the wellbeing of a woman or when advice or additional support was needed.

Safety alerts in relation to medical devices and medicines were communicated to staff at the hospital.

3.1.4 Written policies, procedures and guidelines

The hospital had a comprehensive suite of policies, procedures and guidelines in relation to maternity care and the management of obstetric emergencies, for example postpartum haemorrhage, shoulder dystocia and umbilical cord prolapse. These were readily accessible electronically to staff in clinical areas visited. The hospital also had policies based on National Clinical Effectiveness Committee guidelines in relation to

sepsis, clinical handover in maternity services and the Irish Maternity Early Warning System. The hospital had a system where policies, procedures and guidelines were ratified through the hospital's guideline committee. Inspectors were informed that there was a Policy, Procedure and Guideline Committee in place and inspectors found that the majority of policies, procedures and guidelines were up to date.

The Maternity Unit had a standardised procedure for the estimation and measurement of maternal blood loss.

A safe surgery checklist[§§§§§] was completed for surgical procedures in the Operating Theatre Department in line with national policy.[11] Implementation of the safe surgery procedure was audited in May 2019 and the audit findings showed that the checklist was consistently used in line with national policy.

3.1.5 Maternity service infrastructure, facilities and resources

Emergency Department

There was a designated assessment room for pregnant and post natal women in the Emergency Department. Equipment and supplies were available in the assessment room including a fetal ultrasound machine, overhead light for examinations and an emergency delivery pack. Additional equipment could be accessed from the Maternity Unit as required. However, the room did not have ensuite facilities.

Unstable pregnant women requiring urgent care were brought straight to the resuscitation room. Resuscitation bay two was the designated area for unstable pregnant women and contained the necessary emergency equipment and supplies to manage an obstetric emergency including adult and paediatric resuscitation equipment and a neonatal resuscitaire.[******]

Assessment areas

Combined antenatal and postnatal ward

The Maternity Unit comprised 26 beds and provided care to both antenatal and postnatal women and newborns. The ward comprised one six-bedded ward, three five-bedded wards and five single rooms. Space was limited between beds.

[§§§§§] 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.

[******] A resuscitaire is the ideal device to have during labour and delivery procedures. It combines an effective warming therapy platform along with the components you need for clinical emergency and resuscitation.

Labour Ward

The hospital had a Labour Ward with six single en-suite delivery rooms with birthing aids and two en-suite assessment rooms. There was also a partner waiting area.

Critical Care

The Intensive Care Unit was a self-contained unit which comprised five beds and provided high dependency care and intensive care for pregnant and postnatal women when required. It was located directly adjacent to the Operating Theatre Department. Pregnant or postnatal women requiring a higher level of critical care would be transferred to a larger tertiary hospital based on clinical need.

The Coronary care Unit comprised five beds and provided high dependency care and cardiac monitoring for pregnant and postnatal women as required. The infrastructure of this unit was outdated and there was limited space within the open plan area of the unit and adjacent ancillary rooms. The unit had one toilet and did not have isolation facilities. Future development of the Coronary care Unit at the hospital should be in line with recommended guidelines.[12]

Operating theatres for obstetrics and gynaecology

The hospital's Operating Theatre Department which comprised three operating theatres and a post anaesthetic care unit was located directly adjacent to the Labour Ward in line with National Standards. It was practice at the hospital to try and keep one operating theatre free for emergencies during core working hours. Inspectors were informed that on two days of the week all three operating theatres were in use during the day. On these days, theatre nursing staff communicated regularly with midwifery staff in the Labour Ward to ascertain the status of women before an elective case commenced in the operating theatre. If there was a potential that an emergency case could arise, the elective case was postponed so that the operating theatre would be available.

In addition, the hospital had a written contingency procedure for the management of an emergency caesarean section if all operating theatres were occupied. This contingency procedure (2018) was only activated if all three operating theatres had surgery cases in progress none of which could be completed in time to facilitate an emergency caesarean section. The contingency procedure outlined that a category one caesarean section procedure could be performed in an anaesthetic room usually anaesthetic room one if there was no alternative and it also provided details on how this process should be managed. Inspectors were informed that staff were provided with training on this contingency procedure.

