Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of the investigation into the safety, quality and standards of services provided by the Health Service Executive to patients in the Midland Regional Hospital, Portlaoise

8 May 2015

Executive Summary

Safer Better Care

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high-quality and safe care for people using our health and social care services. HIQA's role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** — Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.
- **Supporting Improvement** — Supporting health and social care services to implement standards by providing education in quality improvement tools and methodologies.
- **Social Services Inspectorate** — Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.
- **Monitoring Healthcare Quality and Safety** — Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health Technology Assessment** — Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost-effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.
- **Health Information** — Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Executive summary

Introduction and background to the investigation

This report presents the findings of the investigation by the Health Information and Quality Authority (the Authority or HIQA) into the governance and assurance arrangements that the Health Service Executive (HSE) has in place to ensure the safety, quality and standard of services provided to patients in the Midland Regional Hospital, Portlaoise (Portlaoise Hospital), Co Laois.

On 30 January 2014, the RTÉ Investigations Unit broadcast a *Prime Time* programme about the tragic deaths of newborn babies in Portlaoise Hospital and the subsequent management of patients and their families by the hospital and the HSE. Following the broadcast, the then Minister of Health asked the Chief Medical Officer of the Department of Health to conduct a preliminary assessment of perinatal deaths and related matters from 2006 up to that point in 2014 in the maternity services at Portlaoise Hospital.

Following publication on 28 February 2014 of the Chief Medical Officer's report, the Board of the Authority considered and agreed to a request from the then Minister for Health to conduct an independent investigation into the services provided by the HSE at Portlaoise Hospital. This statutory HIQA investigation, announced by the Authority on 6 March 2014, has been carried out in line with the Authority's published Terms of Reference in order to make recommendations to improve the safety, quality and standards of services provided by the HSE.

As part of this investigation, the Authority considered the effectiveness of the HSE's role in overseeing a hospital where concerns about the quality and safety of services had been raised previously on a number of occasions. The Authority also reviewed the progress that had been made in ensuring that the findings from previous investigations and reviews conducted by HIQA, the HSE, the Chief Medical Officer and others had been implemented. Essentially, this included an assessment against the hospital's service model to assure the delivery of high-quality, safe and reliable care.

Central to this HIQA investigation was the experience of a number of patients and families whose experience of care fell well below the standard expected in a modern acute hospital. The assessment of these patients and families' experience reflects their experience of care and its aftermath when they raised concerns at local and national levels of the HSE. In line with the Terms of Reference, to assess the patient safety culture at Portlaoise Hospital, the Authority used the Safety Culture Index – a survey developed by Applied Research Ltd working from Warwick University in the United Kingdom.

This investigation examined the quality and safety of clinical services, and the governance arrangements in place for the maternity and the general healthcare services at Portlaoise Hospital and how these were governed by the HSE's

relevant national directorate. This report also reflects interim governance arrangements and changes that have occurred at the Maternity Department since February 2014.

Upon publication of the Terms of Reference on 21 March 2014, the Investigation Team commenced gathering and reviewing information in line with the investigation's methodology. The review of pre due process evidence was completed by the end of October 2014. The Investigation Team then began writing a draft report with reviews and contributions from the external members of the Investigation Team and the Board of the Authority. For ease of readership all events which occurred following the end of October 2014 are reflected as footnotes throughout the report.

On 2 February 2015 relevant excerpt(s) of the draft report were circulated for the purpose of due process feedback to relevant healthcare professionals and healthcare managers who were interviewed as part of this investigation. The final submissions for due process were received by 20 April 2015.

Portlaoise Hospital opened in 1936 and is funded by the HSE. It is an acute general and maternity hospital with a mental healthcare service on site. Portlaoise Hospital has 151 beds in total; 108 adult beds (including 29 inpatient maternity beds), 29 paediatric beds and 14 day beds. The general services at Portlaoise Hospital include elective (pre-arranged care) and emergency adult and children's services on an inpatient, day and outpatient basis. The hospital employs 552 whole-time equivalent staff, equating to over 600 members of staff.

Investigation findings

In his report, the Department of Health's Chief Medical Officer said two previous HSE reviews published in 2008 into breast cancer misdiagnosis cases at Portlaoise Hospital should have provided a very strong case for 'external oversight and support to Portlaoise Hospital as it dealt with the legacy of those issues'. The Authority strongly reiterates this view, particularly as throughout this investigation it found examples of weak oversight and inaction by the HSE at local, regional and national level in relation to the model of clinical services being delivered and the associated risks to patients identified at Portlaoise Hospital.

Six previous investigations into hospital care in Ireland have been carried out by the Authority between 2007 and 2013. These have made a number of important findings and recommendations which were intended to be used by all healthcare services to inform and improve practice. Had the relevance of these investigation findings been reviewed in the context of Portlaoise Hospital and the aligned recommendations been subsequently implemented, the Authority is of the opinion this could have vastly reduced the identified risks in the services being provided to patients.