As already discussed above, the hospital had a guideline on the management of the patient pathway for emergency caesarean sections in the operating theatre. This guideline outlined that theatre staff should be made aware of any pending caesarean

sections during core working hours. During out of hours any proposed category one caesarean sections were escalated to the out of hour's site manager to inform theatre staff.

Special Care Baby Unit

The Special Care Baby Unit was staffed and equipped to care for five babies in either cots or incubators in an open plan area. Improvement works had been carried out at the hospital in recent years to increase the size of the unit. Overall, the infrastructure and design of the unit was outdated in that it was not a fully self-contained unit and did not have isolation facilities. Storage facilities for unit supplies were located outside the unit on the opposite side of the adjacent corridor. Future development of the Special Care Baby Unit at the hospital should be in line with recommended guidelines.[13]

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 reviewed by inspectors confirmed that the majority of checklists were up to date, but inspectors found that the emergency resuscitation trolley checklist in the Maternity Unit had not been checked weekly as required. This was brought to the attention of the clinical manager at the time of this inspection.

Cardiotocography[††††††] machines for electronic fetal monitoring viewed by inspectors in the Labour Ward and the combined antenatal and postnatal ward were labelled to indicate they had been serviced.

Inspectors found on the day of inspection that one cot space in the Special Care Baby Unit did not have a wall suction mounted outlet; however, a portable suction machine was available at this point of care. This was brought to the attention of senior management on the day of inspection and should be addressed so that every cot space in the unit has a wall mounted suction outlet.[13]

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

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

Table 5 - HIQA's judgments against the National Standards for Safer Better Maternity Services for Effective Care and Support that were monitored during this inspection
Standard 2.1 Maternity care reflects best available evidence of what is known to achieve safe, high-quality outcomes for women and their babies. **Judgment:** Compliant
Standard 2.2 Maternity care is planned and delivered to meet the initial and ongoing assessed needs of women and their babies, while working to meet the needs of all women and babies using the service. **Key findings:** Maternity care was planned and delivered to meet the initial and ongoing assessed needs of women and their babies, but not all pregnant women were offered a dating scan at 12 weeks' gestation in line with National Standards. **Judgment:** Substantially compliant
Standard 2.3 Women and their babies receive integrated care which is coordinated effectively within and between maternity and other services. **Key findings:** Pathways for the transfer of women who required specialist maternity care to the tertiary maternity hospital in the Ireland East Hospital Group were not formalised. **Judgment:** Substantially compliant
Standard 2.4 An identified lead healthcare professional has overall clinical responsibility for the care of each woman and that of her baby. **Judgment:** Compliant
Standard 2.5 All information necessary to support the provision of effective care, including information provided by the woman, is available at the point of clinical decision-making. **Judgment:** Compliant

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 2.7 Maternity care is provided in a physical environment which supports the delivery of safe, high-quality care and protects the health and wellbeing of women and their babies.

Key findings: Limited space in the Special Care Baby Unit between cots and there was no isolation room facilities. Space between beds was limited in the combined antenatal and postnatal ward.

Judgment: Substantially compliant

Standard 2.8 The safety and quality of maternity care is systematically monitored, evaluated and continuously improved.

Key findings: There were no perinatal and maternal morbidity and mortality meetings at network level. The hospital held monthly perinatal morbidity and mortality meetings, but attendance records were not recorded.

Judgment: Substantially 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.

3.2.1 Maternity service risk management

Wexford General Hospital had systems in place to identify and manage risks. Risks in relation to the maternity service were recorded on the corporate risk register with agreed risk control measures. The hospital had a Risk Register Committee which met four times in 2018 and twice in 2019 to review and update the hospital's risk register. Membership of this committee included the general manager, the quality and safety coordinator, the deputy general manager, the director of midwifery and the clinical nurse manager for the Emergency Department.

Documentation provided to inspectors indicated that the corporate risk register was also discussed at the Board of Management and the Quality and Safety Executive meetings.

Risks that could not be managed at hospital level were escalated to the Director of Quality and Patient Safety within the Ireland East Hospital Group. This Director of Quality and Patient Safety also routinely visited Wexford General Hospital to review the risk register. In addition, a quality and patient safety quarterly review report was presented by either the deputy general manager or the quality and patient safety coordinator to the Ireland East Hospital Group. This report included information on serious reportable events, serious incidents and an update on reviews and risk recorded on the hospital's corporate risk register.

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

- Lack of a second on-call nursing team for category one caesarean sections.
- No piped air supply in operating theatre one or operating theatre two in line with neonatal resuscitation programme guidelines, but portable oxygen is available.

Clinical incident reporting

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

Clinical incidents were recorded on incident report forms which were reviewed by ward managers and sent to the Clinical Midwifery Manager grade three and the Risk Manager.

All clinical incidents were discussed at monthly maternity risk management meetings attended by the risk manager, the Labour Ward clinical midwifery manager and a consultant obstetrician. Clinical incidents within the hospital were tracked and trended to identify emergent concerns. Clinical incident trends including serious reportable incidents were included in the monthly activity and performance presentation and the quality and patient safety quarterly review presentation presented to the Ireland East Hospital Group.

Staff who spoke with inspectors said they were provided with feedback on the outcome of reported clinical incidents and were able to provide inspectors with examples of improvements in care from review of clinical incidents as outlined in the section 3.2.3 of this report.

Documentation of minutes of meetings provided to inspectors showed that patient safety incidents were reported on the National Incident Management System‡‡‡‡‡‡ in line with national guidelines.[14]

Feedback from women

There was a formalised process at the hospital to monitor compliments and respond to complaints from women using the maternity service. Complaints were managed by the General Manager and the Director of Midwifery.

The hospital had carried out annual maternity experience surveys. Inspectors viewed the maternity experience survey for April 2019. The overall findings showed that women were satisfied with the maternity services at Wexford General Hospital and the satisfaction rate ranged from 74% to 85%. Areas for improvement in the survey were identified and an action plan had yet to be devised to address these areas for improvement.

3.2.2 Maternity service monitoring and evaluation

Clinical outcome and activity measurements in relation to the maternity service were gathered at the hospital each month in line with national HSE Irish Maternity Indicator System reporting requirements.[15] Irish Maternity Indicator System data provides important information in relation to maternity service activities and outcomes and it facilitates managers conducting within-hospital analyses of monthly and annual data.

The Board of Management at the hospital proactively monitored, analysed and responded to information from multiple sources including serious reportable incidents,

‡‡‡‡‡‡The State Claims Agencies' (SCA) National Incident Management System (NIMS) is a risk management system that enables public hospitals to report incidents in accordance with their statutory reporting obligation to the SCA (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

incident reviews, legal cases, risk assessments, complaints, audits and patient experience surveys to be assured about the effectiveness of the maternity service as required by National Standards. The General Manager presented a monthly activity and performance report to the Ireland East Hospital Group using key performance indicators to monitor and reflect clinical activity relating to obstetrics, gynaecology and paediatric services.

Irish Maternity Indicator System data and clinical activity at the hospital was reviewed at the Women and Children's Clinical Governance Group meetings and at the Board of Management meetings. The hospital published monthly maternity patient safety statements in line with national HSE reporting requirements. The Irish Maternity Indicator System and midwifery metrics were also presented at Ireland East Hospital Group monthly performance meetings.

Midwifery Care-Metrics in relation to care planning, cardiotocography monitoring and medication were collected and monitored each month at the hospital.

Multidisciplinary perinatal mortality and morbidity meetings were held monthly at hospital level, but attendance records were not recorded. The hospital also held weekly caesarean section meetings to discuss the cases of women who had caesarean sections and to review cardiotocographs. Maternal morbidity cases were also reviewed at these meetings. Consultant obstetricians, members of the obstetric team and midwifery staff attended these meetings. The hospital used the Robson classification[§§§§§§] for assessing, monitoring and comparing caesarean section data for women at the hospital.

Clinical audit

Wexford General Hospital had a clinical audit plan for 2018. Clinical audit was overseen by the Quality and Safety Executive Committee at the hospital. The hospital had audited compliance with the implementation of the national guidelines on the Irish Maternity Early Warning System and had yet to audit compliance with the national guidelines on clinical handover.

A maternal sepsis audit was completed in May 2018 following a retrospective review of healthcare records of patients screened for sepsis in December 2017 at the hospital as part of a HSE national sepsis audit programme. This audit showed evidence of good practice with initiation of the Sepsis Six[*******] which is part of the national guideline on sepsis management and opportunities for improvement were identified and recommendations made. While recommendations were made, there was no time bound

[§§§§§§] Robson Classification: the Robson classification is a system that classifies women into 10 groups based on their obstetric characteristics (parity, previous CS, gestational age, onset of labour, fetal presentation and the number of fetuses).
[*******] The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis

action plan included with the audit findings. The hospital needs to address this following this inspection.