Consequently, the Authority has once again recommended that prior to the hospital-group management boards being formalised, that the HSE assign responsibility and

accountability to a named person or persons for implementing recommendations and actions contained in internal and external reviews and investigation reports.

Two previous HIQA reports with particular relevance to Portlaoise Hospital were the investigation reports into Ennis and Mallow hospitals, published in 2009 and 2011 respectively. In particular, these reports identified the risks associated with treating low numbers of acutely ill patients in smaller, stand-alone hospitals without having senior clinicians on site 24 hours a day. Both reports stressed that patients with complex needs should be directed to hospitals with the necessary staffing, competencies, infrastructure and equipment for safe and effective care.

This current investigation found that the HSE – as the provider of healthcare services – failed to take decisive action on defining the role of Portlaoise Hospital and its model of care in the context of the findings of previous investigations. Corporately Portlaoise Hospital viewed itself as a model-3 hospital and was not included in the national *Smaller Hospitals Framework*. Similar to a model-3 hospital, Portlaoise provided a full range of acute services to patients presenting with all manner of injury and illness, including life support. However, at the time of this investigation, the HSE had failed to resource the hospital sufficiently and to ensure that the governance arrangements in place could safely deliver such a model of care to patients. For example, up until July 2014 the Emergency Department at the hospital – which was open 24 hours a day seven days a week – only had a consultant in emergency medicine on site for six hours four days a week.

Alongside the *Smaller Hospitals Framework*, the report, *Establishment of Hospital Groups as a transition to Independent Hospital Trusts* was published by the Department of Health in 2013. This report outlined how Ireland's acute public hospitals would be organised into seven groups of hospitals, each containing smaller and larger hospitals. It recommended that Portlaoise Hospital be part of the Health Dublin Midlands Group.* At the time of the investigation, the formation of this hospital group, like a number of other hospital groups, was still at an early stage.

In the interim, at the time of this investigation, Portlaoise Hospital continued to operate in the absence of formal systems enabling clinical cooperation and communication between it and some of the larger training hospitals that are to be involved in the group. The Chief Medical Officer's report made a specific recommendation about ensuring the networking of senior clinical leadership between the larger Coombe Women and Infants University Hospital in Dublin and the maternity unit within the smaller Portlaoise Hospital.

* The Health Dublin Midlands Group contains the following hospitals: St James's Hospital, Dublin; The Adelaide and Meath Hospital, Dublin, Incorporating the National Children's Hospital; Midland Regional Hospital Tullamore; Naas General Hospital; Midland Regional Hospital, Portlaoise; and the Coombe Women and Infants University Hospital, Dublin. Its primary academic partner is Trinity College Dublin (TCD). This group has subsequently been renamed the Dublin Midlands Hospitals Group.

At the time of reporting in May 2015 – some 13 months after the publication of this recommendation by the Chief Medical Officer – these arrangements were still not in place.**

The patient experience

This investigation was initiated as a result of the very negative experiences of a number of patients and their families in receipt of services in Portlaoise Hospital. When the investigation started, the Authority was contacted by or received information in relation to 83 patients and their families, most of whom had used the maternity services at Portlaoise Hospital. Some were identified after contacting the HSE helpline set up after the airing of the RTÉ Investigations Unit *Prime Time* programme in January 2014. Members of the Investigation Team facilitated meetings with patients and or their family members to learn about the experience of 15 individual patients.

The Authority and Investigation Team wish to convey their sympathies to those affected by the events which gave rise to this investigation, and to express their gratitude to the people who contacted or who met with the Authority as part of this investigation.

While the purpose of the investigation was not to undertake a detailed examination of individual patients' care, their experiences helped to inform the investigation and give the Investigation Team a range of personal perspectives on the quality of care experienced by those individuals. The Authority acknowledges that such recollections are personal perspectives on their experiences and that the validation and or verification of each of those experiences are outside the scope of the investigation.

Those parents who spoke with the Investigation Team gave examples of poor communication with hospital staff where they were not afforded adequate explanations following an adverse event including the death of a baby or regarding their clinical condition. Some parents said they felt that they were not entitled to an explanation. Others said that unexplained medical jargon left them feeling intimidated and unclear as to what was being said. Parents found that such lack of openness in providing information and explanations compounded their feelings of fear and grief.

Parents also described significant delays in the time it took the HSE to respond to their requests for information and explanations following adverse events. The Authority is aware that such delays in the investigation of adverse events have occurred elsewhere in the health services. The current HSE review process is often protracted and leaves families with unanswered questions pending completion of a final report, thereby increasing their upset and trauma.

** On 26 March 2015, the Minister for Health announced that a memorandum of understanding was signed between The Coombe Women and Infants University Hospital and the Dublin Midlands Hospital Group/ Health Service Executive which will see the Coombe Women and Infants University Hospital assume responsibility for the governance, management and provision of maternity services at Portlaoise Hospital.

Additionally, safety issues may potentially remain unidentified and unresolved for lengthy periods of time.

The experiences described by parents highlighted an apparent lack of skill and sensitivity among some staff, including management, in communicating sensitively and empathising with people. Some parents described having very different and more positive experiences in other hospitals.

The experiences described by those patients and families who spoke to the Authority highlighted significant deficiencies in the delivery of person-centred care at the hospital. The interactions that the Authority had with patients and their families also raised significant concerns about the lack of a formal integrated national response to address their ongoing needs. This fell outside the Terms of Reference of the investigation and outside the remit of the Authority as a regulator. As a consequence, in June 2014, the Authority formally wrote to the then Minister for Health Dr James Reilly TD and raised these issues both as a concern and a risk.

Subsequently, a single contact person was identified in the HSE to assist these patients and their families. In October 2014, a HSE report indicated that a total of 176 complaints or contacts have been made by patients through a variety of channels and that these complaints were being dealt with on a phased basis. While these cases involved a number of hospitals, the vast majority of them related to the maternity services at Portlaoise Hospital.

As part of this process, the HSE committed to reviewing each person's experience on an individual basis and to facilitate an independent external clinical review of patient care where necessary.

Governance Health Service Executive – National

There were many reasons why the HSE should have maintained very close oversight of the quality and safety of services at Portlaoise Hospital. These reasons included local and national HSE inquiries and clinical reviews into patient-safety incidents, significant service failures, statutory investigations of hospital services, and resultant publication of findings and recommendations. However, there was no evidence that the HSE nationally was proactively exercising meaningful oversight of the hospital and the inherent risks there. Up until the publication of the Chief Medical Officer's report in February 2014, it appeared that senior HSE managers were predominantly focused on controlling healthcare expenditure.

Another concern for the Investigation Team was that for seven years prior to the Chief Medical Officer's report, the State Claims Agency through its Clinical Indemnity Scheme knew of actual or potential risks in the maternity services at Portlaoise Hospital. The Investigation Team recognises that the State Claims Agency does not have statutory powers by which it can compel healthcare institutions, including the HSE, to engage with it or to implement any recommendations which it may make. However, the Investigation Team was concerned that the interaction between the State Claims Agency and the

HSE in relation to the sharing and use of available information did not result in effective mitigation of the identified risks. In addition, some senior HSE managers informed the Investigation Team that before the RTÉ Investigations Unit *Prime Time* programme they were unaware of safety concerns at Portlaoise Hospital.

Evidence gathered during the course of this investigation showed that up until late 2014, patient safety issues were not a standing agenda item for discussion at meetings of the Health Service Directorate, the highest level of management within the HSE. Despite the seriousness of the patient safety concerns at the hospital at the time of the *Prime Time* programme, there was no evidence that key senior HSE managers had visited the hospital in the immediate aftermath of the broadcast to assess the situation in the maternity services.

During the course of the investigation, many of the senior HSE managers interviewed placed significant weight on the organisation's future plans, particularly in the context of the patient quality and safety agenda and the development of the hospital-group structures. The Authority is of the opinion that the success of the emerging hospital-group structure depends on:

- developing formal clinical arrangements which facilitate a stronger focus on identifying and managing clinical risks and incidents
- improved clinical cooperation with robust arrangements to ensure that higher-risk patients are managed at the most appropriate clinical site within the group.

Clinical services at Portlaoise Hospital – national planning and oversight

Contrary to the findings and recommendations of the Authority in 2009 and 2011 in investigation reports into acute general hospital services similar to Portlaoise Hospital, the Investigation Team found that Portlaoise Hospital continues to provide:

- undifferentiated (all manner of conditions) emergency services 24 hours a day 7 days per week (24-seven), and
- undifferentiated surgical services where there is a low number of complex surgical cases.

In addition, the Investigation Team found that Portlaoise Hospital had other major deficiencies in corporate and clinical governance arrangements including not having:

- effective corporate accountability arrangements and performance management processes
- effective clinical governance arrangements in the Emergency Department
- effective risk management structures to include dealing with adverse patient events and or complaints
- effective clinical audit arrangements
- comprehensive systems of workforce planning.

Although described as a 'model-3 hospital' by senior HSE and local hospital staff, the Investigation Team found that the hospital was neither governed, resourced nor equipped to safely deliver this level of clinical services. Furthermore, the HSE itself in 2012 and 2013 had specifically identified clinical risks associated with surgery and emergency medicine, going as far as to say that surgical services at the hospital should cease. However, at the time of publication of this report, the hospital continues to deliver these services.

It was also notable to the Investigation Team that an unpublished 2014 HSE report had reinforced its findings about performance, quality and safety issues within the hospital. Senior HSE managers reported to the Investigation Team that as a result of the findings contained in that HSE report, they had:

- assigned a senior HSE manager to work on site with the hospital management team to ensure that patient pathways of care were safe
- reinforced the paediatric trauma bypass protocol, whereby children with certain serious conditions would be taken by ambulance to another hospital
- begun the process of creating the hospital-group structure, citing examples of clinicians meeting to work towards agreeing the best possible patient pathways and service model for people attending Portlaoise Hospital.