Other clinical audits undertaken at the hospital in the previous 12 months included:

- a safe surgery checklist audit
- audit of post-partum haemorrhage
- integrated hospital community Midwifery Led service audit
- audit of neonatal and maternal discharge checks in the Maternity Unit
- audit of babies admitted to the Special Care Unit with hypothermia
- audit of intrauterine growth restriction in infants born in Wexford General Hospital over 35 weeks' gestation in a six month period and investigations performed

Annual clinical report

Wexford General Hospital produced a Women's Health Annual Report in 2018. This report reflected the Early Pregnancy Unit activity, antenatal clinical activity, community Midwifery-Led service activity and clinical outcomes for infants in the Special Care Baby Unit including audit results.

3.2.3 Quality improvement initiatives

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

- a checklist for neonatal therapeutic hypothermia (cooling)
- a poster outlining how to prevent hypothermia in the newborn
- Venous Thromboembolism[†††††††] risk assessment form
- introduction of a difficult intubation trolley
- use of cardiotocograph sticker
- use of Bishop Score[‡‡‡‡‡‡‡] for cervical assessment
- maternity experience survey
- bereavement room with ensuite
- a memory booklet to create memories for parents of their baby's death in line with the National Standards for Bereavement Care following Pregnancy Loss and Perinatal Death[16]
- Newborn Early Warning Sore with an escalation guide
- patient information leaflet regarding fetal movement in pregnancy

[†††††††] 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.

- induction of labour leaflet
- implementation of routine Anti-D immunoglobulin
- the introduction of a baby box programme offered to parents to access free parenting education and products to assist them with parenting
- introduction of antenatal obstetric referral pathway for all babies with an antenatal diagnosis of congenital abnormality.

The Operating Theatre Department had introduced a difficult intubation trolley as a quality improvement initiative that was clearly labelled and stocked in a logical sequence so that supplies were readily available for use in emergency situations. There were plans at the hospital to expand this initiative to other critical care areas in order to standardise this equipment at the hospital. Inspectors were informed that operating theatre nursing staff and medical staff in anaesthesiology at the hospital had completed a training programme in relation to difficult airway management.

The hospital implemented a change in practice following audit findings relating to the number of babies being admitted to the Special Care Baby Unit with hypothermia. A colourful poster was developed and circulated for display in the Labour Ward, the postnatal ward and the Special Care Baby Unit. This poster clearly outlined how to prevent hypothermia in newborn babies.

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

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

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

4.0 Conclusion

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

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

HIQA found that Wexford General Hospital was not part of a formalised maternity network under a single governance structure. The Ireland East Hospital Group needs to progress with the establishment of a single system of clinical governance as recommended in the National Maternity Strategy and National Standards. Ireland East Hospital Group should ensure that formalised care pathways are progressed between Wexford General Hospital and specialist maternity services in the group.

Maternity care was planned and delivered to meet the initial and ongoing assessed needs of women and their babies. However, inspectors found that while pregnant women were offered scans in the second and third trimester of pregnancy, not all pregnant women were offered a formal dating scan in the first trimester of pregnancy in line with National Standards. The hospital had recruited an additional fetal ultrasonographer in order to provide this service to women, but this person had not yet commenced employment at the hospital due to a moratorium on recruitment.

The hospital had clearly defined training requirements for clinical staff in relation to electronic fetal monitoring, adult and neonatal resuscitation and multi-professional training for the management of obstetric emergencies. However, the hospital needs to ensure that mandatory training is completed by medical, midwifery and nursing staff within recommended timeframes and the uptake of training by all staff is documented.

HIQA found that the Maternity Unit at Wexford General Hospital had arrangements in place to identify women at higher risk of complications and to ensure that their care is provided in the most appropriate setting. In addition, the hospital had 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.

While the hospital had clinical handover arrangements in place, this arrangement was not multidisciplinary. Following this inspection, the hospital should review the arrangements in place for multidisciplinary clinical handover to ensure that all specialities involved in the care of pregnant and postnatal women share information to identity potential clinical concerns and to improve the safety of care provided in the maternity unit.