At the time of reporting, it was too early for the Investigation Team to assess the efficacy or impact of these arrangements. The Investigation Team is of the view that these plans, which are long term, are intrinsically dependent on the formation of a hospital-group structure supported through effective clinical and corporate governance structures and arrangements.

Corporate and clinical governance arrangements in Portlaoise Hospital – HSE regional and local structures

Regional structures

The HSE assumed responsibility for providing health and social care services in Ireland in 2005 with Portlaoise Hospital becoming part of the HSE Dublin Mid Leinster Region, the largest of the four HSE regions which catered for a population of 1.31 million.

In 2013 following interaction with the Authority in relation to concerns about the governance arrangements in place at Portlaoise Hospital, the then HSE regional management altered the local management arrangements that were in place. The purpose of these alterations was to increase the interaction between regional and local management structures and bring decision-making powers onto the hospital site.

However, it is apparent that despite overwhelming evidence to indicate that the local management team at Portlaoise Hospital was struggling to deliver the service, there is no evidence to show that regional HSE managers took effective

control of the situation at that time. For example, although the HSE was aware of risk management deficiencies at the hospital, known risk management gaps were not actively addressed. Furthermore, in December 2012 the Authority raised with the HSE the immediate requirement to appoint an experienced and qualified risk manager to the hospital. However, this did not happen.

Following the RTÉ Investigations Unit's *Prime Time* programme in January 2014, relevant minutes from regional quality and patient safety committee meetings held during February 2014 do not detail any remedial action at regional level to either deal with the issues raised in the television programme or to support local managers in dealing with its aftermath.

Local management at Portlaoise Hospital

The local management team within the hospital – which consisted of the Hospital Manager, the Director of Nursing and the Clinical Director, reporting collectively to a regionally based Assistant National Director – were responsible for all clinical services including maternity services up until the publication of the Chief Medical Officer's report in February 2014. As an immediate response to that report, the HSE revised the management structure and at the time of the investigation the maternity services were being governed separately. Management arrangements for the general services remained the same.

A Senior Hospital Management Committee was responsible for providing safe effective services through leading and directing the performance of the hospital. Only nine meetings of this Committee were recorded as taking place between April 2013 and March 2014. In the minutes of meetings reviewed by the Investigation Team, there was little evidence to show that the Committee was effective in identifying or implementing actions aimed at addressing quality and safety issues within the hospital.

A Quality and Safety Executive Committee was in place for the hospital. This Committee has approximately 20 different local committees reporting into it. In a hospital the size of Portlaoise Hospital, this committee structure was overly complicated and not effective. The same small group of people were responsible for directing the implementation of quality and patient safety at local committee level and overseeing the entire process at executive management level.

It was also evident that at this time, the hospital's senior management team did not collectively conduct formal safety walk-rounds.

There was poor connection between local and regional risk management structures. The Investigation Team found that local and regional managers had very different opinions on what constituted the most immediate and serious risks for Portlaoise Hospital.

There was no evidence to show that the Portlaoise Hospital management team used these structures to address issues of concern with more senior regional managers in order to achieve positive outcomes for the hospital.

The Investigation Team concluded there were significant ongoing problems with workforce planning relating to Portlaoise Hospital. The absence of a clear vision for the hospital coupled with the national imperative to reduce the staff headcount ensured that workforce planning was focused on counting staff rather than on the type of service the hospital should be delivering and the workforce needed to deliver that service.

Risk management structures in the Hospital were poorly developed with the result that risks were not comprehensively reviewed or addressed at a senior level in an effective and proactive manner. The risk management system did not capture all known risks in the hospital, for example risks identified following investigation of complaints and clinical incidents were not included.

It was evident at interview that not all hospital staff had confidence in the local and regional systems in place to deal with and resolve risk issues. Staff members described an endless process of escalation which did not result in informative feedback or tangible results.

The process of incident management at Portlaoise Hospital was largely a reactive process focused on recording incidents that occurred. Incident forms were not entered on to the National Incident Reporting Database at a local level. Rather they were inputted at a regional level. This process meant that there was no validation or ownership to ensure that what was entered on to the incident reporting system was accurate and timely.

A crucial step in the management of adverse incidents is the review of incidents which have occurred. The management team at Portlaoise hospital did not corporately collate, analyse, trend or use this information proactively to address risks, investigate incidents and share any resulting learning. It was evident that the deficiencies in risk management processes in the hospital contributed to the poor experiences as described by patients who met with the Investigation Team.

At the time of the investigation, Portlaoise Hospital did not have a dedicated on-site complaints manager. Complaint management was assigned, along with multiple other duties, to one individual. The Hospital did not manage complaints in line with the national HSE complaints management process. In particular, complaints were not managed within recommended time frames and patients were not updated about delays in addressing their complaints.

The Investigation Team found that there was no evidence that learning following investigations into specific complaints was put into practice for the benefit of other patients. The Investigation Team concluded that the arrangements in place to effectively manage patient complaints at Portlaoise Hospital was inadequate. In October 2014, senior managers at the hospital reported that significant changes were being made to improve the complaints management process at Portlaoise Hospital.

Although there was evidence of some clinical audits being carried out in different areas of the hospital, there was no strategic plan for clinical audit across the hospital. The regional clinical audit function in place at the time was described as 'supportive and advisory', but no dedicated staff member was in place on site with oversight of an audit programme. In addition, the hospital did not have the information technology structures necessary to support an effective system of multidisciplinary audit.

Patient safety culture in Portlaoise Hospital

As part of the investigation, HIQA assessed the prevailing patient safety culture in Portlaoise Hospital using an assessment tool called the Safety Culture Index. The results, which were used to inform the lines of enquiry of this investigation, suggested that Portlaoise Hospital did not have a strong safety culture. At an organisational level, the results indicated an absence of standard monitoring and the lack of a clear vision and mission for the hospital. While there were different perceptions about safety culture between staff groups at the hospital, the results from most staff groups indicated an immediate need for management intervention or monitoring of the safety culture.

In August 2014, the Investigation Team provided the HSE with a report of the assessment of the patient safety culture at Portlaoise Hospital. The Investigation Team advised the HSE that this report should not be viewed in isolation but rather as a starting point from which action planning begins and effective safety initiatives emerge. At a final meeting in October 2014 with senior managers in Portlaoise Hospital, some senior managers at the hospital reported that they had not been provided with the results by HSE management. The Investigation Team views this as a missed opportunity, particularly as the process yielded a report that could be used to inform the development of a culture of safety.

Maternity services at Portlaoise Hospital

The continued absence of a national maternity strategy as recommended by the Authority in 2013 makes it difficult to assess and compare maternity services in Ireland.*

Furthermore, a clinical governance network linking Portlaoise Hospital's Maternity Department to the Coombe Women and Infants University Hospital, as recommended by the Institute of Obstetricians and Gynaecologists in 2006 and in the Chief Medical Officer's report, has not formally been implemented.

* On 30 April 2015 the Minister for Health announced the establishment of a Steering Group to advise on the development of a National Maternity Strategy and published a list of its membership.

Such a clinical network would facilitate:

- a common system of governance
- capacity for medical, midwifery and other staff to be appointed to the network and to rotate between the two sites to facilitate training and service delivery
- training of junior doctors and midwives on both sites
- risk categorisation of patients to ensure that higher risk patients are managed at the Coombe Women and Infants University Hospital.

The Investigation Team advised that the development of such a clinical network is an essential step in ensuring the quality and safety of the maternity services at Portlaoise Hospital by creating one single maternity service operating over two sites.

Increasing pressure on the maternity services at Portlaoise Hospital was highlighted as far back as 2004. Additionally, deficiencies in midwifery staffing had been identified in a review carried out by the hospital in 2006. These issues were not substantially addressed until 2014, following publication of the Chief Medical Officer's report.

Local management structures in Portlaoise Hospital were revised in early 2014 following publication of the Chief Medical Officer's report. An Interim Maternity Services Management Team was appointed. There was evidence to show that this arrangement was working well.

The pivotal appointment of a director of midwifery to a maternity department located within a general hospital is unique to Portlaoise Hospital. This role has had a very positive influence in terms of assessing and improving the standard of midwifery care, enhancing multidisciplinary working relationships, improving staff morale and re-energising a patient-centred approach to care. However, at the time of writing, a senior obstetric lead had not been appointed to the Maternity Department to provide independent senior experienced obstetric clinical leadership. This is despite a direct request by the Authority to the Director General of the HSE in September 2014 to do so because of the investigation team's concerns about the absence of adequate clinical leadership within the maternity unit and the failure to progress the development of a clinical network with the Coombe Women and Infants University Hospital.

Since the Chief Medical Officer's report, midwifery staffing levels have been significantly improved with the appointment of senior clinical midwifery managers, shift leaders, a bereavement specialist, a clinical skills coordinator and a clinical midwife specialist. One additional consultant obstetrician has also been appointed.

Clinical experts on the Investigation Team identified the current staffing arrangements for non-consultant hospital doctors (NCHDs) as a serious concern and risk for the sustainability of the maternity services at Portlaoise Hospital.

These experts considered it vital that a clinical network and system of rotation be designed between Portlaoise Hospital and a large maternity hospital such as the Coombe Women and Infants University Hospital. Setting up a clinical network incorporating Portlaoise Hospital and the Coombe Women and Infants University Hospital is an essential first step in developing such a system of rotation.

Poor standards of multidisciplinary communication were highlighted by a number of people who met with the Authority. Yet, these concerns were reported as far back as 2007 and had not been addressed. Multidisciplinary communication had also been highlighted as problematic in the safety culture assessment carried out as part of this investigation.