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 any opportunities for improvement identified in this report and requires the support of the hospital group and the HSE to progress with the transition to a maternity network.

5.0 References

1. Health Information and Quality Authority. *National Standards for Safer Better Maternity Services.* Dublin: Health Information and Quality Authority. 2016. Available online from: https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-maternity-services

2. Health Act 2007. Dublin: The Stationery Office; 2007. Available online from: http://www.irishstatutebook.ie/eli/2007/act/23/enacted/en/print

3. Health Information and Quality Authority. *Guide to HIQA's monitoring programme against the National Standards for Safer Better Maternity Care with a focus on obstetric emergencies.* Dublin: Health Information and Quality Authority. 2019. Available online from: https://www.hiqa.ie/sites/default/files/2018-07/Guide-to-Maternity-Standards-Monitoring-Programme.pdf

4. Health Service Executive (HSE) Ireland East Hospital Group Operational Plan 2018. Available on line from: https://www.hse.ie/eng/services/publications/serviceplans/service-plan-2018/operational-plans-2018/ireland-east-hospital-group-operational-plan-2018.pdf

5. Association of Anaesthetists of Great Britain & Ireland Obstetric Anaesthetists' Association. *OAA/AAGBI Guidelines for Obstetric Anaesthetic Services 2013*. Available online from: ttps://www.aagbi.org/sites/default/files/obstetric_anaesthetic_services_2013.pdf

6. Health Service Executive Obstetrics & Gynaecology, Anaesthetic and Critical Programmes Clinical Strategy & Programmes Division. *Guidelines for the Critically Ill Woman in Obstetrics*. Dublin: Health Service Executive. Dublin. Version 1.1. 2014. Available online from: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/05/25.-Guidelines-for-the-Critically-Ill-Woman-in-Obstetrics.pdf

7. Health Service Executive. *Model of Care for Neonatal; Services in Ireland.* Dublin: Health Service Executive. 2015. Available online from: https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/model-of-care-for-neonatal-services-in-ireland.pdf

8. National Institute for Health and Care Excellence. Caesarean Section. Clinical Guideline 2011. Available online from: https://www.nice.org.uk/guidance/cg132/resources/caesarean-section-pdf-35109507009733

9. Royal College of Obstetricians & Royal College of Gynaecologists. 2010. Classification of urgency of caesarean section - a continuum of risk. Available online from: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-11/

10. National Clinical Effectiveness Committee. *Communication (Clinical Handover) in Maternity Services - National Clinical Guidelines No.5*. Dublin: Department of Health; 2014. Available online from: http://health.gov.ie/wp-content/uploads/2015/01/National-Clinical-Guideline-No.-5-Clinical-Handover-Nov2014.pdf

11. Health Service Executive. National Policy and Procedure for Safe Surgery. 2015.Available online from: https://www.hse.ie/eng/about/who/qid/resourcespublications/safesurg14june.pdf

12. Department of Health United Kingdom. Health Building Note 04-02 Critical care units. London: Department of Health. 2013. Available online from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147865/HBN_04-02_Final.pdf

13. Department of Health United Kingdom. Health Building Note 09-03 Neonatal Units. London: Department of Health. 2013. Available online from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147879/HBN_09-03_Final.pdf

14. Health Service Executive. Incident Management Framework. Dublin. Health Service Executive. 2018. Available online from: https://www.hse.ie/eng/about/qavd/incident-management/hse-2018-incident-management-framework-guidance-stories.pdf

15. Health Service Executive. National Women and Infants Health Programme and the National Clinical Programme for Obstetrics and Gynaecology. Irish Maternity Indicator System. National report 2017. Dublin: Health Service Executive; April 2018. Available online from: https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/national-reports-on-womens-health/imis-national-report-201711.pdf

16. Health Service Executive. National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death. Health Service Executive. 2016. Available online from: https://www.hse.ie/eng/services/list/3/maternity/bereavement-care/national-standards-for-bereavement-care-following-pregnancy-loss-and-perinatal-death.pdf

For further information please contact:

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7

Phone: +353 (0) 1 814 7400
Email: qualityandsafety@hiqa.ie
URL: www.hiqa.ie