Before the Chief Medical Officer's report, the Maternity Department at Portlaoise Hospital did not have a midwife or a social worker in post to support bereaved patients, parents and families. At the time of reporting, a midwife had been appointed to the role of bereavement specialist and three midwives were also undertaking formal training in the care of bereaved patients. In addition local guidelines in relation to pregnancy loss and perinatal death had been developed and implemented by the Maternity Department.

Concerns in relation to the governance arrangements for ultrasound scanning services at Portlaoise Hospital were identified during the investigation. Specific issues in relation to service capacity, staff competency and clinical oversight of the ultrasound service were acknowledged by the hospital management team. However, despite awareness of these concerns at the time of the investigation, the effectiveness of ultrasound services had not been comprehensively evaluated through clinical audit to identify and address potential risks to patients.

In January 2015, the Investigation Team was informed that three obstetric registrars and one additional consultant obstetrician were in the process of completing formal training in ultrasound scanning. In addition a revised model of service had been agreed with consultant obstetricians in the hospital whereby a consultant with formal accreditation in fetal ultrasound scanning would assume a clinical lead position in relation to scanning.

While existing facilities in the Maternity Department had undergone some refurbishment and essential renovations, major inadequacies remained in its infrastructure, presenting an inherent risk to patient safety. Plans to commission and resource new maternity facilities are under consideration at the time of preparing this report but had not been agreed.

General hospital services

Emergency Department

Portlaoise Hospital provides a 24-seven emergency service for adult and paediatric patients with any degree of seriousness or complexity of illness or injury who present themselves at the hospital.

The clinical governance arrangements in the hospital's Emergency Department were unsatisfactory and overcomplicated. Despite the fact that both the HSE's Emergency Medicine Programme and the HSE's Acute Medicines Programme had previously identified concerns in relation to these arrangements, the inherent risks remained unaddressed.

The HSE's own Emergency Medicine Programme considered that the Emergency Department was not appropriately resourced to provide a 24-seven model of emergency care. Also, the HSE's unpublished performance review in 2014 concluded that a 24-seven emergency care service at Portlaoise Hospital was not clinically sustainable. Despite these reports, neither the HSE nor Portlaoise Hospital effectively collected nor analysed emergency department data at the hospital to best inform service delivery. This means that at the time of this investigation the clinical profile of Emergency Department patients is not being actively assessed to inform the type of service that is required to best meet the needs of those patients presenting to it.

Intensive and critical care

The overall volume of critical care activity within the Intensive Care Unit of the hospital was low, hindering the ability of staff to maintain their clinical skills. Floor space was limited in the Intensive Care Unit, and it was not self-contained. The Intensive Care Unit does not meet the minimum requirements for critical care, patient confidentiality and privacy and was not fit for purpose. Senior clinical staff were aware of the limitations of the care that could be safely provided there. They confirmed that if necessary, patients are transferred to a more appropriately resourced hospital for care.

A report by the HSE in 2014 recommended that critical care services in the hospital should be discontinued. This HSE report acknowledged that on-site anaesthesia cover would be required for obstetric patients and that pre-hospital emergency care resources would have to be reconfigured to divert patients requiring admission to an intensive care unit to another facility. In light of this HSE review and the concerns of senior local clinicians, the Investigation Team is not assured that critical care services are sustainable in Portlaoise hospital.

Surgical services

The surgical services at Portlaoise Hospital operate a 24-seven emergency service, catering for all degrees of surgical illness or injury arriving at the hospital. Most hospital inpatients using the surgical services at Portlaoise Hospital were admitted through the Emergency Department.

Two recent clinical reviews of the surgical services at Portlaoise Hospital, both concluded that the Hospital on its own was not structured to provide safe, acute and pre-planned surgical care. In particular, one of these reviews outlined serious concerns about significant surgical risks in the hospital, and advised that these risks could only be dealt with in the context of providing a rationalised surgical service within a hospital-group setting. Such a setting would help develop a clinical network approach to service delivery which would ensure that each hospital site within the group delivers care appropriate to the resources, facilities and services available on that site.

The Investigation Team found that low numbers of complex surgical procedures were being carried out at the hospital. As previously reported by the Authority, surgeons who do not have the opportunity to treat sufficient numbers of patients and or carry out a sufficient volume of procedures run the risk of becoming de-skilled. This potential risk has not been addressed in Portlaoise Hospital.

Despite the findings of the HSE reviews, Portlaoise Hospital was in the process of appointing two colorectal surgeons at the time of the investigation. Such appointments did not reflect the surgical demand, general practitioner (GP) patient referral patterns, or any clear direction for the hospital and are contrary to previous findings that the service was not set up to provide safe pre-planned surgery.

Medical services

The Investigation Team found that medical services at Portlaoise Hospital required significant restructuring and resourcing in order to deliver a service aligned to the HSE's Acute Medicine Programme. Despite the recommendations of the HSE's Acute Medicine Programme, the hospital did not have a medical assessment unit or a bed management structure.

This investigation also found that the medical team was under-resourced, with local clinicians reporting that two additional medical consultants were needed for care of the elderly and endocrinology. These appointments would also help release the hospital's Clinical Director from general medical duties for 25 hours each week in order to increase time for the functions of the clinical director role. However, the model of care at the time of the investigation (and its associated risks) remained unchanged.

Diagnostic imaging

The diagnostic imaging service at Portlaoise Hospital is significantly under-resourced with a lack of resources preventing the development of strong clinical governance arrangements to ensure the quality of service delivery. At the time of reporting, the diagnostic imaging service is overly reliant on one lead clinician. Therefore, this model of care is clearly not sustainable. A clinical network linking Portlaoise hospital with other hospitals in the group would provide support for clinicians as well as centrally agreed protocols and care pathways, and opportunities for peer review and quality assurance across hospitals.

Despite these constraints, there was evidence of regular clinical audit within the diagnostic imaging services, the recent implementation of 24-seven computerised tomography (CT) scanning, with reporting of scans being introduced since October 2013, and improved information technology systems to facilitate viewing and reporting of images.

Conclusion

The findings of this investigation reflect an ongoing failure on the part of the HSE to evaluate the services provided at Portlaoise Hospital against the risks and recommendations identified in previous local and national reviews and investigations conducted by the Authority and the HSE.

The findings of this HIQA investigation highlight again issues and recommendations that have been identified on a number of occasions previously in both internal HSE reviews and independent HIQA investigations.

The HSE conducted a number of local and national reviews of services at Portlaoise hospital. The HSE National Clinical Programmes also reviewed the model of clinical services provided with particular reference to emergency medicine and adult and paediatric surgical services, highlighting significant patient safety concerns.

This investigation concludes that Portlaoise Hospital was allowed to struggle on despite a number of substantial governance and management issues in relation to the quality, and safety of services. Sufficient action was not taken by the HSE at a national, regional or local level to address these issues.

At the time of reporting there was still no national maternity strategy. Also, while it had been recommended in 2006 and again in 2014 that Portlaoise Hospital be formally integrated into a clinical network with the Coombe Women and Infants University Hospital, this was in the very early stages of implementation at the time of reporting. While significant progress has been made in restructuring the maternity service at Portlaoise Hospital, until the memorandum of understanding is fully implemented and operational, this service continues to function in isolation without the support of a maternity-services network of care and without an assured clinical leadership arrangement.

The establishment of formal clinical networks is a critical point in the modernisation of the Irish healthcare system. Each hospital group must prioritise the development of systems of care that embody quality and safety at all levels including managed clinical networks for maternity services.

Every healthcare system must ensure that national, regional and local systems learn from errors and strive where possible to ensure that errors are not repeated. This includes learning from incidents within a healthcare setting and also learning from the findings and recommendations of relevant investigations, inquiries, and inquests nationally, and also internationally, wherever possible to ensure that clinical practice and models of care are safe, effective and up to date.

The experiences outlined by patients and families during the course of this investigation were disturbing when viewed within the context of the delivery of a modern health service. These experiences highlight significant deficiencies in the delivery of person-centred care at Portlaoise Hospital. Poor experiences by patients and families were compounded by ineffective governance arrangements at all levels of the HSE with the result that the patient's voice was ignored and valuable insights and learning to inform better care was lost.

Moving forward

The HSE must now address the risks and deficiencies identified within this report in order to improve the quality, safety and experience of patient care in Portlaoise Hospital. It must also ensure that where similar risks and deficiencies exist in other hospitals, these are also addressed as a matter of urgency. The HSE at a national level must oversee the necessary improvements as part of its performance management arrangements.

The HSE governance arrangements to support the implementation of the national recommendations contained in this investigation must be clear, with a named accountable person with overall delegated responsibility for their implementation. The implementation plans should include clear timelines and identified individuals with responsibility for each recommendation and action.

A national maternity strategy must be developed and published as a matter of urgency. The purpose of this strategy should be to agree and implement standard, consistent, modern-day models of maternity care in order to ensure that all pregnant women have choice and access to the right level of safe care and support on a 24-hour basis. In the interim, inherent risks identified in this report must be urgently addressed and the necessary changes implemented.

The Authority acknowledges the work that has been done to date to incorporate the maternity services at Portlaoise Hospital into a clinical network with the Coombe Women and Infants University Hospital. This process must be concluded as a matter of priority.

The Authority also acknowledges the appointment of a chief executive officer, a chief operating officer and a group director of nursing to the Dublin Midlands Hospital Group. In driving the development of this hospital-group structure, this management team has undertaken to define the services that will be delivered at Portlaoise Hospital and ensure that they are safe and resourced appropriately. Senior management of the Dublin Midlands Hospital Group must now prioritise the development of speciality-based clinical networks between Portlaoise Hospital and larger hospitals within the Dublin Midlands Hospital Group. The recently signed memorandum of understanding between the Coombe Women and Infants University Hospital and Portlaoise Hospital is a first step in this process.

The Authority welcomes the inclusion of quality and safety within the remit of the newly appointed Group Director of Nursing. This appointment should, if effective, ensure that issues of quality and safety will be managed at group executive level.

Given the significant system-wide recommendations outlined in this Report, it will be vital that there is the necessary political commitment to their managed implementation in order to drive further improvements in the quality, safety and governance of the care provided in our health system. The Authority therefore recommends that the Minister for Health should establish, as a priority, an oversight committee in the Department of Health to ensure the implementation of the recommendations in this HIQA investigation report.

The Health Information and Quality Authority – in conjunction with the relevant clinical and professional organisations and patient advocacy groups – will, in 2015 develop for public consultation, service-specific draft standards for maternity services in Ireland, which will be a sub-set of the Authority's *National Standards for Safer Better Healthcare*.

Finally, the Authority wishes to acknowledge the courage and fortitude of all patients and families who made contact with the Authority to outline their experience of care within Portlaoise Hospital. It should be acknowledged that their efforts, harnessed with the required actions of those charged with delivering services, should ensure a better experience for those availing of services at Portlaoise Hospital in the future.

Recommendations

Recommendation 1

The Department of Health should commence discussions with the Health Service Executive (HSE) to establish an independent patient advocacy service, with a view to having a service in place by May 2016. This service's role would be to ensure that patients' reported experiences are recorded, listened to and learned from. Such learning needs to be shared between hospitals within hospital groups; between hospital groups; nationally throughout the wider health system; and published. In the interim, the Department of Health and the HSE should provide regular updates on their websites to inform the public on the progress of establishing this service.

Recommendation 2

The Department of Health should, in line with its published Profile Table of Priority Areas, Actions and Deliverables for the Period 2015-2017, ensure implementation of the recommendations contained in this investigation report and previous investigations undertaken by the Authority.[1]

Recommendation 3

A. The Department of Health must now develop a national maternity services strategy for Ireland, as specified in recommendation N7 of the Authority's October 2013 *Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway, and as reflected in the care and treatment provided to Savita Halappanavar.**

B. The Department of Health should provide regular updates on its website to inform the public of progress with developing and implementing this national maternity strategy.

* On 30 April 2015, the Minister for Health announced the establishment of a Steering Group to advise on the development of a National Maternity Strategy and published a list of its membership.

Recommendation 4

In line with the Department of Health's policy to develop independent hospital groups, the Department should expedite the necessary legal framework to enable the group boards of management and chief executive officers of each hospital group to comprehensively perform their governance and assurance functions.

Recommendation 5

The Health Service Executive (HSE) should ensure the appointment of a director of midwifery, before September 2015, in all statutory and voluntary maternity units and hospitals in Ireland that currently do not have such a post.

Recommendation 6

The Health Service Executive (HSE), along with the chief executive officers of each hospital group, must ensure that the new hospital groups prioritise the development of strong clinical networks underpinned by:

a. a group-based system of clinical and corporate governance informed by the *National Standards for Safer Better Healthcare*.

b. a clearly defined, agreed, resourced and published model of clinical service delivery for each hospital within the group. This must be supported by clearly defined, agreed and documented patient care pathways to ensure that patients are managed in or transferred to the most appropriate hospital.

c. regular evaluation and audit of the quality and safety of services provided.

d. systems to support a competent and appropriately resourced workforce

e. a system to proactively evaluate the culture of patient safety in each hospital as a tool to drive improvement.

f. systems in place to ensure patient feedback is welcomed and used to improve services and that patient partnership and person-centred care is promoted, as per the *National Standards for Safer Better Healthcare*.

g. effective arrangements to ensure the timely completion of investigations and reviews of patient safety incidents and associated dissemination of learning. These arrangements must ensure that patients and service users are regularly updated and informed of findings and resultant actions.

Recommendation 7

The Health Service Executive (HSE), in conjunction with the Chief Executive Officer of the Dublin Midlands Hospital Group should:

A. review all of the findings of this investigation and address the patient safety concerns at the Midland Regional Hospital, Portlaoise

B. immediately address the local clinical and corporate governance deficiencies in the maternity and general acute services in Portlaoise Hospital

C. publish an action plan outlining the measures and timelines to address the safety concerns and risks at Portlaoise Hospital, to include both general and maternity services. This action plan should include a named person or persons with responsibility and accountability for implementation of recommendations and actions in internal and external reviews and investigation reports, and be continuously reviewed and updated in order to drive improvement and mitigate risk.

The HSE and hospital group CEOs must now ensure that every hospital undertakes a self-assessment against the findings and recommendations of this investigation report, and develop, implement and publish an action plan to ensure the quality and safety of patient services.

Recommendation 8

The Health Service Executive (HSE), the chief executive officer of each hospital group and the State Claims Agency must immediately develop, agree and implement a memorandum of understanding between each party to ensure the timely sharing of actual and potential clinical risk information, analysis and trending data. This information must be used to inform national and hospital-group patient safety strategies.

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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
URL: www.hiqa.ie

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